chapter 6

The Boy Who Was Raised as a Dog

WHAT ALLOWS SOMEONE to make the right choice, even if he hasn't been given the optimal developmental opportunities he needs? What made Virginia continue to seek help for her baby, rather than simply abandoning her? What could we take from Mama P.'s book and prescribe for other children like Laura? Could the right treatment help prevent children like Leon from becoming a threat? Is there anything new I could say today to Cherise's mom—and to Frank, Alan and Maria—about why Leon had committed his terrible crimes?

Just as we only gradually came to understand how the sequential development of a child's brain is affected by trauma and neglect, it also only gradually dawned on us that this understanding could help us find possible treatments. These insights led us to develop what we came to call the neurosequential approach to therapeutic services for maltreated and traumatized children. One of the first children on whom we used this method had suffered neglect far, far worse than what had been done to Leon.

I met Justin in 1995 when he was six years old. He was in the Pediatric Intensive Care Unit (PICU). I had been invited by the PICU staff to come and, using *that-psychiatric-voodoo-that-you-do-so-well,* try to stop him from throwing feces and food at the staff. The PICU was almost

always full and was typically busy 24/7. Nurses, physicians, aides and families crowded the unit. The noise from medical machines, phones, and conversations kept the large room filled with a nonstop buzz. There were always lights on, people were always moving around and, although each individual moved with purpose and each conversation was focused, the overall effect was chaos.

I walked unnoticed through the din to the nurses' station and studied the board to find the boy I'd been asked to see. Then, I heard him. A loud, odd shriek made me turn immediately to find a bony little child in a loose diaper sitting in a cage. Justin's crib had iron bars and a plywood panel wired to the top of it. It looked like a dog cage, which I was about to discover was terribly ironic. The little boy rocked back and forth, whimpering a primitive self-soothing lullaby. He was filthy with his own feces, there was food all over his face and his diaper was heavy, soaked with urine. He was being treated for severe pneumonia, but he resisted all procedures and had to be held down to draw blood. He tore out his IVs, he yelled and screamed at staff and he threw his food. The closest this hospital had to a psychiatric unit was the PICU (where the ratio of staff to patients was very high), so Justin had been transferred. There, they had jury-rigged his crib/cage arrangement. And once placed in the cage, the boy began to throw feces and anything else he could get his hands on. That's when they called psychiatry.

Over the years I had learned that it is not a good idea to take a child by surprise. Unpredictability and the unknown make everyone feel anxious and therefore less able to process information accurately. Also, and importantly for clinical evaluation, the more anxious someone is the harder it is for him to accurately recall and describe his feelings, thoughts and history. But most critically, when a child is anxious it is much more difficult to form a positive relationship, the true vehicle for all therapeutic change.

I had learned the power of first impressions, as well. I could get a much better sense of a child's prognosis if he had a favorable or at least a neutral first impression of me. So rather than just start asking ques-

tions of an unsuspecting and usually frightened and disoriented child, I'd found it was best to give him a chance to meet me first. We'd have a brief humorous or engaging conversation, I'd let him size me up a little, provide a clear, simple explanation of what I wanted to learn from him, and then leave him alone for a while to process that information. I'd assure him that he was in control. The child didn't have to say anything if he didn't want to: if any topic came up that he didn't wish to share with me, I'd tell him to just let me know and I would change the subject. Any time he decided to stop, the conversation was over. Over the years I've only had one adolescent girl say that she did not want to talk. But later that week, she told the staff that the only person she would speak with was the "psychiatry guy with the curly hair."

When I saw Justin I knew this case was going to be different. I needed to know more about him before I could approach him. I took his chart, went back to the nurses' station and read his old records, occasionally glancing over to watch him rock with his knees up by his chin, his arms around his legs. He was humming or moaning to himself, and every few minutes he would let out a loud angry-sounding shriek. The PICU staff had become used to this; no one even glanced his way anymore.

As I read through his records it became clear that Justin's early life had not been normal. Justin's mother was a fifteen-year-old girl who left him with her own mother permanently when he was two months old. Justin's grandmother, by all accounts, was a kindhearted, nurturing woman who adored her grandchild. Unfortunately, she was also morbidly obese and had related health problems that made her very ill. When Justin was about eleven months old, she was hospitalized and died several weeks later.

During her illness her live-in boyfriend, Arthur,* babysat for Justin. Baby Justin's behavior became difficult, surely a result of losing both his mother and his grandmother in such a short time. Arthur, still grieving himself, didn't know what to do with a crying, tantruming young child, and being in his late sixties, he wasn't physically or mentally prepared for such a challenge. He called child protective services, seeking a permanent

placement for the boy who, after all, was not even a relative. CPS apparently felt the boy was safe and asked if Arthur would keep Justin while they found alternate placement. He agreed. Arthur was a passive man, in general, and patient. He assumed that CPS would get around to finding a new home for Justin. But CPS is a reactive, crisis-focused agency and, with no one putting pressure on it to do so, it didn't act.

Arthur was not malicious, but he was ignorant about the needs of children. He made a living as a dog breeder and, sadly, applied that knowledge to the care of the baby. He began keeping Justin in a dog cage. He made sure the baby was fed and changed, but he rarely spoke to him, played with him or did any of the other normal things parents do to nurture their children. Justin lived in that cage for five years, spending most of his days with only dogs as his companions.

If we could witness a child's moments of comfort, curiosity, exploration and reward—and his moments of terror, humiliation and deprivation—we would know so much more about him, who he is and who he is likely to become. The brain is an historical organ, a reflection of our personal histories. Our genetic gifts will only manifest themselves if we get the proper types of developmental experience, appropriately timed. Early in life these experiences are controlled primarily by the adults around us.

As I read through Justin's chart I began to imagine his life as it unfolded. At the age of two Justin had been given a diagnosis of "static encephalopathy," meaning that he had severe brain damage of unknown origin that was unlikely to improve. He had been taken to the doctor because he was severely developmentally delayed: he was unable to walk or say even a few words by the time most children are actively exploring toddlers who have begun to speak in sentences. Tragically, when Arthur had brought Justin in for medical check-ups, no one inquired about his living situation. And no one took a good developmental history. The boy had been tested for various physical ailments, and his brain had been scanned, revealing atrophy (shrinkage) of the cerebral cortex and enlargement of the fluid-filled ventricles in the center of the brain. In fact,

his brain looked like that of someone with advanced Alzheimer's disease; his head circumference was so small that he was below the second percentile for children his age.

Back then, many doctors were still unaware of the damage that neglect alone can do to the brain. They assumed that something so clearly visible on scans had to be evidence of a genetic defect or intrauterine insult, such as exposure to toxins or disease; they couldn't imagine that early environment alone could have such profound physical effects. But studies done by our group and others later found that orphans who were left to languish in institutional settings without receiving enough affection and individual attention do indeed have visibly smaller head sizes and tinier brains. The brains show obvious abnormalities, virtually identical to those seen in Justin.

Unfortunately, as in Laura's case, Justin's problems were exacerbated by a fragmented medical system. Over the years, even though he'd been given tests as complicated as high-tech brain scans and chromosomal analysis to look for genetic problems, he rarely saw the same doctor twice. No one followed his case over time or learned about his living situation. By age five a repeat screening showed he had made minimal progress in fine and large motor, behavioral, cognitive or speech and language capabilities. He still couldn't walk or talk. To the doctors, who didn't know about the deprivation the child was experiencing, it appeared as if most of his brain-mediated capabilities just did not work properly. They assumed that Justin's "static encephalopathy" was due to some, as of yet unknown and untreatable, birth defect. The unspoken conclusion with children exhibiting this kind of severe brain damage is that they do not respond to therapeutic interventions. In essence, the doctors had told Arthur that the boy was permanently brain damaged and might never be able to care for himself, so he wasn't given any incentive to seek further help.

Whether because of this medical pessimism or because of his irregular care, Justin was never provided any speech therapy, physical therapy, or occupational therapy, and no in-home social services were

offered to his elderly caregiver. Left to his own devices Arthur made caregiving decisions that fit his understanding of child rearing. He'd never had children of his own and had been a loner for most of his life. He was very limited himself, probably with mild mental retardation. He raised Justin as he raised his other animals: giving him food, shelter, discipline and episodic direct compassion. Arthur wasn't intentionally cruel: he'd take both Justin and the dogs out of their cages daily for regular play and affection. But he didn't understand that Justin acted like an animal because he'd been treated as one, and so when the boy "didn't obey," back into the cage he went. Most of the time, Justin was simply neglected.

I was the first medical professional Arthur had told about his child-rearing practices because, unfortunately for Justin, I was the first to ask.

After interviewing Arthur, reading Justin's charts and observing his behavior, I realized that it was possible that some of the boy's problems were not due to a complete absence of potential. Maybe he didn't speak because he had rarely been spoken to. Maybe, unlike a normal child who hears some three million words by age three, he'd been exposed to far fewer. Maybe he didn't stand and walk because no one had coaxed him with her hand out to steady and encourage him. Maybe he didn't know how to eat with utensils because he had never held any in his hands. I decided to approach Justin with the hope that his deficits were indeed due to lack of appropriate stimulation, essentially a lack of opportunity and not lack of capacity.

The nursing staff watched as I walked carefully toward his crib. "He's gonna start throwing," one of them said cynically. I tried to move in slow motion. I wanted him to watch me. I figured that the novelty of my measured pace in contrast to the typical hurried motion in the PICU would catch his attention. I did not look at him. I knew eye contact might be threatening, just as it is for many animals. I pulled the curtains surrounding his crib partially closed so that all he could see was me or the nurses' station. That way he would be less distracted by the children in the adjacent beds.

I tried to imagine the world from his perspective. He was still ill, his pneumonia only partially resolved. He looked terrified and confused; he had no understanding of this new, chaotic realm in which he'd been placed. At least his home in the dog kennel had been familiar; he'd known the dogs around him and knew what to expect from them. Also, I was sure he was hungry, since he had thrown away most of his food over the last three days. As I got close, he sneered, scrambled around the small space of his crib and gave out one of his screeches.

I stood still. Then I slowly started to take off my white coat, letting it slip to the floor. He stared at me. I slowly undid my tie and pulled it off. I rolled up the sleeves of my shirt. With each action I took one small step closer. I did not speak as I moved. I tried to be as nonthreatening as possible: no quick movements, no eye contact, trying to speak in a low, melodic, rhythmic tone, almost like a lullaby. I approached him as one would a terrified baby or a frightened animal.

"My name is Dr. Perry, Justin. You don't know what is happening here, do you? I will try to help you, Justin. See, I am just taking off my white coat. That's OK, right? Now let me come a bit closer. Far enough? OK. Let's see what might work here. Mmm. I will take off my tie. Ties are not familiar to you, I'll bet. Let me do that."

He stopped moving around the crib. I could hear his breathing: a rapid wheezy grunt. He had to be starving. I noticed a muffin on a lunch tray, far out of his reach but still within his view. I moved toward it. He grunted louder and faster. I took the muffin broke a small piece off, and slowly put it in my mouth and chewed deliberately, trying to indicate pleasure and satisfaction.

"Mmm, so good, Justin. Do you want some?" I kept talking and reached my arm out. I was getting closer. In fact, I was close enough now for him to reach my outstretched hand and the food. I stood still, keeping up my banter and holding the muffin out to him. It seemed like hours, but within thirty seconds he tentatively reached out of the crib. He stopped halfway to the muffin and pulled his arm back in. He seemed to be holding his breath. And then, suddenly, he grabbed at the muffin

and pulled it into the crib. He scooted over to the furthest corner and watched me. I stood in the same place, smiled, and tried to bring some light into my voice, "Good, Justin. That is your muffin. It's OK. It's good."

He started to eat. I waved goodbye and walked slowly back to the nurses station.

"Well. Just wait a minute he'll be screaming and throwing things again," said one of the nurses, who seemed almost disappointed that he hadn't displayed his "bad" behavior for me. "I expect so," I said on my way out.

From what I'd learned so far about the effects of neglect on the brain, I knew that the only way to find out whether Justin had unexpressed potential, or had no capacity for further development, was to see if his neural systems could be shaped by patterned, repetitive experience in a safe and predictable environment. But I hadn't yet learned the best way to structure this experience.

I did know that the first thing I needed to do was decrease the chaos and sensory overload surrounding Justin. We moved him to one of the PICU "private" rooms. Then we minimized the number of staff interacting with him. We began physical, occupational and speech/language therapy. We had one of our psychiatric staffers spend time with him every day. And I made daily visits as well.

The improvement was remarkably rapid. Each succeeding day was better for Justin. Every day he appeared to feel safer. He stopped throwing food and smearing feces. He started to smile. He showed clear signs of recognition and comprehension of verbal commands. We realized he had received some social stimulation and affection from the dogs he'd lived with; dogs are incredibly social animals and have a sophisticated social hierarchy in their packs. At times he responded to unfamiliar people much like a scared dogs will: tentatively approaching, backing off and then moving forward again.

As the days went by he began to be affectionate with me and several other staff members. He even started to show signs of a sense of humor. For example, he knew that "throwing poop" made the staff crazy. So

once, when someone gave him a candy bar, he let the chocolate melt into his hands and raised his arm as though he were about to throw it. The people around him moved back. And then he broke into a big, hearty laugh. It was this primitive sense of humor—which demonstrated that he understood the effects of his actions on others and connected with them—that rapidly gave me hope about his capacity for change.

At first, however, my colleagues thought I was wasting hospital resources by asking that physical therapists try to help him stand, to improve his large and fine motor strength and control. But within a week Justin was sitting in a chair and standing with assistance. By three weeks he had taken his first steps. Then an occupational therapist came to help him with fine motor control and fundamentals of self-care: dressing himself, using a spoon, brushing his teeth. Although many children who suffer this kind of deprivation develop a highly tuned sense of smell and often try to sniff and lick their food and people, Justin's sniffing was particularly pronounced and may have had to do with his life among the dogs. He had to be taught that this isn't always appropriate.

During this time speech and language therapists helped him begin to speak, providing the exposure to words he'd missed in his childhood. His once dormant, undeveloped neural networks began to respond to these new repetitive patterns of stimulation. His brain seemed to be like a sponge, thirsty for the experiences it required, and eagerly soaking them up.

After two weeks, Justin was well enough to be discharged from the hospital and placed in a foster family. For the next few months he made remarkable progress. This was the most rapid recovery from severe neglect that we had yet seen. It changed my perspective on the potential for change following early neglect. I became much more hopeful about the prognosis for neglected children.

SIX MONTHS LATER Justin was transferred to a foster family who lived much further away from the hospital. While we offered our consultation services to his new clinical team, ultimately we lost track of

him in the massive caseload that our group was beginning to attract. But we often talked about Justin when we consulted with other families who had adopted severely neglected children; he had made us reevaluate how we assessed and treated such children. We now knew that at least some of them could improve more dramatically than we'd previously dared to dream.

About two years after Justin's hospital stay a letter came to the clinic from a small town—a brief note from the foster family giving us an update on the little boy. He was continuing to do well, rapidly hitting developmental milestones that no one had ever expected him to reach. Now eight, he was ready to start kindergarten. Enclosed was a picture of Justin all dressed up, holding a lunch box, wearing a backpack and standing next to a school bus. On the back of the note, in crayon, Justin himself had written, "Thank You, Dr. Perry. Justin." I cried.

TAKING WHAT I'D LEARNED from Justin's case—that patterned, repetitive experience in a safe environment can have an enormous impact on the brain—I began to integrate Mama P.'s lessons about the importance of physical affection and stimulation into our care. One of the next cases that would help us develop the neurosequential approach was that of a young teenager whose early life experience turned out to have been similar to that which had started Leon on his destructive and ultimately murderous path.

Like Leon, Connor had an intact nuclear family and an early childhood that, on the surface, did not seem traumatic. Connor's parents were both successful, college-educated businesspeople. Like Leon, Connor had an above-average IQ but, unlike him, he did well in school. When we did a simple review of his previous psychiatric treatment, we noted that he had been given, at various points, more than a dozen different neuropsychiatric diagnoses starting with autism, then ranging from pervasive developmental disorder, childhood schizophrenia, bipolar disorder, ADHD, obsessive-compulsive disorder (OCD), major depression, anxiety disorder and more.