

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

<b>Treatment Description</b>	<ul style="list-style-type: none"> <li>• <b>Acronym (abbreviation) for intervention:</b> CBITS</li> <li>• <b>Average length/number of sessions:</b> 10</li> <li>• <b>Aspects of culture or group experiences that are addressed</b> (<i>e.g., faith/spiritual component, or addresses transportation barriers</i>): During the CBITS training and ongoing consultation with sites, we have specifically included in our training ways to implement this program to address cultural competency. We encourage sites to use culturally appropriate examples during the treatment, and we discuss the cultural issues pertinent to each trainees site. Although there are examples for each of the exercises in the manual, clinicians are encouraged to substitute these for culturally salient ones. For example, in working with immigrant populations, we focused some of the parent sessions on separation and loss issues that so many had experienced during the migration process. When we've worked in Catholic schools, faith-based clinicians openly discussed the students' examples of coping through prayer and complementing this with CBT skills.</li> <li>• CBITS is an ideal trauma intervention for underserved ethnic minority students who frequently do not receive services due to a whole host of barriers to traditional mental health services. This school-based program is designed to be delivered in school settings, whether it is in an urban or Midwestern public school serving a diverse student body or a religious private school providing outreach to an immigrant community. CBITS has been successfully used in a wide variety of communities because it can be flexibly implemented and addresses barriers such as transportation, language, and stigma.</li> <li>• In addition, CBITS has also addressed the barrier of parent and family involvement that can be so common in many communities. We have used a community-based participatory partnership model of including ethnic minority parents from the community being served along with community leaders, clinicians, and researchers to design the implementation plan so that the program is presented in a relevant and culturally congruent way.</li> <li>• <b>Trauma type (primary):</b> community violence</li> <li>• <b>Trauma type (secondary):</b> domestic violence</li> <li>• <b>Additional descriptors (not included above):</b> CBITS is appropriate for a wide range of traumas also including: physical abuse, disasters, accidents, witnessing death, assault, war, terrorism, immigration related trauma, and traumatic loss.</li> </ul>
<b>Target Population</b>	<ul style="list-style-type: none"> <li>• <b>Age range:</b> (<i>lower limit</i>) 10 to (<i>upper limit</i>) 15</li> <li>• <b>Gender:</b> <input type="checkbox"/> Males <input type="checkbox"/> Females X Both</li> <li>• <b>Ethnic/Racial Group</b> (<i>include acculturation level/ immigration/refugee history--e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans</i>): : CBITS has been used in a broad range of populations across the US and internationally.</li> </ul>

	<ul style="list-style-type: none"> <li>• Immigrant populations: CBITS has been delivered to newly immigrated students such as Latino (primarily from Mexico and Central America), Korean, Russian, and Western Armenian students.</li> <li>• Acculturation Levels: CBITS has been implemented and evaluated in a broad range of acculturation levels, from the newly immigrated youth to highly acculturated youth, as well as multigenerations of African Americans.</li> <li>• Ethnic Racial Groups Served: CBITS has been successfully delivered to Latinos, African Americans, Asian American/Pacific Islanders, and Native American communities (the Navajo, Chippewa-Cree, Black Feet, and Yakima communities).</li> <li>• <b>Other cultural characteristics</b> (e.g., SES, religion) Faith-based: CBITS has been delivered in a Catholic school by clinicians with lay health promoters and parish nurses providing outreach and parenting support. We are in the process of conducting an evaluation (RCT) in this setting.</li> <li>• SES: CBITS has been used in communities of wide ranges of SES including the very poor and middle class populations across the United States.</li> <li>• <b>Language(s)</b>: Spanish, Korean, Russian, Western Armenian, Japanese</li> <li>• <b>Region</b> (.e.g., rural, urban): Urban, suburban, and rural</li> <li>• <b>Other characteristics</b> (not included above): High Risk Populations: CBITS has also been delivered in schools for students in Special Education and for youth at risk for HIV and for children who are war refugees.</li> </ul>
<p><b>Essential Components</b></p>	<ul style="list-style-type: none"> <li>• <b>Theoretical basis:</b> Cognitive Behavioral</li> <li>• <b>Key components:</b> CBITS is a program developed for use in schools for a broad array of traumas and populations.</li> <li>• <b>CBITS was originally developed in a community-based participatory research partnership with school-based clinicians, clinician researchers, and community members which has enhanced its relevancy for school communities.</b></li> <li>• <b>CBITS is a skills-based, child group intervention that is aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to multiple forms of trauma.</b></li> <li>• <b>CBITS Child Groups: The program consists of ten group sessions (6-8 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.</b></li> <li>• <b>One unique aspect of CBITS is the focus on trauma from the child's perspective. For those children who have multiple traumas, CBITS recommends that the child be the one to choose, with help from the clinician, which trauma will be the focus of treatment. Frequently, although a clinician will perceive one trauma to be the most salient for a child, the child will associate greater impact from another trauma.</b></li> <li>• <b>In addition to the group sessions, participants receive 1-3 individual sessions, usually held before the exposure exercises.</b></li> <li>• <b>CBITS also includes two parent education sessions and one teacher education session.</b></li> <li>• <b>CBITS teaches six cognitive-behavioral techniques:</b> <ul style="list-style-type: none"> <li>• Education about reactions to trauma</li> <li>• Relaxation training</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Cognitive therapy</li> <li>• Real life exposure</li> <li>• Stress or trauma exposure</li> <li>• Social problem-solving</li> <li>• Parental permission is sought for children to participate.</li> <li>• A screening procedure is recommended to assist in identifying children in need of the program. A brief screening instrument has been developed for this purpose and should be followed by an individual meeting with a clinician to confirm the screening results.</li> </ul>
<p>Clinical &amp; Anecdotal Evidence</p>	<ul style="list-style-type: none"> <li>• <b>Are you aware of any suggestion/evidence that this treatment may be harmful?</b> <input type="checkbox"/>Yes <input checked="" type="checkbox"/>No <input type="checkbox"/>Uncertain</li> <li>• <b>Extent to which cultural issues have been described in writings about this intervention</b> (scale of 1-5 where 1=not at all to 5=all the time). 5</li> <li>• <b>This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group.</b> <input type="checkbox"/>Yes <input checked="" type="checkbox"/>No</li> <li>• <b>Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)?</b> <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No If YES, please include citation: 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.</li> <li>• <b>Has this intervention been presented at scientific meetings?</b> <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No If YES, please include citation: Stein BD, S Kataoka, L Jaycox, A Fink, M Wong. A School Based Intervention for Traumatized Immigrant Children: Description and Preliminary Results, presented at the Colloquium for Junior Investigators, Annual Meeting of the American Psychiatric Association, New Orleans, LA, May 2001.</li> </ul> <p>Wong. M. School Crisis Counseling after National Disasters: Evidence Based Practices. Tokyo, Osaka, and Sapporo, Japan - Sponsored by the Japanese Ministry of Education, Aug 2001.</p> <p>Kataoka S, BD Stein, L Jaycox, M Wong, A Fink Improving Mental Health and Academic Performance: Preliminary Results from a School-Based Program. In <i>School Mental Health Services: Working with Children, Parents, and Teachers</i> (symposium; S Kataoka, chair), American Academy of Child and Adolescent Psychiatry Annual Meeting, Oct 2001.</p> <p>Stein BD, L Jaycox, S Kataoka, M Wong, A Fink. School Screening for Violence Exposure and PTSD Among Latino Immigrants. In <i>School Mental Health Services: Working with Children, Parents, and Teachers</i> (symposium; S Kataoka, chair), American Academy of Child and Adolescent Psychiatry Annual Meeting, Oct 2001.</p> <p>Kataoka S, Stein B, Jaycox L, Wong M, Fink A. Meeting the Mental Health Needs of Traumatized Latino Children: Results of a School-Based Program,</p>

Robert Wood Johnson Foundation Annual Meeting (presentation), Nov 2001.

Jaycox, LH, BD Stein, S Kataoka, M Wong, A Fink. Helping traumatized immigrant children: A participatory research model. In Development of Community-Based Services for Trauma Survivors, International Society for Traumatic Stress Studies 17th Annual Meeting, New Orleans, LA, Dec 2001, (symposium, A. Prins, Chair).

Kataoka, S.H. Meeting the Mental Health Needs of Traumatized Latino Children: Development of a School-Based Program, Latino Research Program Project Annual Meeting: Advancing the Next Generation of Latino Mental Health Research, (presentation), 2001.

Kataoka S, L Jaycox, BD Stein, M Wong, A Fink. Can a School Mental Health Program Impact Academic Performance? Scientific Proceedings of the 48th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Honolulu HI, 2001.

Stein BD, L Jaycox, S Kataoka, M Wong, A Fink. School Screening for Violence Exposure and PTSD Among Latino Immigrants, Scientific Proceedings of the 48th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Honolulu HI, 2001

Stein BD, S Kataoka, L Jaycox, M Wong, A Fink. Meeting the Needs of Children Exposed to Violence Through a School-based Program, Scientific Proceedings of the 49th Annual Meeting of the American Psychiatric Association, Philadelphia, PA, 2002.

Wong, M. National Videoconference on School Safety, Harvard School of Public Health/US Department of Education, 2002.

Kataoka S, BD Stein, L Jaycox, M Wong, A Fink. Healing Children Exposed to Violence: A School-Based Program for Traumatized Students, Children's Institute International National Forum, Pasadena, CA., April 2003.

Wong, M. From Columbine to Code Red: Cognitive Behavioral Intervention After Targeted School Violence; Institute of Medicine, National Meeting, Washington, DC Oct 2003.

Stein BD, LH Jaycox, S Kataoka, M Wong, W Tu, MN Elliott, A Fink. The Cognitive Behavioral Intervention for Trauma in Schools: An Effective School Based Program for Children Exposed to Violence, Scientific Proceedings of the 50th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Miami FI, 2003.

Kataoka S. Mental Health Intervention for School Children Exposed to Violence: A Randomized Controlled Trial, The 17th Annual Research

Conference, "A System of Care for Children's Mental Health: Expanding the Research Base," Tampa, FL, March 2004.

Langley, AK, & Kataoka, S. Cognitive Behavioral Intervention for Trauma in Schools: The CBITS Program. Annual Meetings of the National Child Traumatic Stress Network: Intermountain West, Snowbird, Utah, Sept 2004.

Langley, AK, LH Jaycox, BD Stein, SH Kataoka, M Wong, & K Dean. Children exposed to community violence: An examination of trauma related coping strategies. Poster presented at the Annual Meetings of the Association for the Advancement of Behavior Therapy, New Orleans, LA, Nov 2004.

Kataoka S, AK Langley, BD Stein, L Jaycox, L Zhang, M Wong. Violence Exposure and PTSD: The Role of English Language Fluency on Latino Children. Latino Research Program Project Annual Meeting, April 2005.

Wong, M. National VideoConference on School Emergency Response and Crisis Management: Effective Recovery Strategies in Schools, US Department of Education, Washington, DC, 2005.

Cohen, J, D Kolko, T Mannarino, BD Stein. Pittsburgh STEELERS--Steel city's Trauma Efficacy and Effectiveness Leading Research Studies. Presented at 20th Annual San Diego International Conference on Child and Family Maltreatment, Jan 2006.

Wong, M. The Recovery Phase of School Crisis Management: Evidence Based Practices Emergency Response and Crisis Management Conference, US Department of Education. Atlanta, GA Jan 2006.

- **Are there any general writings which describe the components of the intervention or how to administer it?** Yes No

If YES, please include citation: Stein BD, Kataoka, S, Jaycox LH, Steiger EM, 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.W. Evans, N.A. Lever (Eds.), Handbook of School Mental Health Advancing Practice and Research, 2003 (pp.179-190) Kluwer Academic/ Plenum Publishers, New York, New York.

Jaycox L. (2004). Cognitive-Behavioral Intervention for Trauma in Schools. Sopris West, Longmont, CO.

- **Has the intervention been replicated anywhere?** Yes No
- **Other countries?** (please list) **Australia, Japan**
- **Other clinical and/or anecdotal evidence** (not included above):
- Adaptation and community-based participatory research collaboration with the faith-community described in: Kataoka, S., Fuentes, O'Donoghue, V., Castillo-Campos, P., Bonilla, A., Halsey, K., Avila, J., Wells, K. (2005). Piloting of a Faith-Based Intervention for Children Exposed to Violence (in press).
- • Implementation of different adaptaions of CBITS described in: Jaycox, L.H.,

	<p>Kataoka, S.H., Stein, B.D., Wong. M. &amp; Langley, A. Responding to the Needs of the Community: A Stepped Care Approach to Implementing Trauma-Focused Interventions in Schools (in press).</p> <ul style="list-style-type: none"> <li>• The following papers describe the screening component of CBITS:</li> <li>• Jaycox LH, Stein BD, Kataoka SH, Wong M, Fink A, Escudero P, Zaragoza C. "Violence Exposure, PTSD, and Depressive Symptoms among Recent Immigrant School Children," Journal of the American Academy of Child and Adolescent Psychiatry, 2002, 41(9):1104-1110.</li> <li>• Dean KL, Stein BD, Jaycox LH, Kataoka SH, Wong M. "Acceptability of Asking Parents about Symptoms in Their Traumatized Children," Psychiatric Services, 2004, 55(8):2985.</li> </ul>				
<p><b>Research Evidence</b></p>	<p><b>Published Case Studies</b></p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<p><b>Number of Participants</b></p> <p>N =</p>	<p><b>Sample Breakdown</b></p> <p>By gender:</p> <p>By ethnicity:</p> <p>By other cultural factors:</p>	<p><b>Citation</b></p>
	<p><b>Pilot Trials/ Feasibility Trials (w/o control groups)</b></p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<p>N =</p>	<p>By gender:</p> <p>By ethnicity:</p> <p>By other cultural factors:</p>	
	<p><b>Clinical Trials (w/ control groups)</b></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p>N = 199</p>	<p>By gender: 50% female</p> <p>By ethnicity:</p> <p>Latino:</p> <p>Country of Origin</p> <p>Mexico: 57%</p> <p>El Salvador: 18%</p> <p>Guatemala: 11%</p> <p>Other: 13%</p> <p>By other cultural factors: all participants had immigrated to the US in the past 3 years. The intervention was conducted in Spanish by bilingual, bicultural clinicians</p>	<p>Kataoka, S., Stein, B. D., Jaycox, L. H., Wong, M., Escuerdo, P., Tu, W., Zaragoza, C., &amp; Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. Journal of the American Academy of Child and Adolescent Psychiatry, 42(3), 311-318.</p>
	<p><b>Randomized Control Trials</b></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p>N = 126</p>	<p>By gender: 54% female</p> <p>By ethnicity:</p>	<p>Stein BD, Jaycox LH, Kataoka, S, Wong M, Tu W, Elliott MN, Fink A</p>

				By other cultural factors:	(2003) A Mental Health Intervention for Schoolchildren Exposed to Violence: A Randomized Controlled Trial, JAMA, 290(5): 603-11.
	<b>Studies describing modifications</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	N =	By gender: By ethnicity:  By other cultural factors:	
	<b>Other research evidence</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	N =	By gender: By ethnicity:  By other cultural factors:	
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• <b>What assessments or measures are used as part of the intervention or for research purposes, if any?</b> Screening Measures:             <ul style="list-style-type: none"> <li>• Modified Life Events Scale (Singer) to assess the level of exposure to violence</li> <li>• Child PTSD Symptom Scale (Foa)</li> <li>• Outcome measures:                 <ul style="list-style-type: none"> <li>• Child PTSD Symptom Scale (Foa); Children’s Depression Inventory (Kovacs);</li> <li>• Pediatric Symptom Checklist</li> </ul> </li> </ul> </li> <li>• <b>If research studies have been conducted, what were the outcomes?</b> In a randomized controlled study, children in the CBITS intervention group had significantly greater improvement in PTSD and depressive symptoms compared to those on the waitlist 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 6 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.</li> </ul>				
<b>Implementation Requirements and Readiness</b>	<p><b>Space, materials or equipment requirements? CBITS needs to be conducted in a private space that can accommodate 6-8 students and the group leader. It is helpful to have the following materials available during the groups: blackboard or flip chart, copies of handouts for the students which can be found in the manual, M&amp;M's for the first session, art supplies. No equipment is needed.</b></p> <p><b>Supervision requirements (e.g., review of taped sessions)? Regular supervision/consultation (weekly to every other week) with a local CBT expert is</b></p>				

	<p><b>recommended at least for the first round of CBITS groups that a clinician conducts. Clinicians could also participate in a Learning Collaborative model for ongoing support. Dr. Audra Langley can coordinate this support.</b></p> <ul style="list-style-type: none"> <li><b>In order for successful implementation, support should be obtained from: Dr. Audra Langley can coordinate this support.</b></li> </ul>
<p><b>Training Materials &amp; Requirements</b></p>	<ul style="list-style-type: none"> <li>List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained. 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></li> <li><b>How/where is training obtained?</b> Contact Audra Langley for details</li> <li><b>What is the cost of training?</b> Dependent on the training arrangements made with Dr. Langley.</li> <li><b>Are intervention materials (handouts) available in other languages?</b>  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                      If YES, what languages? Spanish</li> <li><b>Other training materials &amp;/or requirement</b> (not included above): other implementation materials available upon request</li> </ul>
<p><b>Pros &amp; Cons/ Qualitative Impressions</b></p>	<ul style="list-style-type: none"> <li><b>What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)?</b></li> <li>• CBITS is specifically designed and evaluated in multicultural and multilingual populations.</li> <li>• CBITS has been used in multiple languages including: Spanish, Korean, Western Armenian, Russian, and Japanese.</li> <li>• CBITS has been adapted for use on a variety of Native American reservations</li> <li>• CBITS has been used successfully in a faith-based private school</li> <li>• CBITS has been used throughout the U.S. and internationally (Japan and Australia)</li> <li>• CBITS treatment materials have been translated into other languages</li> <li>• CBITS is a flexible, manualized intervention that can be easily adapted for different populations</li> <li>• CBITS is specifically designed for use in schools and by school-based clinicians with training that specifically focuses on implementation of trauma services in the school setting</li> <li>• CBITS's school-based format alleviates common obstacles to treatment such as transportation barriers, stigma of seeking "mental health" care, and dependence on parents and families to seek and find care.</li> <li>• CBITS includes training on important factors involved in delivering a program in the schools successfully such as integrating the program into the school calendar, using a brief assessment tool to detect eligible students, and understanding and supporting the roles of school staff.</li> <li>• CBITS is an intervention that can be readily accessible to all eligible students, regardless of parent ability to be involved in treatment.</li> <li>• CBITS has had significant involvement of multiple stakeholders in the development and implementation of the program.</li> <li>• CBITS is the only trauma intervention that has been found to be effective in</li> </ul>

	<p>an RCT for multiply traumatized youth.</p> <ul style="list-style-type: none"> <li>• <b>What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)?:</b> CBITS is not yet adapted for early Elementary school students (K-2) and for older adolescents/young adults.</li> <li>• <b>Other qualitative impressions:</b> The CBITS team has conducted multiple focus groups across the Los Angeles area in private and public schools and have found an overwhelming need identified by communities for an intervention in schools. These focus group participants have also described the school and faith-based settings to be not only appropriate but ideal for delivering CBITS for traumatized youth.</li> </ul>
<p><b>Contact Information</b></p>	<p><b>Name:</b> Sheryl Kataoka  <b>Address:</b> 10920 Wilshire Blvd., #300; Los Angeles CA 90024  <b>Phone number:</b> 310-794-3727  <b>Email:</b> skataoka@ucla.edu <b>Website:</b> pending</p>