



Therapy or No Therapy

Featured Article by Juli Alvarado

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Much of the work at coaching for LIFE! is consulting with and training groups from child welfare and mental health about becoming Trauma Informed and creating Trauma Sensitive Practice for 'our' wounded children.

I was recently asked for my recommendation regarding therapy for young children of sexual abuse and severely neglectful backgrounds. The case in question is a sibling group of 3, all under 9 presently acting their abusive past out, at times, on each other. The entire treatment team (more than 9 professionals for this one family) is scared and has a strict safety plan in place to protect the children from further harm.

The children are not living all in one foster home but the goal is to get them back together as soon as possible, in one home! YEA for this decision~

Should all of the children see the same or different therapists?

Should foster mom be involved in treatment?

Should visits happen at the home in which they will reside or a neutral location?

Should therapy be home or office based?

How long should sessions be?

What therapeutic orientation would I recommend?

What about alarms on the doors?

Common questions, important questions for us to consider carefully.

My response to this agency is here and is not so common.

But then, if we continue to do what we always do nothing will change and I am quite confident that if you are reading this and follow our work at cfL! you agree that things must drastically change, and quickly.

To Whom It May Concern:

Regarding: XXX

coaching for LIFE! and Juli Alvarado, MA, LPC, NCC has been retained by XXX, Inc to serve in the role of consultant regarding Trauma Informed Program Development and practice. A component of our role is to consult on specific cases, one of which is referred to here.

For more information on the background, expertise and role of this author, please visit www.coaching-forlife.com

I write this brief in response to a staffing that was held regarding the X children.

The staffing was requested in order to review the 'safety plan' in place in the XX home. One area in question that arose out of this staffing is whether 'therapy' is indicated as a need at this time for these children. I offer a response to this question.

This author holds high regard for the role of the safety plan and of therapy in healing; the role of the providers involved in this case and the imminent, consistent need for protection of all of 'our' children in child welfare.

Observation and Feedback:

The behaviors on the part of the XX children that have resulted in the need for this safety plan are the result of an *evolution of occurrences*. They are not isolated, nor single incidents. *Their behaviors are normal given their abnormal life experiences.*

The goal of this program and its partner providers is to achieve permanency for children that may otherwise prove challenging to maintain in family homes. The support, training, expertise in trauma and 24/7 availability of staff are key in assisting parents in maintaining these placements.

While there are many elements (far too numerous to include in this brief) that contribute to the success of this program with very vulnerable children, the two underlying and most vital components are the twin concepts of relationship and engagement. The value in these concepts, the intensity with which staff in this program pay attention to them and the focus that is directed to these concepts in treatment is regularly evident in the organizational, individual and clinical interactions throughout this organization.

There is a commitment of 'unconditional care' which is most simply defined as an agreement to never discharge children for showing the behavior that originally led to their referral for placement in the program to begin with. We realistically expect that some of the behaviors will continue; that they do not magically disappear simply because the children are living in a new home. As a matter of fact, brain research indicates that an increase in stress behaviors is a normal reaction to a novel situation for children who have experienced trauma (Brain and Mind, 3, 79-

100; Perry, Bruce and D. Pollard, 1997) and we may expect to see an increase in negative behavioral presentation at the onset of new placement.

The process for the elimination of negative behaviors is in-depth for children who come from the hard place of trauma, abuse and neglect; and whose very neurophysiological systems have been negatively impacted via their experiences.

The X children live in an underlying, constant, psychological state of fear which induces stress in relationship to self and others. This stress manifests in negative behaviors. It is typically these negative behaviors that result in a referral for therapy. It is typically negative behaviors that result in disrupted placements.

Our goal is to reduce the trauma manifestation for children and the negative behaviors that come with it thereby achieving permanency in an expedited manner.

Working within the boundary of the safety plan, we strive to provide an environment and a family that is the foundation for safety, acceptance, calm, nurturing, healing and protected living.

A common reaction on the part of the current child welfare system is to refer these children for therapy. For all of our best efforts, all of the money, resources and energy that we direct at treatment for this population today we continue to see rising recidivism rates, increasing disruptions and failed adoptions and rising levels of acuity in our families being referred through child welfare. We spend exorbitant amounts of money for little positive outcome. It is a difficult burden to consider, but we are failing our most vulnerable children. Current treatment protocols are most often not effective in long term healing of complex trauma. The system itself has become as traumatized, crisis driven, and fragmented as the very children we are called to serve.

Recent research is indicative of the ineffective and often traumatizing experience that therapy is for young children and adolescents (Applying Principles of Neurodevelopment to Childhood Trauma; Perry, Bruce MD, 2009) Being asked to relive the experience of trauma in an office, or in relationship to a transient adult is a fearful experience that can and often does trigger the primary trauma response leaving the child to contend with an internal experience beyond their ability to manage. The turnover in staff and therapists leaves attachment challenged children yet another broken relationship through the system that is intended to provide healing. And the foster parents are at home attempting to manage a dynamic unseen and often unbearable for all.

Abuse, neglect and trauma are bad for children. These experiences during childhood cause abnormal organization and function of important neural systems in the brain, compromising the ability to relate to others. Children do need help to deal with them. *The abuse, neglect and trauma that occur in relationship to adult caretakers/parents will most effectively be healed in relationship to adult caretakers/parents.*

This author, along with the expansive field of childhood neuroscience and trauma experts recommend that in place of therapy for 'our' children, we provide extensive training, support and therapy for the adults responsible for their care. In that manner, we

- 1) teach the new caretakers the capacity for healing in relationship to these children,
- 2) we provide a much more *normal life experience* for our wounded children;
- 3) and through the home based provision of this service to the new adult caretaker, we have in sight supervision of the children, the relationship between the child and caretaker and
- 4) can influence in real time the evolution of healing dynamic between parent/child.

The X children come from a fragmented, chaotic, crisis driven background. It is our responsibility to reply to their need from a place of calm, well thought out and clinically indicated planning.

Additional, new adults in their life are a threatening experience. Additional time talking about their horrendous past is scary. **These children are living with a foster mother who has been trained in Trauma Informed Parenting, has 24/7 availability for support, is receiving home based support weekly and additional expert parent coaching by phone weekly. This mother is willing to provide all that these children need in a home setting that has been prepared for safety, is monitored regularly and is fully supported.**

It is my hope and recommendation that we allow these children to calm back into the normalcy of childhood as much as is possible while residing in foster care; while providing all of the necessary ingredients for healing.

I am happy to provide further testimony on my position, to have further discussion with this team and others or to provide further research documentation regarding the impact of trauma on development and effective response to that trauma through trauma informed parenting rather than solely trauma informed therapy.

With respect,

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Juli Alvarado is the founder and Sr. Clinical Consultant at coaching for LIFE!, a personal and professional development organization.

For further information about our trainings, coaching and consulting work, please visit us at www.coaching-forlife.com