School-Based Interventions for Children Exposed to Violence

To the Editor: Dr Stein and colleagues[1] found that a 10-session, school-based cognitive-behavioral treatment (CBT) program was effective for reducing the levels of posttraumatic stress disorder (PTSD) and depression among children exposed to violence.

I am concerned that the authors did not find a significant difference in classroom behavior after the intervention. Schools have limited mental health resources and need to prioritize how they choose to provide them for students, whether they emphasize preventive interventions or focus resources on the more disruptive, demanding students.[2,3] Thus, the decrease in PTSD and depression might have been due to increased support of the teachers and administrators, rather than to the CBT program itself. The authors stated that they provided "frequent consultations with school staff about implementation issues" and made "efforts to educate teachers and administrators about how violence affects children" that "helped to make the program acceptable and relevant to schools." This is an important point, as such standardized curricula may be ineffective without the infrastructure to modify the behavior of staff.[4]

Stein et al were concerned that their intervention did not affect teachers' assessments of acting-out, shyness, and learning problems. However, the authors excluded students who were "too disruptive to participate in a group treatment"—the very students for whom most schools would be inclined to direct their mental health clinicians invest their valuable time.

Finally, as this study population was primarily Latino, there should have been a greater effort to increase bicultural competency,[5,6] wherein children receive explicit instructions about how to negotiate conflict and access help in the classroom.

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To The Editor: In their randomized controlled trial of school-based CBT, Dr Stein and colleagues[1] excluded children "with symptoms of PTSD . . . that they were not willing to discuss in a group." The scientific and ethical value of this restriction, however, has not always been appreciated in international psychosocial relief efforts. Group interventions for children traumatized by civil wars and genocide in the developing world have used methods similar to the approach of Stein et al, emphasizing exposure to trauma memories through imagination and artistic expression.[2] However, children uncomfortable with emotional self-disclosure have been included and sometimes pressed to participate actively.[2] Perhaps not surprisingly, uncontrolled trials of these interventions found that a substantial proportion of children experienced symptom exacerbation, rather than alleviation.[3]

Although Stein et al found CBT to be safe and effective for children sufficiently willing to discuss their problems, it would be of interest to know what proportion of potential participants were excluded solely because they failed to meet this criterion. It would also be interesting to examine their symptom levels at 3 months after randomization of the trial participants. In cultures that prize emotional restraint or in which continuing political and military instability place child witnesses in peril, the proportion of socially "reserved" children may be substantial. Interventions for these children—possibly the most damaged or most at risk for persistent disturbance—is an urgent issue in international humanitarian crises.

Finally, in their analysis Stein et al only included children who completed the intervention. The correct primary analysis of controlled trial data uses all randomized participants[4]—ie, an intention-to-treat (ITT) analysis—in which one of several approaches is used to impute scores to participants for whom some or all postbaseline measures are absent. Given the substantial intervention effects for posttraumatic stress symptoms and psychosocial dysfunction, an ITT analysis would be unlikely to alter the study's basic conclusions. However, such an analysis might weaken the results regarding depressive symptoms. In any case, with controlled trials, reporting the ITT findings is always required.

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