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Making It Easier for School Staff to Help Traumatized Students

Ten years ago, RAND researchers joined colleagues at the Los Angeles Unified School District and the University of California Los Angeles to confront one of the saddest realities in the United States: the large numbers of children who go to school weighed down by experiencing or witnessing some form of violence, trauma, or maltreatment.

Out of this concern and collaboration grew the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), a school-based early intervention program aimed at reducing children’s symptoms related to existing traumatic experiences and enhancing their skills to handle future stresses.

CBITS is designed to be delivered by school mental health clinicians, but these professionals are a luxury for most schools. Responding to requests from school districts, the research team adapted the program so that teachers and school counselors with no mental health training can deliver it. This Research Highlight presents results from a small pilot test of the CBITS adaptation known as Support for Students Exposed to Trauma.

Why the Need for a School-Based Trauma Program?

From community and family violence to natural disasters, around one in four youngsters is thought to be affected by trauma. A recent national survey of children and youth ages 2 to 17 provides a more detailed picture:¹

- More than half of the children had been physically assaulted in the study year.
- More than one in eight had experienced some form of child maltreatment.
- One in twelve had experienced sexual victimization.

¹ Finkelhor D, et al., “The Victimization of Children and Youth: A Comprehensive, National Survey,” *Child Maltreatment*, Vol. 10, No. 1, 2005.

Key findings:

The Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) has been adapted for delivery by regular school staff with no mental health training. In a small pilot test:

- The new program—Support for Students Exposed to Trauma—was successfully delivered by teachers and a counselor.
- Students experienced small reductions in their trauma symptoms; those with an initial high level of symptoms benefitted the most.
- Both students and parents were satisfied with the program.
- The results indicate that a full evaluation of effectiveness is warranted.

- More than one in three had witnessed violence or experienced some other form of indirect victimization.

Exposure to trauma, whether caused by humans or nature, often manifests in children and adolescents as learning difficulties and/or behavioral problems. CBITS is founded on cognitive-behavioral therapy; of the common approaches used to treat childhood trauma, this therapy is the only one with strong evidence of effectiveness.² For many students, especially those in poor and minority neighborhoods, school is one of the few sources for mental health care.

² U.S. Task Force on Community Preventive Services, “Recommendations to Reduce Psychological Harm from Traumatic Events Among Children and Adolescents,” *American Journal of Preventive Medicine*, Vol. 35, No. 3, 2008.

CBITS targets the general school population, with flexibility built in to make the program relevant to racially, ethnically, and socioeconomically diverse groups. See the box for an update on CBITS.

A CBITS Version for Nonclinical School Personnel

With funding from the National Institutes of Health, the CBITS research team sought feedback from teachers, school counselors, clinicians, and national experts on how to make their program easier for schools to implement. The result is Support for Students Exposed to Trauma (SSET). SSET keeps the same cognitive-behavioral approach and ten group-session structure as CBITS, but the clinical aspects of the original program have been modified (see the table). Changes include the following:

- Instructors use the lesson-plan format familiar to teachers.
- Individual student sessions and optional parent sessions are eliminated.
- Students draw or write about their traumatic experiences rather than recounting them one-on-one with a counselor.

SSET Pilot Test

Beginning in 2005, SSET was pilot-tested for two years in two Los Angeles middle schools, one in the San Fernando Valley and the other in South Central LA. Most of the students were Hispanic and came from lower socioeconomic backgrounds, and more than half were English learners.

Of the students screened for participation in SSET, 58 percent met the initial study criteria: They had experienced

CBITS Update

- The CBITS manual is available from Cambium Learning at <http://store.cambiumlearning.com>.
- CBITS resources are disseminated through the Trauma Services Adaptation Center for Schools and Communities (<http://www.tsaforschools.org>), part of the National Child Traumatic Stress Network (NCTSN).
- Among CBITS outreach activities was a learning collaborative in 2008–2009 through the NCTSN.
- The effectiveness of CBITS is cited by numerous organizations, including

National Child Traumatic Stress Network’s Promising Practices
 (http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/cbits_general.pdf)

Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices—Legacy Programs, currently under re-review
 (http://www.nrepp.samhsa.gov/legacy_fulldetails.asp?LEGACY_ID=63)

Office of Juvenile Justice and Delinquency Prevention’s Model Programs Guide
 (http://www.dsgonline.com/mpg2.5/mpg_index.htm)

- **The CBITS website (<http://www.rand.org/health/projects/cbits/>) includes a list of CBITS and SSET publications, information about user products including program manuals, and related links.**

Comparison of CBITS and SSET School Trauma Programs

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)			
Targeted Population	Therapeutic Aims	Program Delivery	Intervention Approach
Students in grades 5–9 with exposure to trauma who have elevated symptoms of PTSD, depression, and anxiety	Reduce symptoms of PTSD, depression, and anxiety, resulting in better coping and cognitive skills	School mental health counselors receive a two-day training session During a class period, they deliver CBITS over ten weekly group sessions (6–8 children/group) and 1–3 individual student sessions One teacher-education session, and 2–4 optional parent sessions	1. Psycho-education (common reactions to stress or trauma) 2. Relaxation training 3. Cognitive coping (thoughts and feelings, helpful thinking) 4. Gradual mastery of trauma reminders and generalized anxiety 5. Processing traumatic memories through writing and drawing 6. Social problem solving
Support for Students Exposed to Trauma (SSET)			
Same	Same	Teachers or counselors, after a two-day training session, deliver SSET over ten weekly group sessions during a class period No individual sessions; no parent sessions	Core elements are the same but delivered in lesson-plan format and without one-on-one sessions.

severe violence in the prior year and had moderately severe symptoms of post-traumatic stress disorder (PTSD). In the end, the pilot test sample consisted of 76 students with appropriate parental and student consent to participate in the study.

Three teachers and one school counselor without any specific mental health clinical background were trained over two days to deliver SSET. One teacher was an experienced social studies instructor; the second was an experienced algebra teacher; and the third was a new math teacher. The school counselor had training in school safety, peer relationships, and suicide prevention.

Each of the four instructors led four SSET groups; each group met once a week during the school day and received a total of ten lessons. Half of the students were given SSET immediately, while the start of the other half was delayed until the first intervention group had ended. Those students served as controls.

Students were surveyed to measure their trauma symptoms at baseline, at three months after the first group had completed SSET, and at six months after the control group had completed the program. Additional assessments focused on the instructors' ability to faithfully deliver quality SSET lessons. Both students' parents and teachers were surveyed about the students' behavior at home and at school, and students were surveyed about their own symptoms and behav-

iors. Parents and students were also surveyed about their satisfaction with the program.

Promising Results

Even in this small pilot test, the results indicate that SSET can be implemented successfully by teachers and school counselors without mental health training to address violence-related PTSD and depression, especially in low-income, urban students. The pilot test results indicate the following:

- Overall, students showed small reductions in trauma symptoms, with those having a high level of symptoms before taking SSET benefitting the most.
- Both students and parents reported good-to-high satisfaction with the program.
- Teachers reported small improvements in student behavior, but parents did not.

Next Step

Given the promising pilot test results, a larger evaluation of SSET effectiveness is warranted. Until that time, the impact of this intervention is not fully known, but it does show promise. Schools interested in conducting SSET will be able to obtain detailed information from the manual, as well as information about training from the author, Lisa Jaycox, PhD (Lisa_Jaycox@rand.org). ■

This Highlight summarizes RAND Health research reported in the following publications:

Jaycox LH, Kataoka SH, Stein BD, Wong M, Langley, A, "Responding to the Needs of the Community: A Stepped Care Approach to Implementing Trauma-Focused Interventions in Schools," *Report on Emotional and Behavioral Disorders in Youth*, Vol. 5, No. 4, 2005, pp. 100–103.

Jaycox LH, Langley A, Dean KL, *Support for Students Exposed to Trauma: The SSET Program*, Santa Monica, Calif: RAND Corporation, TR-675-NIMH, 2009. Available online: http://www.rand.org/pubs/technical_reports/TR675/

Jaycox LH, Langley AK, Stein BD, Wong M, Sharma P, Scott M, Schonlau, M, "Support for Students Exposed to Trauma: A Pilot Study," *School Mental Health*, Vol. 1, No. 2, 2009, pp. 49–60.

Abstracts of all RAND Health publications and full text of many research documents can be found on the RAND Health Web site at www.rand.org/health. This research brief was written by Elizabeth Maggio. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. RAND® is a registered trademark.

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