An interview with Bruce D. Perry, M.D., Ph.D.

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The Child Trauma Academy

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About the ChildTrauma Programs at Baylor College of Medicine

CD: I saw you on Good Morning America with Rob Reiner who is the Founder of I am Your Child, what is the purpose of the I am Your Child Foundation?

BDP: *I am Your Child* is not really a foundation in any traditional sense. *I am Your Child* is a public engagement campaign which was started by Rob Reiner, his wife Michelle and a collection of foundations and organizations interested in early childhood. These foundations include the Carnegie Corporation of New York, the Harris Foundation and the Heinz Foundation -- among others. The purpose of this campaign was to increase public awareness about recent advances in early childhood education and brain development. This information is very important in helping parents, caregivers, and teachers understand ways to provide the very best environments for young children.

The campaign was motivated by the recognition that our current efforts to support families with young children and provide optimal childcare are inadequate. By providing the latest information about child development, the participants in the campaign hoped to provide the information required for the public and policy makers to make decisions about childrearing practices and policy. This campaign continues in many settings, including an ongoing relationship with the National Governor's Association focused on the concrete tasks of funding Early Head Start, Healthy Family Programs (modeled after the Hawaii Healthy Family Program).

CD: You have a contract with the county to replicate your clinic if it proves successful, has it been replicated?

BDP: Contract? Well, I have not taken "contract law" so I'm not exactly sure what you mean by contract. And our work is actually much broader than the 'clinic.' We have a set of program projects; some of them clinical, some of them are much more focused on program development (in

many areas), training, early childhood education and 'enrichment' activities rather than 'therapeutic' services.

Many of the activities of the ChildTrauma Program are successful – but we must also make sure that they are practical, exportable and effective. To evaluate that, all of our activities have 'built-in' outcomes/evaluation components. Some aspects of what we are doing have met those standards – for example our information management practices (using computerized databases), our assessment protocols in the child protective services (CPS) and some of our treatment approaches. The process of exporting and replication has started. In Texas, for example, by the year 2000, Harris County (the third largest county in the country) will be using our assessment and information management protocols for all of the children entering the CPS system.

We feel very strongly that when we find something – anything – that makes life better for children and families, we have a moral obligation to share that with our colleagues and with other systems and communities.

CD: How does your clinic differ from others in Texas?

BDP: Our clinical activities are different from other traditional mental health settings in a number of ways.

First, we are distributed in a variety of settings in the community: a public hospital emergency center, a private pediatric hospital, a residential treatment center for the Juvenile Justice system, a shelter for children entering the CPS system, the local children's museum, schools, local theaters, among others.

Second, our clinical practices and activities have been integrated into the matrix of the public systems serving children – public education, child protection, child welfare, mental health and juvenile justice. We have worked hard to develop relationships and integrated practices with the large systems. This is crucial because, in the end, these are the systems where the children are and, as important, these are the systems with the resources. They all have huge budgets that our society has given them to address these problems. We feel that if we give them better practices, policies and programs – and if we have some solid relationship with these systems – we can impact the way they structure their vast resources. So far, we have been successful at doing this. For example, we have integrated our activities into the Child Protective System and the Juvenile Justice System and implemented proactive early assessment of the strengths and weaknesses of a child which then allows us to better match placement and services. This proactive approach has helped save money and prevent the exacerbation and development of more chronic problems.

Third, all of our clinical activities have integrated training and research components. Using the most modern computer technologies and quantitative practices standard in research settings, we have been able to bring a cost-efficient and effective way to assess children and track their progress over time. This allows us to comment on what seems to work – and what does not work.

Finally, we are, without doubt, the most fun clinical group in Texas. Children like to visit us. They feel better because we try to be respectful and, for them, age-appropriate. We work where the

children are – emotionally and, when we can, physically. We select people based upon their capabilities to work with children and with each other. Our clinical, research and training staff all work hard and work hard to work together. It is a great pleasure for me to be in our clinic – sit in our staffings and learn from these children and my colleagues. This sense of fun – and excitement about our work – is something that all of our visitors comment on. We have professionals visit us from all over the world and the pervasive comment is that something exciting is going on there. I am very lucky to have such a good group of people to work with.

CD: What is your primary area of research at the moment?

BDP: We have a number of active research projects examining some aspect of the impact of experience of child development. We have research projects that are focusing on the emotional, behavioral, social and physiological impact of experiences. In the past we primarily focused on bad experiences, experiences of neglect and abuse. We have made great progress in describing the various results of traumatic or neglectful experiences during childhood. Now, however, we are beginning to focus more and more on how positive experiences can result in healthier and more adaptive functioning in children. The more that we learn about the development of strengths the more input we will have into the development of treatments for children who have certain kinds of specific deficits.

A major focus of our pre-clinical neuroscience work is in the impact of neglect on brain development. We are using a variety of new brain imaging techniques to examine and compare the size of various brain regions following different types of neglect. In the next few months we will begin using a new method called functional MRI, which will allow us to examine, in real time, the actual activity of various brain areas during different tasks – such as reading, problem solving, listening to music and so forth. This will allow us to actually examine potential functional differences in brain areas following abuse and neglect.

CD: What have you found and what do you expect to find?

BDP: We and others in this field have found many things, not the least of which is that traumatic experiences literally alter the physical development of the brain. Abuse and neglect can result in chronic neurobiological conditions that make children vulnerable to the development of emotional, behavioral, cognitive, social and physical disorders. We continue to do research and realize that it will take many years to fill in all of the unknowns regarding the impact of trauma on children.

CD: What are the implications of this for the Juvenile Justice System and Child welfare?

BDP: The implications are quite broad. Some of the most important implications have to do with the urgent need to reorganize and restructure these systems in a way that provides early identification and intervention with children at greatest risk.

The second most important implication of our work for these systems is that children have the capability of changing in positive ways but that this capability diminishes the older a child gets. The earlier a child receives services the more likely they are to have positive change. The older someone is, the more costly and time intensive the intervention.

CD: What areas of research do you plan to pursue within the next five years?

BDP: We will continue looking at the neurobiological impact of trauma. By using new methodologies, including functional MRI, we will be able look at the actual functioning of different brain regions in real time.

The key area of my interest over the next few years, however, will be trying to use our traditional, individual-focused, neurobiological methods to examine the neurobiology associated with the group and group function. For many years we have focused primarily on individual functioning missing the point that human beings are in fact part of a larger biologic whole -- the clan. I think in the next five years as we begin to learn more about the way the human brain is specifically designed for social communication and affiliation we will learn more about how groups function.

Understanding human behavior in groups and the functioning of groups is crucial to understanding and changing the systems serving children. This insight into how groups function can assist in the development of better systems for managing the complex and multidimensional tasks of caring for children in our society.

CD: How many times have you appeared as an expert witness in abuse and neglect cases?

BDP: We see of hundreds of children who have been abused and neglected every year and occasionally we are asked to participate in legal proceedings that have to do with disposition or criminal proceedings. Our recommendations have been used hundreds of times in CPS cases. It is rare that I actually have to appear in Family Court. I have been a witness in about 20-25 cases.

I have been an expert witness in about ten abuse and neglect cases that were in criminal court and not family court. It is more typical that after our review, evaluation, report, and deposition that the other side will plea-bargain. I would say that fewer than 15 percent of the cases I am involved with in criminal cases get to court.

CD: What advice would you offer to lawyers in conducting an examination of an expert witness?

BDP: I think that one of the most important things that lawyers and expert witnesses should do is define what the specific goals are in the specific context of a given case. And, once clear, everyone does his or her job. Experts be experts. Lawyers be lawyers. It has been my experience that expert witnesses like to speak beyond their expertise and often feel pressured in the context of a forensic situation to do so. Similarly, I find that there are lawyers who develop a great body of knowledge about a topic and begin to act as experts. They try to stretch, modify or edit the expert's opinions to fit their case. This is a mistake.

I love to be cross-examined by a lawyer who thinks he or she knows my area. They often set themselves up and it is easy for the expert to make the lawyer frustrated. On the other hand, it is very important for the lawyer to prepare and defend their expert. Many experts feel very anxious during a deposition or in court. These situations can make an expert so anxious that their usual capacity to think, explain or clarify is altered. If your witness feels that you are protecting them,

they can better access the 'expertise' stored in their brains. If they get mixed up, confused or anxious, they can look very foolish. Protect your witness. Prepare your witness.

CD: The topic of this issue is corporal punishment, do you believe in moderate corporal punishment of children?

BDP: The issue in my mind is whether it works. All of the data I've seen suggests that it does not work. While I know many families say they 'use' this as a discipline technique, it is clear that most families actually just use that label when they hit their child. When you talk with people who practice this, you find that they typically do not have a rationale progressive discipline program. They hit their kids when they get out of line. They do not have consistent and predictable rewards or consequences. The kid gets hit when the parent decides they have had enough. Sometimes for the same offense a child may be yelled at, other times grounded, other times just hit. This is never going to work. So in that regard, corporal punishment, as it is used in the vast majority of American homes, does not work.

It is our observation that in the families we work with it is ineffective. In many cases a child is hit while the parent is enraged and that can be detrimental to the development of the child.

CD: Have you found that children who are physically punished are more prone to violence?

BDP: There are a number of studies that have demonstrated that if children are physically 'disciplined' or hit by a parent they are more likely to be physically aggressive in school settings. The relationship between physical punishment and violence has been less clearly demonstrated.

CD: Do you see any behavioral patterns with children who are physically punished as opposed to those children who have been disciplined in other ways.

BDP: The vast majority of children we serve come from settings where they have not been structured or disciplined and they have been exposed to inappropriate physical discipline or even abuse when the parent gets frustrated. The physical "discipline" is reactive and done in anger rather than something that is part of coherent/cohesive disciplinary model. In general if children are living in settings where there is consistent predictable reward for positive behavior and consistent predictable consequence for negative behavior they will not escalate to the point where they will enrage the adult to an anger-induced physical response such as hitting.

Typically, children from these chaotic settings are more impulsive, inattentive, aggressive, undersocialized and tend to do poorly in school.

CD: At what age is a child able to connect the discipline with the inappropriate behavior?

BDP: Children, from birth, begin the key process of reward and 'lack of reward' associated with their behaviors. In the infant – indeed in most of us – the smile of a loved one is a tremendous reward and reinforces a behavior. In the infant, a frown, disengagement from eye contact is a 'punishment.' Even an infant begins to learn which behaviors get these rewards and these consequences. They are putting in place the roots of a discipline. With consistent, predictable and

nurturing behaviors from the parent the child begins to build in an internal sense of structure. Discipline is taught. Discipline is structure, predictability and the reward of nurturing, engaged parental behavior while 'punishment' is the temporary withholding of this attention. There is no need hit an infant (yes, many families and groups encourage hitting infants that cry), there is no need to hit a toddler, there is no need to hit a child or an adolescent.

It is very important to distinguish between discipline and punishment. Discipline need not always involve punishment. Punishment or negative consequences should only be one component of an overall strategy for providing the structure for the developing child.

CD: Newsweek, the White House, Morning Shows, there is quite a bit of press regarding children from birth to age three, what do you attribute this to?

BDP: The reason that the White House, Morning Shows and Newsweek have been paying attention to children from birth to age three is the active, aggressive activities of the public engagement campaign mentioned earlier in this interview. The I am Your Child campaign spearheaded by Rob and Michelle Reiner has contacted people in various sectors of our society - government, business and academia -- to create a unique coalition. This coalition is dedicated to educating policy makers and the public about the importance of early childhood. And people are listening.

Now, in many instances, there is political mileage to be made from this topic. For many in the public sector, this appears to be a no-lose issue. Everyone likes babies. Sure, support families. Great idea, everyone knows that we should treat children well. "Children are our future." Lots of people talk the talk – few really walk the walk. We pay lip service to our children in this society, and by every measurable factor associated with 'value' we really are ambivalent and not invested in our children.

CD: Is it true that overwhelming experiences can change the structure of an infant's brain?

BDP: Yes. All experiences, good and bad, change an infant's brain. The brain develops in a 'use-dependent' way. So, in very concrete ways, the child is a reflection of the nature, quality, quantity of the experiences they have during development. This is a tremendous opportunity for us. If we provide consistent, predictable, nurturing and enriched experiences, we can have a child with a high probability of being consistent, predictable, nurturing and enriched! Seems almost too simple, eh? But it is the way the brain works. And, as we see all too often, if we provide inconsistent, unpredictable, chaotic, violent and empty experiences there is a high probability that the child will be impulsive, disorganized, anxious, unattached and cognitively limited.

CD: So, is rehabilitation a possibility for these people who had traumatic experiences from ages 0-3?

BDP: Of course. The brain continues to be capable of modifying or responding to the environment through your entire life. The key issue is the way in which the brain responds over time. The brain is much more malleable when you are young. As we get older the brain is harder to modify and alter. That is why interventions, rehabilitation, mental health services, programs, practices or education focused on children who are older require much more money and more time to result in the same impact as interventions focused on young children.

Adults with traumatic childhood experiences can get better. Treatment, time, relationship, education – all can change the brain in positive ways. It is never hopeless. Indeed, the vast majority of abused, neglected and traumatized children come out "okay." The question is what does "okay" mean. Is average good enough? Do we think that its a suitable outcome to take a child who could have had an IQ of 130 and say that they are "okay" if they have an IQ of 100. Do we think that it's an "okay" outcome if the child who could have been happy, adaptive and socially appropriate comes out with no real relationships but is not suffering from a mental illness? What are the outcomes we follow after abuse? What could we become as individuals? What could we become as a society?

The issue is not whether or not children can survive childhood. The issue is how they survive childhood and what they become. If a child is lucky enough to have consistent, predictable and nurturing experiences they have an opportunity to meet their potential. If that is not the case, however, the vast majority of these children will be "okay." I would argue, however, that we should stop settling for "okay."