ABSTRACT. This paper describes an innovative approach to preparing MSW students for work with traumatized clients via a trauma certificate program. It explores conceptual and ethical principles of the program and presents results of the formative evaluation done with faculty, field instructors and students from the program’s pilot year. Students reported gains in self-ratings of their efficacy in working with trauma in children, adults and communities, as well as articulating what parts of trauma theory were most useful to them in post-graduation. Field instructors were enthusiastic about the knowledge and skills students were building, and suggested further refinements to the program, including increased communication and networking on the topic of trauma.

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KEYWORDS. Trauma curriculum, vicarious trauma, certificate programs, teaching trauma

Marian C. Bussey, PhD, MSW, LCSW, is Assistant Professor, Graduate School of Social Work, University of Denver, 2148 South High Street, Denver, CO 80208 (E-mail: mbussey@du.edu).

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INTRODUCTION

Students preparing to work with vulnerable populations are often faced with the need to respond to crisis, disaster, violence, and history of childhood trauma in the clients they seek to help. While several classes in the Graduate School of Social Work at the University of Denver's existing curriculum incorporated information on assessment and intervention with traumatic stress, the school identified a need for a more intensive, holistic approach to trauma. Starting in 2002, administrators, faculty, field instructors, and alumni began meeting to design a way to offer students a specific curriculum around trauma. The specialized content was created as a certificate within the MSW program, and was implemented in 2003. This study reviews the literature on teaching students about client trauma and disaster, describes the structure of the program, and presents information on how the program was received by the first cohort participating in the certificate.

THE NATIONAL CONTEXT OF TRAUMA CERTIFICATE WORK

At the national level, there are several other trauma and/or disaster-focused certificate programs within schools of social work, psychology or medicine (in addition to numerous private, non-academic programs open to clinicians and the public). In social work, most other trauma certificate programs are offered through the schools' continuing education curriculum, though in some cases current graduate students may also participate. In both social work and related disciplines, the different trauma certificate programs tend to focus mainly on either personally experienced trauma, such as childhood abuse, or on mass disasters and emergencies. There is not yet a formal literature on these certificate programs or their outcomes; however, there is literature on incorporating trauma and disaster work into the curriculum, and on social work efforts in this field.

LITERATURE ON TRAUMA IN THE SOCIAL WORK CURRICULUM

Several key social work articles have been published calling for increased attention to trauma issues, sometimes in response to a recognized
national crisis and in other cases focused on the possibility of vicarious traumatization in social work students.

When van Wormer wrote the 1994 article on preparing students to work with Gulf War veterans and casualties, she felt social work had turned too far away from psychodynamic exploration of a client’s past in favor of a problem-solving here-and-now focus. And if any past trauma was discussed—it was usually only childhood abuse. At that time she found that there were very few references to Vietnam in the literature and that Posttraumatic Stress Disorder (PTSD) remained a controversial diagnosis. Her recommendations for curriculum began with the recognition that the current war (the Gulf War at that time) would both bring its own new issues as well as trigger PTSD in veterans of prior wars. She further suggested starting in a direct practice course to train social work students about the symptoms of PTSD, present case examples, discuss the impact on families, and to make the links between trauma at any time (childhood or adulthood) and substance abuse. She felt that in order to incorporate trauma conceptually in the Person-in-Environment (PIE) framework, social work educators would need to add the dimension of time, so that they would think not only concentrically from the individual to the family, group, and community, but also go back in time to include layers of the past:

The task for the field of social work today is to reconceptualize the eco-systems framework in order to encompass the impact of emotional trauma, the unconscious as well as the conscious experience, and the there-and-then as well as the here-and-now. In this way, the client’s deep psychic wounds will be validated. Mental health educators can prepare students to address the complex psychosocial issues that emerge when soldiers leave families for war and then return home to find that they can’t really go home again. . . Educators can make a major contribution in relieving pain by training their students for work with survivors of trauma. The diverse issues of incest, childhood sexual abuse, and battle stress are all of a common mold: The consequences are felt long after the individual acts of violation have passed. (p. 163)

There is a growing literature on the ethics of teaching about trauma, and most authors in this area stress the need for preparing students in advance. Barter (1997) suggests that social work programs must prepare students for course material that is inevitably going to be painful (singling
out courses on child abuse and domestic violence). But she adds that it is not just students with a personal history of abuse who will find the material upsetting, and goes on to write that if students do not find it upsetting “they are probably dangerously insensitive” (p. 122). McCammon (1995) allows students to choose an alternate make-up assignment if they make that request in advance—her example was of a student who felt it would be too soon after her own trauma for her to see and discuss a video on date rape. Miller (1999) brings up the complex issues of students who may turn their discomfort with the material into anger, and of the possibility of triggering memories of previously forgotten or repressed trauma. Like O’Halloran and O’Halloran (2001), she recommends attention to boundaries of personal disclosure, but more indirectly than directly. Her discussion of this topic is worth quoting directly:

With the inevitability of a discovery process for some students, it is essential that the instructor provide a safe environment—for both individual students and the collective classroom experience. The instructor must ensure that no expectation is placed on students regarding the sharing of their own histories . . . Nor should the instructor directly introduce not sharing one’s own history. Instead, the instructor’s educational focus, tone, boundaries, and frame for the class can define the parameters of the class discussion and shared expression. . . . A consistent and active recognition of the course work’s deep impact on the student—and, as well, of the even greater demands it places on those students who are themselves survivors of trauma—validates each student’s experience. (Miller, 1999, p. 72)

Cunningham’s (2004) recent article presents some of the ethical issues of dealing with traumatic material in any social work course (not just courses with a trauma focus). She provides an illustration of the way students may bring graphic material from case examples into any practice course, not just those with a focus on client trauma. This can be very stressful for any students who are unprepared to hear details of horrific situations, and it also has the potential to re-trigger strong reactions in other students who have themselves lived through childhood abuse or other violence. Cunningham suggests taking the time needed in class to process the strong emotions hearing about client trauma can evoke, at the same time pointing out that “genuine emotional reactions are an important part of clinical work and it would be a mistake to confuse
reducing risk with eliminating risk. It is the empathic connection with the client that makes the clinician vulnerable to vicarious traumatization” (p. 312). She also discusses the importance of learning about vicarious traumatization (VT) as a cognitive tool to help students anticipate and ultimately alleviate those painful feelings.

Dane (2002) also addressed vicarious trauma in required social work practice classes, and presented a model to simultaneously teach about and prevent it. She emphasized the concepts of burnout prevention and dealing with countertransference (which can happen to any professional helper who is overburdened or whose clients’ issues raise unexamined difficulties in his/her own life) as precursors to understanding VT, which is specific to working with trauma. Dane suggested a curriculum sequence that progresses through four stages: objective knowledge, examining personal reactions; organizational awareness; and spiritual renewal. Her first level involves specific knowledge about trauma, including definitions of normative stress versus PTSD, discussion of empathy, burnout, countertransference and VT. The second level examines personal attitudes and reactions through videos, small group discussion, guest speakers, and class materials on reframing shame and guilt. The third level identifies the organizational supports, supervision, consultation, and networks of caring that students will need to seek out as they enter their first jobs. The fourth level was spiritual renewal, teaching meditation techniques to help future social workers face each new day with energy and warmth.

Social work faculty, too, are not immune to trauma or vicarious trauma, even if those are their areas of specialization. Prichard (1998) reminds us of the importance of realizing helper vulnerability and the possibility of secondary trauma both from clients seen for therapy and from first responders (fire, police, EMT) seen as part of a disaster response team. In working through his own experience, and after years of helping clients and teaching about trauma, he emphasizes the role of meaning-making after trauma, rather than focusing on the precipitating event.

There is not yet a common ground of social work knowledge about trauma and disaster, and there remain areas of controversy. While developing curricula for school-based social workers to respond to the aftermath of the Chernobyl nuclear disaster, Chazin, Hanson, Cohen, and Grishayeva (2002) had to overcome past tendencies on the part of social workers to emphasize the pathological aftermath of trauma, such as family conflict and alcoholism, and move toward a strengths and ecological model, while still realistically addressing those real consequences.
Smith, Lees, and Clymo (2003) describe some of the cautions and the benefits in community-level preparation for disaster work. When there is no coordinated planning for supportive care after a disaster, multiple uncoordinated efforts may arise that only confuse the survivors and first responders, but on the other hand the authors describe some criticism in both England and the United States of being too prepared or perhaps “manufacturing victims” (part of the title of a recent British book). They affirm that planning for the unthinkable, and training in disaster response, is a valid social work role.

When an unprecedented disaster occurs, such as the September 11 tragedy, the response of New York City’s mental health disaster response committee (in existence since 1997) showed the importance they placed on trauma education and networking, in a way that can apply to a graduate program in social work as well (Miller, 2003). September 11 was unique in the extent to which it was a shared disaster that affected New York City social workers in parallel ways that it affected their clients. To cope with the needs of social workers, the training reviewed the three primary areas of trauma symptoms—intrusive re-experiencing, isolation/detached feelings, and hyperarousal/hypervigilance—and noted that these are all normal reactions, only to be considered PTSD if they persist unabated for months after the trauma and if the persons having them were unable or barely able to function in their life roles. The training also covered the issue of working with clients already traumatized by prior abuse, war, immigration, or other loss. Traumatic loss was emphasized—loss with no ability to prepare or say goodbye. The training reminded social workers of the importance of a self-care plan and of strengthening support networks or connection. Miller felt the group served an important role for New York City social workers because it was also a safe forum for expressing these new emotional realities around traumatic loss and shared trauma, and because helpers in the field of trauma, perhaps more than in other fields, highly value group settings where they can connect with others doing the same work.

It is not just in the field of social work that the need for a more focused curriculum on trauma has been expressed. Courtois’ (2002) article in the first issue of the Journal of Trauma Practice builds the case that all mental health and medical fields should incorporate specific material about trauma and traumatic stress into undergraduate and graduate courses in order to prepare helpers to be most effective. O’Halloran and O’Halloran (2001) provide specific suggestions for the field of psychology on including content on child abuse in all graduate programs, and concurrently addressing the secondary stress students will usually feel
when encountering this material by using the same steps as Herman's (1997) trauma recovery model. They suggest building safety in the classroom through establishing clear boundaries between an academic class and group therapy, setting limits on personal disclosure, and encouraging discussion of self-care. They address remembrance and mourning in the classroom as it arises through student exposure to increased knowledge of the prevalence of interpersonal and societal violence. They encourage reconnection by having their students think about ways to advocate for violence prevention in their communities. They estimate that between 40 and 50% of their students have experienced past abuse, though they do not define what kind of abuse.

Several social work authors have addressed the issue of prior sexual abuse in social work students, both in terms of prevalence and as a dynamic influencing the students' professional development. Black, Jeffreys, and Hartley (1993) compared sexual abuse histories of social work and business students and found the rate to be significantly higher in social work students—22%, compared to 2% of business majors. Lafrance, Gray, and Herbert (2004) discuss prior abuse history in the context of social work gate-keeping, asking the difficult questions of when and to what extent an untreated trauma history might result in a student's withdrawal from a social work program. The key word for them is untreated—while they suggest that "a background of personal distress may result in a wounded healer, who is prevented by the internal pressure of unresolved needs from fully attending to client needs," they also recognize that: "on the other hand, this same background experience may render a practitioner more insightful, sensitive and empathic to others" (p. 333).

It is clear from this brief review of literature about teaching about trauma that it is an active topic of reflection for those teaching clinical classes, and that many educators, across mental health fields, are engaged both in designing curricula about trauma and in reflecting on ways to ethically deliver the content.

**TRAUMA RESPONSE AND RECOVERY CERTIFICATE PROGRAM DESCRIPTION AND HISTORY**

While the formal work to create the Trauma Response and Recovery Certificate Program (TRRCP) began in 2002 at the request of the school's administration, suggestions for more emphasis on trauma content arose
simultaneously from several sources. Several faculty members already included material on assessing and responding to trauma in a variety of clinical courses; other faculty had been involved in the efforts to help the Denver community understand and deal with the Columbine shootings of April 1999. As in other schools of social work across the United States, the almost unfathomable losses of the September 11 tragedy called forth special efforts in classes, school-wide assemblies, and university-wide teach-ins, to deal with student, staff and faculty emotions and reactions. At the same time, alumni of the school reached out to offer their expertise and suggestions for incorporating material on trauma, particularly after they read in the alumni newsletter that GSSW was in the process of redesigning the curriculum and clarifying a series of four practice "tracks" within the overall clinical concentration.

Designing a certificate program involves a series of steps, including: deciding where to locate it within the curriculum (credit, non-credit, or continuing education); knowing the university-wide criteria for a graduate certificate program; researching existing trauma programs or training centers in the region to avoid duplication; deciding on the mission, goals, and objectives; networking with social workers and practitioners from related disciplines; and coordinating with field practicum sites. With her career-long emphasis on work with families facing multiple crises plus her work with Ukrainian and Russian social workers and survivors of the Chernobyl disaster, Dr. Judith Bula Wise was asked to design the TRRCP and to see it through the required stages of departmental and university approval. Designing the program and getting final approval from the faculty and the university administration took approximately a year. The next sections describe the rationale, theory, curriculum, and structure of the trauma program.

**Rationale**

The rationale for the program, taken from the proposal, introduces several important themes that locate this specialized attention to trauma within the broader social work context:

Social workers have addressed the needs of individuals, families, groups and organizations experiencing trauma and crisis since the mid 1800s. Our long-standing history in practice and theory development related to "crisis intervention" serves us well in these current times when dramatic local, national, and global events swiftly erase the capacity to minimize, deny, or cover up the trauma
that has always been a part of our human community. Part of our mission as social workers is to make explicit the wounds of oppression in our society—poverty, discrimination, violence, addictions, to name a few—to move them from the covert to the overt, form that which has been silenced to that which is now spoken. The breadth of our perspective calls to address trauma at personal, interpersonal, social/community, and political levels. (Wise, 2003, p. 1)

There was a recognition when beginning this new certificate that helping clients recover from trauma has always been a part of the social work mission, and that the recovery work could take place at many levels, not just in the context of a therapeutic relationship. Healing and/or preventing some trauma requires work at broader systemic levels, and in fact may require social and political action. The program rationale also encompasses a multicultural awareness of the variety of factors that have been the basis of oppression, including: age, gender, ethnicity, sexual orientation, religion/spiritual belief, socio-economic status, language, geography, differing abilities, and developmental stage (factors defined by the National Association of Multicultural Education). Finally, as part of GSSW’s commitment to strengths and empowerment, the certificate program has as a cornerstone the awareness that experiencing trauma responses after a horrific event or series of events is universal, and that the developmental course of healing that people take will draw upon both the support they receive and the strengths and resilience they develop.

**Trauma Theory and Curriculum**

The concept of trauma, as taught in the certificate program, has multiple meanings. At one level, trauma refers to harmful experiences themselves. These experiences may take the form of physical violence and injury or psychological violence—whether perpetuated by strangers, family members, terrorist attacks, natural disasters or accidents. The program addresses childhood exposure to violence, chronic trauma, and early trauma’s potential for life-changing physiological responses. It also addresses trauma related to recent terrorism, and trauma in specific systems/occupations (school, home, work/law enforcement, emergency medical technicians and veterans).

In addition, the program addresses social and historical trauma. Social trauma is defined as any social condition that perpetuates forms of oppression against vulnerable populations—including discrimination, poverty, hate crimes, violence against women—and the social institutions
that condone the oppression or blame those affected (Wise, 2003). Historical trauma includes past violence toward a whole culture—such as the Holocaust, massacres of American Indian tribes, and the internment of Japanese Americans (Yellow Horse Brave Heart, 1998). In addition to these kinds of traumatic events, trauma can also be understood as the internal condition that may arise from exposure to these events or experiences.

While it is expected that students will be familiar with the common DSM-IV (American Psychiatric Association, 2000) definitions of PTSD and Acute Stress Disorder (ASD), trauma response and trauma interventions are framed in a more empowering, strengths-based philosophy. Everstine and Everstine (1993) point out that trauma reactions are normal and to be expected in the immediate aftermath of a disaster, an attack, an accident, a threat to one’s life or integrity, or witnessing others being traumatized. They emphasize the experience of trauma as a response rather than trauma as a mental health disorder.

The effects of trauma on mental health extend beyond PTSD and ASD, a fact that has been both controversial and political in the DSM-IV debates (Herman, 1997). There is certainly unrecognized or hidden trauma in many clients served by social workers, and the degree to which intervention focuses on the trauma may depend on how ready the client is to address it and what role it plays in the client’s current life (Everstine & Everstine, 1993). There is evidence that some clients’ experiences of depression, anxiety, impulsiveness, self-mutilation, addiction, and dissociation may be linked to earlier traumatic events (Molnar, Buka, & Kessler, 2001; Everett & Gallop, 2001). Results from a nationally representative population survey show that, even controlling for other adverse childhood circumstances such as parental violence, depression, and substance abuse, the trauma of childhood molestation leads to a higher incidence of several mental health and substance abuse problems (Molnar et al.). Men and women who had lived through childhood molestation were approximately twice as likely as others to experience depression and substance abuse. For PTSD, the odds were closer to five times more likely. Other studies, of clinical populations, confirm these national findings. Jasinski, Williams, and Siegel (2000) found that African American women who were sexually abused in childhood (identified through earlier hospital emergency room files from their childhood) had a high percentage of binge drinking (22%, compared to national averages for this population of between 12 and 15%), particularly if there had been multiple instances of the abuse. Cohen, Brown, and Smailes (2001) found elevated anxiety, depression, substance abuse
and Cluster B personality disorders (such as Antisocial or Borderline) among a group of adults who had been abused in childhood. What this means to social work students is that a certain percentage of clients in any mental health or substance abuse treatment center are likely to have experienced hidden trauma, whether or not they bring it up at intake.

**Trauma Certificate Structure**

The TRRCP requires that interested students fill out an application, meet a minimum grade point average, participate in an individual interview, take two courses on trauma, and complete a concentration-year field placement in a setting that includes a focus on trauma.

**Coursework:** The content on understanding trauma is provided through two specialized courses taken after the foundation year: *Trauma and Recovery in Social Work Practice* and *Social Work Interventions for Responses to Trauma*. The first course used Herman’s *Trauma and Recovery* (1997) as a text, supplemented by additional readings and videos, and presented a basic theoretical background about acute trauma, complex trauma, and community disaster. It included new material from recent findings on the neurobiology of trauma—the effects trauma has on both the developing and the adult brain.

The course also introduced the concepts of vicarious traumatization in those who help survivors of trauma (Figley, 1995; Pearlman & Saakvitne, 1995) and required the students to complete a self-care plan. This plan helped them identify potential triggers this work could present for them and their strategies for coping and getting support. Herman’s book (1997) describes the importance of establishing safety, remembrance and mourning, and then reconnection and support. In a parallel way, the self-care plan must address a student’s physical and psychological safety needs as well as their connections and networks.

The second course used a course pack of materials addressing interventions for a variety of populations, guest speakers on special issues, and during the pilot year used Violanti, Paton and Dunning’s *Posttraumatic Stress Intervention: Challenges, Issues, and Perspectives* (2000) and Rosenbloom and Williams’ *Life After Trauma: A Workbook for Healing* (1999) as texts. Speakers included social workers in the community who had specialized knowledge of working with:

- Veterans and homeless veterans;
- American Indian clients and recognizing the effects of historical trauma;
• Children;
• Adolescents and youth in foster care;
• Survivors of domestic abuse; and
• Accident victims, or anyone experiencing strong somatic symptoms.

Part of the coursework during the pilot year included six hours of training from the American Red Cross that comprised the beginning courses for certification in Disaster Mental Health Services. Students were able to complete the rest of that certification in a weekend workshop offered at the Red Cross after the last week of class.

Trauma Field Placements: In addition to the two courses, students chose a concentration field practicum offering the opportunity to work with clients who have experienced trauma. While many social work practicum sites serve clients who've experienced trauma (clearly rape crisis centers and domestic violence shelters, but also any mental health agency, hospitals, children's protective services, residential treatment centers for youth, and schools), the sites chosen for this certificate needed to fulfill several specific additional criteria. The students needed to spend at least half of their time in work dealing with trauma, and the supervisor needed to be willing to focus on client trauma, secondary trauma, and linking the academic theory taught to practice issues. The TRRCP sent out a one-page needs assessment to all field supervisors to gauge the interest in participating and the need for additional training. As a result, the first training for field instructors was held in August 2003, taught by the instructor of the initial trauma course, presenting main concepts of that course and a video on secondary trauma.

The trauma certificate program graduated its first cohort of students in 2004, with 15 out of the original 18 finishing that year.

**METHODOLOGY**

The plan for formative evaluation of the Trauma Response and Recovery Certificate Program involved qualitative interviews with the faculty who were instrumental in the program’s creation (which will be referred to as the task force) and with the field instructors, as well as mailed surveys to the students who graduated after the pilot year. The emphasis on qualitative interviews for the formative evaluation was designed to elicit useful information on program processes and areas for improvement for its second year (Royse, Thyer, Padgett, & Logan, 2001).
But in addition, follow-up questionnaires for students were designed to provide measures of program satisfaction, measures of student self-efficacy, and applicability to post-MSW job experiences. The University’s IRB reviewed and approved the study design and instruments. Faculty and field supervisors provided signed informed consent and students indicated their informed consent by returning the anonymous surveys. Types of questions/surveys and the numbers participating are included in each of the three sections, for: faculty task force, field instructors, and students.

**FACULTY TASK FORCE PERSPECTIVE**

Four key members of the faculty task force were invited to participate in interviews about the certificate program, and all four agreed. They were asked about: the impetus for the program, the vision and the way the vision had been realized in the pilot year, anticipated challenges, unanticipated challenges, and lessons learned. As described earlier, there were a variety of factors influencing the creation of the TRRCP. Faculty mentioned the need to include this material after a series of well-known national traumas, as well as the desire on the part of students to complete a certificate program as they finished an MSW. Why trauma, specifically? In one person’s words:

> It is a logical extension of what we used to call crisis intervention, and the concepts and methods of trauma intervention should be infused across a good portion of the curriculum—not just in practice courses. Trauma intervention is a way of thinking that is responsive to where our world is right now, unfortunately... [The interest in this area came from] war, Iraq, bio-terrorism threats—the heightened awareness we all have of different sources of violence that are potentially very traumatic for people—as well as the whole growing awareness that it isn’t just military people that have stress, that people growing up in violent circumstances through family dysfunction or poverty, also have PTSD.

Another part of the impetus was that faculty were already teaching and writing about trauma, and thus had the expertise to develop the program. The vision for the TRRCP had to fit within GSSW’s mission, and incorporate a commitment to strengths, to a multicultural awareness, and to a systems approach, as opposed to a psychopathology approach.
It was important to the vision that the program address both personal and universal traumatic events, and encompass historically transmitted, childhood, and current-day trauma, as social work students may encounter all of these issues in the field.

Was the vision implemented in the pilot year? Faculty felt it made a good start, and that the speakers chosen for the second, practice-oriented class brought with them the multiple perspectives that the program was seeking to convey. Students did integrate their field and academic learning, and gave their feedback at the end of the year that they had appreciated the emphasis on both theory and practice. There were several lessons learned, however, both about the challenges associated with a trauma certificate and about practical administrative details.

The task force had anticipated two primary challenges: ensuring that the field experience would link with what students were learning, and dealing with the possibility that some students would have their own trauma re-triggered or would experience vicarious traumatization. The way the first anticipated challenge (integration with field) was met was to offer a training for field instructors on the TRRCP, to have regular meetings with the field director, who also served as the trauma certificate students’ field liaison, and to set up a series of Brown Bag lunches once a month that addressed field issues as well as serving as a support group. Meeting the second anticipated challenge, about vicarious trauma (VT) or re-triggering, required the same kinds of support any students experiencing VT (certificate or not) would be offered, as well as some specific to the program. The specific support included the creation, during the first trauma course, of a self-care plan, plus attention to VT in class. In addition, the training for field supervisors included a 40-minute video on secondary trauma. While having a personal history of trauma did not disqualify any student from participating in the TRRCP (and indeed many students disclosed this kind of history), not having a good support system or not being able to describe it without a flood of emotion during the initial interview process did result in several requests that the applicants to the program reflect on whether this was the right time to take on this academic work (and after reflection, they decided not to take the certificate). However, even with an initial interview and attention to secondary trauma, the task force knew there was always a possibility a student might need more help than a self-care plan or a monthly meeting could provide:

Any group of students has a subset of people who experienced trauma. Is studying trauma going to trigger a past stress? The answer
is yes—so what do you do with it? You’re obligated to respond as you would to anyone with trauma. . . The school has to have a plan for responding appropriately; there has to be someone available and a way to make referrals.

One thing anticipated was to wonder if as a program we would be able to meet the needs of students who were re-triggered. Several experienced profound re-triggering and had to leave field, go get more extensive help for themselves, had to slow down, and go from full time to part time. The quantity [of students experiencing secondary trauma] was not more but the quality—it went to a greater depth of understanding—a higher level awareness or self awareness . . . The number was similar [to other non-TRRCP students], but the depth of self understanding and learning and knowledge went to different levels.

There were also some unanticipated challenges, several related to students’ secondary trauma. One was the fact that the United States invaded Iraq during this pilot year for the TRRCP:

We had not anticipated—there was no way to anticipate—that another war would start. The new war retriggered every post-war veteran in the class. They brought it up in the Brown Bags, and all of them ended up getting extra help.

Students were not the only ones vulnerable to re-triggering. As one faculty noted: “creating this program also caused some of us [faculty and administration] involved to flash back to—for me—a violent incident.” Another unanticipated challenge came up in regard to field instructors—an agency might see clients with known medical or psychosocial trauma, but that did not guarantee that the MSW supervisor there would be willing to address client trauma issues in supervision. One instructor called after finding out that the student placed at his agency was in the trauma certificate program to say that he wouldn’t be able to provide that kind of help. A final challenge was the amount of time administering the certificate program took in addition to a regular faculty load. Because several students needed to take a break from field halfway through the certificate program, the coordinator needed to attend the field reviews held for those students. The position also required work through the summer, whereas the normal faculty commitment is a 9-month contract. Networking with
trauma specialists inside and outside the university was another time require-
ment, in addition to curriculum development, teaching, and respond-
ing to requests for information (including the media). That leads to one of
the lessons learned: directing this kind of certificate program cannot be
an "add-on" to a regular faculty deployment.

Similarly, the process of developing the TRRCP took time and re-
quired many preliminary steps—as one faculty said, "you have to do both
the groundwork and the homework; that can’t be short-circuited." But
in addition:

There’s a wonderful national network, so you don’t have to create
everything from scratch all on your own. You can call on col-
leagues . . . Find other programs that are similar in structure; if you
build from that you can save a lot of time. There are levels—you have
to know what’s there in your own community first, do your home-
work. Then you have to know what’s already there on your campus.
From that, create a unique niche—so it doesn’t duplicate pro-
grams. I recommend taking all the time you think is necessary to
have the support and blessing of your own department. Ours was
easy because it grew from the strategic plan . . .

Some of the other lessons learned touched on the depth of spirit con-
tained within the students themselves. Two faculty discussed this depth
as the most profound lesson of the pilot year:

It was amazing to see a student who came in for personal reasons
[related to others in that student’s family] who went from a focus
on that mission to a broader mission of helping children in poverty
who’d been traumatized . . . and learned altruism towards the
world rather than just healing a few . . .

I learned about an amazing generosity of the human spirit. People
came wanting to participate in the program out of an amazing
depth of compassion for human suffering . . . To hear their inter-
view and stories about what leads them to do this work—was amaz-
ing . . . I learned through observing the students that there is a bond
between them in knowing that they are drawn to this work because
of something pretty significant in their lives. Probably this hap-
pens in general in the student body, but there seemed to be a qual-
ity of real connection for these students.
FIELD INSTRUCTOR PERSPECTIVE

Field instructors for the 15 TRRCP students were contacted about participating in short telephone interviews about the certificate, and 8 interviews were completed (53% response rate). They were asked about: the kinds of trauma experienced by clients in their agency, the kinds of intervention used in the agency, how they became aware of the certificate, whether or not they had attended the one-day training for field instructors, their understanding of the student’s learning goals and processes in the trauma curriculum, any challenges encountered, and suggestions for the future. Their responses varied quite a bit depending largely on the agency’s client issues (particularly the difference between medical social work settings and more psychosocial ones), on their own awareness of the new certificate program, and on the student and his/her commitment.

The eight agencies represented in these field instructor interviews serve clients with a wide variety of potential traumatic events. On the medical side there were hospitals (two adult psychiatric, one medical/psychiatric for youth) and a public medical agency providing support for families of children with chronic medical conditions. On the more psychosocial, outpatient side there were settings serving veterans, serving parents referred for child maltreatment, and providing outpatient mental health services. The kinds of interventions offered ranged from support and education, casework and crisis intervention, to group and individual therapy.

The school sent out a group e-mail to field instructors before the Fall Quarter of the trauma certificate’s pilot year, letting them know of the new certificate’s existence and inviting them to a day-long training on trauma, delivered by faculty teaching the first trauma course. Two of the 8 supervisors responding had attended the training—one (from the public medical agency) felt it was extremely helpful, particularly the discussion of trauma as potentially accumulated stressors rather than only single incidents, and the film about vicarious trauma. This supervisor suggested that in future years the trauma training for field instructors be extended to two days, though she was aware of how difficult this might be to implement. The other supervisor, from a youth hospital setting, felt the training covered ground she knew, focused too much on long-term therapeutic issues, and was thus not applicable to acute care hospital social work.

None of the other six supervisors interviewed had attended the training, and in fact most said they were unaware of it. Four of them found out about the certificate from a visit early in the year with their field liaison,
the other two said they learned about the trauma certificate from the students themselves. All were willing and prepared to address client trauma and trauma recovery in supervision, and some made many extra efforts to connect the course material to the field experience. An example of the latter effort was the fact that one supervisor read the text for the first class, Herman’s *Trauma and Recovery* (1997) along with the student and discussed how it applied to their agency’s population. Another supervisor arranged for the student to attend extra training on crisis intervention and trauma treatment. Other comments on student goals and learning processes focused on the value of addressing trauma as early as possible. One supervisor (in a setting serving veterans) felt that students would ideally take the trauma certificate classes in their first (foundation) year and thus begin the field placement with this knowledge; she also felt the certificate program was important because it gave students a “handle on what they will be facing in the field.” This is similar to another comment that students need this kind of preparation for a trauma placement because otherwise they are “so blatantly deer in the headlights.” Some comments may have been more general about the school’s curriculum rather than the trauma certificate itself: some supervisors wanted students to have a basic grounding in casework, others in theories of therapy (as one put it, either cognitive or psychodynamic; they should just know one of these well). Other comments specifically on the two trauma courses were that: “the classes fit well with the field placement”; that the course curriculum “seemed well thought out”; and finally that “the course work had good speakers and good topics but the material was not applicable to medical social work.” There were two comments on the timing and material in the first course that came up under the area of challenges.

Most students took the first trauma course during the summer between their first and second year. However, for students interested in the trauma certificate who entered the second year in the advanced standing program, or those unable to take the summer course for other reasons, an intensive, interterm version of the same class was offered in December (interterm courses contain the same number of classroom contact hours, but meet for longer hours and more frequently). The two supervisors who brought this up as a challenge both had students who found this pace difficult, and who became overwhelmed at a time of year most other students have finished the quarter and are taking a month off. Coincidentally, one student received word during this time that a serious medical condition had recurred, so she felt particularly vulnerable. The other student became “re-triggered,” not just by the compressed nature
of the interterm course but also by the similarity between her own past history and that of some of the younger clients served. Compounding this, the supervisor felt that the student was reluctant to deal with her reactions in supervision. This re-triggering was serious enough that this supervisor wants to screen all future student interns for the potential that this could happen again. There were other challenges noted by these same two supervisors, though they may also relate more to overall student issues rather than to the trauma certificate. One challenge involved a student in a bilingual agency who really struggled with the second language and thus was not able to address client trauma (or any other issues) with clients. The other was the observation that students should probably not be going to school full time and also working a lot of hours outside of school and field. Other than these two interviews, supervisors interviewed felt there were no “glitches” or major challenges. One supervisor commented that the communication between the school and the field had been very good, the coordination between course work and field was a “good fit,” and that “any student should be satisfied with their experience in the trauma certificate program.”

Seven of the eight supervisors interviewed would definitely welcome another trauma certificate student; the one supervisor who wouldn’t was the one who wanted to screen future students for the potential of re-triggering.

When the field instructors had a suggestion for the future, the most common one was a desire for more communication from the trauma certificate coordinators and faculty. While one wanted more than a day’s training, others felt very knowledgeable about trauma treatment and thus would not attend a training, but would like to see the trauma course syllabi. One supervisor suggested including specific authors, mentioning Judith Herman, Bessel van der Kolk, and Babette Rothschild (works by all of whom are included in the curriculum: Herman, 1997; Rothschild, 2000; van der Kolk, McFarlane, & Weisaeth, 1996). One suggested circulating a list of all the field placement agencies dealing with trauma as a way for them to network.

What these interviews suggest is that while the majority of practicum instructors were satisfied with the extra training on trauma these certificate students were getting and felt it was a good fit with their agency that was less true for one of the most intense, inpatient, medical/psychiatric hospital settings. Her perception from the training that the curriculum focused more on long-term or outpatient treatment of trauma was probably accurate. Other comments that more communication from the school about this would be helpful point to the ongoing need to keep
field instructors closely informed of any curriculum developments or new programs such as this certificate.

**STUDENT GRADUATE PERSPECTIVE**

Invitations to participate in a follow-up survey of the TRRCP, along with informed consent, the anonymous survey, a $5 coffee gift card, and a return envelope were sent out to all 15 students who completed the pilot year. Six students returned completed surveys (a 40% return rate). Questions on the student survey involved: their motivation to choose the certificate; kinds of client trauma seen at their practicum agency; prevalence and kinds of client trauma in their current (post-graduate) job; a list of the 7 guest presenters for the course and questions about which speakers were most or least helpful at the time and in retrospect; eight questions about self-efficacy; and four open-ended questions. While the quantitative data available from these surveys is limited, there are some trends that may help shape the program's future, and some of the students wrote very perceptive comments and suggestions in response to the final open-ended questions.

The three most commonly checked motivations for entering the certificate program were: “Commitment to trauma recovery work” (5 of 6 responses), followed by “Prior experience with clients surviving trauma” and “Personal experience of trauma” (4 of 6). Slightly fewer students chose the responses of: “Specific agency needs in my chosen field of practice” and “Friend/family experience of trauma” (3 of 6).

The most common kinds of client trauma students reported working with during their internships were: domestic violence (5 of 6) and child abuse (4 of 6), followed by (in descending order of frequency): survivors of rape, historical trauma, traffic accidents, workplace trauma, adult survivors of childhood abuse, and veterans.

All six students now worked in agencies serving some clients who had experienced trauma—half of them responding that a majority of their clients had survived trauma and half responding that the percentage was under 50%. Domestic violence and child abuse were still the most frequently encountered types of client trauma seen (5 of 6 responses for each), with very similar numbers seeing the other types of trauma listed in the section on their field experiences.

Guest speakers had presented on seven specific topics and their relations to trauma: veterans, historical trauma, children, adolescents, family violence, mind/body work, and the Red Cross model of disaster mental
health. Students were asked to rate which had been most (and least) helpful to them at the time, and whether that had changed over time (under the assumption that some clinical issues become more salient once students start their first post-graduation job). For many topics and speakers there were a variety of responses on how helpful they were, but overall, students were most satisfied with the presentations on working with traumatized children and adolescents, and least satisfied with learning about the Red Cross model of disaster mental health.

Students also used a self-efficacy scale to rate their skills working with specific types of trauma, populations, or trauma dynamics. The self-efficacy scale ranged from 1 to 100, in intervals of 10 points, and had a clear and a shaded line for each skill. The first line asked them to rate their skill “before entering the trauma certificate program” and the shaded line their skill “after finishing.” While it might be more ideal to have given this scale as a pre- and post-test, given the limitations of this post-test only pilot study, and the fact that there is evidence that students are actually fairly accurate in rating themselves retrospectively on self-efficacy scales (Holden, Anastas, Meenaghan, & Metrey, 2002), it was felt this would provide an approximation of student progress in these areas.

Table 1 shows the skill areas surveyed, along with the mean scores and range pre- and post-certificate program (using the midpoint of each 10-point range checked), and statistical significance of the change over time (using a non-parametric test, Wilcoxon Signed Rank Test, due to the small sample size).

What the student ratings of self-efficacy show is that, using this retrospective assessment of skills, the growth in skills over the course of the program seemed to be significant in all areas except that of self-care. In that area, students rated themselves higher at the start of the program, so that even while the scores rose, the gain was not as much as in other areas.

Finally, students were asked: if they could identify a trauma recovery model or theory that had been most helpful to them; whether completing the certificate has been helpful to them professionally; what suggestions they had; and to comment on anything else important to them that had not been asked. Student responses to all of these questions provide valuable insight into what they learned and perceived as valuable.

Two students identified Judith Herman’s model of trauma recovery as the most helpful, and one named the three stages: safety, mourning and remembrance, and reconnection. Two students also noted the importance of understanding trauma’s effects on the brain (one naming Bessel van der Kolk as a key writer in this area). One identified the most helpful model as “play therapy, because I work with kids and adolescents.”
TABLE 1. Self-Efficacy Skills in Trauma and Social Work: Perceived Change Over Time

<table>
<thead>
<tr>
<th>Skill Being Rated</th>
<th>Self-Efficacy Rating Before Program (Mean, Range)</th>
<th>Self-Efficacy Rating After Finishing (Mean, Range)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Work with adult clients surviving child-hood trauma</td>
<td>32 (15-55)</td>
<td>70 (55-95)</td>
<td>.024</td>
</tr>
<tr>
<td>2. Work with adult clients surviving recent personal trauma</td>
<td>35 (15-75)</td>
<td>70 (45-85)</td>
<td>.026</td>
</tr>
<tr>
<td>3. Work with clients surviving recent community trauma/disaster</td>
<td>25 (15-35)</td>
<td>65 (45-85)</td>
<td>.043</td>
</tr>
<tr>
<td>4. Work with child or adolescent clients surviving trauma</td>
<td>23 (15-45)</td>
<td>67 (35-85)</td>
<td>.026</td>
</tr>
<tr>
<td>5. Work in a group therapy setting with survivors of trauma</td>
<td>23 (15-35)</td>
<td>65 (45-85)</td>
<td>.024</td>
</tr>
<tr>
<td>6. Work with trauma survivors of different ethnic/SES backgrounds</td>
<td>37 (15-65)</td>
<td>77 (55-95)</td>
<td>.026</td>
</tr>
<tr>
<td>7. Work on your own self-care issues to avoid secondary trauma</td>
<td>60 (15-95)</td>
<td>83 (75-95)</td>
<td>.080</td>
</tr>
<tr>
<td>8. Identify a therapeutic framework for trauma recovery</td>
<td>27 (5-55)</td>
<td>67 (55-95)</td>
<td>.026</td>
</tr>
</tbody>
</table>

Students were very positive about the certificate program’s effect on their professional growth. One person emphasized the nature of the work he/she now does:

My trauma certificate was an asset when hired for my current position. I work in a violent, low-income neighborhood. A majority of the youth and families have experienced community violence, family violence, and are now refugees or immigrants. To have the resources and skills to serve my clients is an exceptional tool.

This student had only one suggestion for the future, and that was to have three required courses on trauma rather than two, and also wrote for a last comment:

The trauma certificate program helped me become more aware of the impact of trauma in our clients’ lives. It is an important certificate to add to my MSW degree.
The other comments about whether the certificate had been helpful professionally were:

Super!

Have a broader/deeper knowledge base about trauma, the certificate has also afforded a sense of practical expertise helpful to a new clinician.

It has been helpful in understanding how different types of trauma affect everyone in unique ways.

To be more understanding and empathetic towards clients who have experienced/are experiencing trauma.

Completing the certificate program has enhanced my confidence in working with survivors of different ages and experiences.

In addition to the comment about having a third course required, students sometimes presented very detailed suggestions for the future. Several wanted more in the way of practice:

Focus more and more on interventions in specific settings (i.e., schools, jails, outpatient, RTCs) in experiential ways (role plays, trips to settings, etc. if possible). Sometimes this is left out of field placements depending on how good/available the field supervisor is.

More practical trauma experience working with select populations, i.e., children, adults, community, etc.

Refine the second course, keep it only for folks in the certificate program. Add new knowledge/research to keep students current—build on first course. Present more practical examples—videos of therapy sessions—trauma treated using EMDR, Cognitive/Behavioral, systems, psychodynamic perspective. More on attachment theory and how it related to resilience and healing of those affected by trauma. Continued discussion/exercises in self-care. Use of humor, strengths perspective, expressive/art therapies, mindfulness, breathing, yoga, exercise.
This last comment contains a wealth of understanding of trauma and shows that the student has done additional reading and/or work in the trauma field.

**DISCUSSION AND IMPLICATIONS FOR SOCIAL WORK**

Results of the formative evaluation suggest that students could see growth in their self-efficacy skills in working with client trauma after completing the certificate program. In addition, some students had a strong grasp of the trauma model taught (Herman, 1997), or had incorporated additional theory and approaches. While the sample was small, it is interesting how often students worked with domestic violence and child abuse, both in their internships and in their first post-MSW jobs.

Faculty task force and field supervisor comments provided a perspective on what lies behind creating this kind of trauma curriculum. Like other social work educators who have written on the need for trauma content and on the ethical boundaries involved, faculty tried to prepare for students’ intense emotional reactions and to respond to them with care when they did occur. Defining the course content required much preparation, and faculty were willing to keep refining that content as they gained experience in offering the trauma certificate. Some of those adaptations are described below.

While the overall structure of the TRRCP was kept for the second year, some changes were made as a result of student feedback or faculty suggestion. It was decided that:

- Students could only take one certificate program during their MSW program—even though the school offers several others, scheduling the extra classes required and finding a field placement that would accommodate more than one certificate program proved to be impossible.
- TRRCP faculty and liaisons will need to check with potential field instructors before the internships begin to make sure that they are comfortable with supervising students around trauma issues, no matter whether or not the agency serves clients in trauma.
- Rather than incorporating six hours of Red Cross Disaster Mental Health training into the second trauma course, students would be free to take that course or not on their own. Many students were interested in the field of disaster work, but found they would not be
Marian C. Bussey

qualified to serve on a Red Cross mental health team until achieving licensure (several years off).

- The textbook for the second trauma class was changed to Everstine and Everstine’s *The Trauma Response*. Guest speakers were asked to include a section on practice skills, and additional time was left after each speaker to process what the students had learned.

- Several additional trauma therapy videos were shown and discussed, including one on empowerment work with survivors of domestic violence (Walker, 1994). Since this is one of the most frequently seen kinds of trauma, both in student placements and in the later job experiences of the students who responded to the survey, it was felt this kind of tape would be important. As many of the authors reviewed in the section on the ethics of teaching about trauma have suggested, this video was announced in advance, shown in three 30-minute segments with breaks for discussion, and students were free to get up and leave the room if they needed to. Even though the film uses an actress to play the domestic violence survivor, it is realistic enough that some students needed to take short time-outs before rejoining the class.

This initial study of the certificate program’s pilot year is limited by the small numbers of students and field instructors responding, but as with many formative evaluations, it was done primarily to identify processes and themes that might point to future changes in this new program. It would be useful in subsequent years to repeat the questions to field instructors, and to ask students if they would be willing to participate in a phone interview in addition to sending in an anonymous survey. It would also be useful to frame some of the questions about trauma work in such a way that differentiates between the actual practice of trauma therapy and the provision of other non-therapy services (such as case management) to populations that have experienced trauma. As Harris and Fallot (2001) point out, sometimes there are agency constraints around mission and resources so that even though it is known that the population served deals with a lot of trauma, the work does not focus on treating trauma. In those cases, do students feel the preparation helps them at least provide “trauma-informed services” (respecting the clients’ past trauma experiences, using Harris and Fallot’s term)?

Recognizing that this is not always an easy topic to address—and that social workers themselves may have a background that includes trauma—the certificate program faculty feel that a holistic and intensive preparation at the MSW level will help prepare students for the work with
individual trauma and societal disasters that are part of modern life. The experience of the University of Denver’s Graduate School of Social Work with creating and implementing a trauma certificate program has deepened its commitment to this area, and shown that students value the specific attention to trauma work. By presenting a framework of trauma as a normal response to often-horrific situations and by making the connection between psychological definitions of posttraumatic stress and underlying societal conditions, students can better understand their traumatized clients and their own reactions.

REFERENCES


