Cognitive Behavioral Intervention for Trauma in Schools

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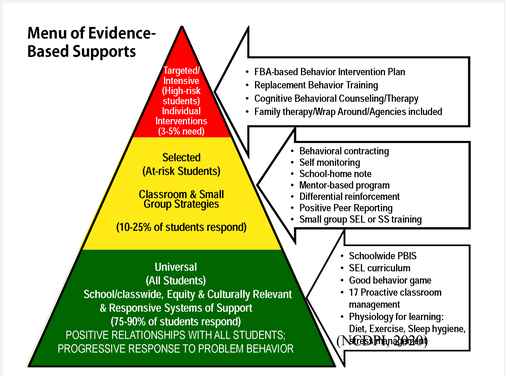
What is Cognitive Behavioral Intervention for Trauma in Schools?

The Cognitive Behavior Intervention for Trauma in Schools (CBITS) is used to decrease post traumatic stress disorder (PTSD) and depression symptoms. It helps improve social functioning, grades, and attendance.

This is considered a Tier II intervention in the MTSS model.



CBITS includes the following techniques: education, relaxation training, cognitive therapy, real-life exposure, and stress or trauma exposure.

The CBITS Protocol

The CBITS intervention is designed for 5th-12th graders and includes:

- 10 group counseling sessions
- 1-3 individual counseling sessions
- 2 parent psychoeducational sessions
- 1 teacher educational session

Impact of Cognitive Interventions

- Exposure to trauma increases the risk for post traumatic stress disorder, anxiety, depression, behavioral problems, and school problems
- Sixty one percent of children under 18 have been exposed to trauma
- Youth in a lower socioeconomic environment or ethnic minority youth are at a greater risk of being exposed to trauma
- Because many youth do not utilize community mental health resources, schools are the optimal environment for interventions and support.
- COVID-19 has led to an increase in anxiety and depressive symptoms

Statewide Implementation of an Evidence-Based Trauma Intervention in Schools

42%
Reduction in Trauma-Related

The goal of this evidence-based intervention is to reduce PTSD symptoms and increase child functioning. Hoover et al., (2018) conducted this research using the Child PTSD Symptom scale (CPSS) as well as the Ohio Scales as a pre-test and post-test to measure initial change. The Connecticut Department of Children and Families (DCF) and the Child Health and Development Institute (CHDI) organized this statewide program by training school-based clinicians and leadership and then **identifying students with a CPSS score greater than 14 and report at least one exposure to trauma** (Hoover et. al., 2018). Twenty counselors went through a rigorous training to ensure they were prepared to implement the CBITS intervention with fidelity to the **350 students** who went through the screening and had parent consent. The results showed a **42% trauma symptom reduction** based on the CPSS, a 25% reduction on the Ohio Problem Severity measure and the increase in child functioning was 5% based on the Ohio Scale. This article presents evidence in support for CBITS in addition to a broader support for school-based trauma services.

Implementing Cognitive Behavioral Intervention for Trauma in Schools with Latinx Youth

Depressive symptoms reduced; large effect size

Allison et al (2016) determined the effectiveness of the 10 week CBITS program among the Latinx population. The CPSS was used as a screener, pre-test, and post-test. The Short Mood and Feelings Questionnaire (SMFQ) is a tool used to screen children for depressive symptoms and was also used. This measure has high internal reliability, internal construct validity, and criterion related validity. In total, **23 Latinx youth participated** in this study with **60% of the group identifying as females compared to the 40% male representation**. The results showed the **effect sizes for these analyses were large**. At the conclusion of the research, the CPSS measure decreased by 6.09 points dropping from 20.78 (pre-test) to 14.69 (post-test). The SMFQ average score also decreased by the end of the 10 week study from 9.91 to 5.26 indicating depressive symptoms were reduced.

CBITS with American Indian Youth

American Indians witness over twice as many traumatic events than white populations (Goodkind et al., 2010). An intervention was adapted for American Indians by integrating cultural sensitivity in its structure. Surface structure was changed from materials to the setting, in addition to deeper structure changes like assimilating cultural beliefs about the effects of trauma of a person's health. This intervention took place in school involving **24 participants**, a member of a school-based health center (SBHC), as well as a school or tribal employee who received training. The CPSS and the CDI were used to self-assess PTSD and depression symptoms. The Children's Coping Strategies Checklist was another measure used for this study. Participants took a pre and post assessment in addition to a follow-up assessment three and six months after treatment. **While symptoms for PTSD, anxiety, and depression did decrease, the change decelerated for PTSD symptoms at the three-month interval.** While PTSD and avoidant symptoms decreased after the intervention and increased at the six-month follow-up, research supports the idea these symptoms could have increased due to additional trauma.

Teacher Perspectives and Collaboration

A team of researchers based out of the University of California, Los Angeles, identified factors that make CBITS more effective. This group analyzed several models which all recognized the need for key stakeholders to endorse and advocate for this program. A qualitative study was conducted involving teachers working in a school that had successfully administered CBITS for two years. Of the eleven schools, 71 stakeholders were recognized as possible participants and 51 completed the survey process. **Participants included teachers, clinicians, school administrators, parents, and those offering regional assistance.** Parents were omitted from the process because they could not speak to the teachers' endorsement of CBITS, which resulted in a total of 40 participants. These volunteers took part in a semi-structured phone interview answering questions to conclude which factors will influence the implementation of an intervention. These interviews were reviewed by two members of the research team and then independently coded. The group focused on codes pertaining to teachers' attitudes about mental health services, specifically the CBITS program. Teachers noted the vital role programs like CBITS plays in the school setting. Reflecting on students who participated in CBITS, teachers reported **improved peer relationships, class participation, and overall functioning.** One theme identified through this study, stressed the teacher's unresolved feelings towards loss of academic instruction. Another theme identified by teachers was **more education on the effects of trauma** so they would be better equipped to assist students in the classroom (Baweja et al., 2015).

Family Treatment Component for CBITS: When and for Whom Is It Helpful?

CBITS includes sessions for parents, which has been a struggle, with previous research stating 37% of parents were present for at least one session. While findings generally conclude **parent involvement leads to more positive outcomes with the child**, this has not always been true. Creating a CBITS-plus-family (CBITS + Family) treatment plan which incorporated interventions for parents, Santiago et al. hypothesize parents would be more involved and have a more positive attitude towards the mental health process. This quasi-experimental design included CBITS student groups in the fall and CBITS + Family in the spring. Both groups participated in 10 group sessions, individual sessions, and educational meetings for parents and teachers. This study included a pre-, post-, and follow-up assessment and involving 48 participants. After **comparing families, the research team concluded there were no significant differences**. The CPSS and the Child Depression Inventory (CDI) were used to assess the child for PTSD and depression respectively. Parents completed the Child Report of Parenting Behavior Inventory (CRPBI), an assessment where they self-reflected on their interactions with their child. The results determined those parents who participated in CBITS + Family were **more involved in their child's academics and presented improved coping skills**. Children participating in the CBITS + Family group showed a greater level of improvement compared to those in the

Parent coping skills improved; more involved in child's academics

School-based Treatment on a Rural American Indian Reservation

CBITS was amended to include aspects of the Native American culture such as history and native linguistic concepts. Morsette (2009) utilized the Life Events Scale (LES) which gauges violence exposure within the last year, as well as the CPSS. The Children's Depression Inventory (CDI), which measures depressive symptoms, and the CPSS were used as baseline and post-treatment probes. While 48 students took part in this study, only seven children met the criteria and **only four completed the program**. This resulted in a high rate of attrition due to cultural differences or skepticism. Morsette et al. explained this was due to a lack of parental consent. **Three out of the four participants showed a reduction of PTSD symptoms and violence exposure**. Follow-up conducted by school personnel six months after the intervention suggests social and academic changes even though no data has been collected. This study, while showing promising signs of support, requires further research on account of the small sample size.

75% of participants reported reduced trauma symptoms

Summary

Research has supported the claim that CBITS can reduce PTSD, anxiety, and depression symptoms. The purpose of all this research was to identify ways to make CBITS more successful and analyze the impact of different factors such as diverse populations and stakeholders. Studies involving the adaptation of CBITS for American Indians demonstrate the decrease in symptoms surrounding trauma. Latino groups also showed positive results based on research surrounding CBITS. Stakeholders are a vital factor to the success of CBITS and research identified components to strengthen teachers' support of CBITS. CBITS + Family supports the hypothesis that stronger parental support positively impacts a participant's results. With this information, schools can yield effective results improving a student's mental health, behavior, and academics. Further research needs to be conducted using a larger sample size. The CPSS measure was used in all the presented research. Conducting research using a different measure would further support the conclusive results regarding the effectiveness of CBITS and remove any idea about instrumentation bias.

School counselors are well positioned to implement Cognitive Behavioral Interventions for students and training for school staff and parents.

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