I. COURSE DOMAIN AND BOUNDARIES

This course incorporates the new National Child Traumatic Stress Network core curriculum on child trauma (CCCT). The course conveys the crucial evidence-based concepts, components, and skills designed by the NCTSN to strengthen competency in assessment, referral, and treatment. This course will introduce students to the common concepts (general theory and foundational knowledge), components (intervention and treatment elements) and skills (practitioner skills) underlying evidence-based treatment for traumatized children and adolescents. Trauma is broadly defined, and includes children and adolescents exposed to traumatic events including, but not limited to natural disasters, war, abuse and neglect, medical trauma and witnessing interpersonal crime (e.g. domestic violence) and other traumatic events. The course will highlight the role of development, culture and empirical evidence in trauma-specific interventions with children, adolescents and their families. It will address the level of functioning of primary care giving environments and assess the capacity of the community to facilitate restorative processes. The course focuses on assessment and intervention; not treatment. Prerequisite: S15-5015, S15-5038 and permission of Instructor.
II. MSW COMPETENCIES ADDRESSED IN THIS COURSE

<table>
<thead>
<tr>
<th>Competency</th>
<th>Code</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate Ethical and Professional Behavior</td>
<td>C1</td>
<td>Reinforced</td>
</tr>
<tr>
<td>Engage Diversity and Difference in Practice</td>
<td>C2</td>
<td>Reinforced</td>
</tr>
<tr>
<td>Advance Human Rights and Social, Economic, and Environmental Justice</td>
<td>C3</td>
<td>Reinforced</td>
</tr>
<tr>
<td>Engage in Practice-Informed Research and Research-Informed Practice</td>
<td>C4</td>
<td>Reinforced</td>
</tr>
<tr>
<td>Engage with Individuals, Families, Groups, Organizations, and Communities</td>
<td>C6</td>
<td>Emphasized</td>
</tr>
<tr>
<td>Assess Individuals, Families, Groups, Organizations, and Communities</td>
<td>C7</td>
<td>Emphasized</td>
</tr>
<tr>
<td>Intervene with Individuals, Families, Groups, Organizations, and Communities</td>
<td>C8</td>
<td>Emphasized</td>
</tr>
</tbody>
</table>

III. BROWN SCHOOL ACADEMIC POLICIES

Academic Integrity: Academic integrity in the completion of tests, oral presentations and written assignments (including statistical syntax) is expected. Violations of academic integrity (e.g., plagiarism) are very serious offenses. Violations will result in notification to the Assistant Dean for the appropriate (MSW or MPH) program and may result in referral to the Academic and Professional Integrity Committee, which could lead to dismissal from the program. Please review and adhere to the entire set of Academic Integrity guidelines in the student handbook on Inside Brown:

Student Handbook 2017-2018

Accommodations: If you have a learning disability, sensory, or physical disability or other impairment, and you may need special assistance in lectures, reading, written assignments, and/or exam taking, please contact the Brown School Director of Student Affairs who can provide coordination of accommodations at Washington University and the Brown School. The Disability Resource Center, a University-wide resource, provides diagnostic and academic accommodations support and referrals.

English Language Proficiency: If your English language proficiency is such that you may need special assistance in lectures, reading, written assignments, and/or exam taking, please communicate these needs to your instructor who may refer you to the English Language Program (ELP), a University-wide resource which provides classes and academic English language support designed to increase non-native English speaking students' English language proficiency and to facilitate their academic success at Washington University. You may also find the Academic Assistance resources available through the Office for International Students and Scholars to be helpful.

Professional Use of Electronic Devices in the Classroom: Computers or other electronic devices, including “smart pens” (devices with an embedded computer and digital audio recorder which records the classroom lecture/discussion and links that recording to the notes taken by the student), may be used by students at the discretion of the faculty member to support the learning activities in the classroom. These include such activities as taking notes and accessing course readings under discussion. If a student wishes to use a smart-pen or other electronic device to audio record lectures or class discussions, they must notify the instructor in advance of doing so. Permission to use recording devices will be at the discretion of the instructor, unless this is an accommodation approved by Disability Resources.

Nonacademic use of laptops and other devices is distracting and seriously disrupts the learning process for everyone. Neither computers nor other electronic devices are to be used in the classroom during class
for non-academic reasons. This use includes emailing, texting, social networking, and use of the Internet. The use of cell phones during class time is prohibited, and they should be set on silent before class begins. In the case of an emergency, please step out of the room to take the call. The instructor has the right to hold students accountable for meeting these expectations, and failure to do so may result in a loss of participation points, a loss of the privilege of computer use in the classroom, or being asked to leave the classroom.

Religious Holidays: The Brown School recognizes the individual student’s choice in observing religious holidays that occur during periods when classes are scheduled. Students are encouraged to arrange with their instructors to make up work missed as a result of religious observance, and instructors are asked to make every reasonable effort to accommodate such requests.

IV. WASHINGTON UNIVERSITY ACADEMIC SUPPORT POLICIES

Accommodations based upon sexual assault: The University is committed to offering reasonable academic accommodations to students who are victims of sexual assault. Students are eligible for accommodation regardless of whether they seek criminal or disciplinary action. Depending on the specific nature of the allegation, such measures may include but are not limited to: implementation of a no-contact order, course/classroom assignment changes, and other academic support services and accommodations. If you need to request such accommodations, please direct your request to Kim Webb (kim_webb@wustl.edu), Director of the Relationship and Sexual Violence Prevention Center. Ms. Webb is a confidential resource; however, requests for accommodations will be shared with the appropriate University administration and faculty. The University will maintain as confidential any accommodations or protective measures provided to an individual student so long as it does not impair the ability to provide such measures.

If a student comes to me to discuss or disclose an instance of sexual assault, sex discrimination, sexual harassment, dating violence, domestic violence or stalking, or if I otherwise observe or become aware of such an allegation, I will keep the information as private as I can, but as a faculty member of Washington University, I am required to immediately report it to my Department Chair or Dean or directly to Ms. Jessica Kennedy, the University’s Title IX Director. If you would like to speak with directly Ms. Kennedy directly, she can be reached at (314) 935-3118, jwkennedy@wustl.edu, or by visiting the Title IX office in Umrah Hall. Additionally, you can report incidents or complaints to the Office of Student Conduct and Community Standards or by contacting WUPD at (314) 935-5555 or your local law enforcement agency. See: Title IX

You can also speak confidentially and learn more about available resources at the Relationship and Sexual Violence Prevention Center by calling (314) 935-8761 or visiting the 4th floor of Seigle Hall. See: RSVP Center

Bias Reporting: The University has a process through which students, faculty, staff and community members who have experienced or witnessed incidents of bias, prejudice or discrimination against a student can report their experiences to the University’s Bias Report and Support System (BRSS) team. See: brss.wustl.edu

Mental Health: Mental Health Services’ professional staff members work with students to resolve personal and interpersonal difficulties, many of which can affect the academic experience. These include conflicts with or worry about friends or family, concerns about eating or drinking patterns, and feelings of anxiety and depression. See shs.wustl.edu/MentalHealth

Additional Issues or Concerns: If you feel that you need additional supports in order to be successful in your time at Brown, beyond the afore mentioned accommodations, please contact Essie Rochman,
Director of Student Affairs at erochman@wustl.edu. She can assist you in navigating a myriad of concerns. Her office is in Brown Hall, room 320.

V. TEXTS/REQUIRED READINGS

REQUIRED TEXTS


RECOMMENDED TEXTS


VI. ORGANIZATION OF COURSE

This is an intensive weekend course that uses Problem-Based Learning (PBL) as the primary methodology. Problem–Based Learning parallels the evidence-based practice approach. Evidence-based practice is conceptualized as a process and not an end product. In the process, students learn how to develop a clinical question, search for evidence, appraise evidence, formulate and apply interventions and evaluate for fidelity of implementation as well as client effectiveness.

Throughout each class session we will focus on a specific clinical case involving a traumatic event experienced by a child or adolescent and use PBL to strengthen case conceptualization and treatment planning skills. In PBL, critical analysis through deep questioning is the primary approach to learning, so there will be very little lecturing. Consequently, it is essential that all students be actively involved at all times during class discussion.

COURSE OBJECTIVES

These objectives outline the practice behaviors expected upon completion of this course. Students will demonstrate through class discussion, activities, and written assignments the ability to:

1. Explain how traumatic experiences are inherently complex and require differential interventions for children and adolescents who may exhibit a variety of responses following exposure to a traumatic event.

2. Describe and give examples of the neurobiological consequences of exposure to trauma.

3. Illustrate how trauma can interact with and exacerbate pre-existing vulnerabilities (e.g., history of prior trauma, loss, or psychopathology) across development.
4. Describe and give examples of how pre-existing protective and promotive factors (e.g., positive attachment relationship with primary caregiver, family cohesion, social support, adaptive coping, social competence) can reduce the adverse impacts of trauma exposure across development.

5. Recognize and name how trauma exposure may generate adverse life events and circumstances (secondary adversities) that may continue to transmit the adverse effects of trauma over time and across development.

6. Recognize and demonstrate how interventions with trauma-exposed children and adolescents include promoting the children or adolescent’s external (objective) safety and internal (psychological) safety.

7. Explain how cultural factors and processes may profoundly influence trauma exposure and should be systematically considered at all stages of intervention.

8. Choose a framework for interventions which address the level of functioning of primary care-giving environments, including the parent/caregiver, family unit, and their relationship with the child or adolescent.

9. Recognize how interventions with trauma-exposed children and adolescents need to address ethical and legal issues as these arise, as well as to describe the profound effect institutions can have on the course of children’s post-trauma adjustments and how to intervene in these systems.

10. Provide examples of how interventions with trauma-exposed children and adolescents impact the practitioner, and to identify and practice appropriate self-care techniques.

The objectives of the course will be met through a combination of an intensive examination of five cases with class discussion in both small and large groups, class exercises, role play, and the use of films and videotapes. The course is structured in 3 units (weekends), organized according to children’s developmental age. Students are expected to come to class prepared to discuss key concepts from the readings during each class session and apply such concepts to practice situations.

VII. ROLE OF INSTRUCTOR AND STUDENTS

1. Students are expected to attend every class for the full length of the scheduled time. Late arrival and early departure will result in a reduction in your course grade. Absences from a class may result in a failing grade.

2. Students are expected to enhance the learning potential of the class by actively participating. Sharing opinions, ideas, concerns and viewpoints is strongly encouraged.

3. Students are expected to be respectful of the opinions and feelings of other students and guest speakers, even though they may differ from their own.

VIII. ASSIGNMENTS AND GRADING CRITERIA

Grades. Grades are assigned based on the student’s ability to assimilate and apply class materials. Course grades will be based on the following assignments. Additional information about each assignment will be provided in class.
A word about grades: Grades are not a reflection of your value as a person. They are a reflection of the reality of balancing school with other life events and responsibilities, as well as your level of effort. Grades also reflect the extent to which the content of a course fits with your existing knowledge and skills, which will vary from course to course. What is most important is that you are challenged and that you learn.

Assignments

There will be three small group presentations and two written assignments during the course. In addition, students are expected to be present during all of each class session and to actively volunteer and participate in all class activities.

1. Written Assignments—Goals:
   - The first paper provides the opportunity to organize and conceptualize case data using one core concept so that students will be able to demonstrate in-depth understanding and application of the core concepts to the assessment of children and adolescents who have experienced trauma.
   - Because self-care is important for providers, the second paper provides an opportunity to demonstrate the ability to reflect on reactions to case material and "rehearse" steps that one can take to examine and manage one’s own responses, using literature on vicarious traumatization and self-care to inform the discussion.

Paper #1: Core Concepts   Due: Feb 2nd

Using the Amarika, Juan, OR Geraldine case, organize selected facts of the case through the lens of one core concept, and discuss the facts in a way that promotes understanding of the child’s / family’s experience of trauma. Discuss how the core concept relates to an understanding of risk and protective factors. Please do not select core concept #7 (re: risk and protective factors) for this assignment.

Paper #2: Self-Care   Due: Feb 23rd

Identify your personal reactions to the case of Amarika, Juan, Geraldine, Ibrahim OR James. If you were the social worker, how might your reactions affect your working relationships with the children, caregivers, and/or other professionals in the case? What self-care strategies would you use to manage your own intense reactions and possible vicarious trauma? Review and cite literature about vicarious trauma and self-care that provided help in thinking about care for yourself.

Format: Each paper should be 7-8 pages in length. References are expected, using APA format. Additional guidelines and rubrics for each assignment are available on Blackboard.

Weight: 70% of course grade (each paper is worth 35%)

2. Group Presentations—Goals:
   - The goal of Presentations #1 & #2 is to familiarize students with the evidence-based literature that can inform understanding the experience of a traumatized child, adolescent, and/or their family.
   - The goal of Presentation #3 is to familiarize students with the process of trauma-informed assessment and treatment planning for a case involving child/adolescent trauma.
Presentation #1 & #2: On Jan 20th & Feb 2nd, before you break for lunch, identify an evidence-based question that the group will investigate. This topic or question should emerge from the discussion of the specific case being discussed that day. You will have 1.5 hours total for lunch and working on your presentation. Plan to spend 45 minutes with each group member researching the empirical literature in professional journals online for evidence that helps answer the question. At least 15 minutes are to be used to summarize your findings in your small group, in preparation for a presentation to the class that afternoon. Format: This is a 10-minute oral presentation by the small group followed by a 10-minute facilitation of class discussion. You will need to email each article you present on (citation, weblink, or full-text attachment) to the class and instructor before your presentation.

Presentation #3: On Feb 3rd, your small group will develop an assessment and treatment plan for James using the frameworks provided in our Saxe and Cohen texts. You will have 1.5 hours total for lunch and working on your presentation. Format: This is a 10-minute oral presentation by the small group.

Weight: 15% of course grade (each presentation is worth 5%)

- Participation

This includes demonstrated ability to listen deeply and attentively, integrate knowledge from specific course readings, and to actively volunteer and contribute to class discussions in service of promoting class learning. Participation beyond class sessions is also a requirement for this course. Written course evaluations must be completed by the student independently via the University’s online evaluation system - this is not optional and will be considered as a component of the participation grade for this course. Weight: 15% of course grade

Assignment Point Value

| Reflection Papers (35% each) | 70 points |
| Group Presentations (5% each) | 15 points |
| Class Participation          | 15 points |
| Total                        | 100 points |

Except under extremely unusual circumstances, assignments must be turned in on the due date. Late assignments will result in a deduction of points for each day late (including weekends) off the assignment score unless prior approval is obtained from the instructor or a compelling situation prevents prior approval. A death in the family is an example of a compelling or extreme situation. Additionally, points will be deducted from the final scores accumulated in each lab for lack of attendance and participation.

Grade Scale: 100-94 A 93-90 A- 89-88 B+ 87-84 B 83-80 B- 79-78 C+ 77-74 C 73-70 C- 69 and below F
## IX. COMPETENCY ALIGNMENT TO ASSIGNMENTS AND COURSE ACTIVITIES

<table>
<thead>
<tr>
<th>GRADED ASSIGNMENTS</th>
<th>Competency/ies</th>
<th>Dimension/s</th>
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<tbody>
<tr>
<td><strong>Reflection Papers:</strong></td>
<td></td>
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<tr>
<td>(1) Core Concepts</td>
<td>C7</td>
<td>Knowledge, Skills, Cognitive and Affective Processes, and Values</td>
</tr>
<tr>
<td>(2) Self-Care</td>
<td>C1</td>
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<tr>
<td><strong>Group Presentations:</strong></td>
<td></td>
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<tr>
<td>(1) Evidence-Based Question</td>
<td>C4</td>
<td>Knowledge, Skills, Cognitive and Affective Processes, and Values</td>
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<tr>
<td>(2) Evidence-Based Question</td>
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<td></td>
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<tr>
<td>(3) Assessment</td>
<td>C7</td>
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<tr>
<td><strong>Trauma-Focused Cognitive-Behavioral Therapy (TFCBT) Online Course</strong></td>
<td>C6-9</td>
<td>Knowledge, Skills, Cognitive and Affective Processes, and Values</td>
</tr>
</tbody>
</table>

### Course Activities

| Readings | C1-4, C6-9 | Knowledge, Cognitive and Affective Processes, and Values |
| Problem Based Learning through Five Cases: | | |
| • Core concepts | C1-4, C6-9 | Knowledge, Skills, Cognitive and Affective Processes, and Values |
| • Ecomaps | | |
| • Genograms | | |
| • Timelines | | |
| • Treatment Plans | | |
| • Role Plays | | |
| • Moment-to-Moment | | |
| **Trauma-Focused Cognitive-Behavioral Therapy (TFCBT) In-Person Training** | C6-9 | Knowledge, Skills, Cognitive and Affective Processes, and Values |
The 12 Core Concepts for Understanding Traumatic Stress Responses in Childhood
Concepts for understanding the traumatic experience

1. Traumatic experiences are inherently complex.

Every traumatic event—even events that are relatively circumscribed—is made up of different traumatic moments. These moments may include varying degrees of objective life threat, physical violation, and witnessing of injury or death. Trauma-exposed children experience subjective reactions to these different moments that include changes in feelings, thoughts, and physiological responses; and concerns for the safety of others. Children may consider a range of possible protective actions during different moments, not all of which they can or do act on. Children’s thoughts and actions (or inaction) during various moments may lead to feelings of conflict at the time, and to feelings of confusion, guilt, regret, and/or anger afterward. The nature of children’s moment-to-moment reactions is strongly influenced by their prior experience and developmental level. Events (both beneficial and adverse) that occur in the aftermath of the traumatic event introduce additional layers of complexity. The degree of complexity often increases in cases of multiple or recurrent trauma exposure and in situations where a primary caregiver is a perpetrator of the trauma.

2. Trauma occurs within a broad context that includes children’s personal characteristics, life experiences, and current circumstances.

Childhood trauma occurs within the broad ecology of a child’s life that is composed of both child-intrinsic and child-extrinsic factors. Child-intrinsic factors include temperament, prior exposure to trauma, and prior history of psychopathology. Child-extrinsic factors include the surrounding physical, familial, community, and cultural environments. Both child-intrinsic and child-extrinsic factors influence children’s experience and appraisal of traumatic events; expectations regarding danger, protection, and safety; and course of posttrauma adjustment. For example, both child-intrinsic factors such as prior history of loss, and child-extrinsic factors such as poverty may act as vulnerability factors by exacerbating the adverse effects of trauma on children’s adjustment.

3. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children’s daily lives.

Traumatic events often generate secondary adversities such as family separations, financial hardship, relocations to a new residence and school, social stigma, ongoing treatment for injuries and/or physical rehabilitation, and legal proceedings. The cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community. These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery. Children’s exposure to trauma reminders and loss reminders can serve as additional sources of distress. Secondary adversities, trauma reminders, and loss reminders may produce significant fluctuations in trauma survivors’ posttrauma emotional and behavioral functioning.

Concepts for understanding the consequences of trauma exposure and its aftermath
(Domains of functioning that can be affected)

4. Children can exhibit a wide range of reactions to trauma and loss.

Trauma-exposed children can exhibit a wide range of posttrauma reactions that vary in their nature, onset, intensity, frequency, and duration. The pattern and course of children’s posttrauma reactions are influenced by the type of traumatic experience and its consequences, child-intrinsic factors including prior trauma or loss, and the posttrauma physical and social environments. Posttraumatic stress and grief
reactions can develop over time into psychiatric disorders, including posttraumatic stress disorder (PTSD), separation anxiety, and depression. Posttraumatic stress and grief reactions can also disrupt major domains of child development, including attachment relationships, peer relationships, and emotional regulation, and can reduce children’s level of functioning at home, at school, and in the community. Children’s posttrauma distress reactions can also exacerbate preexisting mental health problems including depression and anxiety. Awareness of the broad range of children’s potential reactions to trauma and loss is essential to competent assessment, accurate diagnosis, and effective intervention.

5. Danger and safety are core concerns in the lives of traumatized children.

Traumatic experiences can undermine children’s sense of protection and safety, and can magnify their concerns about dangers to themselves and others. Ensuring children’s physical safety is critically important to restoring the sense of a protective shield. However, even placing children in physically safe circumstances may not be sufficient to alleviate their fears or restore their disrupted sense of safety and security. Exposure to trauma can make it more difficult for children to distinguish between safe and unsafe situations, and may lead to significant changes in their own protective and risk-taking behavior. Children who continue to live in dangerous family and/or community circumstances may have greater difficulty recovering from a traumatic experience.

6. Traumatic experiences affect the family and broader caregiving systems.

Children are embedded within broader caregiving systems including their families, schools, and communities. Traumatic experiences, losses, and ongoing danger can significantly impact these caregiving systems, leading to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers’ own distress and concerns may impair their ability to support traumatized children. In turn, children’s reduced sense of protection and security may interfere with their ability to respond positively to their parents’ and other caregivers’ efforts to provide support. Traumatic events—and their impact on children, parents, and other caregivers—also affect the overall functioning of schools and other community institutions. The ability of caregiving systems to provide the types of support that children and their families need is an important contributor to children’s and families’ posttrauma adjustment. Assessing and enhancing the level of functioning of caregivers and caregiving systems are essential to effective intervention with traumatized youths, families, and communities.

7. Protective and promotive factors can reduce the adverse impact of trauma.

Protective factors buffer the adverse effects of trauma and its stressful aftermath, whereas promotive factors generally enhance children’s positive adjustment regardless of whether risk factors are present. Promotive and protective factors may include child-intrinsic factors such as high self-esteem, self-efficacy, and possessing a repertoire of adaptive coping skills. Promotive and protective factors may also include child-extrinsic factors such as positive attachment with a primary caregiver, possessing a strong social support network, the presence of reliable adult mentors, and a supportive school and community environment. The presence and strength of promotive and protective factors—both before and after traumatic events—can enhance children’s ability to resist, or to quickly recover (by resiliently “bouncing back”) from the harmful effects of trauma, loss, and other adversities.

8. Trauma and posttrauma adversities can strongly influence development.

Trauma and posttrauma adversities can profoundly influence children’s acquisition of developmental competencies and their capacity to reach important developmental milestones in such domains as cognitive functioning, emotional regulation, and interpersonal relationships. Trauma exposure and its aftermath can lead to developmental disruptions in the form of regressive behavior, reluctance, or
inability to participate in developmentally appropriate activities, and developmental accelerations such as leaving home at an early age and engagement in precocious sexual behavior. In turn, age, gender, and developmental period are linked to risk for exposure to specific types of trauma (e.g., sexual abuse, motor vehicle accidents, peer suicide).


Children’s capacities to appraise and respond to danger are linked to an evolving neurobiology that consists of brain structures, neurophysiological pathways, and neuroendocrine systems. This “danger apparatus” underlies appraisals of dangerous situations, emotional and physical reactions, and protective actions. Traumatic experiences evoke strong biological responses that can persist and that can alter the normal course of neurobiological maturation. The neurobiological impact of traumatic experiences depends in part on the developmental stage in which they occur. Exposure to multiple traumatic experiences carries a greater risk for significant neurobiological disturbances including impairments in memory, emotional regulation, and behavioral regulation. Conversely, ongoing neurobiological maturation and neural plasticity also create continuing opportunities for recovery and adaptive developmental progression.

Guiding concepts for intervention with trauma-exposed children and families

10. Culture is closely interwoven with traumatic experiences, response, and recovery.

Culture can profoundly affect the meaning that a child or family attributes to specific types of traumatic events such as sexual abuse, physical abuse, and suicide. Culture may also powerfully influence the ways in which children and their families respond to traumatic events including the ways in which they experience and express distress, disclose personal information to others, exchange support, and seek help. A cultural group’s experiences with historical or multigenerational trauma can also affect their responses to trauma and loss, their world view, and their expectations regarding the self, others, and social institutions. Culture also strongly influences the rituals and other ways through which children and families grieve over and mourn their losses.

11. Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.

Traumatic experiences often constitute a major violation of the expectations of the child, family, community, and society regarding the primary social roles and responsibilities of influential figures in the child’s life. These life figures may include family members, teachers, peers, adult mentors, and agents of social institutions such as judges, police officers, and child welfare workers. Children and their caregivers frequently contend with issues involving justice, obtaining legal redress, and seeking protection against further harm. They are often acutely aware of whether justice is properly served and the social contract is upheld. The ways in which social institutions respond to breaches of the social contract may vary widely and often take months or years to carry out. The perceived success or failure of these institutional responses may exert a profound influence on the course of children’s posttrauma adjustment, and on their evolving beliefs, attitudes, and values regarding family, work, and civic life.

12. Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care.

Mental healthcare providers must deal with many personal and professional challenges as they confront details of children’s traumatic experiences and life adversities, witness children’s and caregivers’ distress, and attempt to strengthen children’s and families’ belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper
self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time.

X. COURSE OUTLINE

Weekend 1: Friday, January 19th, Saturday, January 20th & Sunday, January 21st, 2018

SECTION I - INFANCY AND PRESCHOOL

Topic Day 1: Amarika: One and one-half year old African American female; witness to community violence (mother shot); historical trauma.

At the conclusion of class session one, the learner will:

- Know that very young children, including babies in the first year of life, are affected by traumatic events in their physiological, emotional, social, and cognitive functioning and enact the traumatic experience through their behavior even when they are unable to describe it verbally.

- Understand that caregiver and child functioning are inter-connected and influence each other, especially during the first five years of life.

- Identify specific ways in which the young child’s biological, emotional, social, and cognitive development may be affected by the experience of trauma.

- Appreciate that historical trauma and other preexisting ecological stressors can affect the family’s perception of, and response to, the trauma.

- Identify engagement skills used with infants and caregivers.

Required Readings:


   *As an alternative to this reading, you could choose to read Chapters 1-2 of Cohen and then complete the online training available at https://tfcbt.musc.edu/, newly revised and expected to open for enrollment on 1/1/18. This online training used to be a required portion of this course but is now optional due to a new cost associated with it, of $35. The additional Cohen chapters have been added in as replacement for completing this training.*


Resource Readings (Recommended):


14. Zero to Three National Center for Infants, Toddlers, and Families www.zerotothree.org

**Topic Day 2: Juan** – Three year old Latino male: victim of alleged paternal sexual abuse.

At the conclusion of class session two, the learner will:

- Appreciate the impact of sexually inappropriate and possible traumatic events on a pre-school child.

- Understand the impact of the parent/caregiver’s reaction to the suspected sexual abuse and how that impacts the child’s experience of and recovery from the traumatic event.

- Be aware of the behavioral manifestations of exposure to sexually inappropriate material (through witnessing) or to sexual molestation

- Learn how to enlist parent/caregiver in the therapeutic process.

- Appreciate the role of external, authoritative systems (e.g. CPS) in securing a safe environment for the child and family.

- Identify the manner in which culture affects and interacts with the child and family response to the trauma, and to helping professionals

**Required Readings:**


**Resource Readings (Recommended):**


**SECTION II - ELEMENTARY**

**Topic Day 3: Geraldine** - 9 year old, African American female, witness to murder of mother.

At the conclusion of class session one, the learner will:

- Identify the unique characteristics of an assessment conducted during the acute phase of a traumatic experience.
- Identify the unique legal considerations that need to be made in the case where a child witnesses one parent kill another.
- Describe the peritraumatic dissociative process Geraldine experiences at the time of her mother’s murder. Describe how this is similar and different to later experiences of dissociation. Identify at least two places in the vignette where Geraldine’s use of dissociation interferes with her ability to function.
- Identify triggering experiences (both internal and external) for Geraldine. Describe the two primary ways in which she seems to cope with being triggered.
- Identify the ways in which Geraldine experiences this murder that are specific to her developmental level.
- Identify the cultural factors and processes that may be influencing this family’s experience of trauma (e.g., kinship family network, spirituality, historical trauma, interactions with legal and child welfare systems).

**Required Readings:**


**Resource Readings (Recommended):**


Research on Social Work Practice, 18, 198-211.


Weekend 2: Friday, February 2nd & Saturday, February 3rd, 2018

Topic Day 1: Ibrahim: 10-year old Somalian male; refugee and victim of new traumatic incident.

At the conclusion of class session one, the learner will:

- Identify specific components of the child’s post-traumatic distress (and the impact of child’s developmental stage, culture, and position in the family).

- Analyze promotive factors in the child’s environment and how to harness them for treatment.

- Identify pre-existing vulnerabilities and describe their interaction with trauma-related symptoms.

- Specify the child’s moment-by-moment experience of the traumatic event and how it relates to current symptoms.

Required Readings:


Immigrant and refugee communities: Resiliency, trauma, policy, and practice. Social Thought, 22, 135-158.

Resource Readings (Recommended):


12. Van der Kolk, B. (2014). Chapter 12: The unbearable heaviness of remembering; Chapter 13:
Healing from trauma: Owning yourself.


**SECTION III - ADOLESCENCE**

**Topic Day 2: James** - 14-year old Caucasian male; victim of complex trauma (physical and psychological abuse, neglect; exposure to caregiver substance abuse).

At the conclusion of class session one, the learner will:

- Describe the complex manifestations of early trauma.

- Recognize an array of trauma exposures (subtle and overt) and their intersect with attachment issues.

- Identify and describe at least three developmental domains impacted by early interpersonal trauma.

- Identify and describe at least three examples of how symptoms of complex trauma exposure represent functional attempts to cope.

**Required Readings:**


**Resource Readings (Recommended):**


**Weekend Three: Friday, February 23rd & Saturday, February 24th, 2018**

**SECTION IV: TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY**

**Topic Days One & Two:** Training in Trauma Focused Cognitive Behavioral Therapy (TFCBT) and review of standardized instruments to assess trauma exposure and associated effects in children and adolescents provided by a nationally certified trainer from the Children’s Advocacy Center.

**Required Readings:**


**ADDITIONAL RESOURCES**

**INTERNET RESOURCES:**

Chicago Safe Start: [www.chicagosafestart.net](http://www.chicagosafestart.net)
Center for Disease Control and Prevention: [www.cdc.gov/ViolencePrevention/index.html](http://www.cdc.gov/ViolencePrevention/index.html)
The Children’s Defense Fund: [www.cdf.org](http://www.cdf.org)
Fun Resources for Kids: [http://kids.niehs.nih.gov/braint.htm](http://kids.niehs.nih.gov/braint.htm)
Information for Practice: [http://www.nyu.edu/socialwork/ip/](http://www.nyu.edu/socialwork/ip/)
Irving B. Harris Training Center for Infant and Toddler Development: The University of Minnesota: College of Education and Human Development: [www.harristrainingcenter.org](http://www.harristrainingcenter.org)
NASW Standards for Practice: (Available by specialty area) [www.socialworkers.org](http://www.socialworkers.org)
National Center for Children Exposed to Violence: [www.nccev.org/violence/index.html](http://www.nccev.org/violence/index.html)
National Center for PTSD: [www.ncptsd.org](http://www.ncptsd.org)
National Institute for Trauma and Loss in Children: [http://www.startraineing.org/tlc](http://www.startraineing.org/tlc)
Ounce of Prevention: www.ounceofprevention.org
The Annie E. Casey Foundation: http://www.aecf.org/
The Urban Institute: http://www.urban.org/
Society for Prevention Research: http://www.preventionresearch.org/
Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/
Trauma Informed Art Therapy:
http://www.cathymalchiodi.com/Trauma%20Informed%20Art%20Therapy.html
Violence Policy Center: www.vpc.org
Yale Child Study: www.info.med.yale.edu/chldstdy/
Zero to Three: http://www.zerotothree.org

RELEVANT RESOURCES:

NATIONAL CHILD TRAUMATIC STRESS NETWORK (NCTSN): http://www.nctsnet.org
Caring for Children Who Have Experienced Trauma: A Workshop for Resources Parents
http://www.nctsnet.org/nccts/nav.do?pid=ctr_rsch_prod_RPC_guide
Facts on Traumatic Stress and Children with Developmental Disabilities:
Facts on Trauma and Homeless Children
http://www.nctsnet.org/ncts_assets/pdfs/promising_practices/Facts_on_Trauma_and_Homeless_Children.pdf
Helping Children in the Child Welfare System Heal From Trauma: A Systems Integration Approach
http://www.nctsnet.org/ncts_assets/pdfs/promising_practices/A_Systems_Integration_Approach.pdf
Culture and Trauma http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_srcv

National Native Children’s Trauma Center
http://www.iersum.org/National_Native_Childrens_Trauma_Center
Indian Country Child Trauma Center http://www.icctc.org/
Chadwick Center for Children and Families http://www.chadwickcenter.org/
Trauma Assessment Pathway-On-line Assessment Training
http://www.chadwickcenter.org/Assessment-Based%20Treatment.htm
Adaptation Guidelines for Serving Latino Children and Families Affected by Trauma
http://www.chadwickcenter.org/WALS.htm
The Research Center for Family Support and Child Mental health http://www rtc.pdx.edu/index.php

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The National Center for Social Work Trauma Education and Workforce Development (The Center) co-directed by Virginia Strand, D.S.W, Professor, Fordham University Graduate School of Social Service and by Robert Abramovitz, MD, Distinguished Lecturer, Hunter College School of Social Work, addresses a major workforce crisis; the shortage of social work graduates equipped to deliver culturally competent, evidenced-based child trauma treatment. This shortage persists even though social
workers constitute the largest front-line discipline seeing traumatized children. The Center’s overarching goal is to increase the capacity of social work education to prepare evidence-based trauma treatment informed practitioners. By building the capacity for evidence-based trauma treatment into the workforce practices of schools of social work and child serving agencies, it advances a key priority of the Substance Abuse and Mental Health Services Administration (SAMHSA).

The National Center for Social Work Trauma Education and Workforce Development (The Center) wishes to acknowledge the special role played by the Core Concepts on Child Trauma workgroup led by Dr. Christopher Layne Ph.D. He has provided the leadership from the National Child Traumatic Stress Network (NCTSN) National Center for the workgroup that created the Core Curriculum for Child Trauma Treatment (CCCT).