

The Cost of Caring

Secondary Traumatic Stress and the Impact of
Working with High-Risk Children and Families

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PROFESSIONAL SERIES 

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Introduction

Each year, millions of children are exposed to some form of severe traumatic event. Many of these children are victims of physical, sexual or emotional abuse or neglect. Many thousands more have been traumatized by natural disasters (e.g., tornadoes, hurricanes, floods), automobile accidents, drowning, community violence or interpersonal violence they witness in their own homes. The trauma suffered by these children is not benign. It can result in serious and chronic emotional and behavioral problems that are very difficult to treat. And each year, day after day thousands of teachers, caseworkers, police officers, judges, pediatricians and child mental health professionals work with and try to help these children. And each year, parents, grandparents, foster parents care for these children.

All too often the adults are working in difficult, resource-limited situations. The children may present with a host of problems that can confuse or overwhelm their caregivers and treaters. The pain and helplessness of these children can be passed on to those around them. Listening to children talk about the trauma, trying to work in a complicated, frustrating and often “insensitive” system, feeling helpless when trying to heal these children – all can make the adults working with these children vulnerable to develop their own emotional or behavioral problems.

The purpose of this booklet is to present an overview of the topic of secondary trauma. The goal would be a better understanding of how to better serve the children we work with by making sure we are at our best. The better we understand how working with traumatized children affects us both personally and professionally the better able we will be to serve them. In order to remain emotionally healthy ourselves it is critically important that we understand how the elements of a child’s trauma of children can be absorbed. All professionals working with traumatized children can learn approaches and strategies to protect themselves from being emotionally overwhelmed by this work. In the end, the ability to help traumatized children depends upon our ability to stay emotionally healthy and motivated in difficult and often very frustrating situations.



Case Examples

There are hundreds of different ways in which professionals and caregivers can be impacted by trauma to children. Several examples below illustrate key elements that may be common to many of the situations confronting professionals working with traumatized or maltreated children.

Case 1: Duress in unusual circumstances: Working with the Branch Davidian Children.

For many weeks, caseworkers and supervisors from the Texas Department of Child and Protective Services (TDPRS) had been working overtime under tremendous duress. The small regional division had been suddenly and dramatically thrust into the public eye in one of the most high-profile child protection issues of the last decade – the Branch Davidian assault and siege. In the three days following the ATF raid, 21 children were released into the care of the state. The local Child Protective Service units mobilized; the State sent supervisory assistance and the entire staff were besieged by press, public and other agencies (e.g., FBI and Texas Rangers). The staff worked hard to find shelter and services and to create disposition plans for these 21 children. This immediate crisis phase - the first weeks following the raid – was followed by a five-week period of “unknown.” The TDPRS and partner clinical treatment team prepared for the release of the other Branch Davidian children (at least 40 more) still in the compound not knowing when or how the remaining children would be released. The pressures from media continued; the additional tasks of helping the 21 released children, screening and briefing the families of these children and trying to find healthy placement continued. The staff was overworked, overwhelmed and over-exposed.

Through video, family interviews and review of case material, the clinical team came to know the children and some family remaining in the compound. The expectation was that the situation would be defused and these children would become the responsibility of TDPRS and the partnering clinical team, as well.



Re-enactment in drawing: Several weeks after living through a shooting in which bullets came within inches of her head while she was in her bedroom, a child draws a picture of her "home." Note the bullet holes in the wall and the window (orange four panel square on the outside of the house boarder).

Over the six weeks, the clinical team came to know the 21 released children very well. By the time of the final assault and the fire, the TDPRS and clinical staff had been emotionally drained. The horror of the fire left so many of the team with sense of helplessness and frustration. The senseless loss of life and the continuing confusion about motivations on all sides added to the distress. The tasks of telling the children, facing the press, the sudden decompression of the chronic tension related to the anticipation of the other children being released all added to the

distress of the staff. Many of the staff were devastated. Emotions ranged from profound sadness to anger to relief to guilt. The staff was listless, numb, exhausted and had a difficult time focusing on any other work. The TDPRS and clinical team were experiencing secondary trauma.

The impact of chronic duress and atypical circumstances can be devastating. These situations reveal the "fault lines" in an organizational structure and magnify any of the typical personality or supervisory issues that are often a common part of any organization. In these situations, the immediate response tends to bring people together; however, with bad outcomes, or if the duress is chronic, the temporary alliances and accommodations fray. With exhaustion, tension and frustration, there are individual and systemic problems.

Examples of extended duress and unusual circumstances include natural and man-made disasters (e.g., floods, hurricanes, school shootings, plane crashes) that will transiently bring out the best in most people but that leave a wake of destruction and pain for the survivors and surviving community (e.g., the Columbine High School shootings, the Oklahoma City bombing). In these situations, as time passes, the pain of senseless loss can easily be turned on others or haunting guilt can be turned internally. The rates of trauma-related symptoms can be astounding. A study of the Oklahoma City community demonstrated that more than 50% of the community has residual trauma-related emotional and behavioral symptoms one year after the bombing.

In the case of the TDPRS staff working with the Branch Davidian children, informal and formal actions led to the long process of coping. Probably the most effective approaches were individual. Caseworkers and the other professionals talked with each other on an informal basis and drew upon their existing personal and professional support systems. A series of community services for the Branch Davidians were helpful to some. There were several 'debriefing' and educational events about secondary trauma that were provided but for the most part, the process of talking with and supporting each other were the major healing processes. So many of the participants will have strong emotional feelings when talking or thinking about the Branch Davidian children or the assault, siege and fire for years to come. Individual members of the treatment team report episodic intrusive ideations, permeating anger or sadness when reminded of this tragic event and actively avoid reminders of the entire event so as not to reexperience those painful feelings and memories. Clearly the "cost of caring" for these healers was high.

Case 2: Acute Traumatic Event (Child Death)

For many years The ChildTrauma Academy has worked with child protection agencies to help their caseworkers and staff cope with traumatic events such as the death of a child in care. We utilize a Critical Incident Response Team to conduct stress debriefings as soon as possible after each incident. These debriefings are a modification of the traditional Critical Incident Stress Debriefing approach developed by Mitchell and co-workers. Over the years, the ChildTrauma Academy has modified this approach to better meet the specific needs of the professionals involved and the incident. A typical response is described below.

The ChildTrauma Academy received a call from a Child Protective Services supervisor stating that an eighteen-month-old child in the protective custody of the department had suddenly died. The child was being cared for by foster parents and had died in the middle of the night, apparently as the result of a previously known medical condition. The supervisor reported that several caseworkers and the foster parents were really struggling over the loss of this child. A debriefing was scheduled for the following morning. CTA staff flew to a rural community in Texas to meet with the caseworkers and supervisor.

At the beginning of the two-hour debriefing, attended by approximately eight people, CTA staff talked about the purpose of the debriefing and emphasized the importance of maintaining confidentiality about what was talked about in the session. The debriefing process was described as an opportunity to talk about their thoughts and feelings related to the death and also an opportunity to offer support to each other.

Each of the participants began by talking about how they were involved in the case. Slowly, the history of the child's involvement with the social service system began to unfold. As the debriefing progressed, participants were given the opportunity to share with each other how "special" and "unique" this little boy had been to them. The foster mother needed to talk about how "guilty" she felt for not maintaining an around the clock vigil with this child. The foster father said that he knew that he was not supposed to view this child as his own, but he found that impossible. He also talked about how painful it was to be prohibited from attending the funeral by the biological parents. He desperately wanted to place a marker on this child's grave - "to show that he had really meant something to the people he came in contact with." The caseworkers universally talked about how unique this child was. As they talked, everyone cried. What made this debriefing especially successful was that not only did people have an opportunity to talk about what they were thinking and feeling, but also because they had an opportunity to be supportive of each other.

At the conclusion of the debriefing, all participants left saying they felt better for having had the opportunity to talk and express their support and for gaining the support of their peers.

As part of the Critical Incident Response Program, a post-debriefing critique was administered. The goal of this survey is to see whether the services

provided actually are perceived to be a benefit to the worker. Responses from more than 800 caseworkers participating in more than 30 separate critical incident debriefings over five years show that more than 85% of the participants found the debriefing opportunity very helpful. More objective data are being collected to see whether or not these interventions actually improve measures of worker motivation and effectiveness. Preliminary impressions, however, would suggest that this relatively simple, responsive intervention following a traumatic incident can be a very useful, if not necessary, component of a child protective system's program structure.

Case 3: Chronic, moderate stress and a 'trigger' incident: Clinical work with maltreated and traumatized children.

The ChildTrauma Clinic's interdisciplinary team works day after day with high-risk children: children living in foster care after being neglected or abused by their biological families; child witnesses to violence, children living through car accidents, cancer treatment, fires, and tornadoes. For many of these children and families there are no resources or services available to act on the recommendations of the clinical team. Child mental health services are scant and, all too often, sub-standard. Enrichment or special educational opportunities for high risk children are difficult to arrange. Optimal adult to child supervision ratios in foster care are almost unheard of (in Texas as many as 10 children can be in one foster home). Very young children with profound developmental delays requiring one-on-one caregiving will be placed in 'therapeutic' foster homes where there are five other children under the age of five – with only one adult caregiver during the day. This can lead to a sense of frustration and futility. In other cases, children in foster care will be moved from placements against our better recommendations. The decisions regarding the health and welfare of these children is often out of the hands of the clinical team. And when hours of clinical work seem to be ignored by a judge, caseworker or supervisor, the sense of hopelessness can eat away at effectiveness and motivation.

Against this background, a child protection worker referred Brenda, a four-year-old child to our clinic. This young girl was the third in a sibship of five. The other siblings were in other placements. Following severe emotional and physical neglect, Brenda was chronologically age four at time of removal but was functioning like a two year old – undersocialized and developmentally delayed. She was placed in the home of an experienced and caring foster family

who, at that time, had no other children in their home aside from their two teenage biological children. Within the first nine months, with lots of attention, consistency, nurturing and predictability, Brenda blossomed. She overcame many of her developmental delays and was approaching age-appropriate motor and behavioral functioning. The foster family was seriously considering adopting her. Things looked great for Brenda and the clinical team felt they needed to see her only once a month – to track her progress.

And then, somewhere, someone made the decision that the family should not be broken up. The caseworker could either move Brenda into a new placement with all of the other sibs or ask the foster family to take in the siblings. The siblings were moved into the foster family. The clinical team knew nothing of this move until a month later at the next visit when the foster family reported a plateau in her progress and, some tantrums and new behavioral problems. The next month, Brenda regressed. She had much less attention in this new situation. Her siblings, older and younger, demanded the attentions of the foster family. The dilution in attention and the increase in the chaos in the foster home just exacerbated her already considerable situation.

The team tried to get the foster family or caseworker or supervisor to understand how Brenda's condition – indeed the capacity of any of these five children to improve – was dependent upon the amount of consistent, predictable and nurturing attention they received. But none of the team's efforts could change the harsh reality of the situation. The system says the sibs must remain together. Ultimately, the situation deteriorated to the point where the foster family asked the caseworker to take all these children. And, for the fourth time in a year, these children were moved to another placement. They were together, but as a group too much for any foster family. Each of these children needed more attention, more consistency, more predictability and more nurturing than could possibly be provided by a single overwhelmed foster parent. With the move, Brenda was "lost to follow-up." The tantalizing progress she made and the recaptured potential she demonstrated only made the situation feel worse to the clinical team. Frustration, anger and a sense of hopelessness about the system permeated the discussions of this girl – the poster child of an ailing foster care/child protective system.

POST-TRAUMATIC STRESS DISORDER

A. RECURRING INTRUSIVE RECOLLECTIONS OF THE

TRAUMA: Intrusive thoughts, dreams, flashbacks, 'dissociative' events, intense emotional and physiological distress when re-exposed to trauma associated stimuli

B. AVOIDANCE OF TRAUMA - ASSOCIATED STIMULI OR

'NUMBING': Sense of detachment, restricted range of affect, dysphoria, loss of recently acquired developmental skill, sense of a foreshortened future

C. PERSISTENT PHYSIOLOGICAL HYPERAROUSAL:

Sleep difficulties, hypervigilance, difficulty concentrating, increased startle response, lability, impulsivity, irritability, physiological hyperreactivity

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Unfortunately, the sad reality for many maltreated and traumatized children is that there are no good choices. The clinical, academic and dispositional decisions are typically choices between a bad and a worse situation. Any clinicians working with these children and in these systems will be faced with many situations like those above. It is imperative that the effectiveness and motivation of the clinician is maintained. This can be a challenge.



Post-Traumatic Stress Disorders and Secondary Trauma

In the first days and weeks following the traumatic event, the symptoms listed above, 1) re-experiencing phenomena, 2) attempts to avoid reminders of the original event and 3) physiological hyper-reactivity are all relatively predictable, and indeed, highly adaptive physiological and mental responses to a trauma. Unfortunately, the more prolonged the trauma and the more pronounced the symptoms during the immediate post-traumatic period, the

more likely there will be long term chronic and potentially permanent changes in the emotional, behavioral, cognitive and physiological functioning of the child. It is this abnormal persistence of the originally adaptive responses that result in trauma-related neuropsychiatric disorders such as Post-traumatic Stress Disorder (PTSD). The symptoms developed by persons suffering from PTSD or Secondary Trauma are nearly identical. The only difference is that with Secondary Trauma, the traumatizing event experienced by one person becomes a traumatizing event for the second person.



Secondary Traumatic Stress, Burnout and Vicarious Trauma

Secondary traumatic stress is a risk we incur when we engage empathically with an adult or child who has been traumatized. According to Charles Figley (1995), secondary traumatic stress is “the natural consequent behaviors resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from wanting to help a traumatized or suffering person.” Until recently, when we spoke about persons being traumatized we were speaking of those people who were directly exposed to the trauma. It has only been recently that researchers and practitioners have acknowledged that persons who work with or help traumatized persons are indirectly or secondarily at risk of developing the same symptoms as persons directly affected by the trauma. Clinicians and parents who listen to their clients or children describe the trauma are at risk of absorbing a portion of the trauma.

Secondary traumatic stress is sometimes confused with burnout. It should not be. According to Pine, Aronson and Kafry (1981) burnout is “a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations.” Unlike secondary traumatic stress, burnout can be described as emotional exhaustion, depersonalization and a reduced feeling of personal accomplishment. Burnout is a condition that begins gradually and becomes progressively worse. Secondary Trauma, conversely, can occur following the exposure to a single traumatic event. When there is some interaction between the adult professional (or caregiver) and the traumatized child secondary trauma can occur.

Secondary traumatic stress may also be used interchangeably with the term “vicarious” trauma. This can be somewhat confusing. In our work, we use the term vicarious trauma to refer to the traumatic impact on those who feel the intensity of the traumatic event through another person. Children of Vietnam veterans, for example, have been reported to exhibit emotional, behavioral and physiological symptoms similar to their parents with post-traumatic stress disorder (PTSD). Parents of children suffering from chronic, painful medical conditions can become vicariously traumatized. Significant vicarious traumatic symptoms were experienced throughout the United States following the horrific events of September 11th. The power and intensity of the actual event can be powerful enough to impact others even though they were not themselves witness to or threatened by the actual experience.



Secondary Trauma: Who is at risk?

Generally speaking, persons at risk for developing secondary trauma are those who have the responsibility of providing care to a person who has had some type of crisis. Historically, persons at greatest risk were those in the emergency services professions: police officers, fire fighters, emergency medical technicians, police officers, fire fighters, nurse crisis workers, and clergy. In recent years that list has expanded to include a wide range of professionals who work with children and families in crisis. Included in that list are pediatricians, psychologists, psychiatrists, family lawyers, adult mental health professionals, child protective services workers, prison guards, juvenile probation officers, foster parents, and teachers.

There are several reasons why professionals working with maltreated or traumatized children are at increased risk of developing secondary trauma.

1) **Empathy** is a valuable tool used by mental health workers, educators, childcare providers and other professionals working with traumatized children. Children get better in therapy not because we talk to them or at them, but because we are emotionally there for them. However, by empathizing with a child or “feeling their pain” the professional becomes vulnerable to internalize some of the child’s trauma-related pain.

2) **Insufficient Recovery Time:** Professionals working with children and families are often required to listen to children describe some very horrific situations they have experienced. These same professionals are secondarily traumatized by having to listen to the same or similar stories over and over again without sufficient recovery time.

3) **Unresolved Personal Trauma:** Many professionals have had some personal loss or even traumatic experience in their own life (e.g., loss of a family member, death of a close friend). To some extent, the pain of experiences can be "re-activated." Therefore, when professionals work with an individual who has suffered a similar trauma the experience often triggers painful reminders of their own trauma.

4) **Children are the Most Vulnerable Members of Our Society:** Young children are completely dependent on adults for their emotional and physical needs. When adults maltreat these vulnerable persons it evokes a strong reaction in any person with a sense of decency and morality. At times, the senseless and almost evil nature of some of the trauma inflicted on children shakes one's sense of humanity.

5) **Isolation and Systemic Fragmentation:** New research and clinical wisdom point to the important role of group cohesiveness in regulating individual stress reactions. When individuals feel valued and are in the presence of others who respect and care for them, they are more capable of tolerating extreme stressors. Clearly this means that the current practices in child protection, mental health, probation and education - specifically, individual service delivery rather than team-oriented practice within a fragmented system with high-turnover - are a set up for increased stress for individuals working in that system.

6) **Lack of Systemic Resources:** A lack of economic and personnel investment in front-line services for high-risk children exacerbate each of the problems listed above. In our current socio-political climate, no public system is likely to address adequately the issues related to development of secondary trauma in front-line personnel. The task of addressing these problems, then, falls to the mid-level leader, supervisors, program directors and others who are working to create a positive work-climate for their co-workers.



Secondary Trauma: The Need for Leadership

The supervisor in any system is in a pivotal position to assist co-workers in preventing the development of secondary trauma. To be effective in their role as unit leader, supervisors must be able to handle stress well themselves while providing encouragement and emotional support to their workers. Supervisors need to be aware of the extent to which their workers have become separated from the original meaning and purpose of their work. When the work demands exceed the worker's endurance and their ability to cope they are at an increased risk for developing secondary trauma.

It is imperative that the supervisor, representing the agency, be responsive to the unique skills, needs, stresses and values of the professionals working for them. He/she must set a good example by modeling good communication, providing support and feedback and insuring variety in the workload and autonomy in the workplace. More specifically, they should assist workers in establishing boundaries between themselves and their clients, provide them with an opportunity to "talk" about how they have been impacted by the trauma they encounter in their work lives, and assist them in recognizing the need to find balance in their work and personal lives.

"It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself."

Ralph Waldo Emerson

In the event that a worker feels distraught or emotionally overwhelmed because of their involvement in a particularly difficult or series of difficult cases they should assist and encourage the worker to seek counseling outside of the agency. The supervisor should know that it is very normal for a worker to exhibit some short-term problems (e.g. sleeping, eating, lack of enthusiasm) following their involvement in a difficult case. However, should this condition persist for more than a month it is imperative that the worker get additional outside help from a psychotherapist or other professional with training and experience in this area.



Secondary Trauma: Individual Indicators of Distress

There are “individual indicators of distress” which can tell us all that we are at increased risk for developing secondary trauma. Examples of distressing emotions we might feel include anger, sadness, rage, depression or anxiety. The list of these emotional reactions is almost endless. Other indicators of distress could include physical complaints (e.g. headaches, stomachaches, and lethargy), nightmares, avoidance of certain clients and impaired work habits (e.g. tardiness or missed appointments).

Individual Indicators of Distress	
<p><u>Emotional Indicators</u> Anger Sadness Prolonged grief Anxiety Depression</p>	<p><u>Physical Indicators</u> Headaches Stomach aches Lethargy Constipation</p>
<p><u>Personal Indicators</u> Self-isolation Cynicism Mood swings Irritability with spouse/family</p>	<p><u>Workplace Indicators</u> Avoidance of certain clients Missed appointments Tardiness Lack of motivation</p>



Self-Care Strategies for Combating Secondary Trauma

Understanding your own needs and responding appropriately is of paramount importance in combating secondary traumatic stress. It is also critically important to balance work and play. Working with children and families who have been traumatized is immensely rewarding in many respects. However, it is also often frustrating, discouraging and painful to listen to children describe how they have been harmed. To avoid feeling overwhelmed by feelings of frustration and sadness it is important to engage in activities professionals consider fun or playful. It is also important to spend time with emotionally healthy children who can bring joy, hope and meaning to our lives. Child mental health professionals need to set aside time to rest, emotionally and physically, both their minds and their hearts. Also, they need to connect with their communities in ways other than through their work. For example, they need to help their neighbors, join a garden club or just sit on their back porch and enjoy the sights and sounds of a warm, sunny day.

There is no better way to combat secondary traumatic stress than to take good care of your physical health and well being. More specifically, professionals need to eat healthy and regularly, and exercise. Examples of physical activities that are fun include dancing, swimming, walking, running and playing sports. Psychological self-care is also very important. To take good care of yourself psychologically, you should take time to self-reflect, write in a journal, read books unrelated to your work and seek out new activities such as going to an art museum, attending a sports event or seeing a performance at a theater. Examples of emotional self-care include: spending time with friends and family; seeking out important people in your life; praising yourself; allowing yourself to cry; and finding things to laugh about. Caring for yourself at your place of employment is also very important. Examples of caring for yourself in your workplace include: taking a break during the workday; making quiet time to complete tasks; setting limits with your clients and colleagues and diversifying the tasks in your workload. (Saakvitne and Pearlman, 1996).

Self-Care Strategies for Combating Secondary Trauma			
<i>Physical</i>	<i>Psychological</i>	<i>Emotional</i>	<i>Workplace</i>
Sleep well Eat well Dancing Walking Jogging	Self-reflect Pleasure reading Say "no" Smile Solitude	See friends Cry Laugh Praise yourself Humor	Take breaks Set limits Peer support Get supervision Use vacations



Key References

Figley, C.R. (Ed.) (1995). *Compassion fatigue: Coping with secondary traumatic stress in those who treat the traumatized*. New York: Brunner/Mazel

This book consists of eleven chapters each written by different specialists in the field. The purpose of this very readable and informative book is to bring into clear focus the psychological vulnerability of crisis workers exposed daily to trauma victims and the efforts that can be made towards averting compassion fatigue.

Stamm, B.H. (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Maryland: Sidran Press.

This landmark volume in the field of secondary traumatic stress includes articles by fifteen highly respected professionals in the field. This book will broaden and deepen your understanding of secondary traumatic stress. It will be very useful to trainers and clinicians alike.

Stamm, B.H. (1997) Work-related secondary traumatic stress. *PTSD Research Quarterly* 5:2 1-6

This is an excellent summary and review of the status of this emerging field. Pines, A., Aronson, E., & Kafry, D. (1981) *Burnout: From tedium to personal growth*. New York: Free Press.

These three authors have published extensively on the subject of burnout and are recognized as experts in their field.

Saakvitne, K., & Peelman, L. (1996) *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton

These two authors and their colleagues at The Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy have put together a short, but inspiring book about secondary trauma. It includes information about why we are risk for developing secondary trauma and techniques we can employ to protect ourselves.

These resources will be periodically updated and posted in a special section of the ChildTrauma Academy web site www.ChildTrauma.org Visit this site for updates and for other resource materials about traumatic events and children.



About the Author

Dr. Perry is the Senior Fellow of The ChildTrauma Academy, a not-for-profit organization based in Houston, TX (www.ChildTrauma.org), and adjunct Professor in the Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University in Chicago. He serves as the inaugural Senior Fellow of the Berry Street Childhood Institute, an Australian based center of excellence focusing on the translation of theory into practice to improve the lives of children..

Dr. Perry is the author, with Maia Szalavitz, of *The Boy Who Was Raised As A Dog*, a bestselling book based on his work with maltreated children and *Born For Love: Why Empathy is Essential and Endangered*. His most recent multimedia books, BRIEF: Reflections on Childhood, Trauma, and Society and RESILIENT: Six Core Strengths for Healthy Development were released in 2013. Over the last thirty years, Dr. Perry has been an active teacher, clinician and researcher in children's mental health and the neurosciences holding a variety of academic positions.

Dr. Perry has conducted both basic neuroscience and clinical research. His experience as a clinician and a researcher with traumatized children has led many community and governmental agencies to consult Dr. Perry following high-profile incidents involving traumatized children such as the Branch Davidian siege in Waco, the Oklahoma City bombing, the Columbine school shootings, the September 11th terrorist attacks, Katrina hurricane, the FLDS polygamist sect and most recently, the earthquake in Haiti, the tsunami in Tohoku Japan, and the recent Sandy Hook Elementary school shootings.

Dr. Perry is the author of over 400 journal articles, book chapters and scientific proceedings and is the recipient of numerous professional awards and honors. He has presented about child maltreatment, children's mental health, neurodevelopment and

youth violence in a variety of venues including policy-making bodies such as the White House Summit on Violence, the California Assembly and U.S. House Committee on Education. Dr. Perry has been featured in a wide range of media including National Public Radio, The Today Show, Good Morning America, Nightline, CNN, MSNBC, NBC, ABC and CBS News and the Oprah Winfrey Show. His work has been featured in documentaries produced by Dateline NBC, 20/20, the BBC, Nightline, CBC, PBS, as well as dozen international documentaries. Many print media have highlighted the clinical and research activities of Dr. Perry including a Pulitzer-prize winning series in the Chicago Tribune, US News and World Report, Time, Newsweek, Forbes ASAP, Washington Post, the New York Times and Rolling Stone.



About The ChildTrauma Academy

The ChildTrauma Academy (CTA) is a not-for-profit organization based in Houston, Texas working to improve the lives of high-risk children through direct service, research and education. A major activity of the CTA is to translate emerging findings about the human brain and child development into practical implications for the ways we nurture, protect, enrich, educate and heal children. The “translational neuroscience” work of the CTA has resulted in a range of innovative programs in therapeutic, child protection and educational systems.

The mission of the ChildTrauma Academy is to help improve the lives of traumatized and maltreated children — by improving the systems that educate, nurture, protect and enrich these children. We focus our efforts on education, service delivery, program consultation, research and innovations in clinical assessment/treatment.

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