

**GUIDELINES FOR USING THE CANS  
- CHILD AND ADOLESCENT NEEDS AND STRENGTHS –  
IN TRAUMA-INFORMED ASSESSMENT, TREATMENT PLANNING  
AND TREATMENT**

Revised Draft 2011, developed by  
The Center for Child Trauma Assessment and Service Planning (CCTASP) at  
Northwestern University,  
A Partner of the National Child Traumatic Stress Network (NCTSN)

# **Guidelines for Trauma Informed Assessment and Treatment**

## **WORKING DRAFT 7-20-11**

### **Overview: The Use of the CANS in Trauma-Informed Treatment Planning**

The Center for Child Trauma Assessment and Service Planning (CCTASP) at Northwestern University is a newly funded NCTSN Center focusing on the application of the Child and Adolescent Needs and Strengths (CANS) as a trauma-informed assessment and treatment planning tool to guide the selection and use of trauma-informed treatments in relation to complex trauma in public sector settings, including child welfare. We have been working with DCFS outpatient therapy providers over the past several years to enhance knowledge and skill in identifying and addressing child trauma and supporting the use of the CANS in relation to trauma-informed treatment planning. In these revised guidelines we are building upon this existing work.

There are three important areas to consider in a comprehensive approach to address the needs of traumatized. These include: 1) Trauma-informed Assessment, 2) Trauma-focused Treatment Planning, and 3) Trauma-informed or trauma-focused Treatment. The guidelines in this document are designed to support outpatient therapists and supervisors in each of these three areas.

There is a full range of trauma specific and trauma informed assessment measures available to clinicians today. These guidelines focus on the use of the **NCTSN CANS Comprehensive**, a measure that is uniquely qualified for trauma-focused work with children and families in at least three ways: the NCTSN CANS is comprehensive and assesses a wide range of needs exhibited by children and their caregivers; it assesses a full range of post-traumatic stress disorder (PTSD) symptoms and taps into a range of areas of functioning that are often impacted by exposure to complex traumatic experiences; and finally, it places an emphasis on the assessment of protective factors, or strengths, of the child and caregiving system as part of the overall assessment.

The CANS is also unique in that it is available at no cost to the clinician or agency and it is designed for quick clinical application in a variety of ways. The CANS has built in “action levels” that immediately reflect the degree to which each item should be considered for inclusion as a target of treatment. Both the individual items and domains on the CANS can be used in monitoring treatment progress over time. The CANS is an information integration tool, in that the scores on the CANS can be derived from the input of multiple informants as well as other assessment tools that might be used in a given agency or setting.

In the first section of these guidelines, the assessment section, we have addressed the use of the CANS in assessing children with histories of exposure to traumatic experiences. In the treatment planning section we offer examples of how to use the CANS findings in planning treatment for children with trauma related symptoms. In the treatment section, we have provided an overview of the core components of trauma-focused treatment and related treatment tasks.

In sum, this document will aim to provide guidance in using the CANS for clinical purposes, namely treatment planning and monitoring treatment progress over time. Please contact the Center for Child Trauma Assessment and Service Planning for further assistance and support in using the CANS for treatment monitoring.

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### Part 1: Use of the CANS in Trauma-focused Assessment

The NCTSN CANS Comprehensive is the most recent and enhanced trauma informed version of the CANS to date (Kisiel, Lyons & Germain, Revised July, 2011). This trauma version of the CANS is designed with three overall purposes: 1) to document the range of difficulties exhibited by traumatized children that cut across current diagnostic classification systems, 2) to describe the contextual factors and systems that can support a child's adaptation from trauma, and 3) to assist in the management and planning of services for children and adolescents with exposure to and adaptation from traumatic experiences. The **NCTSN CANS** can be used either as a *prospective* assessment tool for decision support during the process of trauma-informed treatment planning or as a *retrospective* assessment tool based on the review of existing information for use in the design of trauma-informed systems of services and for use in identifying "service gaps" in the current system. This flexibility allows for a variety of innovative applications.

A large number of individuals from the NCTSN have collaborated in the development of this NCTSN version of the CANS-Comprehensive, including. Cassandra Kisiel, Ph.D., Glenn Saxe, M.D., Margaret Blaustein, Ph.D, Heidi Ellis, Ph.D., Tracy Fehrenbach, Ph.D., Gene Griffin, Ph.D. and several other NCTSN partners.

This version of the CANS contains two trauma-specific domains: Exposure to Potentially Traumatic/Adverse Childhood Experiences and Symptoms Related to Traumatic/Adverse Childhood Experiences. These domains screen for exposure to a full range of traumatic events and assess for a full range of Complex Trauma reactions.

An important prerequisite to trauma-informed treatment planning is conducting a comprehensive trauma assessment that identifies a range of traumatic experiences, traumatic stress symptoms, and trauma-related responses across domains of functioning, caregiver capacity, and child, caregiver and community-based strengths. The CANS allows us to gather this critical information and integrate it in one tool for immediate use in treatment planning (See Part 2 for more detailed information).

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**I. General Scoring Guidelines for the CANS**

**Domain Specific Scoring and Action Levels:**

**Scoring the Potentially Traumatic /Adverse Childhood Experiences Domain:** this domain on the CANS is unique in that it is the ONLY domain that reflects a “lifetime history” meaning that any traumatic experience the child has experienced in his or her life will be recorded here. Following are the scoring options for the 14 items in this domain:

- 0- No evidence of any trauma of this type
- 1- A single incident or trauma occurred or suspicion exists of this type of trauma
- 2- Multiple incidents or a moderate degree of trauma of this type
- 3- Repeated and severe incidents of trauma of this type.

**Scoring for the remaining needs and strengths domains on the CANS** reflects ‘Action Levels’ which are used in making scoring and treatment planning decisions for each individual item. There are four scoring options for each item and each score suggests a different pathway for service or treatment planning. These ‘action levels’ are particularly helpful when the client you are trying to assess does not fit nicely into one of the examples given in the manual.

**Action Levels For Needs Domains:** Symptoms Related to Trauma/Adverse Experiences, Life Domain Functioning, Acculturation, Child Behavioral/Emotional Needs, Child Risk Behavior, Children Five and Younger, Transition to Adulthood, Caregiver Domain

- 0- No evidence of a need / no need for action
- 1- Watchful waiting / prevention / mild need
- 2- Action needed / moderate need
- 3- Immediate / Intensive Action / severe need

**Action Levels For Strength Domain:**

- 0- Centerpiece strength
- 1- Useful Strength
- 2- Strength has been identified in this area but it must be built
- 3- No strength is identified in this area / no information

Note that although the scoring options on the needs and strengths are different, a score of 0 on both reflects no need for ‘action’ by the clinician.

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#### **Scoring Challenges Making Difficult Decisions:**

It is strongly recommended that the assessor refer to the CANS Manual for guidance in scoring all CANS items. The manual provides scoring guidelines and examples for each item on the CANS; however, there are several reasons why an assessor may struggle in deciding between two scoring options. Below are some common struggles and recommendations on making these sometimes difficult scoring decisions.

**1. “My client’s presentation does not match the examples listed in the manual.”** It is impossible for the CANS manual to list all possible symptom presentations in the examples for each item. Therefore it is not uncommon to find that your client does not match any of the examples perfectly. In these cases we strongly recommend that you refer to the action levels listed above. For instance, if your client presents with a ‘severe’ need in a particular area, or a symptom in need of immediate or intensive action then they would receive a score of “3” on that CANS item(s). You would use a score of “2” for areas where your client has a ‘moderate’ difficulty that requires intervention/inclusion in a treatment plan. If your client has only a “mild” need or you suspect your client has a need but you need more information to be sure you can rate those items as 1.

**2. “I am getting conflicting information from multiple reporters and I do not know the child/family well enough to decide which is most valid.”** Sometimes family members have different perspectives on the client’s needs and strengths. This is okay and can be handled in a few different ways when scoring the CANS. First, it is okay to consider all of the information you’ve received and assign a score that would reflect an average of what you know, (e.g., averaging the discrepant ratings across reporters). Second, you could decide whether a particular report is more accurate and should be considered over the other perspectives based on clinical judgment. It would also be okay to assign a 1 to a particular item, for “watchful waiting” so that you can keep an eye on this particular need while you get to know the client. Once you know the client well, it is okay to use your clinical opinion to move a score in one direction or another and give one rating more salience than the other based on what seems most clinically accurate. Finally, you can always choose to use another assessment measure to gather more symptom specific information.

- For example, dissociation is an area where there may be differing reports. The clinician may see signs of dissociation in therapy but get denial of such symptoms from the child’s caregiver (who might instead report inattention and/or opposition) or the child’s teacher (who might report laziness or excessive daydreaming) with no report of dissociation. This would be a good opportunity for further clinical assessment of the child, the administration of a dissociation scale based on some evidence of dissociative symptoms.

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**3. Overlapping Needs: “The symptom(s) reported by my client seem to fit into more than one item on the CANS.”** Sometimes assessors wonder about what to do when a client has overlapping needs, co-morbid and related symptoms or a single type of symptom that can be recorded in multiple CANS items. Below are guidelines in how to handle these situations:

The assessor should score as many CANS items as is necessary to capture the client’s full symptom presentation and plan for treatment.

- The cause, or etiology, of a particular symptom is not always clear, and does not need to be known to score the CANS which reflect the current needs and strengths of the child. In these cases, until clarity is achieved either with further assessment or responses to treatment, it is okay to rate as many different items as need be on the CANS to reflect the child’s current (potential) needs. Please see examples below:
  - If a child presents with frequent crying before bed and the clinician does not yet have sufficient information to know whether this is anxiety related, depression related or trauma related; he or she might consider rating a “1” for all of the items that are potentially related: depression, anxiety, sleep and adjustment to trauma items on the CANS, while s/he gathers more information.
  - Nightmares, loss of interest in previously enjoyable activities, moodiness/irritability, and fear can be symptoms of anxiety disorders, mood disorders and/or traumatic stress symptoms. You can rate the anxiety, depression, and adjustment to trauma items at a low level until you are able to determine the etiology of these symptoms.
  - A child who is unable to focus, hyperactive in their behavior and speech, who seems to ‘zone out’ at times could be suffering from biologically based Attention Deficit Hyperactivity Disorder or this child may be reacting in a hypervigilant way to reminders of his/her trauma and using dissociation as a coping mechanism. It is OK to initially rate all of these items at a low level as they all reflect the behavioral needs of the child.

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### II. Scoring the Trauma Domains:

#### Exposure to Potentially Traumatic/Adverse Childhood Experiences

The NCTSN CANS Comprehensive has 14 items in the trauma exposure domain titled Exposure to Potentially Traumatic/Adverse Childhood Experiences. These items are meant to provide a “snap shot” of the traumatic stressors the child has experienced over the course of his/her life. The information recorded in this area, while relevant to treatment planning, is not meant to indicate or measure how well the child has managed or is managing in the face of such traumatic stressors. Rather, these items allow the rater to document the child’s history of exposure to traumatic events without making assumptions about the impact this event has had on the child.

There is one exception to this rule: Medical Trauma (item #5) takes the child’s perception of the medical intervention/experience into account, and if the event was perceived as ‘overwhelming’ by the child then the item is scored based on the severity of the medical experience and the degree to which it was perceived by the child as overwhelming at the time of the experience (not the impact of the experience on the child’s current functioning).

#### Symptoms Related to Traumatic/Adverse Childhood Experiences

The CANS Comprehensive includes a total of 8 items in the Symptoms Resulting from Exposure to Trauma or Other Adverse Childhood Experiences domain. This domain reflects the child’s CURRENT functioning, unlike the Trauma experiences domain which reflects the child’s life time experience. Current functioning is usually defined as the child’s functioning over the last 30 days. This domain has items that assess “classic” post-traumatic symptoms and other common but more complex reactions to traumatic events. Items in this domain are: Adjustment to Trauma, Traumatic Grief, Reexperiencing, Hyperarousal, Avoidance, Numbing, Dissociation and Affective and/or Physiological Dysregulation.

**Pointers for Adjustment to Trauma (Item #15):** This item covers the youth's reaction to any traumatic or adverse childhood experience. This item covers adjustment disorders, posttraumatic stress disorder and other diagnoses from DSM-IV that the child may have as a result of their exposure to traumatic/adverse childhood experiences.

*Please review all bullets below and see the CANS glossary for more guidance on this item.*

- This item is meant to capture a broad range of traumatic reactions. This might include the classic symptoms of PTSD (avoidance, reexperiencing and hyperarousal) as well as trauma symptoms that fall outside of the traditional PTSD diagnostic categories. This item can also capture symptoms that may not be considered ‘common’ trauma reactions but which are related to an individual child’s experience of trauma (e.g., school avoidance).
- A child who meets diagnostic criteria for PTSD would be rated with a score of 2 (moderate) or a 3 (severe) on this item. However, a child does not need to exhibit ‘traditional’ PTSD symptoms to be rated on the Adjustment to Trauma item. Rather, a child with mild,

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moderate or severe complex trauma symptoms or other adjustment difficulties clearly linked to the trauma would be rated as a 1, 2, or 3 respective to their degree (mild/suspected, moderate, or severe).

- For example, a child who had few problems relating to peers and did well in school prior to a trauma, but subsequent to a trauma has moderate problems in both of these areas, can and should be rated as a “2” on the Adjustment to Trauma item.
- This is one of the only items on the CANS where the assessor pays attention to “cause and effect” or etiology. It is important to note that not all children with histories of trauma have adjustment to trauma difficulties. There may be a natural but incorrect tendency to elevate a child’s rating on Adjustment to Trauma in order to provide explanation for particular emotional or behavioral problems. However, if there is no apparent evidence that child’s trauma history is related to their current needs, then this item should be rated as a 0, for no evidence, or a 1 for a suspicion that a child’s reactions is related to the trauma.

#### **Pointers for Traumatic Grief (Item #16):**

- *Please note that in order to give a child a 2 or 3 on this item they must have experienced and suffered from a ‘traumatic loss’ such as the death or unexpected separation from a loved one. Additionally, they must have current, on-going symptoms of traumatic grief which are disrupting their ability to function in some way.*
- *Please see the CANS glossary for more guidance on this item.*

#### **Pointers for Avoidance, Numbing, and Dissociation (Items #19, 20 and 21):**

- Different children may exhibit the same trauma symptom differently. Two children, both experiencing dissociation may look very different from one another.
- Sometimes a child does not appear to be totally engaged or “present” and it is not entirely clear if s/he is avoiding, numbing or dissociating. In these cases, where the clinician is initially unable to distinguish between these symptoms, consider rating two or more of the items as a “1” to indicate that the child has a suspected need in this area and to flag it as an area where the clinician needs more information. Once more information is gathered the score can be revised if the symptom picture changes.
- The line between numbing and dissociation is not always clear. In general, a child who numbs may have a restricted range of emotional responses or become disconnected from his or her emotions in a way that is protective. The child who numbs is generally cognitively present and in touch with his/her environment. A dissociating child may also exhibit emotional numbing or a disconnection from his/her emotions as part of his/her response. But this disconnection often includes emotions as well as thoughts/ /body/self and/or

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environment in a way that is greater than numbing. She may be so disconnected that he/she cannot experience, identify and/or express emotions.

#### **Pointers on Affective/Physiological Dysregulation and Hypervigilance (Items # 19 and 22):**

- Affective/Physiological Arousal is broader than Hyperarousal and can be experienced by children with no history of trauma; Hyperarousal is a symptom specific to post traumatic reactions
- Affective/Physiological Dysregulation is a core symptom of Complex Trauma. It can be manifested in children in a number of ways with the key being difficulty regulating emotions and physiology.
- It may seem tricky to differentiate between Affective/Physiological Dysregulation and Hyperarousal because while they are different, there is some overlap between the two.
  - For instance, both can include heightened arousal and problems regulating physiological states such as difficulty sleeping. As a result, if a child presents with these symptoms they may be rated on both of these items in addition to the sleep problem item and impulsivity.
- A key feature of hyperarousal is a prolonged state of physiological arousal which is commonly expressed as irritability, jumpiness, and being on edge. This aroused state can disrupt sleep and eating patterns and can lead to somatic complaints such as stomachs and headaches.

Affective/physiological dysregulation can be expressed in many ways including a child's, difficulty in identifying and describing internal emotional states, problems labeling or expressing feelings, difficulty or inability in controlling or modulating his/her emotions, and difficulty communicating wishes and needs.

#### **When the Presence of Traumatic Stress Symptoms is Unclear: Areas for more detailed Assessment**

- The CANS is a measure that provides a comprehensive, trauma-informed assessment. At times, it will be beneficial to assess a specific trauma symptom (e.g., Dissociation) in a more detailed way. Getting a more detailed assessment may help to inform better treatment recommendations.
- Clinicians using the CANS are encouraged to use additional assessment strategies and measures as appropriate and to incorporate their findings into the CANS assessment.

This may be indicated in the following scenarios:

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- If a child is scored at a “1” on reexperiencing, avoidance, hyperarousal or dissociation items with the notation to “flag for more information” this may suggest the need for to administer a diagnosis specific or symptom specific measure (e.g., a PTSD scale or a dissociation scale) to get more detailed information.
- Additional assessment measures can provide additional information on whether symptoms meet a specific clinical cutoff or meet full or partial diagnostic criteria.
- Additional diagnostic or symptom-focused assessment tools may also help build specific interventions into the treatment plan.

**When a symptom is “broad enough” to be rated in both the traumatic stress symptom domain and other need domains on the CANS.**

- As noted in the general scoring section, the same symptom can be rated in more than one item on the CANS. In fact rating a symptom in multiple areas sometimes helps in conceptualizing the case or in treatment planning decisions.
  - When a child presents with dysregulation of mood, their symptoms may indicate a need to score the Affective/Physiological Dysregulation item in the trauma symptom domain as well as the Anger Control item in the Child and Behavioral Emotional Needs domain. Endorsing as many items “as fit” the symptom will help the clinician develop a more comprehensive picture of the child’s needs, and how they may fit together for treatment planning. For instance, a child struggling with emotional regulation problems, whether they are trauma related or not, would likely benefit from psycho-education and skill building around feeling identification.

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**III. CANS Scoring Issues: Child and Caregiver Strengths**

The CANS has 11 items designed to assess strengths or protective factors, of the child and his or her environment. There are additional family/caregiver strengths assessed in the Caregiver Needs and Strengths section.

Many traumatized children exhibit a range of strengths and positive coping behaviors that have the potential to buffer them from more serious or long-term effects of trauma and serve an important function for children and families in the process of recovery from trauma.

- Research suggests that increasing strengths while addressing behavioral/emotional needs and traumatic stress symptoms leads to better functioning and outcomes than just focusing on the needs.
- Identifying areas where strengths exist and can be built is a critical element of trauma-focused treatment.

**When scoring the strengths items, the rater may want to consider the following:**

- If there is no evidence of a strength, or you have no information about a strength in a particular area, score that item “3”
- The ‘family’ refers to all biological and adoptive relatives but could also include individuals who have long-term relationships with the child if the **child** defines them as family.
- Educational strengths refer to the strength of the school system and NOT to any functional ability of the child.
- The presence of talents/interests and spiritual/religious strengths are strong predictors for placement stability and positive outcomes among traumatized children from both a clinical and research standpoint and should not be overlooked during the assessment.
- Relationship permanence refers to the stability NOT the quality of the relationship.

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**Using CANS Strengths in Trauma Focused Treatment:** strengths can be incorporated into trauma-informed treatment planning and treatment in many ways.

Please see the following examples of how this can be done. This list is meant to provide clinicians with concrete examples but is not exhaustive.

**Remember, for Child's Strengths, the following CANS scores and action levels are used:**

**0** = a “centerpiece strength” or an area where strengths exist that can be used as a centerpiece for a strength-based plan.

**1** = a “useful strength” or an area where strengths exist but require some strength building efforts in order for them to serve as a focus of a strength-based plan.

**2** = a “potential strength” an area where a strength has been identified but requires significant strength building efforts before it can be effectively recognized and utilized by the child and in trauma-focused, strength based treatment.

**3** = not currently an area of strength for the child, an area in which efforts are to identify potential strengths

**23. FAMILY** - Family refers to all biological or adoptive relatives with whom the child or youth remains in contact along with other individuals in relationships with these relatives.

*The therapist should strive to improve and use positive family relationships throughout trauma-focused treatment. A child with high family strengths will have at least one or two adults who are actively engaged in the treatment process in an active supportive way. These caregivers should be mobilized as an important part of the trauma recovery process for the child, both within and outside of the therapy context. The therapist should spend one-on-one time with the caregivers of children with less developed family strengths. Caregivers should be provided with much support with regards to learning how to communicate with and provide support to their child. These efforts can be written as goals in the treatment plan.*

**24. INTERPERSONAL** - This rating refers to the interpersonal skills of the child or youth both with peers and adults.

*Interpersonal skills are necessary for successful day-to-day functioning. The rating on this item will help the clinician decide how much therapeutic focus to place on building the client's interpersonal skills. If the client already has well-developed interpersonal skills, it may benefit the child to be enrolled in extracurricular group activities where s/he might be able to further develop and practice leadership skills to contribute to his/her self-esteem and self-enhancement. Enrollment in a social-skills group is one way to address and build interpersonal strengths for a child who is not well-developed in this area*

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**25. EDUCATIONAL SETTING-** This rating refers to the strengths of the school system and may or may not reflect any specific educational skills possessed by the child or youth.

*If a child's educational system is functioning well, school partners can provide information on the child's functioning in the school setting as well as be kept informed of the child's progress in therapy and engaged in a trauma-informed service plan as deemed appropriate (and upon the consent of the caregiver/child). If a child's school is not providing an educational plan and intervention well-matched to the child's needs, a plan for reconciling this should be put into the treatment plan. The child and family can be educated about the types of supports the school system can provide.*

**26. VOCATIONAL** - Generally this rating is reserved for adolescents and is not applicable for children 14 years and under. Computer skills would be rated here.

*If a child has vocational interests or skills, these should be noted and used as appropriate in treatment. For example, a child with computer skills might like to create an electronic narrative of his trauma experiences with clipart and other computer graphics. Likewise, if a child has vocational interests (i.e., to be a fireman) the skills necessary in that career can be used as motivation to continue in treatment. For example, a child can be encouraged to be brave like a fireman or learn to breathe and stay calm when in danger like a fireman.*

**27. COPING AND SAVORING** - This rating should be based on the psychological strengths that the child or adolescent might have developed including both the ability to enjoy positive life experiences and manage negative life experiences. This should be rated independent of the child's current level of distress.

*This item refers to a child's ability to enjoy the good and deal with the bad – both are essential skills for a successful, fulfilling life. If the child's CANS rating is a 2 or 3 in this area, trauma-focused treatment can emphasize helping the child safely experience and regulate a range of emotions as well as learn new coping mechanisms. If the child has well developed well-being skills, and a score of 0 or 1 on the CANS these abilities can be highlighted in therapy by participation in fun activities and praise for the use of appropriate coping mechanisms.*

**28. OPTIMISM** - This rating should be based on the child or adolescent's sense of him/herself in his/her own future. This is intended to rate the child's self-esteem and positive future orientation.

*A child with a trauma history may have a particularly hard time seeing him/herself and his/her future in a positive manner – this may be legitimately due to a long history of exposure to negative life events. If a child does not have well developed optimism, this needs to be a focus of treatment. The therapist should take every opportunity to point out ways the child has been successful in coping. Treatment interventions might include cognitive replacement strategies can be used to help the child identify and replace their tendency to catastrophize or generalize negative events. Treatment goals can include engaging in enjoyable tasks in therapy over which the child can gain mastery and/or enrolling the child in extracurricular activities in which they*

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*can excel to build their sense of competency. Children with already well-developed optimism strength can use their skills during treatment in many ways.*

**29. TALENT/INTERESTS** - This rating should be based broadly on any talent, creative or artistic skill a child or adolescent may have including art, theatre, music, athletics, etc.

*It is essential that children develop talents and interests. Development of talents and interests increases a child's positive sense of self. Well-developed talents or interests can also be used as a way to make therapeutic tasks more salient or interesting for the child. For example, a child interested in Pokemon can see skill building as a way to build their power; those interested basketball can liken learning certain athletic skills to learning trauma specific coping skills. Further, therapists can be creative in helping children use their talents or specific creative interests (e.g., drawing or music or dance) in developing their trauma narrative or to cope with their traumatic symptoms. The therapist should be sensitive to the way they use the child's interest in treatment because sometimes children desire to keep their talents and interests completely separate from their trauma. For those children with few strengths in this area, efforts should be made to identify topics or activities that interest the child during the course of therapy and once identified, the child should be enrolled in activities to support the further development of these interests.*

**30. SPIRITUAL/RELIGIOUS** - This rating should be based on the child or adolescent's and their family's involvement in spiritual or religious beliefs and activities.

*Spirituality is one of the greatest protectors a child can have and can be a useful resource when coping with traumatic experiences both throughout the course of treatment and beyond. If a child has significant strength or interest in this area, they can be encouraged and supported in participating in spiritual or religious events outside of therapy. Strengths in this area can also be used specifically to assist with the process of making meaning of traumatic experiences in the course of recovery. Building strengths in this area, when they do not already exist, should be done so respectfully and in accordance with the child and caregivers beliefs and preferences.*

**31. COMMUNITY LIFE** - This rating should be based on the child or adolescent's level of involvement in the cultural aspects of life in his/her community.

*Children who are involved in healthy community activities tend to do better over the course of treatment and in sustaining treatment gains. Any efforts the clinician can make to connect the child to their community in a healthy way will likely benefit the child. Getting the child involved in community sports or scouts or even connect with support, strong members of the community are ways of doing this. If the child is already well engaged in their community, they can use such ties to support them as they progress through treatment.*

**32. RELATIONSHIP PERMANENCE** - This rating refers to the stability of significant relationships in the child or youth's life. This likely includes family members but may also include other individuals.

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*Family members who have been consistently available to the child client may be brought into treatment to witness and support the child's trauma processing; may serve as a positive role model for the child; or may be used as an example to contradict or address maladaptive beliefs (i.e., serve as an example that not all adults are abusive or bad). This is a strength that may be difficult to build if it is not available or there are no identified resources. If the child is rated as a 2 or 3 on this item, the clinician may want to work more to facilitate relationship building between the child and his/her foster parents or assist with helping the child develop more secure adult relationships both within and outside of their home.*

**33. RESILIENCE** – This Resilience item on the CANS refers to the child's ability to identify his or her own strengths and to use them to cope or excel as developmentally appropriate.

*Building resilience in trauma-focused therapy will likely include work on positive affect enhancement and self-reflective information processing in which the child begins to build his/her capacity to accurately judge his/her own strengths and capacities and to use problem solving techniques that build upon these. For instance, if a child has a good sense of humor and creative skills these would be skills to bring to light and help the child build upon when in difficult situations.*

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**Part 2: Use of the CANS Scores in Trauma-informed Treatment Planning**

CANS scores can be used in a number of ways. The CANS scores can be used to facilitate communication between a number of different professionals working with the child; they can be used to “educate” caregivers and youth about why we want to focus on certain areas in treatment and engage them in the process of treatment; they can be used to decide the best placement or type of service for a child and can be used to monitor a child’s progress (e.g., treatment progress) over time. The purpose of this document is to highlight ways that CANS scores can be used in Trauma-informed treatment planning. Please see the recommendations below. As you review, please also consider how you’ve used the CANS scores in the setting where you work....

The concept of Trauma-informed treatment planning can take on a variety of meanings. Trauma-informed treatment planning involves the consideration of the child’s traumatic history and trauma related mental health symptoms in conjunction with the child’s other needs and strengths in planning for treatment intervention. Trauma-informed treatment planning is meant to be a flexible process based on the particular needs and strengths of a child and caregiving system. It recognizes that children may change with regards to their needs, strengths, readiness and ability to engage in different aspects of trauma-focused treatment over time. Trauma-informed treatment planning, like all ethical and effective treatment planning, should always reflect the best clinical judgment of the clinician and his/her supervisor.

**Trauma-informed treatment planning, as informed by the NCTSN CANS Comprehensive, is meant to ensure the following:**

- 1) Prevents the assessor/clinician from overlooking a child’s history of exposure to traumatic events
- 2) Cues the assessor/clinician to consider and rate the impact trauma exposure may have on the child’s current functioning/adjustment by comprehensively assessing all of the following areas:
  - a. Symptoms of Post-Traumatic Stress Disorder
  - b. Symptoms of Complex Trauma
  - c. Other Behavioral and Emotional Health Symptoms
  - d. Child’s participation in Risk Behaviors (often used for coping with trauma)
  - e. Functioning in Day-to-Day Environment and Activities
- 3) Prompts the assessor/clinician to consider and rate the Strengths or Protective Factors present within the child, his/her caregiver and environment, all of which can provide a buffer to the on-going impact of trauma

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**I. General Recommendations for Trauma-informed Treatment Planning using the CANS**

- **All of the child's needs and strengths must be considered:**  
There is nothing in trauma-informed treatment planning that suggests that traumatic stress symptoms 'trump' the other needs in a child's life. Rather, trauma-informed treatment planning, especially when initiated through a comprehensive trauma assessment process (e.g., with the use of the NCTSN CANS Comprehensive) involves a consideration of all of the child's presenting symptoms (needs) as well as their strengths.
  
- **Include the child and family in the treatment planning process:**  
Once the NCTSN CANS Comprehensive has been completed, the clinician and child's family should work collaboratively to determine an appropriate course for treatment planning. Alternately, caregivers or older youth can also be engaged in the completion of CANS ratings as appropriate and as part of the engagement process. Successful treatment intervention depends on the child and family's investment in treatment, as well as the child and family's needs and strengths. To increase such investment, the child's self-identified needs and the family's preferences for treatment planning should be given considerable weight. In ideal cases, the child's therapist, the child's caregiver, and the child (if developmentally appropriate) should together discuss and determine the focus and goals of treatment. Other professionals such as a child's case manager would also be beneficial in this process.
  
- **Collaborate with other professionals serving the child:**  
When planning for treatment, all resources in the child's life should be considered. For instance, the clinician should consider what roles the other professionals in the child's life (e.g., case worker, teachers, school counselors, coaches) can have in helping the child address some of the needs identified on the CANS, or increasing some of the child's strengths in need of development.

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**II. Use of the CANS Scores in Developing Trauma-informed Treatment Goals**

**Incorporating the Child’s Needs and Strengths into the Treatment Plan:**

- **Priority in treatment planning must be given to the “actionable” items, which are those needs that have been rated as a 2 or 3 on the CANS.**
  - The rating of a 3 indicates that the child is in immediate and intense need of intervention in a particular area(s). These items rated as 3 may help to determine the level or intensity of care the child requires. For instance, a child who is rated as a 3 on several risk behaviors or suicidality/self harm may need to be supervised at all times, requiring a plan to be made to do this successfully in the home or transfer the youth to a higher level of care (i.e., residential) where such supervision can be guaranteed.
  - The items rated as 2 on the CANS Comprehensive also deserve attention in the treatment planning, though the need for intervention will not be as immediate as those rated as 3.
- **Risk behaviors scored at a 2 or 3 on the CANS should be given priority in trauma-informed treatment planning** as many times these behaviors (e.g., substance use, running away, self-mutilation) are used for coping with traumatic stress or other systems that are dysregulated (e.g., emotions) due to past trauma exposures. Often times before a child can engage in trauma-specific work in therapy they need to learn healthy coping mechanisms they can use to manage the discomfort that may come up for them as they focus more on the impact of trauma in therapy. .
- **Traumatic stress symptoms, especially those with ratings of 2 or 3, need to be included and addressed in a developmentally sensitive way in trauma-informed treatment plans.**
- **Other trauma-related emotional/behavioral needs, especially those with ratings of 2 or 3, should be included in trauma-focused treatment plans.** These include areas of need that have been linked to difficulties with adjustment following trauma, possibly as a means of coping with trauma experiences, triggers, or ongoing stressors related to the trauma.
- **Other non-trauma-related needs can also be included in treatment planning.** For instance, items rated as 2 or 3 sometimes reflect issues that can be addressed outside of the course of therapy. For instance, if a child has a 2 on school attendance because they have no transportation to school, that child’s caseworker may work with the family and local community resources to ensure that child has a safe way to school. Other items may require attention in therapy such as suicidal ideation, which needs to be addressed by a trained mental health professional.
- **Child strengths, including interests and talents should be considered in treatment planning.** This is especially the case because traumatized children sometimes develop distorted and negative views of themselves and the world around them. The literature on

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resilience indicates core strengths are critical in buffering children against the harmful effects of trauma. Building and using a child's strengths can increase their sense of hope, esteem and/or their ability to recognize the positive aspects of life.

- Strengths with any score (a rating of 0, 1, 2, or 3) on the CANS can be incorporated into treatment planning. Centerpiece strengths, those scored as 0 on the CANS, can be highlighted in therapy as areas where the child is presently doing well and may be used as a vehicle in meeting other treatment goals. Additionally, these centerpiece strengths (if applicable) can be used as a medium for helping a child process his/her trauma when appropriate (e.g., use of a particular talent/creative interest as a format for developing a trauma narrative). See Trauma Treatment section for further details.
- Strengths rated as 1 or 2 may need some attention in therapy in order to help them develop further. Maximizing development of particular strengths can even be written as a treatment goal.
- Strengths rated as 3 may deserve immediate attention in or outside of therapy. They should to be included in therapy treatment planning if their absence is debilitating (i.e., optimism) or if development thereof would benefit the particular child or family (i.e., spirituality).

### **Incorporating Caregiver's Needs and Strengths into the Treatment Plan:**

**Caregivers' strengths as reflected on the CANS should also be considered and built upon in therapy with the child as appropriate to assist with the process of recovery from a child's traumatic experiences.**

- Caregivers should be acknowledged for any strengths rated as 0.
- Strengths rated as 1 or 2 may be developed enough and continue to grow if used appropriately to support the child in treatment.
- Strengths rated as a 3 may help the clinician determine if the caregiver has or lacks the skills necessary to participate in the child's treatment or if they need individual attention or support to first develop these skills themselves.

**Caregivers' needs, as rated on the CANS, should be considered in treatment planning.** This will help the clinician determine how to best fit the caregiver into the child's treatment and whether the caregiver would benefit from their own treatment or additional supports.

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### **Potential Challenges with using the CANS in Trauma-informed Treatment Planning:**

**There will be too many 2 or 3s in the treatment plan to realistically include and address all of them at once!** Many traumatized children, especially those with long histories of abuse and neglect will present with many types of elevated needs. In this case we encourage you to consider the following:

- 1) The needs on the CANS are sometimes related to one another, as you are looking at your CANS Score sheets ask yourself how the items marked as 2 or 3 may be related. Consider the following:
  - Which of these needs are actually the youth's coping responses?
  - Which of these needs are surfacing when the child is faced with trauma triggers?
  - Which of these needs have to do with the youth's difficulty in forming or maintaining healthy relationships?
  - Which of these needs are related to the youth's difficulty with emotional regulation (e.g., difficulty in identifying and describing internal emotional states, problems labeling or expressing feelings, difficulty or inability in controlling or modulating his/her emotions, and difficulty communicating wishes and needs)
  - Which of these needs might be related to the youth's current perception of their own safety?
- By grouping the needs together in this way, you are able to formulate treatment plans that address several needs at once. If you are working with a child who has experienced Complex Trauma, you should consider using the CANS Scores and Core Components of Complex Trauma worksheet developed by CCTASP. This worksheet groups the CANS items together in a way that helps clinicians see and monitor the child's treatment needs according to those most often addressed in cases of complex trauma.
- By grouping needs together you can also help youth, caregivers and other adults in the child's life see the connection between trauma experiences and behavioral issues.
- 2) Remember that you can rely on other professionals working with the child (e.g., case worker) to address some of the needs identified in the CANS
- 3) Only include the number of needs you can actually address in treatment planning; these should ALWAYS include the items rated 3 for intensive or immediate intervention. You should consider completing the CANS and revising the treatment plan on a frequent and regular basis (every 45 days) if you are unable to include all of the remaining needs in the plan.
- 4) Finally, if the child presents with needs that are too great to address in outpatient treatment, the assessor and /or clinician should consider the need to get the child into a more intensive service (e.g., day treatment, residential treatment program).

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**Questions to Guide the Development of a Trauma-Focused Treatment Plan Using the CANS**

Below are questions and answers that may facilitate rating a child appropriately the on CANS, developing trauma-informed treatment plans, and prioritizing treatment interventions.

1. Does the child have a history of chronic exposure to multiple traumas?

*If the child has a history of chronic exposure to multiple traumas (rated as a 2 or 3 on two or more CANS Trauma Experiences items), especially if the traumas were interpersonal in nature, he/she may display a wide range of complex traumatic symptoms which fall outside of the traditional range of PTSD. Symptoms which are trauma related but fall outside those traditional PTSD symptoms, can and should be addressed using trauma-focused interventions.*

2. Were this child's mental health symptoms evident prior to his/her trauma exposure?

*If the child's symptoms were evident prior to his/her trauma exposure, assess to see if child's symptoms worsened or changed following the trauma. If symptoms changed or worsened following the trauma, then the intervention approach should be trauma sensitive if not trauma-focused. At the very least, the child and family should be provided with psycho-education about how trauma can exacerbate already present mental health symptoms.*

3. Does this child have a family history of mental health problems?

*If yes, you should consider the possibility that this child's symptoms are due to a genetic predispositions and/or other life events rather than related to traumatic life events alone and may require diagnosis or symptom-specific treatment that either falls outside of or is done in addition to trauma-focused therapy.*

4. Are this child's "symptoms" actually his/her efforts to cope?

*This question is essential to working with traumatized children. Symptoms such as dissociation and isolation and substance use are often adaptive coping responses in the face of a trauma but maladaptive if the child uses them in everyday, non-traumatic situations. It is important for the trauma therapist to understand the "role" such areas of needs/ symptoms might play in the child's attempts to cope with current stressors and trauma reminders. Before a child is able to stop engaging in unhelpful or unhealthy coping techniques they must learn to use replacement coping measures, they may also need to focus on building affect tolerance and regulation skills as part of this work in therapy.*

5. Are this child's symptoms expressed differently in different situations (e.g., home vs school) or with different people?

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*If so, this child may be expressing symptoms in reaction to specific trauma triggers which can include particular situations, smells, tastes, touches or sounds. If symptoms appear related to trauma triggers (e.g., specific times, places, events, noises, people or other stimuli related to the traumatic event or circumstances) trauma treatment should assist the child in identifying their triggers and coping with them appropriately.*

6. Has this child been on medication for the treatment of their mental health symptoms, and if so, how did/do they respond?

*If a child has received medical treatment for a non-trauma related diagnosis with little benefit, the therapist should consider speaking with the prescribing practitioner about traumatic stress as a possible underlying cause and explore this with the child and family in the assessment and treatment process.*

7. How does the child/family view the symptoms?

*Sometimes families fail to recognize trauma related symptoms due to a lack of education about traumatic stress, a desire to minimize the impact of the trauma, or a heightened concern related to symptoms or risk behavior that require a good deal of attention from caregivers or service providers. In this case, the child/family would likely benefit from psycho-education on common reactions to trauma in a non-blaming, normalizing fashion.*

8. Do problems appear to be associated with family or system dynamics?

*Sometimes, family or community reaction to a traumatic event is more difficult for the child to cope with than the traumatic event itself. Therefore, caregivers and children's thoughts and beliefs regarding the traumatic event should be assessed. If incorrect or maladaptive beliefs exist, the child/family should be provided with appropriate psycho-education in a validating, non-blaming manner as part of the broader trauma-focused therapy.*

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### **Other Clinical Applications of the CANS Data:**

CANS scores provide the assessor/clinician with more than just a snap-shot of the child's needs at the time they present for treatment. The CANS should be used to monitor and track treatment progress overtime and provides "data" to support the need to adjust treatment planning.

**Specifically, the CANS data helps the clinician do the following:**

- Watch the client's initial needs and note changes in needs overtime, including the development of new needs
- Watch and better conceptualize/understand worsening of symptoms as they change together
- Watch to see if some symptoms peak prior to decreasing once in therapy (not uncommon in trauma-focused treatment)
- See the changes in a child's strengths over time
- Identify areas the clinician didn't expect or intend to change
- Understand the child's needs at the termination of/post-treatment, to identify needs to be addressed in step-down services or monitored by caregivers over time.

All of the above can be done by looking at changes in individual items or averaging the changes in specific domains or grouping overtime.

**Finally, CANS scores can be considered on an agency or systems level (e.g., across multiple children) can be to determine specific program level needs, if a program is meeting their program goals (e.g., is a trauma focused treatment service addressing all or just a subset of trauma symptoms for most children?), and if there are adequate resources to meet these needs or gaps in resources that need to be addressed.**

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### **Part 3: Trauma-Focused Treatment**

Beginning the process of trauma-focused treatment involves several important steps. First, the clinician reviews the primary needs and strengths identified during the assessment process and identifies those that should be represented in the treatment plan. Next, the clinician drafts and prioritizes the goals in the treatment plan. Finally, the clinician selects the treatment interventions or components thereof that will best address the treatment goals.

There are many different child trauma treatment approaches and specific practices available today. Despite some differences, most follow similar phases and contain an agreed upon list of core components related to effective, trauma-focused treatment, based on the work of national trauma experts in the field.

All trauma-focused treatment interventions require that the therapist take an active and direct role in therapy while remaining flexible and patient. Treatment should be delivered in a creative, clinically-sensitive manner, meeting the child at his/her developmental level. Savvy clinicians will use child's strengths and interests throughout treatment; clinically relevant games and other enjoyable activities building upon the child's interests and strengths can be used to address the treatment goals (i.e., skill building). The therapist engaging in trauma-focused therapy must be able to tolerate the expression of a range of traumatic thoughts, emotions, and behaviors.

In trauma-focused treatment, clients can move back and forth between phases or components of treatment. Sometimes different phases or components of treatment are addressed simultaneously during the course of treatment. The amount of time that each client will need to spend in each phase or component of treatment will depend on his/her strengths, needs/symptoms, and developmental level.

To date there are a variety of well-established, empirically supported treatments for childhood trauma. There has also been concerted effort in our field, especially by select members of the National Child Traumatic Stress Network, to identify core components of trauma-focused treatment that are particularly suitable for children with complex trauma histories and responses. These experts have discussed these core components of treatments often by referring to "phases" of treatment. There are a variety of published examples of phased treatment approaches for trauma. In the section below we provide an example of one of the most common ways of conceptualizing phased treatment. In addition, we have identified core components of trauma-focused treatments and examples of common intervention strategies based on a review of the work of several child trauma experts.

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### I. Phases of Trauma Treatment

Several experts in the field (e.g., Luxenberg, Spinazzola, Hidalgo, Hunt, & van der Kolk, 2001) have often identified three primary phases of trauma-focused treatments particularly when emphasizing complex trauma

**Phase 1: Safety and Stabilization** - focuses on stabilizing the client via psychoeducation addressing issues of trust, safety, support, boundaries, self-soothing, and building support networks.

**Phase 2: Processing and Grieving the Trauma** – explores traumatic memories, integrates memories into life narrative, desensitizes client to traumatic memories, corrects maladaptive cognitions.

**Phase 3: Reconnection** – works on self-enhancement with focus on growth and reconnection to day-to-day occupational, spiritual, and recreational activities as well as current and future relationship building.

### II. Common Core Components of Trauma-focused Treatments

(Adapted from the TAP model 2006; Luxenberg et. al., 2001; & Cook, et. al., 2005)

Usually in Phase 1 – Safety and Stabilization:

1. **Building a Therapeutic Alliance**
2. **Skill Building and Psycho-education**
  - **Creating Safety**
  - **Self-Soothing & Regulation of Emotions, Behavior, Physiology, and Cognition**
  - **Self-reflective Information Processing**
  - **Parenting Skills**
3. **Relational Engagement**

Usually in Phase 2 – Trauma Integration:

4. **Trauma-Specific Psycho-education**
5. **Exposure to Traumatic Memories and Processing of Related Grief**
6. **Addressing Maladaptive Cognitions**

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Usually in Phase 3 – Reintegration and Reconnection:

- 7. System Dynamics**
- 8. Enhancing Positive Affect, Strengths, Resources, and Competencies**
- 9. Social Support and Relationship Building**

**III. Suggested Treatment Tasks for Each of the Core Components Listed Above**

(Adapted from the TAP model 2006; Luxenberg et. al., 2001; & Cook, et. al., 2005)

**Note:** the use of all of these skills/treatment tasks depends greatly on the style of the therapist and on the developmental stage, needs and strengths, personality, preference, and ability of the client to tolerate distress and engage in trauma-informed treatment.

**1. Component: Building Therapeutic Alliance**

***Building a Safe Therapeutic Relationship: Suggested Treatment Tasks***

- Establish a working relationship w/ client (using unconditional positive regard, genuineness, empathic understanding)
- Establish a working relationship with parent or caregiver (using unconditional positive regard, genuineness, empathic understanding)
- Develop trust, feelings of safety and security in therapy
- Help client develop sense of control in therapy
- Educate and model appropriate boundaries
- Meet and interact with the child at his/her developmental level
- Develop cultural competence for all client populations served/related to the client in a culturally informed, culturally competent way.
- Set a positive tone for therapy, and establish the expectation (hope) that therapy will lead to positive change

**2. Component: Skill Building and Psycho-education**

- Creating Safety (inside and outside of therapy)
- Trauma Specific Psycho-education
- Self Soothing & Regulation of Emotion, Behavior, Physiology, and Cognition

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- Self-reflective Information Processing
- Parenting Skills

***Building External Safety: Suggested Treatment Tasks***

- Help child identify safe places and safe people in their environment
- Make efforts to help child be and feel safe at home, and in other settings (e.g., school) by working with key adults
- Develop safety plans as appropriate/ necessary
- Help child develop accurate interpretation of safety-related environmental cues

***Enhancing Emotional and Physiological Regulation to Increase Sense of Internal Safety: Suggested Treatment Tasks***

- Identify and label feelings
- Model and help client experience, express, and communicate feelings
- Help client understand and appropriately manage range of emotions
- Develop positive self-feelings
- Resolve troubling emotions
- Integrate feelings
- Teach and practice relaxation techniques such as diaphragmatic breathing, muscle relaxation, guided imagery, and movement exercises
- Teach and practice mindfulness techniques
- Acknowledge, validate, and normalize child and family traumatic stress reactions

***Providing Initial Psycho-education: Suggested Treatment Tasks***

It may benefit children and families to be provided with information about:

- What to expect from therapy, including the treatment rationale
- Healthy, safe relationships – Including setting appropriate boundaries and communication skills
- Safety skills by teaching the child how to recognize and circumvent unsafe situations

Trauma-specific psycho-education can take place during this phase or the trauma integration phase. Some initial pieces of trauma-specific education to cover include:

- Facts about prevalence of traumatic events (they are not alone)

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- Information about common reactions to trauma in children and caregivers

***Enhancing Behavior Regulation: Suggested Treatment Tasks***

- Identify linkage between thoughts, feelings, and behaviors and how behaviors are usually a result of thoughts and/or feelings
- Identify which problem behaviors are actually coping mechanisms
- Provide behavior management skills to caregivers
- Teach and practice problem solving skills with client
- Teach and practice impulse control strategies with client
- Teach/enhance and reinforce positive behaviors/social skills
- Cue client's use/practice of relaxation techniques
- Work on improving verbal and nonverbal communication skills

***Enhancing Cognitive Regulation / Executive Functioning: Suggested Treatment Tasks***

- Identify linkage between thoughts, feelings, and behaviors and how certain thoughts lead to certain behaviors
- Education about cognitive errors and maladaptive thoughts
- Discover/discuss the child's attributions (e.g., about himself and the world) and how they are related to the child's past and his present behavior
- Work to challenge and correct unhelpful or incorrect attributions, while validating the child's current perceptions
- Teach thought stopping skills and thought replacement strategies
- Work on improving verbal and nonverbal communication skills

***Self Reflective Information Processing: Suggested Treatment Tasks***

- Help child develop more complete sense of self: "Who am I?"
- Construction of self-narratives
- Assist client in reflection on past and present life experiences
- Create positive self-affirmations
- You may need to address deficits/build capabilities in child's ability to maintain and focus attention, anticipate consequences, problem solve, and using reasoning abilities, planning and decision making skills in order to help the child build a more consistent and coherent sense of self

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***Enhancing Parenting Skills: Suggested Treatment Tasks***

- Provide caregiver with education on developmental stages and tasks
- Help caregiver develop appropriate expectations for his/her child
- Teach positive parenting skills: use of attention, praise and positive reinforcement
- Teach safe discipline skills/techniques: active ignoring, effective commands, effective use of Time Out
- Acknowledge caregiver's own history of being parented and related trauma history as relevant/appropriate and offer resources for further support as needed

**3. Component: Relational Engagement**

***Relational Engagement: Suggested Treatment Tasks***

- Attachment work with child's current caregivers / important interpersonal relationships
- Reinforcing and emphasis on development of interpersonal skills including assertiveness training, cooperation, perspective taking, boundaries, limit setting, reciprocity, social empathy
- Build or develop capacity for trust, physical and emotional intimacy

**4. Component: Trauma-Specific Psycho-education**

***More Trauma-Specific Psycho-education: Suggested Treatment Tasks***

Children and families should be provided with information about the following (note, some of this may be started earlier in treatment)

- Facts about prevalence and common reactions to trauma seen in both children and caregivers
- Normal reactions to trauma
- Understanding how past experiences trigger current responses
- Differentiating fearful memories and body responses from current level of safety/danger
- Common misperceptions or questions

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**5. Component: Exposure to Traumatic Memories and Processing of Related Grief**

*Trauma Exposure: Suggested Treatment Tasks and Clinical Pointers*

*Techniques:*

- Review trauma-focused psycho-education and skills learned earlier in treatment as needed
- Tell the story or narrative of the trauma through various mediums such as writing, singing, acting, dancing, poetry - preference may be given to certain mediums based on identified interest of child or as noted in CANS Strengths section
- Identify and experience full range of emotions associated with trauma experience and reminders of the trauma with goal of client experiencing a reduced emotional charge related to trauma in time
- Process grief and loss associated with trauma
- Identify physical reactions to traumatic experience and process
- Integrate traumatic experience into cognitive schema
- Allow for corrective emotional re-working of the trauma

*Important Considerations for Trauma Exposure/ Narration and Organization:*

- **If the child is engaging in self-destructive or risk behaviors she/he is likely not ready for full exposure or development of their personal trauma narrative.**
- **A child should have some solid, healthy coping skills and support people they can go to outside of therapy before they engage in trauma exposure or processing.**
- **Timing of the trauma exposure technique is especially important; the child must have acquired the emotional regulation skills that were focused on in Phase I of the trauma-focused treatments.**
- **Only a clinician with training and available supervision in trauma exposure/processing techniques should engage in this aspect of the intervention.**
- **It is imperative that the clinician provide the child and family with a developmentally appropriate and motivating rationale for conducting trauma exposure, as this part of treatment can be intimidating to the child/family.**
- Some children will benefit from increased awareness about their trauma triggers; others may need to be safely exposed to trauma triggers to break their association with the traumatic event. Some may need to act out, discuss, write, or draw a detailed account of the trauma that occurred to them. Clinical judgment

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and knowledge of the child determine if a child would benefit from such interventions.

- Remember to use age and situation-appropriate exposure techniques (to trauma related triggers or events).
- The child’s readiness for trauma exposure, including their present needs and strengths, will determine to what degree exposure is incorporated into treatment planning.
- Sometimes, it helps to practice going through a narrative of a non-traumatic event prior to the trauma narrative as a way to familiarize a child and increase their level of comfort with the process.

**6. Component: Adapting Maladaptive Cognitions**

*Addressing Maladaptive Cognitions: Suggested Treatment Tasks*

- Identify linkage between thoughts, feelings, and behaviors specific to trauma narrative
- Identify thinking distortions specific to trauma narrative
- Re-define attributions
- Process guilt and self-blame
- Identify link between behaviors and personal experiences (includes triggers)
- Enhance understanding that client has control over choices – self-power
- Provide cognitive corrections when needed

**7. Component: Systemic Dynamics**

*Addressing Systemic Dynamics: Suggested Treatment Tasks*

Child:

- Educate client about availability and use of community resources
- Work with client to identify ways in which the client might feel betrayed or lacking trust in their family or the community due to the traumatic incident or events following the traumatic incident
- Work with client to re-gain faith in the family and the community

Family:

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- Share trauma integration with appropriate system people
- Assure caretaker has necessary resources
- Support caregiver in development and use of parenting skills
- Work on implementation and maintenance of appropriate boundaries
- Share and practice safety plans
- Assist family in navigation of child protection services, courts, school, and other social service agencies

School and Community:

- Keep open lines of communicate with school (i.e., teachers, counselors) to keep abreast of how child is functioning in that setting and help school staff understand how to best support the child
- Gain support of appropriate community resources

**8. Component: Enhancing Positive Emotions, Strengths, Resources and Competencies**

*Enhancing Strengths, Resources, and Competencies: Suggested Treatment Tasks*

- Identify creative, child-friendly techniques, consistent with the child’s strengths or interests, to build or improve a child’s coping skills (i.e., relaxation, thought-stopping, problem-solving)
- Positive affect enhancement – building child’s self-worth, esteem, positive self-appraisal
- Engage child in exploring their own personal creativity, imagination and future orientation
- Build child’s capacity to experience pleasure

**9. Component: Social Support and Relationship Building**

*Building Interpersonal Skills and Relationships: Suggested Treatment Tasks*

- Teach and practice age-appropriate social skills including the expression of positive and negative feelings
- Teach and practice socially appropriate ways to express needs and desires
- Teach child assertiveness skills
- Help child identify and engage in social situations that evoke feelings of success
- Help child identify and problem solve social situations that evoke feelings of anxiety or insecurity

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#### **Determining the Structure of Trauma-informed Treatment:**

Consider the following questions when developing trauma informed treatment plans / before beginning goal-directed, trauma-focused treatment:

1. Has a careful risk screening been conducted to determine if a child's current placement and environment is safe or if there is any risk for ongoing harm?
2. Who besides the child should be included in the treatment process? It is important to involve other important people in the child's life (i.e., caregiver, siblings) unless this would be detrimental.
3. Are there issues with engagement of the child or caregiver in treatment or barriers to service-seeking? How can these best be addressed?
4. Is there need for additional trauma-focused assessment (via a referral or use of additional trauma-specific assessment measures) to assist with development of treatment goals?

#### **How to Identify Appropriate Trauma-informed or Trauma-focused Treatments**

The specific trauma-focused interventions selected should match the child's trauma-related needs (see below for further details). Today, there are many trauma-focused treatment interventions that have been well investigated and received support for their effectiveness (see [www.NCTSN.org](http://www.NCTSN.org) for more information). There are also trauma-focused treatments that seem to work, but have not yet been fully investigated. Finally, there are trauma-focused treatments that are used but have little or no evidence that they actually benefit traumatized children. This must be kept in mind when choosing an appropriate trauma-focused treatment intervention.

Though it is not always an easy task, efforts should always be made to match a child's needs and strengths to a trauma-focused, evidence-based practice. When selecting the practice to implement with a given child or at your particular agency, there are several steps you can take:

- Identify client needs (e.g., trauma types, emotional/behavioral needs) that are to be addressed by practice-what are you trying to accomplish?
- Search out possible best practices for child trauma.
- Assess strength of evidence of these practices.
- Assess the fit between the evidence and the population you wish to serve and the service environment in which you wish to operate (e.g., mental health center, school-based, home-based, etc.)
- Assess the fit of the practice with your organization

As an additional resource, the National Child Traumatic Stress Network offers fact sheets on trauma-focused practices which can help clinicians determine which may be a good match for them and their clients (see ([www.NCTSN.org](http://www.NCTSN.org) under tool bar Resources/Treatments that Work).