Intervention to Lessen the Effects of Violence Among Urban School Children

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Cognitive-Behavioral Therapy Intervention for Trauma in Schools (CBITS)

- Delivered by school-based mental health professionals
- Decreases symptoms of posttraumatic stress disorder, depression, and psychosocial dysfunction
- Designated a Promising Program by the Substance Abuse and Mental Health Services Agency
- Dissemination and replication studies in progress

Background

Children who witness or experience violence may subsequently suffer symptoms of posttraumatic stress disorder (PTSD) or depression that lead to problems in educational attainment and psychological development. The burden of violence falls disproportionately on people living in low-income urban areas. Therefore, the children at highest risk for violence-related emotional distress are least likely to have access to mental health services through health insurance. In 2000, the U.S. Surgeon General issued a report on children's mental health that included a call for schools to increase their capacity to provide mental health services.

Context

A team of researchers and practitioners from the Los Angeles Unified School District (LAUSD) and UCLA/RAND partner organizations† have been collaborating to document the magnitude of students' exposure to violence and develop a cognitive-behavioral therapy intervention for trauma in schools (CBITS) that can be delivered by school-based mental health professionals for students experiencing postexposure symptoms. Pilot-testing of the intervention in the LAUSD using a quasi-experimental study design showed CBITS to be promising, and a more rigorous study was undertaken.

Methods and Results

A randomized controlled trial of CBITS was conducted in the LAUSD in collaboration with UCLA and RAND in two large urban middle schools serving primarily Latino students in East Los Angeles. Sixth-grade students were screened for exposure to violence and subsequent symptoms of PTSD and depression. Those students who had substantial exposure to violence and had clinical levels of PTSD symptoms were eligible to participate in the program; 159 (20%) of 769 students met the eligibility criteria. For the intervention group, 61 students were assigned to small groups of 6 to 8 students that received 10 sessions of CBITS. The sessions were led by LAUSD psychiatric social workers from the mental health unit. The sessions introduced students to several techniques for dealing with fear and traumatic memories (e.g., methods to combat negative thoughts, cope with memories, solve social problems, and prevent relapse). The students practiced the techniques during the sessions and, with the social workers, developed assignments specific to their personal situations as homework to do between sessions. The comparison group (65 students) also received the intervention after a delay of 3 months.

At 3 months, when the early intervention group had completed the intervention and the other group had not yet begun it, participants in the early intervention group showed significantly fewer symptoms of PTSD (adjusted mean difference of 7 on a 51-point Child PTSD Symptom Scale) and significantly fewer symptoms of depression (adjusted mean difference of 3.4 on a 52-point Child Depression Inventory). Parent-reported indicators of psychosocial dysfunction were also significantly lower (adjusted mean difference of 6.4 on a 70-point Pediatric Symptom Checklist that included behavioral problems and problems at school). When compared at 6 months, the improvements seen in the early intervention group had persisted for 3 months after completion of the intervention, and the students in the delayed intervention group showed comparable significant improvements.

Consequences And Potential Impact

This study is the first randomized controlled trial of an intervention for school children experiencing symptoms after exposure to violence. The significant improvements in symptoms of PTSD and depression that were obtained in a school setting are especially promising for populations, such as urban minority groups living in poverty, that have limited access to mental health care. The close collaboration of researchers and school personnel made it possible to administer the intervention in schools while minimizing disruption of the school curriculum. This model of collaboration should be kept in mind in future efforts to replicate the intervention in other communities.

Long-term follow-up of the impact of the intervention and its replication in other populations are important next steps to confirm its effectiveness and assess its generalizability and portability. The LAUSD is now screening approximately 28,000 students to identify schools with the greatest need for the intervention. The National Child Traumatic Stress Network (NCTSN), a coalition of treatment centers funded by the Department of Health and Human Services through a Congressional initiative, disseminates effective, evidence-based trauma treatment programs and is supporting CBITS dissemination. Several partner centers are conducting replication studies of CBITS (under the auspices of different institutions), and others are using the CBITS program for other populations (such as American Indians). A new effort funded by the National Institute of Mental Health is under way to adapt the program so that nonclinical school personnel can administer it.

Based on the available evidence of effectiveness, the Substance Abuse and Mental Health Services Agency has designated CBITS a Promising Program, the Center for Substance Abuse Treatment has designated it a Pre-approved Program, and the NCTSN is disseminating information about CBITS as an Empirically Supported Treatment and Promising Practice. CBITS originators have trained more than 200 people to administer the program at 15 sites around the country and internationally. Some of these people have implemented the program and have co-trained other potential implementers. As the network of trainers grows, the program will likely expand to reach many more children exposed to violence.

References

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Jaycox LH, Stein BD, Kataoka SH, Wong M, Fink A, Escudero P, Zaragoza C. Violence exposure, Post traumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. Journal of the American Academy of Child and Adolescent Psychiatry 2002;41(9):1104–10.

Kataoka SH, Stein BD, Jaycox LH, Wong M, Escudero P, Tu W, Zaragoza C, Fink A. A school-based mental health program for traumatized Latino immigrant children. Journal of the American Academy of Child and Adolescent Psychiatry 2003;42(3):311–8.

Jaycox L. Cognitive-Behavioral Intervention for Trauma in Schools: Training Manual. Longmont, CO: Sopris West Educational Services, 2004.

National Traumatic Stress Network

http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/NCTSN_E-STable_21705.pdf (PDF-77K)*

Substance Abuse and Mental Health Services Administration

http://www.modelprograms.samhsa.gov/pdfs/promising/cognitive-behavioral-intervention-for-trauma-in-schools-cbits-.pdf (PDF-21K)*

Promising Practices Network

http://www.promisingpractices.net/program.asp?programid=145&benchmarkid=55*

Center for Substance Abuse Treatment, Treatment Improvement Protocol Series

http://www.treatment.org/Externals/tips.html*

† For this project, the partners of the LAUSD include RAND Health, the UCLA/RAND National Institute for Mental Health (NIMH) Center for Research on Quality in Managed Care, and the UCLA/RAND Center for Adolescent Health Promotion (one of CDC's Prevention Research Centers).

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