

## Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

<b>Treatment Description</b>	<p>CBITS is a skills-based, group intervention that is aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to trauma. Children learn skills in relaxation, challenging upsetting thoughts, and social problem solving, and children work on processing traumatic memories and grief. These skills are learned through the use of drawings and through talking in both individual and group settings. Between sessions, children complete assignments and participate in activities that reinforce the skills they've learned. CBITS also includes parent and teacher education sessions.</p>
<b>Target Population</b>	<p>The CBITS program has been used most commonly for children in grades six to nine (ages 10 to 15) who have experienced events such as witnessing or being a victim of violence, being in a natural or man-made disaster, being in an accident or house fire, or being physically abused/injured, and who are suffering from moderate to severe levels of PTSD symptoms. Preliminary versions of the CBITS program have been used in children as young as eight years old.</p>
<b>Intensity</b>	<p>The program consists of 10 group sessions (six to eight children/group) of approximately an hour in length, usually conducted once a week in a school setting. The CBITS intervention has also been delivered in other settings, such as mental health clinics. In addition to the group sessions, participants receive one to three individual sessions, usually held before the exposure exercises. CBITS also includes two parent education sessions and one teacher education session.</p>
<b>Essential Components</b>	<p>CBITS teaches six cognitive-behavioral techniques:</p> <ul style="list-style-type: none"> <li>• Education about reactions to trauma</li> <li>• Relaxation training</li> <li>• Cognitive therapy</li> <li>• Real life exposure</li> <li>• Stress or trauma exposure</li> <li>• Social problem-solving</li> </ul> <p>Parental permission is sought for children to participate. A handout is sent home to parents, and a call to parents at the beginning of treatment is used to answer questions and reinforce the ideas in the handout. Between-session activities help</p>

<p><b>Essential Components Cont'd</b></p>	<p>consolidate skills and allow group members to apply these skills to real life problems. A step-by-step guide to each session, including scripts and examples for use by the group leader, common obstacles and their solutions, and handouts and worksheets for group participants is available.</p> <p>A screening procedure is recommended for use in the general school population to assist in identifying children in need of the program. A brief (less than five-minute) screening instrument has been developed for this purpose, and its use should be followed by an individual meeting with a clinician to confirm the screening results.</p>
<p><b>Assessment Measures Used</b></p>	<p>Participant screening measures utilized:</p> <ul style="list-style-type: none"> <li>• Life Events Scale to assess the level of exposure to violence</li> <li>• Child PTSD Symptom Scale and the Children's Depression Inventory providing validated cut-offs for scores to indicate clinical levels of PTSD and depression</li> <li>• Pediatric Symptom Checklist completed by parents to assess child functioning</li> </ul> <p>Parents and children completed these measures prior to beginning the program, at program completion, and three months after program completion.</p>
<p><b>Outcome Measures Used</b></p>	<p>All children completed the Child PTSD Symptom Scale and the Children's Depression Inventory at the completion of treatment, and parents completed the Pediatric Symptom Checklist at completion of treatment. Program effectiveness has been demonstrated in several studies, including a randomized control trial.</p> <p>Assessment of change in PTSD, depressive symptoms, and child functioning is recommended following CBITS program completion in order to be able to make an informed referral for children who are still symptomatic at the end of the intervention program.</p>
<p><b>Training Requirements</b></p>	<p>It is recommended that someone with clinical mental health training deliver the CBITS program.</p> <p>Depending on the level of pre-existing expertise and the availability of an onsite CBT expert, the recommended training varies. A common training approach is for trainees to read background materials and the manual, watch a training video prior to training, attend a two-day training, and then receive ongoing supervision from a local clinician with expertise in CBT.</p> <p>This training also addresses issues related to successful delivery of a mental health program in a school setting.</p> <p>The order form for the CBITS manual is available on the internet from Sopris West publishers (see below). However, clinician training is also recommended.</p>

<p><b>Fidelity Monitoring Procedures</b></p>	<p>CBITS treatment fidelity may be monitored by having an independent rater watch sessions (live or videotaped) or listen to audiotapes of sessions and rate the adherence to elements in the manual and the quality of the therapeutic approach on the CBITS Fidelity Assessment Measure (the measure used in the CBITS evaluation studies.)</p>
<p><b>Implementation Requirements and Readiness</b></p>	<p>Full support of the school principal and administration should be obtained prior to initiating any of the CBITS activities.</p> <ul style="list-style-type: none"> <li>• Notebooks containing the program handouts should be prepared for participants and extra copies made in case children lose them.</li> <li>• A chalkboard or large writing pad and extra copies of the activity worksheets are used for each session.</li> <li>• Active parental consent is usually required for participants.</li> <li>• Teachers whose students will be impacted by the program are identified and asked to participate in the teacher education program.</li> <li>• Referral paths should be identified for children who require more intensive services in addition to CBITS or who remain symptomatic at the end of the group.</li> </ul> <p>CBITS is not a crisis intervention. If an entire school is affected by a disaster or violence, it is recommended that school counselors wait at least a month after the trauma before identifying those children in need of CBITS.</p>
<p><b>Outcomes/ Evaluation</b></p>	<p>In a randomized controlled study with children from Los Angeles Unified School District (LAUSD), children in the CBITS intervention group had significantly greater improvement in PTSD and depressive symptoms compared to those on the wait list at a three-month follow-up. Parents of children in the CBITS intervention group also reported significantly improved child functioning compared with children in the wait-list group. The improvements in symptoms and functioning in the CBITS group continued to be seen at a subsequent follow-up at six months. Results from another study showed that those in the CBITS intervention group had significantly fewer self-reported symptoms of PTSD and depression at post-test adjusting for relevant covariates as did children in a comparison group.</p>
<p><b>Adaptations for Special Populations or Settings</b></p>	<p>The CBITS intervention has now been effectively implemented with a wide range of racially and ethnically diverse children. CBITS is currently being used in the general school population in LAUSD, and parent materials of the current version of the CBITS program are available in Spanish as well as English, but the manual is available in English only. Several Network members are currently working to adapt the CBITS intervention for Native American children. During CBITS development, preliminary versions of the CBITS intervention were delivered to recent immigrants who speak primary languages other than English, such as Spanish, Russian, Korean, and Western Armenian.</p>

<p><b>Recent Publications</b></p>	<p>Jaycox, L.H., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudera, P. &amp; Zaragoza, C. (2002). Violence exposure, PTSD, and depressive symptoms among recent immigrant school children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 41(9): 1104-1110.</p> <p>Kataoka, S., Stein, B. D., Jaycox, L. H., Wong, M., Escuerdo, P., Tu, W., Zaragosa, C., &amp; Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 42(3), 311-318.</p> <p>Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Eliot, M.N., &amp; Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trial. <i>JAMA</i>, 290(5), 603-611.</p> <p>Stein, B.D., Elliott, M.N., Tu, W., Jaycox, L.H., Kataoka, S.H., Wong, M., &amp; Fink, A. (2003). "School-based intervention for children exposed to violence": Reply. <i>Journal of the American Medical Association</i>, 290(19): 2542.</p> <p>Stein, B. D., Kataoka, S., Jaycox, L.H., Steiger, E.M., Wong, M., Fink, A., Escudero, P., Zaragoza, C. (2003). The Mental Health for Immigrants Project: Program design and participatory research in the real world. In: M.D. Weist, S. Evans, N. Lever (Eds) <i>Handbook of School Mental Health: Advancing Practice and Research</i>. (pp. 179-190). New York: Kluwer Academic/ Plenum Publishers.</p> <p>Stein, B., Kataoka, S., Jaycox, L., Wong, M., Fink, A., Escudero, P., &amp; Zaragoza, C. (2002). Theoretical basis and program design of a school-based mental health intervention for traumatized immigrant children: A collaborative research partnership. <i>Journal of Behavioral Health Services and Research</i>, 29(3), 318-326.</p>
<p><b>Treatment Developers</b></p>	<p>RAND Corporation, the Los Angeles Unified School District, and UCLA (Lisa Jaycox, Bradley Stein, Marleen Wong, Sheryl Kataoka.)</p>
<p><b>Contact Information</b></p>	<p>For more information on the CBITS model, contact Marleen Wong (<a href="mailto:marleen.wong@lausd.net">marleen.wong@lausd.net</a>) at the LAUSD Community Practice Site, Lisa Jaycox (<a href="mailto:jaycox@rand.org">jaycox@rand.org</a>) or Bradley Stein (<a href="mailto:stein@rand.org">stein@rand.org</a>) at the RAND Corporation, or Sheryl Kataoka (<a href="mailto:skataoka@ucla.edu">skataoka@ucla.edu</a>) at UCLA.</p> <p>For consultation regarding training opportunities and implementation procedures for this model within the Network, contact Charlene Allred (<a href="mailto:callred@psych.duhs.duke.edu">callred@psych.duhs.duke.edu</a>) at Duke or Cassie Kisiel at UCLA (<a href="mailto:ckisiel@mednet.ucla.edu">ckisiel@mednet.ucla.edu</a>).</p> <p>Copies of the treatment manual can be ordered from Sopris West Educational Services (800) 547-6747. <a href="http://www.sopriswest.com">www.sopriswest.com</a>.</p>