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Adapting a School-Based Trauma Intervention to Support Students: A Pilot Study

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ABSTRACT

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) has effectively alleviated symptoms of trauma in some students. However, schools struggle to implement interventions due to time limitations caused by required core instruction. This pilot study assesses the effectiveness of CBITS sessions with modifications to length of time and the elimination of trauma exposure sessions. Using a mixed-methods approach, this study evaluates the impact of CBITS for nine middle school students who presented with symptoms of trauma. The BASC-3 Behavioral and Emotional Screening System (BESS) was used to conduct pre-test and post-test analysis. Four repeated-measures t-tests were conducted to examine differences in mean scores on the Behavioral and Emotional Risk Index and the Internalizing, Self-Regulation, and Personal Adjustment Sub-Indices. Post-test scores were higher than pre-test scores but not significant. Qualitative analysis of post-test interview questions suggested students experience a positive change in thought patterns, support systems, and coping..

Keywords: trauma, CBITS, school-based, intervention

Researchers continue to underscore that childhood trauma continue to adversely impact many youth across our society (Hertal & Johnson et al., 2020). Felitti et al.'s (1998) seminal study highlighted that exposure to Adverse Childhood Experiences (ACEs) has long-lasting negative implications for children even into adulthood such

as psychological problems, drug abuse, cancer, and early death. Similarly, the Centers for Disease Control and Prevention (2019) reported that ACEs are associated with depression, asthma, cancer, diabetes, substance abuse, and early death in adulthood. Further, adults with higher ACEs scores had higher rates for high school incompletion, unemployment, and living in a household below the federal poverty level (Metzler et al., 2017). Carlson et al. (2019) conducted a systematic literature review of studies examining ACEs from 1990-2015 and found the prevalence rate of childhood traumatic events in the United States ranges between 41% to 97%. Another study suggested that 45% of children in the United States have experienced at least one ACE, and 10% of children nationally have experienced three or more ACEs (Sacks & Murphey, 2018).

Approximately 30% of children living in rural or small towns are likely to be exposed to ACEs such as parental separation (Crouch et al., 2019), poverty, child abuse and neglect, parental absence, and exposure to community violence (Dye, 2018; Turney, 2018). For instance, of the 18 per 1000 children living in Indiana who were identified as victims of child abuse and neglect, over 16% lived in poverty, and nearly 10% had a parent who had been incarcerated (Indiana Youth Institute, 2021). The experiences of parental absence, parental loss, parent suffering with a mental health or substance abuse issue, and family violence can all have lasting ramifications, including a higher rate of negative physical, social, emotional, educational, and mental health outcomes for children (Brown, 2020; Cerniglia et al., 2014; Crouch et al., 2019).

Bethell et al. (2014) indicated that teaching children to cope with challenging events can lessen the negative impact of ACEs. In response, many researchers and practitioners have used programs such as the Cognitive Behavioral Intervention for Trauma in Schools (CBITS). Researchers have found that CBITS has been effective in alleviating symptoms related to trauma in students (Stein et al., 2003). For example, Hoover et al. (2018) reported there was a correlation between students who participated in CBITS sessions and a reduction in behavior severity. CBITS was developed at a time where there was increasing recognition of the negative influence of trauma on children's development and functioning (Kataota et al., 2003). CBITS is a school-based group or individual intervention program designed to reduce symptoms of trauma-related disorders, depression, behavioral problems and to improve academic and socioemotional functioning (Jaycox et al., 2018). It is designed for students in grades 5-12 who have experienced a traumatic event such as the death of a loved one, physical abuse, and domestic violence. CBITS consists of ten 45–60-minute sessions with a focus on one of the following components at each weekly session: (a) psychoeducation, (b) relaxation, (c) social problem-solving, (d) cognitive restructuring, and (e) exposure (Jaycox et al., 2018). The purpose of the psychoeducation session is to teach students how stress and trauma can impact thoughts, feelings, and behaviors (Jaycox et al., 2018). The relaxation session offers opportunities for students to learn common reactions to trauma and skills such as deep breathing, positive imagery, and progressive muscle relaxation to relax the body and feel calmer (Jaycox et al., 2018). While the cognitive restructuring component provides students with the skills to replace negative thoughts with more helpful thoughts, the social problem-solving component teaches students how to brainstorm

solutions to problems by weighing the advantages and disadvantages of each possible solution (Jaycox et al., 2018). Lastly, the exposure component helps to desensitize students to the event or situation that causes stress for them (Jaycox et al., 2018).

Since the conception of CBITS and its elementary version, Bounce Back, several studies have researched its effectiveness across cultures (Langley et al., 2015). Researchers reported that Spanish-speaking Latino youth who had been exposed to trauma reported fewer symptoms of trauma, PTSD, and depression after participating in CBITS (Allison & Ferreira, 2017). Kataoka et al. (2011) found a correlation between implementing CBITS with ethnically diverse youth and improved academic functioning in language arts and mathematics. Auslander et al. (2020) indicated that CBITS was as effective or more effective than their standard protocol for reducing symptoms of PTSD and depression in adolescent girls who were in the child welfare system. They also found that the girls in this study reported a higher increase in social problem-solving skills than those receiving the standard protocol.

Ngo et al. (2008) have stressed the importance of understanding the culture of people and schools to improve the likelihood that CBITS is being implemented with fidelity to maximize effectiveness. Many schools may struggle with finding the time to implement trauma-informed group interventions due to the constraints of the required core instructional minutes. When considering implementation practice, we must understand that a nine-month academic calendar creates extreme demands on schools, effecting every aspect of intervention implementation (Owens et al., 2014). Therefore, it is necessary to understand how schools can implement trauma-informed interventions in a meaningful way within these constraints. Researchers must determine how to adapt manualized programs to fit the school context (Owen et al., 2014). Thus, the purpose of this pilot study is to determine the effectiveness of CBITS with modifications to the time length of each session implemented and the elimination of the trauma exposure sessions.

METHOD

Participants

Nine students participated in the study, six male and three female. Of the nine students, five were 12 years old, three were 13 years old, and one was 15 years old. Five were in 6th grade, three were in 7th grade, and one was in 8th grade. All students attended a Title 1 middle school located in a rural Midwestern area. More than 80% of the students at the school received free or reduced lunch. The school's neighborhood had a higher percentage of poverty compared to other neighborhoods in the town and had been deemed a highest priority to improve the quality of life for the residents through a city-university partnership. The students were selected based on a referral to the School Building Level Committee (SBLC) and a screening process that consisted of BASC-3 Behavioral and Emotional Screening System (BASC-3 BESS) Self-Report rating forms and student and guardian interviews. For those students selected, the principal investigator obtained consent from guardians and assent from students to participate in the intervention.

Materials

The BASC-3 BESS offers a systematic way to determine behavioral and emotional strengths and weaknesses of children and adolescents in preschool through high school. It is generally used as a screener and a progress monitoring tool (Kamphaus & Reynolds, n.d.). The measure consists of items relating to four dimensions of behavioral and emotional functioning including Adaptive Skills, Externalizing Problems, Internalizing Problems, and School Problems (Kamphaus & Reynolds, n.d.). This instrument allows for the detection of problems associated with developing and maintaining positive relationships with others, which can be an indicator of underlying behavioral and emotional deficits. When caught early, these can be corrected before negatively effecting a child or adolescent (Kamphaus & Reynolds, n.d.).

CBITS Sessions

The school principal indicated middle school students were required to have approximately 315 minutes of direct core instruction each day, so there was limited flexibility in the school schedule. Therefore, due to the length restriction imposed by the school principal, the CBITS sessions were implemented once per week for 20 minutes over 10 weeks, instead of the 45-60 minutes per session designated by CBITS. The principal investigator led all sessions with the assistance of the three research assistants. The principal investigator and research assistants completed an online 5-hour CBITS course, which included clinical skills needed to deliver the program effectively and important logistical materials to facilitate implementation. The principal investigator met weekly with the research assistants to review, role-play, and troubleshoot each lesson. Due to the limited time available, the trauma exposure sessions were eliminated. Salloum and Overstreet (2012) reported that it might be possible for youth to receive effective grief and trauma support without trauma narration. It was determined that, given the shortened length of each session, it would be unethical to maintain the exposure sessions where students would have to relive their traumatic experiences through a narration activity. Such activity could cause significant emotional distress for students in a setting where there might not be sufficient time to help students process any discomfort. Therefore, due to the time limits and the elimination of the exposure, booster sessions were provided to offer students more time to practice coping skills. Group sessions progressed each week as follows: Week 1 - Introductions; Week 2 - Education and relaxation; Week 3 - Introduction to cognitive theory; Week 4 - Combating unhelpful negative thoughts; Week 5 - Introduction to problem solving; Week 6 - Practice with social problem-solving; Week 7 - Booster session of relaxation strategies; Week 8 - Booster session of combatting unhelpful negative thoughts; Week 9 - Booster session of social problem-solving skills; and Week 10 - Practice of all skills taught and celebration.

Study Design

A pre-post test was conducted using the students' BASC-3 BESS ratings to measure the effectiveness of the intervention. We also conducted post-intervention qualitative interviews with each student to gain their perspective on coping before and after they participated in the intervention. Post-intervention interview questions included the following:

1. Prior to participating in this intervention, what did you think about trauma and some of the unfortunate events that occurred in your life?
2. After participating in this intervention, what are your thoughts about trauma and the awful things that happened to you?
3. Since the completion of the intervention program, how would you describe yourself? How is your description different than before you participated in the intervention?
4. Prior to participating in this intervention, what sort of emotions, thoughts, and feelings dominated your day? How has it changed since the completion of the intervention?
5. Currently, how prepared do you feel to handle difficult conflict or situations in your life compared to 10-12 weeks ago?
6. Prior to the intervention, how did you deal with stressful situations? How do you think you will handle stressful situations moving forward?
7. How can your parents and teachers support you as you continue to process some of the negative events that occurred in your life? Are the supports you identified different from 10-12 weeks ago?

Interviews were audio recorded and transcribed for thematic analysis. Two members of the research team used a combination of inductive and deductive coding to develop a final list of codes. Transcripts were reviewed line-by-line to extract text matching each code. The two qualitative research analysts met to review their codes for intercoder agreement and disagreements were resolved through consensus. The two research analysts then searched for and named themes across the codes to further reduce the data.

RESULTS

Risk Index Scores

Study researchers did four separate repeated-measures t-tests to examine differences in mean scores on the Behavioral and Emotional Risk Index and the Internalizing, Self-Regulation, and Personal Adjustment Sub-Indices. Although student scores were lower on the Behavioral and Emotional Risk Index and the Internalizing and Self-Regulation Sub-Indices following the intervention, there was no statistically significant difference between the post-intervention and pre-intervention scores on these indices. With a mean of 13.9, the post-intervention Personal Adjustment scores were slightly higher than pre-intervention scores, which had a mean of 13.4. However, this difference was not statistically significant. Given the small sample size, no further analysis was conducted.

Post-Intervention Interviews

Study researchers conducted post-intervention interviews with the nine students to evaluate their coping behaviors and feelings before and after their participation in the CBITS program, and interviews did reveal differences. The themes below capture the students' thoughts, emotions, coping, and support before and after the intervention.

Before Intervention

Negative emotions. Before the intervention, student thoughts about traumatic or adverse events were avoidant or generally negative. One student responded, "I didn't think about it," while another student stated that they felt "angry, sad, and/or stressed." Similarly, when asked about the emotions and thoughts that dominate their day, students responded with anger or aggression, "I always wanted to punch people;" irritation, "I came to school always irritated;" and sadness, "Always sadness." A third student stated, "I would call myself names." They also expressed a lack of preparedness for handling difficult situations. One student stated, "… [I] wasn't confident in myself. Like I wasn't going to get anywhere," while another responded, "…[I] didn't feel prepared at all." Students also express negative or avoidant coping strategies for dealing with difficult situations.

Maladjusted coping style and lack of support. Several students named aggressive behaviors as their way of coping. One student stated, "I would punch a wall," and another shared, "I got mad and yelled at people a lot." Students also expressed avoidant coping strategies for dealing with feelings, such as "I held it in," "I slept a lot," and "I didn't deal with them." Prior to the intervention, two themes emerged about supports: (a) having support from family members and (b) no support at all. Two students mentioned support from family members. One shared that "My grandma lets me talk to my mom on the phone and is going to let her move in," and another shared "My mom helps me calm down… my dad never helped because he has anger issues." However, more students expressed not having any support to cope with difficult feelings, thoughts, or situations. They said things like "Nobody supported me," "[Teachers] used to shrug me off," "[Teachers] would give up," and "I used to not think they could help."

After Intervention

Positive emotions. Different themes emerged after the intervention when researchers again asked the students about their thoughts, emotions, coping, and supports. Students expressed more positive thoughts and emotions in response to traumatic or adverse events: "I can handle it better," "I learned how to get over it," and "I learned how not to be mean." The dominant feelings and thoughts that students experienced throughout the day were also more positive. Themes included happiness and joyfulness, with less anger and sadness. "Now, I don't want to punch people and I feel happiness," said one student. Others stated, "I feel happier now," "… now I feel

more happy and joyful," "Not that sad anymore, not that much angry," "Now I don't feel so angry," and "I'm not as angry now that I've learned to calm down." Students' descriptions of themselves reflected feelings of making progress and improvements. Students describes themselves as "… aggressive at some points and kind most of the time," and, "… more calm… it's easier to help people because I can understand." One student stated feeling "better than before" and shared that they "still have off days…but I work harder."

Healthy coping mechanism and teacher support. Students also felt more prepared to handle difficult situations and were less impacted by negative situations. When asked about this, students shared, "I feel more prepared." Another stated, "Not to take them so hard, I still feel sad about my mom and cry in my room. When I'm angry now count to 10, or 20, or 50." Students also expressed more active coping strategies, including exercising, problem-solving, talking to others, and thinking before acting. Students stated, "… now I can do the body movements he taught me," "… now I can talk to people about how I feel, and I can talk it out instead of getting angry," and "Now I take a second and think and find out what happened and think of ways to not get mad." Students also expressed support from others being more available post-intervention. Students still reported family support, such as, "[My grandma] supports me the same" and, "My mom helps me calm down and did before the program." Students reported support from teachers post-intervention, whereas student-reported teacher support was not present before the intervention. Students stated, "Now [teachers] talk to me," and, "Teachers were different before [the intervention]."

DISCUSSION

The current study revealed CBITS having a weaker impact on the participants' trauma-related stress than findings from existing literature. Results from the quantitative analysis revealed no change in trauma-related stress from pre-test to post-test. The discrepancy between this study and other published research findings may be attributed to the small sample size. Also, the reduced time of each session might have weakened the potency of the intervention. Therefore, this study should be replicated with larger sample size.

Qualitative analysis of post-intervention interviews did reveal some change in student responses to trauma and adverse events. Three thematic areas emerged from the analysis of responses from post-intervention interviews: internal supports, changes in thoughts and emotions, and coping situations. Students reported thoughts in response to traumatic events being more negative and avoidant before the intervention. After the intervention, there was a shift to more positive thoughts and a more positive view of their lives. Further, participants expressed effective coping mechanisms and much more resilience and readiness to deal with similar traumatic events post-intervention. The students also had a more favorable view of external and internal supports after participating in the intervention. Overall, the CBITS sessions changed the students' perceptions of their thoughts, emotions, and coping preparedness for dealing with their traumatic stress. These perceptual changes can lead to healthier mental health status and general wellbeing (Kataoka et al., 2011)..

CONCLUSION

CBITS, a standardized skill-based and school-based group intervention strategy designed to address the trauma needs of youth, can help manage symptoms of trauma and depression (Jaycox et al., 2018). This study highlights the effectiveness of CBITS as an intervention program by making modifications to the length of each session in implementation and the elimination of the trauma exposure sessions. Ten sessions were reduced from 45-60 minutes to 20-minute sessions. The exposure sessions were also replaced with booster sessions in combating negative thoughts, avoidance and coping. Available literature has shown the efficacy of CBITS when implemented with at-risk youth (Allison & Ferreira, 2016; Auslander et al., 2020; Kataoka et al., 2011; Langley et al., 2015; Ngo et al., 2008) and its positive effect on academic achievement in addition to reducing symptoms related to trauma (Kataoka et al., 2011). The results of this study further shed light on the efficacy of the CBITS on re-orienting and restructuring the thought processes of students experiencing trauma-related symptoms.

There appears to be strong evidence for the effectiveness of CBITS in alleviating symptoms of traumatic events among students, which then improves their general wellbeing. However, implementation in many schools is met with the challenge of finding the appropriate amount of time to implement trauma-informed group interventions. This is due to constraints of the core instructional minutes required by educational standards. Conducting more research into the applicability, effectiveness, and long-term potency of the CBITS sessions with reduced time lengths and replaced trauma exposure sessions can provide more insight and data to support how these solutions might help address time constraints. Although some results from the analysis could not support existing literature, findings provide insights regarding the ways that CBITS sessions can change and restructure negative thoughts, emotions, coping strategies, and support mechanisms to a more positive and healthy perspective for youth.

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