

Revised and Updated Edition

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THE BOY WHO WAS RAISED AS A DOG

*And Other Stories from a
Child Psychiatrist's Notebook*

What Traumatized Children
Can Teach Us About Loss,
Love, and Healing

BRUCE D. PERRY, MD, PhD,
and MAIA SZALAVITZ



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Bruce D. Perry:

For my Clan

Barbara, Jay, Emily, Maddie, Benji, Elizabeth,
Katie, Martha, Grant, and Robbie

In memory of Arlis Dykema Perry (1955–1974)

Maia Szalavitz:

For my mother, Nora Staffanell

Author's Note

THE STORIES IN THIS BOOK are all true, but in order to ensure anonymity and protect privacy, we have altered identifying details. The children's names have been changed, as have the names of their adult family members if that information would identify the child. All other adult names are real names, except those identified with an asterisk. Despite these necessary changes, the essential elements of each case are reported as accurately as possible. Conversations, for example, are depicted as recalled and/or as recorded in notes, audio tapes, or video.

The sad reality is that these stories are but a tiny percentage of the many we could have told. Over the last ten years, our clinical group at The ChildTrauma Academy has treated more than a hundred children who have witnessed the murder of a parent. We have worked with hundreds of children who endured severe early neglect in institutions or at the hands of their parents or guardians. We hope that the strength and spirit of the children whose stories we tell in this book, and the many others who have suffered similar fates, come through on these pages.

Preface to the 2017 Edition

ONE LATE AFTERNOON IN THE SPRING of 2001, I was sitting in the Minneapolis-St. Paul Airport listening to my voicemail. I had spent the whole day talking; first to community leaders at a breakfast meeting, then at an all-day training session for clinicians working with maltreated children, and finally, at a meeting with academic colleagues who were hosting my visit. After fourteen hours of talking, the last thing I wanted to do was be on the phone—there were dozens of messages waiting. I decided to return just one call and deal with the rest later.

Maia Szalavitz, a science writer and reporter, wanted to get my thoughts for a story she was writing. Maia and I had spoken before. I liked her; she was very curious, well prepared, asked great questions, and, to the degree possible in the popular press, was accurate with both the context and content of our conversations when she wrote her final story. Unlike most of the journalists I had run into, she always read the key scientific literature related to the stories she was writing—and was willing to read more. She also had a deadline.

I have no recollection of what we talked about, but at the end of the call she said, “You should write a book.”

“I’ve thought about it, but I just don’t have time. And the currency of academics is research articles and grants. Although I like to write—maybe someday—but I’m just too busy.”

“I can help; we can write it together.” And this started a series of conversations that led to our ongoing collaboration and *The Boy Who Was Raised as a Dog*.

When we started writing, we had no idea how the emerging field of traumatology was about to change, how many people hungered to understand the effects of trauma on the mind and brain, and the tremendous interest that would soon be generated in “trauma-informed” care. We didn’t know that the book would be used as a textbook in undergraduate and graduate classes in sociology, neuroscience, psychology, criminology, and many other disciplines.

While we had hoped, of course, to have an impact, we did not expect

the flood of responses we got from so many youth and adults who had been affected by trauma and neglect. Parents, teachers, social workers, police officers, military personnel, child welfare workers, juvenile justice officials, judges, coaches, psychiatrists, nurses, psychologists, pediatricians—and just about anyone else who lives or works with individuals experiencing trauma or maltreatment—have contacted us and written or spoken about having read and used concepts from the book in their work.

In the last ten years, awareness of the importance of developmental trauma and “adverse childhood experiences” (now widely known as “ACE’s”) in mental, physical, and even societal health has spread—almost explosively—from a relatively small group of clinicians and researchers into public systems and to the lay public. Public and private systems in education, child welfare, health, mental health, juvenile justice, and more are implementing “trauma-informed,” “trauma-aware,” “trauma-focused,” and “ACE aware” initiatives. *The Boy Who Was Raised as a Dog* has been a useful introduction to many of the core concepts, principles, and practice elements for a “trauma-informed” approach.

But when we started, I didn’t really know what I was doing, at least as a writer. Unlike Maia, I had never written a book. We had several discussions about how to put everything together. We decided to use a series of clinical narratives—stories, basically—about patients whose experiences illustrated key concepts about the brain, development, or trauma. We sought a balance between these detailed, individual stories and the teaching of scientific material; we wanted the reader to be engaged and not overwhelmed by either the complexities of the brain or the emotional intensity of a child’s painful history. It was a fine line, and, as it turns out, for some readers the intensity or complexity were too much. So please note: if you are reading this book for the first time and have a history of traumatic experience, be aware that it does contain some extremely disturbing material. Pace yourself accordingly.

For most, however, the balance worked. And if, for some moments, the reader was overwhelmed, she could put it down and come back to it later. We sought rhythm in our writing; both in the structure and the prose. I would like to say we were intentional about finding the right “doses” of emotional intensity, which can obviously be a stressor for the reader, and novelty, which can also cause stress. I’d also like to say that we intentionally had the proper pace to allow optimal learning to take place;

that we were intentionally creating a resilience-building pattern of stress activation that included moderate, controllable and predictable stress for the reader. But we didn't know as much about those concepts then as we do now.

We both appreciated the beat of language and the power of storytelling but we went by feel—and ultimately, I think we got the balance mostly right. In the new sections we've added to this edition, we will highlight just how crucial the rhythm, “dose,” and spacing of experience is for building resilience. In the last ten years, we have come to much better understand these concepts as they apply to development, learning, therapy, parenting, and any other intentional process of changing the brain. But more on that later...

A second major choice in the book was the sequencing of the clinical vignettes.

We felt it was important to present these in roughly chronological order—to reflect the growth of the field and my personal growth as a clinician and researcher over time. My educational experiences in the neurosciences, medicine, and child and adolescent psychiatry occurred in parallel with the growth of the general field of traumatology. Being very developmentally focused, I knew it was always useful to understand “history”—how did this person come to be this way? How did this field come to be this way? Where did this idea come from? It has always been easier for me to understand the present if I knew what had happened in the past.

As we wrote *The Boy Who Was Raised as a Dog*, I had a rough outline of the key concepts that I felt were important in understanding trauma and maltreated children, as well as the sequence in which I first learned about these ideas and theories during my professional development. With this general structure in mind, we got to work.

Our process involved a set of hour-long interview style phone conversations; I lived in Houston and Maia lived in New York. Roughly once a week we would have an hour-long call in which I would either narrate the clinical work I had done with a client or elaborate on a concept or principle about development or the neurosciences. These interviews were recorded, transcribed and Maia would edit, arrange, and add to these and then send me a copy; then I would revise as well. Through this back and forth process our work together went remarkably smoothly.

After the publication of the book a trickle of positive feedback started.

We received emails and letters from readers; many of these shared powerful personal experiences of childhood trauma, some were grateful that the book helped them “connect the dots” in their own lives. Over the years, as the popularity of the book has grown, it has been translated into twelve languages, and as noted above, has been adopted for use all types of classes that cover child development, trauma, and how they affect psychology and physiology.

In addition, the approach to clinical problem solving outlined in *The Boy Who Was Raised as a Dog*—the Neurosequential Model of Therapeutics (NMT)—has continued to generate strong interest. As we will discuss in more detail in the new final chapter ([Chapter Twelve](#)), “A Picture, Not a Label,” the growth of this approach has been equally explosive. When we first published this book, my colleagues at The ChildTrauma Academy were the only people trained to use the approach. Today, over 10,000 clinicians are using some version of the Neurosequential Model in their work, directly affecting more than 200,000 clients. We estimate that more than 1,000,000 children, youth, and adults have been exposed to some aspect of the NMT.

We decided to write this updated and annotated version to ensure that *The Boy Who Was Raised as a Dog* continues to be a useful and accurate resource. In the last ten years, there have been advances in research, practice, program development, and policy related to trauma in childhood. This updated version will 1) correct and clarify content in the original book; 2) expand, elaborate, and update key concepts and principles described in the original and 3) present new and promising directions in these fields.

Again, we had some discussion on how best to accomplish this. The overwhelming feedback we had about the book was positive; the rhythm and balance of the narrative and the science worked well for most people. The science was overwhelmingly still accurate. We decided to leave each chapter fully intact (only making a few corrections in factual content where the data, in fact, has changed). At the end the book, a series of essays related to each chapter have been added to reflect and comment on the key elements in that chapter from our current perspective.

As we write these commentaries, we’d like to imagine sitting with our readers and having a short conversation about what you just read. Sometimes it might be updating you on the most current thinking about one of the key neuroscience concepts presented; in another instance, it may

be elaborating on the clinical work or progress related to the issues of the particular case. In all cases, the intent is to enrich, update, and elaborate.

Of course, the process of creating these small sections required that I go back and actually read each chapter. As odd as this sounds, when the book was ultimately published, I never picked it up and read it. Obviously when we were writing—and doing the back and forth revisions—I read each chapter again and again. However, by the time we sent off the final draft for publication, I couldn't stand to even look at it. In some ways, now ten years later, I read each chapter with new eyes. Sometimes I was impressed with how well we explained something; other times, I cringed. I know more now; I have taught about these concepts more—I've learned more from my colleagues and my patients. And I think that we can use that to make the reader's experience more complete.

In keeping with our sequential presentation, we have also added one new chapter at the end of the book, as well as a study guide. This new chapter brings us to the present. We hope that here we can clarify the important core concepts and foreshadow future directions in this field.

The new study guide is adapted from a teacher's book study that I wrote with my colleague Steve Graner, a retired teacher and the Director of our Neurosequential Model in Education (NME) initiative. We hope it will be helpful for anyone who would like to have more structured discussion of the key concepts presented in *The Boy Who Was Raised as a Dog* and who would like to consider how to use the ideas in it for their interactions and work with children.

Taken together, the updates, the chapter addenda, the new chapter, and the book study guide are intended to ensure that *The Boy Who Was Raised as a Dog* remains an accessible and up-to-date source for anyone interested in—or affected by—childhood trauma.

Introduction

IT'S HARD TO IMAGINE TODAY, but when I was in medical school in the early 1980s researchers didn't pay much attention to the lasting damage that psychological trauma can produce. Even less consideration was given to how trauma might harm children. It wasn't considered relevant. Children were believed to be naturally "resilient," with an innate ability to "bounce back."

When I became a child psychiatrist and neuroscientist, it was not my goal to refute this misguided theory. But then, as a young researcher, I began to observe in the lab that stressful experience—particularly in early life—could change the brains of young animals. Numerous animal studies showed that even seemingly minor stress during infancy could have a permanent impact on the architecture and the chemistry of the brain and, therefore, on behavior. I thought: why wouldn't the same be true for humans?

That question became even more salient to me as I began my clinical work with troubled children. I soon found that the vast majority of my patients had lives filled with chaos, neglect, and/or violence. Clearly, these children weren't "bouncing back"—otherwise they wouldn't have been taken to a child psychiatry clinic! They'd suffered trauma—such as being raped or witnessing murder—that would have had most psychiatrists considering the diagnosis of post-traumatic stress disorder (PTSD), had they been adults with psychiatric problems. And yet these children were being treated as though their histories of trauma were irrelevant, and they'd "coincidentally" developed symptoms, such as depression or attention problems, that often required medication.

Of course, the diagnosis of PTSD was only itself introduced into psychiatry in 1980. At first, it was seen as something rare, a condition that only affected a minority of soldiers who had been devastated by combat experiences. But soon the same kinds of symptoms—intrusive thoughts about the traumatic event, flashbacks, disrupted sleep, a sense of unreality, a heightened startle response, extreme anxiety—began to be described in rape survivors, victims of natural disaster, and people who'd had or

witnessed life-threatening accidents or injuries. Now the condition is believed to [affect at least 7 percent of all Americans](#) and most people are familiar with the idea that trauma can have profound and lasting effects. From the horrors of the 9/11 terrorist attacks to the aftermath of Hurricane Katrina, we recognize that catastrophic events can leave indelible marks on the mind. We know now—as my research and that of so many others has ultimately shown—that the impact is actually far greater on children than it is on adults.

I have made it my life's work to understand how trauma affects children and to develop innovative ways to help them cope with it. I have treated and studied children faced with some of the most horrendous experiences imaginable—from the surviving victims of the Branch Davidian cult conflagration in Waco, Texas, to neglected Eastern European orphans, to genocide survivors. I have also helped courts sort through the wreckage of misguided “Satanic Ritual Abuse” prosecutions based on coerced accusations from tortured, terrified children. I have done my best to help children who witnessed their parents' murders, and those who've spent years chained in cages or locked in closets.

While most children will never suffer anything as awful as what many of my patients have undergone, it is rare for a child to escape trauma entirely. By conservative estimates, [about 40 percent of American children](#) will have at least one potentially traumatizing experience by age eighteen: this includes the death of a parent or sibling, ongoing physical abuse and/or neglect, sexual abuse, or the experience of a serious accident, natural disaster, or domestic violence or other violent crime.

In 2004 alone, an estimated three million official reports of child abuse or neglect were made to government child protection agencies; [around 872,000 of these cases were confirmed](#). Of course, the true number of abused and neglected children is far higher because most cases are never reported and some genuine cases cannot be sufficiently corroborated for official action to be taken. In one large survey, about [one in eight children under the age of seventeen](#) reported some form of serious maltreatment by adults within the past year, and [about 27 percent of women and 16 percent of men](#) reported as adults having been sexually victimized during childhood. In a national survey conducted in 1995, [6 percent of mothers and 3 percent of fathers](#) even admitted to physically abusing their children at least once.

Furthermore, [up to ten million American children](#) are believed to be

exposed to domestic violence annually, and [4 percent of American children under the age of fifteen](#) lose a parent to death each year. Also, each year [some 800,000 children will spend time in foster care](#) and millions more are victims of natural disasters and devastating automobile accidents.

Although I do not mean to imply that all of these children will be severely “damaged” by these experiences, the most moderate estimates suggest that at any given time, [more than eight million American children suffer from serious, diagnosable, trauma-related psychiatric problems](#). Millions more experience less serious but still distressing consequences.

Roughly [one-third of children who are abused](#) will have some clear psychological problems as a result—and research continues to show how even seemingly purely “physical” problems like heart disease, obesity, and cancer can be more likely to affect traumatized children later in their lives. Adults’ responses to children during and after traumatic events can make an enormous difference in these eventual outcomes—both for good and for ill.

Over the years, research from my lab and many others has produced a much richer understanding of what trauma does to children and how we can help them heal from it. In 1996 I founded The ChildTrauma Academy, an interdisciplinary group of professionals dedicated to improving the lives of high-risk children and their families. We continue our clinical work and still have much to learn, but our primary goal is to bring treatments based on the best of our existing knowledge to others. We train people who work with children—whether they are parents or prosecutors, police officers or judges, social workers, physicians, policy makers, or politicians—to understand the most effective ways of minimizing the impact of trauma and maximizing recovery. We consult with government agencies and other groups to help them implement the best practices in dealing with these issues. My colleagues and I travel extensively around the world, speaking to parents, doctors, educators, child protection workers, and law enforcement officials, as well as high level stakeholders such as legislative bodies or committees and concerned corporate leaders. This book is part of our efforts.

In *The Boy Who Was Raised as a Dog* you’ll meet some of the children who taught me the most important lessons about how trauma affects young people. And you’ll learn what they need from us—their parents and guardians, their doctors, their government—if they are to build healthy

lives. You'll see how traumatic experience marks children, how it affects their personalities and their capacity for physical and emotional growth. You'll meet my first patient, Tina, whose experience of abuse brought home to me the impact of trauma on children's brains. You'll meet a brave little girl named Sandy, who at the age of three had to be put in a witness protection program, and who taught me the importance of allowing a child to control aspects of her own therapy. You'll meet an astonishing boy called Justin, who showed me how children can recover from unspeakable deprivation. Each child I've worked with—the Branch Davidian children, who took comfort in caring for each other; Laura, whose body didn't grow until she felt safe and loved; Peter, a Russian orphan whose first grade classmates became his “therapists”—helped my colleagues and me place a new piece in the puzzle, allowing us to advance our treatment for traumatized children and their families.

Our work brings us into peoples' lives when they are most desperate, alone, sad, afraid, and wounded, but for the most part the stories you'll read here are success stories—stories of hope, survival, triumph. Surprisingly, it is often when wandering through the emotional carnage left by the worst of humankind that we find the best of humanity as well.

Ultimately, what determines how children survive trauma, physically, emotionally, or psychologically, is whether the people around them—particularly the adults they should be able to trust and rely upon—stand by them with love, support, and encouragement. Fire can warm or consume, water can quench or drown, wind can caress or cut. And so it is with human relationships: we can both create and destroy, nurture and terrorize, traumatize and heal each other.

In this book you will read about remarkable children whose stories can help us better understand the nature and power of human relationships. Although many of these boys and girls have had experiences far more extreme than most families will encounter (and thank goodness for that), their stories carry lessons for all parents that can help their children cope with the inevitable stresses and strains of life.

Working with traumatized and maltreated children has also made me think carefully about the nature of humankind and the difference between humankind and humanity. Not all humans are humane. A human being has to learn how to become humane. That process—and how it can sometimes go terribly wrong—is another aspect of what this book is about. The stories here explore the conditions necessary for the development of

empathy—and those that are likely, instead, to produce cruelty and indifference. They reveal how children’s brains grow and are molded by the people around them. They also expose how ignorance, poverty, violence, sexual abuse, chaos, and neglect can wreak havoc upon growing brains and nascent personalities.

I have long been interested in understanding human development, and especially in trying to figure out why some people grow up to be productive, responsible, and kind human beings, whereas others respond to abuse by inflicting more of it on others. My work has revealed to me a great deal about moral development, about the roots of evil and how genetic tendencies and environmental influences can shape critical decisions, which in turn affect later choices and, ultimately, who we turn out to be. I do not believe in “the abuse excuse” for violent or hurtful behavior, but I have found that there are complex interactions beginning in early childhood that affect our ability to envision choices and that may later limit our ability to make the best decisions.

My work has taken me to the intersection of mind and brain, to the place where we make choices and experience influences that determine whether or not we become humane and truly human. *The Boy Who Was Raised as a Dog* shares some of what I’ve learned there. Despite their pain and fear, the children in this book—and many others like them—have shown great courage and humanity, and they give me hope. From them I have learned much about loss, love, and healing.

The core lessons these children have taught me are relevant for us all. Because in order to understand trauma we need to understand memory. In order to appreciate how children heal we need to understand how they learn to love, how they cope with challenge, how stress affects them. And by recognizing the destructive impact that violence and threat can have on the capacity to love and work, we can come to better understand ourselves and to nurture the people in our lives, especially the children.

CHAPTER 1

Tina's World

TINA WAS MY FIRST CHILD PATIENT, just seven years old when I met her. She sat in the waiting room of the University of Chicago child psychiatry clinic: tiny and fragile, huddled with her mother and siblings, unsure what to expect from her new doctor. As I led her to my office and shut the door, it was hard to tell which one of us was more nervous: the three-foot-tall African-American girl with meticulously neat braids or the six-foot-two white guy with the long mane of unruly curls. Tina sat on my couch for a minute, checking me out, looking me up and down. Then, she walked across the room, crawled into my lap and snuggled in.

I was touched. Gosh, what a nice thing to do. What a sweet child. Stupid me. She shifted slightly and moved her hand to my crotch and tried to open my zipper. I was no longer anxious. Now, I was sad. I took her hand, moved it from my thighs, and carefully lifted her off my lap.

The morning before I first met with Tina I read through her “chart”—one small sheet of paper with minimal information taken during a phone interview with our intake worker. Tina lived with her mother, Sara, and two younger siblings. Sara had called the child psychiatry clinic because her daughter’s school had insisted that she get her evaluated. Tina had been “aggressive and inappropriate” with her classmates. She’d exposed herself, attacked other children, used sexual language, and tried to get them to engage in sex play. She didn’t pay attention in class and often refused to follow directions.

The most relevant history the chart contained was that Tina had been abused for a two-year period that started when she was four and ended when she was six. The perpetrator was a sixteen-year-old boy, her babysitter’s son. He had molested both Tina and her younger brother, Michael, while their mother was at work. Tina’s mom was single. Poor, but no longer on public assistance, at the time Sara worked a minimum wage job at a convenience store to support her family. The only childcare

she could afford was an informal arrangement with her next-door neighbor. That neighbor, unfortunately, often left the children with her son so she could run errands. And her son was sick. He tied the children up and raped them, sodomized them with foreign objects, and threatened to kill them if they told. Finally, his mother caught him and put a stop to the abuse.

Sara never let her neighbor care for her children again, but the damage had been done. (The boy was prosecuted; he went to therapy, not jail.) Here we were, one year later. The daughter had serious problems, the mother had no resources, and I didn't know squat about abused children.

“Here. Let's go color,” I said gently as I took her from my lap. She seemed upset. Had she displeased me? Would I get angry? She anxiously studied my face with her dark brown eyes, watching my movements, listening to my voice for some nonverbal cue to help her make sense of this interaction. My behavior didn't fit with her internal catalog of previous experiences with men. She had only known men as sexual predators: no loving father, no supportive grandfather, no kind uncle or protective older brother had touched her life. The only adult males she'd met were her mother's often inappropriate boyfriends and her own abuser. Experience had taught her that men wanted sex, either from her or her mother. So quite logically from her perspective, she assumed that's what I wanted as well.

What should I do? How do you change behaviors or beliefs, locked into place from years of experience, with one hour of therapy a week? None of my experience and training had prepared me for this little girl. I didn't understand her. Did she interact with everyone as though they wanted sex from her, even women and girls? Was this the only way she knew how to make friends? Was her aggressive and impulsive behavior at school related to this? Did she think I was rejecting her—and how might that affect her?

It was 1987. I was a fellow in Child and Adolescent Psychiatry at the University of Chicago, just starting the final two years of some of the best medical training in the country. I'd had almost a dozen years of postgraduate training. I was an MD, a PhD, and had finished three years as a medical and general psychiatry resident. I ran a basic neuroscience research laboratory that studied the stress response systems in the brain. I had learned all about brain cells and brain systems and their complex networks and chemistry. I had spent years trying to understand the human mind. And after all that time all I could think to do was this: I sat down

with Tina at a small table set up in my office and handed her a set of crayons and a coloring book. She opened it up and paged through. “Can I color in this?” she asked softly, clearly unsure what to do in this strange situation.

“Sure,” I told her.

“Should I make her dress blue or red?” I asked Tina.

“Red.”

“OK.” She held up her colored page for my approval, “Very nice,” I said. She smiled. For the next forty minutes we sat on the floor, side by side, coloring quietly, reaching over to borrow crayons, showing our progress to each other and trying to get used to being in the same space with a stranger. When the session was over, I walked Tina back to the clinic waiting area. Her mother was holding a young infant and talking to her four-year-old son. Sara thanked me and we set up another appointment for the next week. As they left I knew I needed to talk to a supervisor with more experience, one who could help me figure out how to help this little girl.

Supervision in mental health training is a misleading term. When I was a medical intern learning to put in a central line, or run a code, or draw blood, there were older, more experienced physicians present to instruct, scold, assist, and teach me. I often received immediate—usually negative—feedback. And while it was true that we followed the model “watch one, do one, teach one,” a more senior, experienced clinician was always close by to help during any interactions with patients.

Not so for psychiatry. As a trainee, when I was with a patient, or a patient and her family, I was almost always working alone. After meeting with the patient—sometimes multiple times—I discussed the case with my supervisor. During training, a child psychiatry fellow will typically have several supervisors for clinical work. Often I would present the same child or issue to multiple supervisors to gather their different impressions and gain from their multiple, hopefully complementary, insights. It is an interesting process that has some remarkable strengths but also has some clear deficiencies, which I was about to discover.

I presented Tina’s case to my first supervisor, Dr. Robert Stine^{*}. He was young, serious, intellectual, and in training to become a psychoanalyst. He maintained a full beard and wore what seemed like the exact same outfit every day: a black suit, a black tie, and a white shirt. He seemed a lot smarter than me. He used psychiatric jargon with ease: “the

maternal introject,” “object relations,” “counter-transference,” “oral fixation.” And whenever he did, I’d look him in the eyes and try to look appropriately serious and thoughtful, nodding as if what he was saying was clearing things up for me: “Ah, yes. OK. Well, I’ll keep that in mind.” But really I was thinking, “What the hell is he talking about?”

I gave a short but formal presentation, describing Tina’s symptoms, history, family, and the complaints from her school, as well as detailing the key elements of my first visit with her. Dr. Stine took notes. When I finished he said, “Well, what do you think she has?”

I had no clue. “I’m not sure,” I stalled. Medical training teaches a young physician to act much less ignorant than he or she really is. And I was ignorant. Dr. Stine sensed this and suggested we use the diagnostic guide for psychiatric disorders, the Diagnostic and Statistical Manual (DSM).

At that point, it was the DSM III. Every ten years or so it is revised to include updates in research and new ideas about disorders. This process is guided by objective principles but is very susceptible to sociopolitical and other nonscientific processes. For example, homosexuality was once considered a “disorder” in the DSM and now it is not. But the main problem with the DSM—to this day—is that it is a catalog of disorders based on lists of symptoms. It is kind of like a computer manual written by a committee with no knowledge of the machine’s actual hardware or software, a manual that attempts to determine the cause of and cure for the computer’s problems by asking you to consider the sounds it makes. As I knew from my own research and training, the systems in that “machine”—in this case, the human brain—are very complex. As a result it seemed to me that the same “output” might be caused by any number of different problems within it. But the DSM doesn’t account for this.

“SO SHE IS INATTENTIVE, a discipline problem, impulsive, noncompliant, defiant, oppositional, and has problems with her peers. She meets diagnostic criteria for Attention Deficit Disorder and oppositional defiant disorder,” Dr. Stine prompted.

“Yeah, I guess so,” I said. But it didn’t feel right to me. Tina was experiencing something more or something different than what was described by those diagnostic labels. I knew from my research on the brain that the systems involved in controlling and focusing our attention were

especially complex. I also knew that there were many environmental and genetic factors that could influence them. Wasn't labeling Tina "defiant" misleading, given that her "noncompliance" was likely a result of her victimization? What about the confusion that made her think that sexual behavior with adults and peers in public is normal? What about her speech and language delays? And if she did have Attention Deficit Disorder (ADD), might the sexual abuse be important in understanding how to treat someone like her?

I didn't raise these questions, though. I just looked at Dr. Stine and nodded as if I was absorbing what he was teaching me.

"Go read up on psychopharmacology for ADD. We can talk more about this next week," he advised.

I left Dr. Stine feeling confused and disappointed. Is this what being a child psychiatrist was like? I had been trained as a general (adult) psychiatrist and was familiar with the limitations of supervision, and with the limitations of our diagnostic approach, but I was not at all familiar with the pervasive problems of the children I was seeing. They were socially marginalized, developmentally delayed, profoundly damaged, and sent to our clinic so we could "fix" things that to me didn't seem fixable with the tools we had at our disposal. How could a few hours a month and a prescription change Tina's outlook and behavior? Did Dr. Stine really believe that Ritalin or some other ADD drug would solve this girl's problems?

Fortunately, I had another supervisor as well: a wise and wonderful man, a true giant in the field of psychiatry, Dr. Jarl Dyrud. Like me, he was from North Dakota, and we hit it off immediately. Like Dr. Stine, Dr. Dyrud was trained in the analytic method. Yet he also had years of real-life experience trying to understand and help people. He had let that experience, not just Freud's theories, mold his perspective.

He listened carefully as I described Tina. When I finished, he smiled at me and said, "Did you enjoy coloring with her?"

I thought for a minute and said, "Yeah. I did."

Dr. Dyrud said, "Very nice start. So tell me more." I started to list Tina's symptoms, the complaints the adults had about her behaviors.

"No, no. Tell me about her. Not about her symptoms."

"What do you mean?"

"Where does she live? What is her apartment like, when does she go to sleep, what does she do during the day? Tell me about her."