

“Wild Child”: How Three Principles of Healing Organized 12 Years of Psychotherapy

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ABSTRACT

Methods of conducting psychotherapy in the most severe forms of childhood posttraumatic stress disorder (PTSD), especially in those traumas discovered very early in life, are rarely reported. This paper presents such a report and in the process emphasizes three elements of treatment: abreaction (full emotional expression of the traumatic experience), context (understanding and gaining perspective on the experience), and correction (finding ways personally or through society to prevent or repair such experiences). With traumatized children, all three elements may be inserted into their therapeutic play, art, and/or talk. An overarching mood of light humor helps the transference stay positive and the child interested. The case of “Cammie,” an infant who was bitten, shaken, and sexually abused, and whose 25-day-old sister was discovered at home, murdered, is the subject of this report. This little girl, upon removal at 13 months of age from her home of origin, growled, bit, sniffed sexual organs, rarely spoke, and behaved like the “feral children” described in the classic psychiatric literature. Two respected professionals diagnosed her as mentally retarded. A year in an outstanding foster home did little to improve her. At 29 months of age she was brought to the author, who saw enough imagination and pithy language to believe the child to be intelligent but severely traumatized. The author had begun to conceptualize three principles of PTSD treatment after a study of normal schoolchildren’s reactions to the 1986 *Challenger* disaster. These three principles were used with varying emphases at different phases throughout the “wild child’s” 12-year course of once-monthly therapy. Improvement beyond anyone’s expectations ensued. *J. Am. Acad. Child Adolesc. Psychiatry*, 2003;42(12):1401–1409. **Key Words:** posttraumatic stress disorder, wild child, feral child, infancy, psychotherapy for posttraumatic stress disorder, terror.

Cammie Brooks is a 14-year-old seventh-grade student who lives in a country town 220 miles south of the city where I practice. When she was 13 months old, the Hispanic American child of unmarried parents was removed by county authorities from her home of origin, a large ranch house her mother and father shared with her maternal grandparents, a maternal aunt, and two young cousins. That day, her 25-day-old sister was found in a bedroom, dead. The coroner discovered deeply penetrating adult male and adult female teeth marks on the infant’s body. Her brain was infiltrated by multiple small hemorrhages, a sign of “shaken baby

syndrome.” The police arrested only the child’s father, and he was subsequently convicted by a jury of killing the baby “without malice.” Cammie had been covered with bite marks, too. Because of her tendencies to shake her own body violently several times a day, it could be assumed that she was shaken dangerously, just as her sister was. An hour after her arrival in foster care, Cammie was taken to an emergency room, where her vagina was found to be torn. It is difficult to imagine worse events from which a 1-year-old child emerges, alive. No one, however, was subjected to criminal charges related to Cammie.

The day after the baby’s murder, Cammie was placed into a foster home that over the years had provided excellent care and comfort to more than 50 at-risk youngsters. In fact, before Cammie arrived, Sandra Brooks, a trained social worker who had never practiced, and her husband Tom, an attorney, both white, had adopted four of their previous foster children, two white and two of multiracial origins. The Brooks family was steady, warm, fun-loving, religious, and intelligent.

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Cammie, however, did not respond much to her new surroundings. She growled. She hardly spoke. When someone approached her, she shuddered. She sniffed at adults' sexual organs. She bit people. She hissed. Spotting a large woman of Hispanic descent, like her birth mother, Bonnie, sent the toddler into a panic. At home, Cammie shook herself with ever-increasing vigor and speed until, exhausted, she fell into a state that looked postorgasmic. Altogether, she strongly resembled the "feral children" described in classic psychiatric and psychological literature (Itard, 1801, 1806; Humphrey and Humphrey, 1932). These were wild young humans who wandered out of forests after having supposedly been raised by animals, usually wolves or bears. They did not improve much, according to the old reports. One contemporary reinterpretation of these cases has this kind of child born impaired (perhaps autistic, perhaps retarded), raised at home, and extruded shortly before their discovery (Frith, 1989; Bettelheim, 1990). Another possibility, based on contemporary newspaper articles, popular books (Curtiss, 1977; Rymer, 1993), a study of Romanian adoptees (Rutter et al., 1999), and a few single case reports is that rarely, very young children who have been inhumanly abused, neglected, and/or sensorially deprived, behave as if they were raised in the wild.

Sandra and Tom Brooks took Cammie to a Southern California university hospital pediatrics department and to a well-trained local child psychologist. Both diagnosed the little girl as mentally retarded. They did not think Cammie would significantly improve.

PSYCHIATRIC EVALUATION

When Cammie was 29 months old, her parents brought her to San Francisco for evaluation, with the following questions: Can trauma create a picture like this? If so, what can be done? The county was pushing for reunification between Bonnie and Cammie; should this happen?

Cammie exhibited immediate positive transference to me. Perhaps this occurred because, from the very beginning, I played and lightly joked with her. I wanted the pleasure of our times together to stand in contrast with the pain of her original home. The toddler was agile and demonstrated good fine motor skills. However, she hardly spoke. When she did, she emitted a bizarre basso growl. Despite her problems vocalizing, she was able to string a couple of words together, most of which conveyed worlds of meaning. Cammie's

choice of play subject, though imaginative, was monotonously repetitive. "Baby die," she rasped, holding a baby doll at arm's length. "Sheep die," she gurgled, throwing two woolly animals to the floor. I asked her about Bonnie, with whom she had recently started having chaperoned visits. "Got boobies," she commented offhand. When she encountered a mother doll among my toys, she discarded her, howling, "Trow away." Cammie was terrified of the traditional nutcracker she spotted high in my bookcase: "he bite," she shuddered. She found a wooden Zuni snake on my desk. "Snake huut," she intoned in her unnaturally deep voice. She managed to enucleate the eye of a small stoneware cat I had just added to my toy collection. I inked the eye back in to prove that I could repair things (like little girls' minds).

Cammie was suffering from infantile posttraumatic stress disorder (PTSD) caused by proven parental abuses and by other extremes of adult behavior that—because of her infantile amnesia—we were highly unlikely ever to hear in words from her (Terr, 1988). She was also exhibiting developmental delays, most likely on the basis of her traumatic, neglected infancy. I told her foster parents that attention and/or learning problems would probably emerge later in Cammie's childhood on the basis of having been shaken and sustaining similar brain hemorrhages to her sister. I did not expect Cammie to turn out retarded, however, because her use of words and her imagination were unusually good.

This toddler was overaggressive and oversexualized on the basis of her PTSD. Her character development had grievously suffered. Most likely, she had witnessed her sister's death ("baby die") and had seen the slaughter of animals ("sheep die") and even, perhaps, the enucleation of a cat's eye (her behavior with my office toy). Parenthetically, Sandra Brooks learned much later, when Cammie was 8, from a cousin of Bonnie's that when the child was just an infant, her "mean and weird" grandparents slaughtered sheep in her presence and bragged to the cousin's family about killing and torturing stray cats. Cammie strongly identified with the perpetrators of her babyhood through two psychological defenses: "passive into active" (Freud, 1920; A. Freud, 1937) and "identification with the aggressor" (A. Freud, 1937). She imitated her birth parents' actions, the way any normal infant does (Piaget, 1952). She also had inherited the genes of murderers. Yet, I believed strongly that she could be helped. She had PTSD, usually a treatable condition. We had enough

time to work on her distorted personality. She had made a good connection to me. I wrote to the court, asking that the child's forced visits with her biological mother be suspended. The judge complied. I bore Bonnie no malice; I simply saw her as a medical problem that had to be excised.

The Brookses proposed bringing Cammie to me for psychotherapy 1 hour once a month. The 440-mile round trip would take up a whole day. Not knowing how such far-apart spacing of sessions would work for so young a child—would she even remember what we were doing from time to time?—I said, “yes.” In this way, Cammie Brooks began her monthly trips to my office. It has been a dozen years . . . and counting.

THREE PRINCIPLES OF TRAUMA PSYCHOTHERAPY AND AN OVERARCHING IDEA

Through research I was conducting on normal childhood reactions to distant traumas and through my clinical work with older traumatized children and adults, I had gradually been coming to the idea of a trio of essentials to the psychotherapy of traumatized individuals. They were abreaction (full emotional expression of the experience), context (understanding and gaining perspective on the experience), and correction (finding ways personally or through society to prevent or repair such experiences). There were roots to these ideas in earlier work. In the late 1930s, for instance, David Levy, a distinguished New York psychoanalyst, came up with the idea of emotional “release” for frightened children (Levy, 1938, 1939). He gave the example of Paul, who stammered after having been scratched twice by another boy at his nursery school and failing to retaliate. Levy suggested that children like Paul could be cured by playing emotively at the child psychiatrist's office. They did not need to say anything or hear a psychiatrist's viewpoint to be cured. Paul was followed up twice by Levy after his “release therapy”—he no longer stammered. I have renamed this kind of experience “abreaction.” As opposed to Levy, whose cases were relatively mild, I find that children with full-blown PTSD must eventually vocalize words for their intense feelings or for their toys' emotions. Otherwise, there is too much tendency to act out the emotions dangerously or inappropriately beyond the doctor's office.

Thirty years after Levy, another metropolitan New York child psychiatrist, Richard Gardner, described a therapeutic process for young children that he named “mutual storytelling” (Gardner, 1971). He used this

technique for a number of different disorders, but it was particularly applicable to PTSD. Here, the child starts telling a story, almost always of his trauma. The therapist then finishes the story with a new, corrective ending. One can therapeutically manipulate posttraumatic play in a similar fashion through “corrective dénouement” (Terr, 1983). Fixing the endings of repetitive and inevitably gruesome play (Terr, 1981) takes advantage of a frightened child's need to repeat, while at the same time inserting new possibilities into the youngster's repertoire of response. My current idea of correction includes one important addition. Therapeutic suggestions may be made and clues given, but in the end a traumatized child should conceptualize the corrective solutions himself.

The third principle of trauma psychotherapy, context, comes from my own clinical work and from a research study on the thinking of schoolchildren after the spaceship *Challenger* exploded (Terr et al., 1997). Following the January 1986 disaster, children clamored for pertinent information. They looked through newspapers and magazines on their own and watched the TV news. I think they were trying to find geographical, historical, and cultural linkages between the lost spaceship and themselves, a kind of context.

One overriding idea dominated all others, however, in my treatment of “wild” little Cammie. It was the idea of play—of having fun. D.W. Winnicott (1971) wrote that play is essential to productive psychological treatment. Unless Cammie and I worked together in a high-spirited fashion, there was no point to her traveling hour after hour to see me. In fact, recently, when I told Sandra Brooks that I would be writing, using disguised names for everyone involved, about Cammie's psychotherapy, she signed her permission slip (as did Cammie) and then said, “Don't forget to write how much fun it all was. In fact,” she added, “it was always more fun driving home than coming. You consistently gave us something to feel ‘up’ about.”

This report is divided into four childhood phases: toddler years; pre-kindergarten/kindergarten; latency; and adolescence. For each section, I will include two subtopics, “child's status” and “therapeutic interventions.” For each childhood phase, I will attempt to show how abreaction, context, and correction fit into the psychotherapy. I will also give examples of how the spirit of playfulness guided our work. I saw Sandra Brooks every month for the first 5 to 15 minutes of Cammie's sessions. She told me what had happened, and I offered solutions to try at home or school, new

formulations, ideas about the future. As the years went on, my future estimates for Cammie rose remarkably. The family's estimates escalated as well. Over the years, too, the three principles behind Cammie's treatment took on much better clarity and form.

TODDLER YEARS

Child's Status

Cammie's voice needed immediate modification. Speech therapy was set up with a practitioner who lived nearby. It took 2 years of twice-weekly speech sessions before Cammie sounded normal. Toward the end of that time, Bonnie, in an attempt to regain Cammie's custody, blamed the child's father for almost everything that had been discovered about Cammie. Bonnie revealed that Nick practiced Satanism and often growled at his daughter. Cammie's low, gravely voice had apparently come in imitation of a man who, as he spoke to her, tried to imitate the devil.

The little girl's first home drawings, at age 3.5, were entirely trauma-related. She drew herself ("me with breasts") with no mammaries, but with stuff that looked like pubic hair on her chin and pubis. In black, she drew two nude adult women, one with red-colored splotches (blood) near her genitals ("Not talk bout dat"). She also drew an adult male "biting monster" with about twice as many teeth as one expects.

When she was just 4, Cammie was caught in the kitchen, looking like a zombie and cutting her shins with a pierced spoon. "Not huut!" she told Sandra, who was shocked at the child's dissociative self-mutilation. "I'll show you what hurts!" Sandra pinched Cammie's arm hard. Later, Sandra told me how guilty she felt. But Cammie never self-mutilated again.

A continuing problem with pets, however, indicated how deeply Cammie had identified with her ferocious-acting birth parents. The Brookses had adopted a number of dogs from an agency that specialized in previously abused animals. Each of the older children in the family owned one. When Cammie turned 3, she violently threw a newly adopted poodle onto his back. He was rendered paralyzed for an afternoon. After he was sent back to the agency, the question came up once again: Was this modern-day "wild child" headed for a life of harm?

Therapeutic Interventions

To begin Cammie's treatment, I developed two forms of therapeutic play for her, each stressing correc-

tion. One was for Cammie's foster mother to administer at home, and one was for my office. I needed Cammie to understand that a terrible situation can be fixed, and I recognized that toddlers do not automatically know such things. I, thus, invented the "Sally stories" for Sandra to tell at bedtime. They originated, in part, in the psychoanalyst Erna Furman's writings on "filial therapy," the treatment of a child through the youngster's parent (Furman, 1957).

One evening when Cammie was still 2, Sandra asked the toddler to give her a girl's name she liked. Cammie said, "Sally." "Tell me a story about Sally," Sandra asked. "Baby die," Cammie told the only story she knew. "Yes, the baby died," Sandra agreed sadly. "But Sally lived. And she was taken to a nice, new house and a nice, new family." "Again!" Cammie demanded. She loved Sandra's personally styled tale, never recognizing that it was herself who was the protagonist. For a month or so, the nightly tales continued on exactly the same theme. Then Cammie became more flexible. "Sally huut," she said. Sandra was ready with our pre-tailored ending. Doctors help hurt children in medical offices or hospitals, she told the toddler. "Again! Again!" Not only was this poor traumatized girl learning that corrections were possible, but she was learning to trust a kind woman, who, night after night, was finding herself a little more in love with this tiny person.

In my office, Cammie and I drank imaginary tea at very proper imaginary tea parties. I wished to introduce the idea to Cammie that through civilization, posttraumatic corrections take place. I gave Cammie the rules for a tea. She listened once and needed no further instruction. Her pretend rested on which characters would be allowed to attend. She was exerting some of the first societally approved controls she ever used. In Cammie's world, there were either perpetrators or victims. At first, two latency-age-looking dolls were the only toys she could designate as safe to come to a tea: "big guhs," she rumbled. I invited a perpetrator, Mr. Nutcracker, to tea. Cammie wanted me to find a correction for his toothy presence, and so I introduced the ideas of "jail" and of "banishment." Quickly, however, I shifted the corrective responsibilities to Cammie. She needed to provide the instructions to "iffy" participants at tea. She learned to lecture, admonish, scold, reason, negotiate. By accomplishing these corrections, Cammie's demeanor outside my office modestly improved. Her outlook brightened. She loved the repairs available within organized society.

PRE-KINDERGARTEN/KINDERGARTEN

Child's Status

During this period, the physical results of Cammie's abusive infancy began—as we had anticipated—to emerge. But something unanticipated also occurred. Sandra and Tom wanted to adopt Cammie, whether or not she was retarded. They arranged for Nick to relinquish his parental rights from prison. When Cammie turned 4, a noticeable problem with dribbly urination required a “double set-up” examination in the operating room at the university hospital where I teach. The gynecologist found extensive anal and vaginal scarring and stretching, but no surgical interventions were required. The urologist found urethral strictures, which he repaired. At my request, the surgeons wrote a letter describing their operating room findings to Cammie's custody judge. These injuries could not have occurred without a second parent participating or neglecting. Now, the judge permanently terminated Bonnie's rights to Cammie. Inviting the Brookses to court, he declared the little girl officially adopted.

To celebrate, I threw Cammie a real tea party, complete with freshly brewed tea, cookies, 19th-century child's china, Sandra, and my office staff. We joked about how there was little to no room that day for dolls. By then, however, every one of my dolls and puppets could qualify for tea because Cammie had taught them how to behave or how to get help for themselves. The preschooler had accumulated a whole repertoire of corrections. We also joked, gently of course, about how different Cammie looked from her parents and siblings. It was a first attempt at achieving context, some perspective, on her situation. We went on to speak about the Brookses being every bit as much of a family—now that Cammie was adopted—as other families who all look the same. Cammie beamed with happiness. She loved our party. But we had joined the world of fantasy to reality. She never suggested playing “tea” again.

Cammie did not attend a school until she was 5.5 years old. Before that, she was far too undersocialized and aggressive to deal with other children. When she finally started at a Christian parochial institution that Sandra and Tom liked, she was academically behind. She repeated kindergarten. An emerging problem, related to being shaken, further compounded her difficulties. She developed several “absence” seizures a day, during which she mentally derailed, made a few facial movements, and then became stuporous. Once, Cam-

mie's UCSF neurologist needed to test her under anesthesia. As the 6-year-old emerged from unconsciousness, she growled at Sandra, “You bad!” “Trow away!” I came to the hospital in answer to Sandra's urgent phone call. Cammie was, in her disoriented postanesthetic state, reliving her traumatic infancy with Bonnie. Sandra was relieved when she understood Cammie's “displacement” (A. Freud, 1937).

When she was 6 Cammie began taking methylphenidate, 5 mg twice daily, as a joint decision between me and her pediatric neurologist. By the time she reached 7, her seizures came under full medical control. Her heart rhythms, however, had recently become fast and erratic. She had to have two cardiac ablation procedures at UCLA and has attended their 1-week heart camp every summer since. The counselors reported Cammie to be a gentle role model for younger, sicker kids. By the time she was 7, however, Cammie was at least 2 years behind in school. She was clearly learning-disabled. She suffered from attention-deficit/hyperactivity disorder (ADHD). She was also obviously smart.

Therapeutic Interventions

In giving up our office teas, Cammie immediately turned to a new mode of pretend, “Red Riding Hood.” She picked up a Russian *matrushka* doll from my table and declared her to be “Red.” She found a raccoon puppet in my toy cabinet and named him “Wolf.” Cammie's interest lay entirely with the animal. She now began for the first time to fully abreact her trauma. Her emotion, however, rested with the perpetrator alone. Cammie's wolf gloated over his kills, and he shook with sexual glee. Red and Grandma, his prey (through the defense of “displacement,” representing Cammie and her baby sister), inevitably died. Cammie handled their deaths in a chillingly matter-of-fact tone.

It was important, I knew, that Cammie begin to feel for victims. She needed to fully experience family tragedies as her own. I asked her questions designed to elicit her empathy. We needed to rechannel her abreactions to the proper places. “How does it feel to die all bitten?” “Not huut.” “Oh, I think Red would have to shut off all her feelings not to be aware of the pain.” “Maybe,” but we went on to play toward Cammie's inevitably disastrous endings. One day, she finally admitted that Red was scared—Grandma, too. This was the beginning of Cammie's empathy. But she still couldn't imagine a single way to defeat Wolf. “How about a gun? Red might hide it in her picnic basket,” I suggested. “No way!” “How about poison? Red can

make poisonous sandwiches at home and pretend they're for Grandma." "No! No! Grandma will eat the poison!" We played Red Riding Hood for 2 years. In those 20 or so sessions, considerable abreaction on behalf of victims came to take place, but Cammie could not yet construct a correction.

I wondered if some contextual thinking would help. "Why do wolves do such things?" I asked Cammie one day as we played. "They're mean," said Cammie. "They don't care." "True," I thought. It was hard, well nigh impossible, to find motivations for Cammie's birth parents' actions. "Wouldn't a wolf in the forest rather eat deer meat than little girls?" "Yes," Cammie said, "but this wolf wants girls!"

There it was! In thinking about this particular wolf's weirdness, as opposed to all other wolves, Cammie finally had been able to gain a perspective on the family of her infancy. They were outliers! They were deeply disordered people! Now, with a new context, Cammie could find her correction. "How does wolf soup taste?" she blurted out that very day. "Let's try some." With gusto, we slurped up our imaginary stew.

Turning the tables ended our Red Riding Hood play. Cammie had reached the conclusion of her kindergarten years. She drew a kindergarten self-portrait—of a real girl with a normal hairstyle, wearing a dress and a wide smile. Perhaps we might end therapy, I thought.

LATENCY

Child's Status

Many people, traumatized early in childhood, eventually need a verbal memory to supply the context for how the trauma fits into their life (Terr, 1994). Cammie's memories up to now had been behavioral, not verbal (Terr, 1988). In preparation for concluding Cammie's psychotherapy within the year, Sandra, Tom, and I decided to tell Cammie what had happened during her infancy. Sandra showed the little girl photos of her old house, the baby's grave (weed-covered and unmarked), the hospital ER, and her birth parents. I then told Cammie the facts as I knew them. I told her about her injuries, both mental and physical. She took it well, as if she had known it all along. Indeed, nonverbally she had. Cammie's parents cleaned up the grave site and installed a little gravestone. They then took Cammie to see it. The first-grader, a pretty and proper person by then, stooped down to place a bouquet near her sister's marker. "You died," she said. "I got to live. I promise you a good life."

Despite this optimism, a number of internal setbacks and external incidents indicated that Cammie's psychotherapy must continue. For first-grade "show and tell," for instance, she brought her pet gerbil, Mousie, to school. She returned home with a dying animal: Mousie had been squeezed too hard. Cammie dug Mousie's grave herself and truly felt sad and guilty. Her impulses to harm, however, remained strong.

In first grade, Cammie began what turned out to be several years of tutorials in reading and math. She had a number of howling tantrums at home about her lessons or homework. We shifted her methylphenidate to include an optional 2.5- or 5-mg dose for late-afternoon schoolwork. Once Cammie could read on her own, she began to use her reading materials (her favorites were about animals) to shake herself to orgasm. There was nothing "latent" about this latency-age girl. At her innermost core, she was still "wild."

Cammie's third grade year was marked by severe stress. An 8-year-old girl down the street, whom Cammie did not know, was raped and murdered by an itinerant handyman. For days, the Brooks' town was abuzz. Cammie felt impelled to draw a picture of herself crying under a torrential downpour. On the heels of this tragedy, Cammie's birth father, Nick, was released from prison. The Brooks family suddenly came under attack: a dead rat in Tom's office mailbox, strangers in parked cars outside their property at all hours, phone threats against their cats (they had no cats). I contacted the judge who had originally sentenced Nick to prison. Could he help this besieged little girl? Nick's parole rules quickly became modified to include staying away from Cammie and her family.

The upsetting events continued, however. By third grade, Cammie was becoming well liked. She enjoyed chatting with her new friends. And, of course, she had ADHD. One day, Cammie's teacher decided to make an example of the tiny whisperer. Calling Cammie to the front of the class, she slapped her, full in the face. The principal backed the teacher. Sandra immediately pulled Cammie out of parochial school.

Cammie rode the bus to her new public school, and a kindergarten boy latched onto her. She was the love of his young life, Andy declared. Would Cammie marry him? No? Well then, why not have sex? Sandra eventually phoned Andy's mother in order to try and stop him. She learned that Andy was very recently adopted after having been sexually abused most of his early years. How this particular boy found this particular girl remains a wonder! Was it chemical? At the very

time when I had hoped to administer a different group of chemicals, the selective serotonin reuptake inhibitors (SSRIs), to my young patient in order to take advantage of their sexually inhibitory side effects, she could not take them because of ongoing problems, despite the ablations, with cardiac rhythms.

Therapeutic Interventions

Between 6 and 10, Cammie played with my office dinosaurs. Her favorite, of course, was *Tyrannosaurus rex*. But we also talked a great deal about the events of her current and past life. Much centered on the idea of randomness, a contextual comfort in PTSD (Terr, 1990). It was now my plan to bring into Cammie's therapy as much thinking as possible, without ruining our sense of fun. It was bad luck to run into learning difficulties, we agreed. She would have to practice reading more than the rest of the kids she knew. I introduced her to the pleasure of borrowing books from a library. Once, when she was 9, I suggested that she do five of her math facts for her mom before all family dinners as an enjoyable way to "sing for [her] supper." She instantly became so angry that she lay on my floor, screamed, moaned, and had a toddler-style fit for the entire session. I stayed cool and said next to nothing. Next time, she was perfectly fine. I had passed a test: Cammie needed to feel certain that I would not hurt her and that I would continue to like her, even at her worst. It was the only negative transference I have observed in 12 years. It came during her most frustrating year, other than the horrible but unremembered first one.

Cammie's usual play scenario in my office was that *T. rex* killed the other dinos and ate their babies. From the first, she was able to bring in societal corrections—for example, dino police squads, jails, and reform schools for younger reptiles. Somehow, at the end of each play session, however, *T. rex* inevitably prevailed. Cammie showed abreaction galore for the infant dinos, but her major identification still rested with the aggressor.

With the full range of piagetian concrete operational skills at Cammie's disposal (Flavell, 1973), she should now be able to negatively compare *T. rex* to her own emerging self, a potentially helpful context, I thought. Humans were brainy; *T. rex* was dumb! If we used our heads and inserted human armies, scientists, even nuclear bombs into our play, we could destroy the huge toothy animals. The idea of the superiority of an educated human mind was a revelation to young Cammie

Brooks. "Do you think I can become a child psychiatrist?" she asked, black eyes veiled in deep concern. "Of course! You'll be a good one!" I said, certain by now that she could if she wanted to.

Cammie began to talk about her animal temptations. She wanted to try sex with the pesky kindergartner. With Cammie's mother's permission, I explained the facts of life. It helped Cammie to see the difference between sex, connected with love, and forced sex, infantile sex, autoerotic sex, and sex with kindergarten pests like Andy. Her new perspective on sex motivated her to hand me the picture books she shook to, so that she could stop. She got rid of Andy. She told me a repeated nightmare she had all her life about an expanding adult vagina. She was actively trying to change.

By the time Cammie reached the end of her middle childhood, the California public schools officially acknowledged her intelligence. She was taken into our state's "Gate" program for gifted students. In fact, by the time Cammie's *T. rex* play ended because the great monster could finally be ignored in deadly quiet museums, Cammie had celebrated her 11th birthday and was reading for fun. She had discovered Harry Potter (Rowling, 1998), another traumatized child and a great context for self-comparison and even for romance.

PUBERTY AND ADOLESCENCE

Child's Status

Cammie's menarche at age 11 was difficult. She bled three weeks out of four for a number of months. Once again, she required the help of the gynecologist who had examined her under anesthesia 7 years earlier. He gave her hormones, and she improved. Cammie's eventual height fell just short of 5 feet. She went to a physical therapist for a few months to correct severe tension of her neck muscles. Despite these medical problems, however, Cammie physically blossomed. She was beautiful. She was popular. Boys like to flirt with her, and she flirted right back, with extremely good humor. She had a few close girlfriends, along with the standard number with whom she was forced to fight the subtle wars of adolescent girlhood. Cammie now recognized that using her brain was the best way to prevail. Her schoolwork had caught up to the level of her peers, and her conversation was at a much higher level. She was kind, unless treated with malice. Then, she was able to defend herself with assurance. She loved her parents and was helpful at home. Any rebellious-

ness she exhibited during latency subsided during Cammie's early teens. "I'm Mexican," she told her peer group with pride. She loved romance and preferred it to sex—"at least for now," she told me. She took methylphenidate (15 mg t.i.d.), but only for school work, not for misdirected behavior. Now, in fact, because of her cardiac status had improved, I was able to put Cammie on a low dose of sertraline. Her shaking stopped.

Therapeutic Interventions

Cammie wanted to talk. She wished occasionally to play, as a matter of fact, with words. Once, at 13, she came to my office making disgusted-sounding grunts and snorts after a class field trip to Ana Nuevo State Park (where a herd of elephant seals mate and raise their young). I wanted her to grasp the evolutionary context of sex, and so I made up a little word game for her, based on William Steig's *CDB* ("see the bee"). In letter language (Steig, 1968, 1984), it went: "CDC? I M C-N D O-C-N. D L-F-N C-L S N D O-C-N. OO! D L-F-N C-L S F-N 6! O.G." (See the sea? I am seeing the ocean. The elephant seal is in the ocean. Oh, oh! The elephant seal is having sex. Oh. Gee.) Once she "got it," Cammie laughed at seals, at sex, at herself.

For Cammie to put her terrifying infancy into the much bigger context of an adolescent life, well lived, or better yet, of a whole life, well lived, we continued her treatment. At times, she saw herself as a monster. Once, when she had just turned 13, she confessed to squeezing her brother's dog too hard. She reluctantly agreed to my correction: to stay away from Zito for a month. Cammie has occasionally drawn self-portraits as a bloody witch or a murderous Apache princess. These coexist with gentle, sweet self-portraits, done within days of the others. It is important, I feel, that my adolescent patient bring her self-image together, both tamed and wild, in order to forge a strong sense of identity (Erikson, 1950).

For Cammie as an adolescent, context and correction are her best medicines. Sandra and I are working on obtaining some baby-sitting opportunities for the teenager, with Sandra coming along as a nonintrusive chaperone. Cammie knows why: she must prove to herself that she can handle children. We learned recently that, once he was off parole, Nick moved back in with Bonnie. They have another baby now. But their lives, beyond these facts, remain a mystery.

Cammie's life is far more open. She appeared at age 14 at a conference of Central Valley special-education

teachers and was given a plaque for her willingness to "teach" them. In her acceptance speech, she was both humorous and corrective. "Don't talk about us [kids with learning or attention disorders] too loud when we're not on task. I don't exactly lay awake at night and say, 'Please, Lord, let me be off task today, so I can make the teacher mad at me in front of my friends and classmates.'" One of the teachers later approached her. "I hope it's OK with you," she said, "if I name my next child—if it's a girl—Cammie." The "big guh" glowed with pride as she told me about it later.

Over her spring vacation, Cammie attended a military school formal dance in a long, pink tulle gown. It was clear to a number of onlookers that the small, but highly civilized, young lady in pink was the belle of the ball.

DISCUSSION

Through 12 years with the most severely traumatized child I have ever treated, three factors—abreaction, context, and correction—organized the child's psychotherapy. The three treatment principles are graspable and generalizable to any form of psychotherapy for PTSD. For example, they can be used in manualized 12-session cognitive-behavioral therapy by making each mechanism a 4-week task or by apportioning each process into every one of the sessions. In group therapies, the leader need only keep the three strategies in mind and make sure that each is adequately covered.

It should be clear that I integrated other modalities beside psychotherapy into Cammie Brooks' treatment. I eventually was able to use small doses of an SSRI drug, entirely for its side effects. I used my medical background, as well, to help select and choose the dosing for the methylphenidate we used for Cammie's attention problems. I helped the child's physicians, nurses, and family to deal with her at the hospital, and I consulted with the medical, educational, and judicial professionals working with her problems at home. I indulged in a great deal of parental counseling with Sandra Brooks. Too often child welfare agencies bring us children still living in a battlefield, asking us to "fix" the child's PTSD. In this case, the social service workers had found a family that could anticipate with me what was coming next and what we could do about it. For the most part, in fact, Sandra Brooks knew exactly what to do. I firmly believe, in fact, that having Sandra and Tom as parents was the best thing that ever hap-

pened to the young “wild child.” Psychotherapy was the next best thing.

Abreaction, context, and correction can be measured and studied. In fact, my colleagues and I are currently working on projects that consider how normal young people spontaneously use the three processes. My modern-day “wild child” was the inspiration for this kind of research. From one single case, representing the very worst kind of trauma, we may eventually learn how larger, more normal groups of children handle terror. Just as a study on *Challenger* shifted my approach to Cammie by emphasizing context, Cammie’s individual treatment is now influencing further research.

Cammie’s treatment is, in a certain sense, a summary of what we child and adolescent psychiatrists do. I planned for Cammie, using her stable, growth-promoting home as the foundation of her treatment. I consulted with professionals, many of whom I also helped select. I served as “primary architect.” My last words are exclusively reserved for Cammie’s psychotherapy, however. Psychotherapy can work dramatically for the problems of PTSD, especially when optimism, humor, and playfulness guide the process. Psychotherapy served Cammie Brooks well for the 12 years I have described. It serves her well today.

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