RISK REDUCTION THROUGH FAMILY THERAPY (RRFT)

11/1/2020

helping teens and families recover from trauma

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HELPING TEENS AND FAMILIES RECOVER FROM TRAUMA

THE PROBLEM | RATIONALE

The road through adolescence can be bumpy. During this stage of life, young people face a variety of developmental tasks and challenges as they transition from the roles and responsibilities of childhood to those of adulthood. As adolescents build more independence and autonomy in their lives, they must also face a wide range of dramatic physical (puberty), social (peers, family), sexual, and emotional changes all while navigating their obligations at home, school, and in the community.

The way the brain develops throughout adolescence predisposes many teens to seek novel, exciting, "high reward" experiences while brain regions responsible for self-regulation, inhibition, and problem-solving are not fully matured[1-2]. This is often **a recipe for impulsive, potentially unsafe behaviors**, particularly when combined with risky environmental factors like spending time with delinquent peers or low parental monitoring. Given this situation, it is perhaps not surprising that adolescence is also a time when many young people begin to experiment with alcohol, other drugs, and sex. The majority of U.S. youth engage in some form of substance use by age 18[3] and approximately 40-65% have had sexual intercourse by the time they graduate high school.[4] For some adolescents, experimentation can cascade into serious problems.

Exposure to interpersonal violence and other traumatic events is one of the strongest and most consistent predictors of adolescent behavioral and emotional health problems, including substance abuse and posttraumatic stress disorder (PTSD). Unfortunately, trauma exposure is quite common. By age 18, approximately 1 in 2 youth will experience interpersonal violence, such as child sexual abuse, child physical abuse, domestic violence, community violence, and dating violence[5-6].

Teens who have experienced interpersonal violence and other types of traumatic events are highly vulnerable to the development of PTSD and other trauma-related mental health problems (PTSD, depression), risk behaviors (substance use disorders, risky sexual behavior, non-suicidal self-injury [NSSI]), and revictimization. Most behavioral treatment models are untested or unsuitable to address these diverse problems concurrently, or have not been designed with sensitivity to the unique developmental needs and challenges faced by adolescents. **RRFT was developed to fill this gap.**

[1] Giedd et al. (1999). Brain development during childhood and adolescence: A longitudinal MRI study. *Nature Neuroscience.*
[2] Steinberg (2008). A social neuroscience perspective on adolescent risk taking. *Developmental Review.*
[3] Monitoring the Future, www.monitoringthefuture.org
[4] CDC, 2010
[5] Finkelhor et al. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. *JAMA Pediatrics.*
[6] Saunders & Adams (2014). Epidemiology of traumatic experiences in childhood. *Child & Adolescent Psychiatric Clinics of N. America.*

WHAT IS RRFT? | DESCRIPTION

Risk Reduction through Family Therapy (RRFT) is an **integrative, ecologically informed** approach to addressing co-occurring symptoms of PTSD, substance use, depression, and other health risk behaviors often experienced by trauma-exposed adolescents. RRFT is novel in its integration of these components given that standard care for trauma-exposed youth often entails treatment of substance use problems separately from treatment of other trauma-related emotional and behavioral health problems.

> **Integrative** | RRFT integrates components, skills, and principles from existing, empirically supported treatments, including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Multisystemic Therapy (MST), Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), Contingency Management (CM) and psychoeducational risk-reduction and prevention programs.
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> **Ecologically Informed** | A variety of risk and resiliency (or protective) factors contribute to one's health and behavior. These factors—or drivers—vary from person to person, and can be classified across several "levels" of one's ecology. For adolescents, some key levels include (a) individual, (b) family, (c) peers, (d) school, and (e) community. By focusing on drivers of trauma-related mental health, substance use, and risk behaviors across these levels of ecology for *each adolescent*, RRFT is highly tailored and can be adapted for a wide variety of trauma types and presenting clinical problems.

RRFT is individualized to the needs, strengths, developmental factors, and cultural background of each adolescent and family. This tailored approach is incorporated throughout all components of treatment. RRFT involves seven intervention components: **Psychoeducation and Engagement, Coping, Family Communication, Substance Abuse, Posttraumatic Stress Disorder (PTSD), Healthy Dating & Sexual Decision Making, and Revictimization Risk Reduction**.

The **pacing** and **ordering** of RRFT intervention components is flexible and is determined by the needs and priorities of each family, as well as the intensity or severity of symptoms in each domain. Symptoms are monitored throughout RRFT using **standardized assessment tools** to help track treatment progress and guide clinical decision-making. The average **frequency** and **duration** of RRFT depends on the symptom level of each youth, but typically involves 16-20, weekly, 60-90 minute sessions with periodic check-ins between scheduled appointments.

Component	Key Concepts and Objectives
Psychoeducation and Engagement	• Review confidentiality • Review assessment feedback • Personalized goal-setting • Identifying treatment motivators for youth and caregiver • Education about (a) trauma and traumatic stress, (b) mental health impacts of trauma, (c) substance abuse and relations to trauma, (d) risk and resiliency • Overview of RRFT model • Prioritization of intervention components based on family needs
Coping	• Definition of coping • Differentiate between healthy and unhealthy coping (address

	substance abuse, self-harm) • Emotion identification, labeling • Emotional acceptance (less reactivity, build distress tolerance) • Anxiety reduction, relaxation • Changing thoughts via cognitive processing (cognitive triangle: thoughts-feelings-behavior) • Effective communication • Problem-solving
Family Communication	• Review and/or set family rules (contingencies) • Assess family's communication norms (eye contact, language) • Teach effective communication skills (e.g., active listening, "I statements") • Role play solutions for "hot spots" and common conflicts
Substance Abuse	• Enhance motivation to reduce use; Identify personalized drivers or motivational factors contributing to substance use • Contingency management to reduce frequency/volume of use • Increase caregiver and school monitoring • Increase prosocial activities (monitored time with non-using peers) • Teach realistic refusal skills • Discussion of link between trauma and substance use and importance of completion of PTSD component as a strategy for addressing substance use • Harm reduction goal setting as needed, especially at start • Prevention (i.e., of future use, relapse, etc.)
Posttraumatic Stress Disorder (PTSD)	• Review PTSD symptoms • Exposure to trauma-related memories and cues/triggers through trauma narrative or similar strategies • Address inaccurate and unhelpful beliefs • Share trauma narrative or 'story' with appropriate caretaker • Skill building to reduce risk of future PTSD
Healthy Dating & Sexual Decision Making	• Address healthy vs. unhealthy relationships • Sexuality and sexual decision-making • Education about prevention of teen pregnancy and sexually transmitted infections (STIs), with emphasis on HIV • Education on proper, consistent condom use as appropriate • Role-play assertiveness in dating relationships • Continued coordination with caregiver • Referrals for medical appointments and testing as needed
Revictimization Risk Reduction	• Education about risk for revictimization • Identify risky situations, people, places • Develop safety plan • Role-play strategies for how to respond to risky situations

Who should receive RRFT?

Trauma Types: The RRFT model is appropriate for adolescents who have experienced any form of trauma, including but not limited to sexual abuse and assault, physical abuse and assault, exposure to domestic violence, community violence, and traumatic grief.

Symptom Profile: RRFT was developed to address co-occurring emotional and behavioral problems associated with traumatic stress. Youth most likely to benefit from RRFT demonstrate:

- Clinically significant symptoms of posttraumatic stress, and
- Past or current substance use. Youth with markedly elevated risk for future substance use (ex: strong family history of substance abuse, affiliation with substance using peers, inadequate parental monitoring, etc.) may benefit from the risk reduction elements of RRFT.

Notably, youth are not required to meet full diagnostic criteria for PTSD or substance use disorder (SUD) to be eligible for RRFT. Adolescents may also have other emotional and behavioral problems, such as depression, non-suicidal self-injury, and risky sexual behavior. Youth do not need to demonstrate all the different types of challenges or problems represented by the RRFT intervention components for RRFT to be used; each component is emphasized to varying degrees based on the needs of each family.

Practice Setting: To date, RRFT has been implemented in a variety of practice settings, including outpatient clinics, residential treatment facilities, school- and home-based outreach services, and through telehealth.

Other Considerations: Because RRFT is a family-oriented intervention, all efforts are made to identify a caretaker—often a parent or family member—as well as any other responsible adult mentors or advocates, who can be involved in the youth's treatment.

Who should not receive RRFT?

RRFT is not appropriate for youth who have:

- No known trauma history
- No clinically significant mental health issues related to traumatic event history
- Severe cognitive disabilities, autism, or other problems that would make it impossible to participate in cognitive behavioral therapy

In general, youth with psychosis, acute mania, or safety concerns that warrant inpatient treatment should receive more intensive services to stabilize their symptoms before beginning RRFT.

Who should deliver RRFT?

RRFT is intended to be delivered by licensed mental health professionals (psychiatrists, psychologists, social workers, licensed counselors) who work with teens and families impacted by interpersonal violence and other types of traumatic events. **A strong foundation—including successful completion of training—in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a prerequisite** for providers to take part in RRFT training.

WHY CHOOSE RRFT? | EVIDENCE & SUPPORT

What is the research evidence for RRFT?

Over the past several years, we have amassed both empirical (scientific) and anecdotal (clinical) evidence for the usefulness of RRFT. RRFT has been designed and evaluated according to **best-practice guidelines**, which emphasize the importance of (1) refining the protocol based on theory, science, and input from patients and providers, (2) testing the feasibility and acceptability of an intervention, and (3) refining evaluation methodologies prior to (4) large-scale trials. The peer-reviewed, published studies and ongoing projects listed below represent key steps in this multi-stage process for developing treatments that work.

OPEN PILOT TRIAL (COMPLETED)

DANIELSON ET AL. (2010), *CHILD MALTREATMENT*

The goal of this study was to evaluate the feasibility of implementation and initial efficacy of RRFT in a small sample of adolescent girls (N=10) aged 13-17 who had experienced at least one episode of sexual assault. Results indicated reductions in substance use and associated risk factors, PTSD symptoms, and depression symptoms that were maintained through 3- and 6-month follow-up assessments.

PILOT RANDOMIZED CONTROLLED TRIAL (COMPLETED)

DANIELSON ET AL. (2012), *JOURNAL OF FAMILY PSYCHOLOGY*

Thirty adolescents aged 13-17 with sexual assault histories were randomized to RRFT or treatment as usual (TAU). Findings replicated the feasibility results and within-group improvements observed in the open pilot trial. Significantly greater reductions in substance use, substance use risk factors, PTSD, depression, and general internalizing symptoms were observed in the RRFT condition relative to TAU.

RANDOMIZED CONTROLLED TRIAL (COMPLETED)

DANIELSON ET AL. (2020), JAMA-PSYCHIATRY

In this only large scale RCT to date demonstrating efficacy of an exposure-based treatment for co-occurring PTSD symptoms and substance use problems, 124 adolescents 13-18 who had experienced interpersonal trauma were randomized to RRFT or treatment as usual (TAU) and were followed up for 18 months post baseline. Significantly greater reductions in substance using days, marijuana use, polysubstance use, and PTSD avoidance and hyperarousal symptoms were observed in the RRFT condition relative to TAU.

HOW DO I LEARN MORE? | CONTACT US

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The development and evaluation of RRFT have been supported by Grants K23DA018686 (PI: Danielson) and R01DA031285 (PI: Danielson) from the National Institute on Drug Abuse and a Young Investigator Award from NARSAD (PI: Danielson).