Northwest (HHS Region 10)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

August 13, 2019

This Evidence-Based Practice Brief was prepared by Pamela Vona, MA, MPH, and Suzanne Dwork-Peck

Effective Programs to Address Trauma in Schools

Pamela Vona, MA, MPH, USC; Suzanne Dworak-Peck, *School of Social Work, Treatment and Services Adaptation Center for Resilience, Hope and Wellness in Schools, and University of Washington School Mental Health Assessment, Research & Training (SMART) Center*

Key Points

- Current rates of child trauma are staggering and likely to increase.
- School-based interventions are essential to providing youth with necessary support to address trauma.
- Early interventions have been shown to ameliorate symptoms of trauma in students
- Skills are reinforced when school systems share a trauma-responsive framework.

The Issue

In the United States, children and adolescents are exposed to violence and other traumatic events at alarming rates. A comprehensive survey of violence exposure found that one in three youth reported having experienced physical violence in the past year, with some experiencing multiple events.[1] Rates of violence exposure are notably higher in under-resourced, ethnic minority communities.[2] A study of sixth grade students in a large urban school district found that 94% of students reported exposure to violence and 40% reported exposure that included a deadly weapon.[3] What's more, large-scale global and national trends including the opioid epidemic, climate change, mass migration, and growing homelessness are likely to increase rates of trauma exposure.

Numerous studies have documented the short-and long-term consequences of exposure to violence and other traumatic events on children and adolescents. Exposure to trauma has been linked to increased rates of PTSD, anxiety, and depression in children and adolescents.[4,5] Additionally, exposure to trauma has been linked to lower academic success including lower grade point average and IQ,[6] as well as deficits in memory and attention.[7] Students exposed to trauma are significantly less likely to graduate high school.

Supported by grant SM 08171 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

Despite these negative consequences, few children and adolescents receive appropriate care. This is particularly true for low-income, ethnical minority youth. Barriers to care include limited resources, language difficulties, and stigma. Strategies to reduce these barriers are needed.

The Approach

Schools have been shown to reduce barriers to mental health care. One study found that nearly half of all mental health services for youth are provided through the school system.[8] This is particularly true in the case of trauma. A study investigating access to mental health treatment following hurricane Katrina found that 98% of youth assigned to receive trauma treatment in school accessed care, while only 37% assigned to receive treatment at a community mental health agency sought treatment.[9]

Given the high rates of trauma exposure and the central role schools can play enhancing access to care, it's essential that school-based counselors and mental health providers receive training in evidence-based trauma interventions. Below we describe three of the most commonly used effective school-based interventions for trauma.

The Interventions

CBITS: The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a 10-week group intervention for middle- and high-school students. Using a community-participatory research framework, researchers from RAND and UCLA partnered with school administrators and school-based mental health providers to design an intervention grounded in theory that could be feasibly implemented in the school setting. CBITS is rooted in cognitive-behavioral theory and includes components of cognitive-behavioral therapy such as: psycho-education, relaxation skills, cognitive restructuring, trauma narrative, and problem solving. CBITS also includes 1-3 individual sessions as well as parent and teacher sessions. A randomized controlled trial found that CBITS successfully reduced symptoms of PTSD and depression in trauma-exposed students.[10] Each year more than 2000 clinicians are trained in CBITS. It is estimated that more than 97,000 students have received the CBITS intervention.[11] CBITS has been successfully adopted in communities following natural and man-made disasters including Hurricane Katrina and the Mandalay Bay shootings.

SSET: Support for Students Exposed to Trauma (SSET) is an adaptation of the CBITS intervention. Recognizing that many

schools do not have a licensed mental health provider on staff, SSET is a 10-lesson curriculum designed to be delivered by school counselors, teachers, or other non-clinical staff. Like CBITS, SSET is rooted in cognitive-behavioral principles and aims to teach students emotional regulation, problem solving, and cognitive restructuring. A study of the SSET intervention found that it reduced symptoms of trauma in sixth and seventh grade students.[12]

Bounce Back: Bounce Back blends the evidence-based practices of cognitive behavioral therapy with a developmentally appropriate approach for young children. This 10-week group-based intervention is designed to be developmentally appropriate for 5-11-year old children. It also includes activities to engage parents, since parental involvement is a crucial component in working with young children. Like CBITs and SSET, Bounce Back is grounded in cognitive behavioral principles and includes sessions that teach psychoeducation about trauma, relaxation training, cognitive restructuring, social problem solving at a developmentally appropriate level. Concepts in each lesson are presented in a straight-forward and concrete manner, with trauma narratives conveyed through the creation of a "storybook" with pictures created by students. Bounce Back has been found to be effective when delivered by school-based mental health providers. In a randomized controlled trial comparing Bounce Back to students on a waitlist, Bounce Back students had greater improvements in child and parent reported PTSD symptoms, parent reported emotional regulation, and child reported anxiety and social adjustment[13] Bounce Back has been implemented widely across Connecticut following the school shooting in Newtown.

The Setting

While each of the interventions described above has been shown to effectively reduce trauma symptoms in students, these interventions are most optimal when they are implemented in a school setting where the entire school community is "trauma-informed". This means that all staff share an understanding about the prevalence of trauma and its potential impact on the social, emotional and academic functioning of students. When the entire school system is trauma informed, students receive support in and out of session that is predictable, consistent, and transparent. The Trauma Informed Skills for Educators curriculum (TISE) (www.traumaawareschools.org) is one such intervention that aims to enhance school-wide trauma responsiveness.

Why This Practice Matters

Rates of child trauma are staggering and likely to increase. These experiences have been shown to negatively impact the social, emotional, and academic functioning of students. Because access to mental health services is limited particularly for minority and under-resourced communities, school-

based interventions are essential to providing youth with necessary support. Early interventions such as CBITS, SSET, and Bounce Back have been shown to ameliorate symptoms of trauma in students. The gains resulting from these interventions are reinforced when the entire school system shares a trauma-responsive framework.

Resources

- Cognitive Behavioral Intervention for Trauma in Schools: www.cbitsprogram.org
- Bounce Back Program: https://traumaawareschools.org/index.php/learn-more-bounce-back/
- Support for Students Exposed to Trauma: www.ssetprogram.org
- Trauma Informed Skills for Educators: www.traumaawareschools.org
- National Child Traumatic Stress Network. Child Trauma Toolkit for Educators: https://www.nctsn.org/resources/child-trauma-toolkit-educators

References

1. Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse: Results from the national survey of children's exposure to violence. *JAMA pediatrics, 169*(8), 746-754.
2. Stein, B. D., Jaycox, L. H., Kataoka, S., Rhodes, H. J., & Vestal, K. D. (2003). Prevalence of child and adolescent exposure to community violence. *Clinical child and family psychology review, 6*(4), 247-264.
3. Ramirez, M., Wu, Y., Kataoka, S., Wong, M., Yang, J., Peek-Asa, C., & Stein, B. (2012). Youth violence across multiple dimensions: a study of violence, absenteeism, and suspensions among middle school children. *The Journal of Pediatrics, 161*(3), 542-546. e542.
4. Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *American Journal of Psychiatry, 159*(3), 483-486
5. Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology, 71*(4), 692-700.
6. Delaney-Black, V., Covington, C., Ondersma, S. J., Nordstrom-Klee, B., Templin, T., Ager, J., Sokol, R. J. (2002). Violence exposure, trauma, and IQ and/or reading deficits among urban children. *Archives of pediatrics & adolescent medicine, 156*(3), 280-285.
7. Grogger, J. (1997). Local violence and educational attainment. *The Journal of Human Resources*, 659-682.
8. Costello, E. J., He, J.-p., Sampson, N. A., Kessler, R. C., & Merikangas, K. R. (2014). Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey–Adolescent. *Psychiatric Services, 65*(3), 359-366.
9. Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., ... & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *23*(2), 223-231.

10. Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: a randomized controlled trial. *JAMA, 290*(5), 603-611.
11. Murphy, J. M., Abel, M. R., Hoover, S., Jellinek, M., & Fazel, M. (2017). Scope, scale, and dose of the world's largest school-based mental health programs. *Harvard review of psychiatry*, *25*(5), 218-228.
12. Jaycox, L. H., Langley, A. K., Stein, B. D., Wong, M., Sharma, P., Scott, M., & Schonlau, M. (2009). Support for students exposed to trauma: A pilot study. *School Mental Health, 1*(2), 49-60.
13. Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D., & Jaycox, L. (2015). Bounce Back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *Journal of Consulting and Clinical Psychology, 83*(5), 853.