

GENERAL INFORMATION

<p><b>Treatment Description</b></p>	<p>Bounce Back is a cognitive-behavioral, skills-based, group intervention aimed at relieving symptoms of child traumatic stress, anxiety, depression, and functional impairment among elementary school children (ages 5-11) who have been exposed to traumatic events. Bounce Back is used most commonly for children who have experienced or witnessed community, family, or school violence, or who have been involved in natural disasters, accidents, physical abuse, neglect, or traumatic separation from a loved one due to death, incarceration, deportation, or child welfare detention. The clinician-led intervention includes 10 group sessions where children learn and practice feelings identification, relaxation, courage thoughts, problem solving and conflict resolution, and build positive activities and social support. It also includes 2-3 individual sessions in which children complete a trauma narrative to process their traumatic memory and grief and share it with a parent/caregiver. Between sessions, children practice the skills they have learned. Bounce Back also includes materials for parent education sessions.</p> <p>Developed as an adaptation for elementary aged students of the <i>Cognitive-Behavioral Intervention for Trauma in Schools</i> (CBITS) program, Bounce Back contains many of the same therapeutic elements but is designed with added elements and engagement activities and more parental involvement to be developmentally appropriate for 5-11 year olds.</p>
<p><b>Target Population</b></p>	<p>Bounce Back is designed to be implemented in schools for children in elementary school grades Kindergarten through 5th grade (ages 5-11) who have experienced events such as witnessing or being a victim of family, school, or community violence, being in a natural or man-made disaster, being in an accident or fire, or being physically abused or injured, and who are experiencing moderate to severe levels of PTSD symptoms.</p> <p>Bounce Back was developed and implemented in schools serving diverse, multicultural, and multilingual students—predominantly Latino, African American, Caucasian, and Asian. It is designed to be used in schools with children from a variety of ethnic and socio-economic backgrounds and acculturation levels.</p>
<p><b>Essential Components</b></p>	<p>Bounce Back includes cognitive-behavioral coping strategies and skills and trauma narrative. Bounce Back is adapted from CBITS. It contains all of the key elements of CBITS and adds feelings identification, positive activities, and social support.</p> <p><b>Key components:</b></p> <ul style="list-style-type: none"> <li>■ Psychoeducation</li> <li>■ Feelings Identification</li> <li>■ Positive Activities</li> <li>■ Relaxation Training</li> <li>■ Cognitive Coping</li> <li>■ Gradual Exposure for functional impairment</li> </ul>

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<p><b>Essential Components continued</b></p>	<ul style="list-style-type: none"> <li>■ Trauma narrative</li> <li>■ Social Support/Connecting with Others</li> <li>■ Problem Solving/Conflict Resolution</li> </ul> <p>With respect to its implementation procedure: Parental permission is sought for children to participate. A handout is sent home to parents, followed by screening of students. A screening procedure is recommended for use in the general school population to assist in identifying children who have been exposed to traumatic events and have current moderate to severe PTSD symptoms. For this age group, we recommend individual screening. A call or in-person meeting with parents/ caregivers is recommended at the beginning of treatment to answer questions and review expectations for child and parent involvement. Developmentally appropriate between-session activities help children (and parents) consolidate skills and allow group members to apply these skills to real life issues. A step-by-step guide to each session, including scripts and examples for activities for various age groups, is available for use by the group leader, as well as a workbook with all of the parent letters, handouts, and materials needed for each session.</p>
<p><b>Clinical &amp; Anecdotal Evidence</b></p>	<p><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</p> <p><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</p> <p><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</p> <p><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</p> <p><b>If YES, please include citation:</b>          Langley, Audra K.; Gonzalez, Araceli; Sugar, Catherine A.; Solis, Diana; Jaycox, Lisa (2015). Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. <i>Journal of Consulting and Clinical Psychology</i>, 83, 853-865.</p> <p><b>Has this intervention been presented at scientific meetings?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If YES, please include citation(s) from last five presentations:</b></p> <p>Langley, A.K., &amp; Jaycox, L.H. (2013, October). An Intervention for Elementary School Children Exposed to Traumatic Events: A Pilot Evaluation of the Bounce Back Program. Symposium presented at the Annual Meetings of the American Academy of Child and Adolescent Psychiatry, Orlando, FL.</p> <p>Jaycox, L.H., &amp; Langley, A. K. (2015, November). Intervening with Elementary School Children Exposed to Trauma: Effectiveness of a School-based Intervention and Recommendations for Implementation. Symposium presented at the Annual Meetings of the Internationals Society for Traumatic Stress Studies, New Orleans, LA.</p>

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<p><b>Clinical &amp; Anecdotal Evidence continued</b></p>	<p><b>Are there any general writings which describe the components of the intervention or how to administer it?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Has the intervention been replicated anywhere?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Other countries?</b> The intervention has been implemented in various parts of the country including, Los Angeles, CA, Chicago, IL, New Orleans, LA, Newtown, CT, Long Island, NY, Oceanside, CA</p>	
<p><b>Research Evidence</b></p>	<p><b>Sample Size (N) and Breakdown</b> <i>(by gender, ethnicity, other cultural factors)</i></p>	<p><b>Citation</b></p>
<p><b>Randomized Controlled Trials</b></p>	<p><b>N=74</b>, at least 40% of the students were eligible for free or reduced lunch. Participants in the analytic sample were 74 students in 1st-5th grade (Mean age: 7.65 years, SD = 1.36; 50% boys) and were ethnically diverse: 49% Latino, 27% Caucasian, 18% African American, 5% biracial, 1% Asian. Nearly one-quarter (24.3%) of families had a highest household education level of less than high school, 20.3% had at least one caregiver who earned a high school degree, and 55.4% had at least one caregiver who had completed at least some college. Nearly half of the participants (43.3%) had a household income of \$40,000 or less, supporting an average of four individuals (Mean = 3.81 individuals, SD = 1.15).</p>	<p>Langley, A.K., Gonzalez, A., Sugar, C.A., Solis, D., &amp; Jaycox, L. (2015). Bounce back; Effectiveness of an Elementary School-Based Intervention for Multicultural Children Exposed to Traumatic Events. <i>Journal of Consulting and Clinical Psychology</i>, 83(5), 853-865.</p>
<p><b>Other Research Evidence</b></p>	<p>Replication study in Cicero, IL currently underway</p>	
<p><b>Outcomes</b></p>	<p><b>Participant screening measures utilized:</b></p> <ol style="list-style-type: none"> <li>1. Modified Traumatic Events Screening Inventory for Children – Brief Form (TESI-C-Brief) (Ford et al., 2000), was used at baseline to assess exposure to direct or witnessed trauma via 21 items. This was utilized as a clinical interview with the children.</li> <li>2. UCLA PTSD Reaction Index to assess current PTSD symptoms.</li> <li>3. SDQ-Parent and Teacher Versions</li> </ol> <p>Parents and children completed these measures prior to beginning the program, at program completion, and three months after program completion.</p>	

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<p><b>Outcomes continued</b></p>	<p><b>Results:</b> <i>Bounce Back</i> was implemented with excellent clinician fidelity. On Pre-Post measures, compared to children in the Delayed Intervention group, children who received <i>Bounce Back</i> in the Immediate Intervention group demonstrated significantly greater improvements in parent- and child-reported posttraumatic stress and child-reported anxiety symptoms over the 3-month intervention. Upon receipt of the intervention, the Delayed intervention group demonstrated significant improvements in parent- and child-reported posttraumatic stress, depression, and anxiety symptoms. The Immediate Intervention group maintained or showed continued gains in all symptom domains over the 3-month follow-up period (6 month assessment).</p> <p><b>Conclusions:</b> Findings support the feasibility, acceptability, and effectiveness of the <i>Bounce Back</i> intervention as delivered by school-based clinicians for children with traumatic stress.</p>
<p><b>Implementation Requirements &amp; Readiness</b></p>	<p>Full support of the school principal and administration should be obtained prior to initiating any of the <i>Bounce Back</i> activities.</p> <ul style="list-style-type: none"> <li>• It is helpful to prepare toolkits containing the program handouts and necessary materials.</li> <li>• A whiteboard or large writing pad and extra copies of the activity worksheets are used for each session.</li> <li>• Active parental consent is usually required for participants.</li> <li>• Teachers whose students will be impacted by the program are identified and asked for input related to group schedules.</li> <li>• Referral paths should be identified for children who require more intensive services in addition to <i>Bounce Back</i> or who remain symptomatic at the end of the group.</li> </ul> <p><i>Bounce Back</i> is not a crisis intervention. If an entire school is affected by a disaster or violence, it is recommended that school counselors wait at least a month after the trauma before identifying those children in need of <i>Bounce Back</i>.</p>
<p><b>Training Materials &amp; Requirements</b></p>	<p>It is recommended that a professional with clinical mental health training deliver the <i>Bounce Back</i> program.</p> <p>The recommended training approach is for trainees to attend an in-person two-day training, and then receive ongoing supervision from a local clinician with expertise in CBT and/ or child trauma treatment. There are also options to receive ongoing consultation from our training team. Virtual or in-person live trainings can be arranged by contacting Pamela Vona at <a href="mailto:pamela@safeandresilient.org">pamela@safeandresilient.org</a></p> <p>Online training is also available at <a href="http://www.bouncebackprogram.org">www.bouncebackprogram.org</a></p> <p>The manual and workbook can be obtained from the treatment developer through the training process.</p>

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<p><b>Pros &amp; Cons/ Qualitative Impressions</b></p>	<p><b>What are the pros of this intervention over others for this specific group</b> <i>(e.g., addresses stigma re. treatment, addresses transportation barriers)?</i></p> <p>Implementation in schools enables clinicians to reach underserved students who might not otherwise receive mental health care. It also reduces barriers to care such as transportation and Bounce Back is typically delivered at no cost to the family.</p> <p><b>What are the cons of this intervention over others for this specific group</b> <i>(e.g., length of treatment, difficult to get reimbursement)?</i></p> <p>Not all students are permitted by parents to participate in screening or intervention in schools. Thus, some students are missed. Some students will need additional treatment above and beyond this early intervention group treatment, so clinicians who deliver Bounce Back also need to link with other services and make appropriate referrals after on in parallel to Bounce Back.</p>
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<p><b>References</b></p>	<p>Gonzalez, A., Monzon, N., Solis, D., Jaycox, L., and Langley, A.K. (2016). Trauma exposure in elementary school children: Description of screening procedures, prevalence of exposure, and posttraumatic stress symptoms. <i>School Mental Health, 8</i>(1), 77-78.</p> <p>Jaycox L.H., Cohen J.A., Mannarino A.P, Walker, D.W., Langley A.K., Gegenheimer K.L., ... &amp; Schonlau M. (2010). Children’s mental health care following Hurricane Katrina : A field trial of trauma-focused psychotherapies. <i>Journal of Traumatic Stress, 23</i>(2), 223-31.</p> <p>Kataoka S.H., Stein B.D., Jaycox L.H., Wong M., Escudero P, Tu W., ... &amp; Fink A., (2003). A school-based mental health program for traumatized Latino immigrant children. <i>Journal of the American Academy of Child &amp; Adolescent Psychiatry, 42</i>(3), 311-18.</p> <p>Langley, A.K., Santiago, C.D., Rodriguez, A., &amp; Zelaya, J. (2013). Improving implementation of mental health services for trauma in multicultural elementary schools: Stakeholder perspectives on parent and educator engagement. <i>The Journal of Behavioral Health Services and Research, 40</i>(3), 247-262.</p> <p>Langley, A.K., Gonzalez, A., Sugar, C.A., Solis, D., &amp; Jaycox, L. (2015). Bounce back; Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. <i>Journal of Consulting and Clinical Psychology, 83</i>(5), 853-865.</p> <p>Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Elliott, M.N. &amp; Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. <i>Journal of the American Medical Association, 290</i>(5), 603-11.</p>