The Importance of Food in Relation to the Treatment of Deprived and Disturbed Children in Care

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Introduction

"D.W. Winnicott (followed by others including Richard Balbernie and myself) found the concept of integration of the individual as a whole person to be of supreme importance in determining the needs of a deprived child" (Dockar Drysdale, 1973).

It is important to understand this conceptual framework for the work undertaken within the Cotswold Community. The Community provides therapy i.e. treatment for some of the most disturbed children in the country. The emotionally damaged and deprived children referred to us are assessed on their level of unintegration (Winnicott, 1988) and our ability to meet the needs of their inner world. Thus, we hope to facilitate integration (Balbernie, 1966).

The unintegrated child has little sense of self and the boundary of self. He is empty inside, with an unending void, that he is constantly unconsciously trying to fill by unsatisfactory and incomplete experiences. This may take the form of acting-out, petty thieving, truancy, violent behaviour, both verbal and physical, underneath it all an aching sadness and emptiness.

Each child is unique – he has his own particular and individual needs. When a child is accepted for treatment at the Community, it is as a result of a referral process to assess suitability for treatment. Many children on their initial visit immediately recognise, at a non-verbal level, that this is a place where inner needs can be met; other children are able to verbalise those needs. It is on visits that particular attention is paid to the child; it is his needs that are being assessed; grown ups talk and listen to him. He is offered opportunities to play. The "working lunch" is relaxed – a simple choice of fruit, rolls, crisps and drinks. The latter provides a glimpse of eating patterns, the need to be greedy, the need to be a "squirrel" and put food away for later …. perhaps to take a bite out of everything and yet not enjoy or feel satisfied by eating.

The unintegrated child has not had his very early primary needs met; feeding may not have been a satisfactory experience. Food is a very important therapeutic tool in the Community. We have deliberately decentralised services so that each of the five households has its own kitchen, manages its budget and functions as a "family" group. The role models allow the grown ups to provide safety and containment around food. One particular staff member, male or female, has the role of "household resource" and the responsibility towards the household for budgeting, buying food and arranging the cooking of meals by each team member.

The role of "household resource" provides the structure of good, reliable provision. This is of immense emotional significance and provides the safety-net of provision. The symbolic meeting of this early need through food has deep meaning for the unintegrated child. His lack of ego, and therefore a sense of boundary, is often met in the area of eating. Children are anxious about "enough of everything to go round", "who will have the most", "who has more than me" and "I'm hungry". The child's anxieties can become the carer's anxieties – the much needed ego-boundary – a sense of containment (in a therapeutic sense) needs to be around food. As Bettelheim states:

"Food represents one of the child's earliest contacts with the external world. It is the activity around which personal relationships first develop and around which they may first break down, with the most dangerous consequences."

The Role of "Household Resource"

Keeping an overall eye on the larder, and the boys' use of it, is the responsibility of one adult in a team of seven per household of ten boys. This is the "mum" of the house, whether the "mum" be woman or man. Without this role the foundation of all other work is greatly undermined, if not impossible. The boys cannot be managed if they feel no one is going to feed them. If the boys cannot be managed they certainly cannot hope to come to trusting relationships and into therapy. Holding this role requires a constant preoccupation. Not only must you have provided enough in a basic sense, but it is important to be flexible enough to accommodate the special or sudden need, for example, for milk. I can remember a difficult period of time in our house when major changes in the adult team were affecting its stability. Over two weeks there was an enormous consumption of milk, as well as white bread and jellies. There is not a large pool of money to turn to, but a careful amount which has to be responsibly used and managed in each household, not centrally. Of course the golden syrup can run out just because you have not bought enough, but more often it has run out because children and adults have been piling it on and keeping the plentiful spoon to lick. Now is not the time to fall into the trap of supply upon scream/demand, but to draw a boundary at need. It is a powerful and anxious role, a bridge between management and therapy. If it is a safe enough bridge and strong enough to take the storms of protest and projection, then boys and adults will be able to cross freely and work can begin.

Probably none of these children have been weaned properly. They have not had in a complete enough sense the essential understanding of any of their needs, or importantly, a reliably and good feeding experience with an adult. Therefore mealtimes are carefully managed. If a meal is not acceptable then a boy can have part of it, perhaps on toast or in a sandwich. If that will not do then he can have bread with a spread of his choice from the larder. However, it is important here to emphasise a boundary. If baby continues to spit out and abuse his food, would you expect mother to fly from cupboard to cooker over and over again to see what baby will eat? Often the anxiety around a child not eating belongs to the adult. Certainly a child can be in protest, powerfully using food to reject all care and concern. A disturbed child may well be more used to providing for himself, so untrusting are his relationships with adults. I remember one child particularly, who had not been at the Community long, who was unable to have a proper summer break. Whenever he came to the table he would seem quite content, but when the food was served he would feign sickness and revulsion. He never "seemed" to eat anything. Then I noticed how often he could be found on a kitchen stool, close to a grown-up preparing food. He would usually have a carrot or piece of cabbage in his mouth, or would be tasting the meal in the making. This boy was tasting and testing and was not yet prepared to be seen as trusting or accepting.

Jack: A Case Study

Jack is in care at the Cotswold Community, which is a therapeutic environment with five different households. There are three "primary" houses who accept unintegrated boys for treatment, and there are two "secondary" houses which the boys move on to having integrated.

Jack is 12 ½ – he has been in the Community 6 months. He grew up in a violent and chaotic environment of unstable parental relationships, finally being admitted to care at the age of 11 years, following neglect and physical abuse. He had moved house 12 times and school 8 times.

Jackie is a boy who implodes his anger and his grief. He uses enormous quantities of food to push his feelings down. These quantities are and never will be enough: the emptiness he feels inside is dreadful and no amount of food will fill him up. He must always have food: it must never be withheld

from him. He needs to fill up, but emotionally. This opens up a practical and emotional minefield – a minefield for the group of people with whom he lives, for the people he sits at the dinner table with and for the adult most concerned with his care.

Jack eats practically all day. He is assisted in doing so by the framework of feeds almost every two hours – as a baby would need. As an unintegrated child Jack is emotionally the age of a baby. In all these feed times Jack charges as if to the head of a queue. He wriggles about on his chair, calling out for an adult to come quickly and serve him. "I like that, and that. Emm, yum yum". What he says is accompanied by lip-smacking and sucking noises. But within Jack there is a tremendous anxiety that he will not get enough, or perhaps any food. His face shows a different picture to the noises he is making. It produces an anxiety in others, boys and grown ups alike, that "they" won't get enough. The adults hopefully will be able to mange these anxieties for themselves. One boy though, who shares the same table, has responded by always asking for more, though he rarely eats more. He then has a false sense of satisfaction where he can look at his plate, now

discarded, which still has healthy portions on it. What both of these children need to be able to do is to experience and internalise a caring adult, who will provide them with what they individually need. The adults and the environment, unlike before, have to be safe enough to be relied upon.

The meals the children eat are prepared in the house where they live, by the grown ups who look after them. Adults and children eat together. A great deal of consideration goes into the food. It is good to have identifiable food that can be chosen from different pots on the table. It is helpful not to present food which could be seen to disguise or hide anything dreadful or poisonous – mixtures, for example. Food that is prepared in individual pots, perhaps personalised in some way, say with an initial, can be fun as well as helpful. It is useful not to cut things up as this can arouse fears of there not being enough or of unfair sharing. Little round, whole cakes are better than one large, whole cake that has to be sliced.

Apart from the regular feeding there is the irregular feeding. There is the spares tin, which must always have something to offer and, except in an emergency, something which has been specially made for the tin with the children in mind. They can go to this tin *at any time.* I stress *any time* because this includes those anxiety filled moments (for conditioned grown ups that is) of 2-3 minutes before a meal. It never spoils their appetite.

Jack looked with wonder and a tinge of fear at the spares' tin before plundering its contents. The time when he was seen walking unsteadily as if on a tightrope beneath a wobbling tower of cakes, was the time for his anxiety around food not to be colluded with. He had to take on a boundary of one piece at a time – if he still wanted more then fine, but one piece at a time. If the spares' tin is not to a child's taste or has, as occasionally happens, been ransacked in moments, adults will make boys toast if they are hungry or need to eat for other reasons. Jack's unwavering homage to the spares' tin has become more comfortable, but not before he has been called names by other boys and adults have received complaints that he eats everything before anyone else can. If at this point in Jack's treatment it is essential for him to go to the spares' tin unimpeded by group pressure, his own spares' tin could be provided for as long as necessary.

One particular grown up has responsibility for Jack – the person as it were to sew the threads between the awful gaps. But for Jack at the moment there is never enough. There is not enough of the grown up who looks after him, so he looks to everyone for provision, and misses out on that which would be special to him. There is not enough time so he never sits with one thing, but rushes and crashes about, looking forever like someone emerging from an awkward hedge. There are not

enough clothes to make him feel good and cared for. The list could be endless. The most obvious way Jack has of dealing with this never-enoughness is through food. It drives away these terrible feelings, but not for long, so that he has to eat constantly. His journey, like most, is to get in touch with his pain and anger, and for those feelings to be safely contained, but expressed and communicated with. Within this, food must take on special meaning for Jack as part of his recovery.

Special provision of any kind is enormously important for these children. If an adult can become special to one child they can focus trust and become dependent upon them for their needs. This is the beginning of their needs being met for the first time. Special food plays an important role here. A special provision can help a child in dependency brave separation from the adult whom he depends on. Food can be an intimate provision symbolic of the mother/baby feeding experience. Thus, food can help to heal the wound left by the first and probably the most incomplete experience of these children's lives.

None of this could happen if food were to be provided from "outside", say a central kitchen issuing mounds of warm food at set times. Jack would still eat it, charging to the front of his imagined queue. He would make "yum-yum" noises, he would look desperate and he would want more. What he would not be able to discover is that through food he is thought of particularly, nurtured and communicated with as a special person. The grown-ups who look after these children invent, prepare and cook their food amongst them and, if they want, with them. A child teetering on a chair at the sink, "washing up" with suds and puddles spreading through the kitchen or with sleeves rolled up sticking and unsticking scone mixture from a fan of fingers is experiencing something therapeutic. The reality of doing all this cooking and the thinking and preparation that goes with it is sometimes daunting. When the day has started with an enormous explosion from him about the colour of his socks, or a point blank refusal to get up or wash or dress or have breakfast, and the child's internal world is chaotically hitting the surface, just about the last thing on your list is to cook a meal for maybe 16 people! But the nature of this routine and of this personal provision can be very restorative. Still hung over from the fury of his dreadful feelings with which he awoke, the child may not be ready to properly face the day. So to sit near you as you potter about the kitchen whilst he gradually thaws out and warms up can be the answer. He can be reassured that, however awful he has been so far today, you are still going to feed him and think of him and want him around and perhaps, if he could, it would be so helpful if someone could stir the custard. Slowly a sense of self-esteem can return. In this way the smell and warmth and central heart-like activity of the kitchen can help to repair an inner sense of loss or despair, and importantly makes a home feel like "home".

Food and Delinquency

We have found that food plays an important part in the treatment of an emotionally deprived child who has turned to delinquency as the main source of excitement in his life. Our hypothesis is that delinquent excitement is frequently a displacement from frustrated, infantile greed.

Imagine a baby getting desperately excited waiting for mother to feed him, and mother not coming at the right time and the baby getting more and more excited. By the time she did come the baby would be hungry but the excitement and wonderful greed would have become split off from the food, where it belonged. If this happened often, such a baby would lose the excitement connected with food. Delinquency can be a way of dealing with this excitement. The therapeutic task is to link excitement with food where it originally belonged, instead of delinquent activity.

Gavin: A Case Study

Gavin, for example, was born towards the end of 1970, weighing 8lbs. It was an uncomplicated pregnancy and birth for both mother and baby. As an infant he fed well, starting on solids after a few weeks. At 2 months he was referred to the GP for failure to gain weight – he was then 6 ½ lbs. On examination he was staring and hungry with a dry mouth. The doctor diagnosed marasmus (emaciation through starvation) and associated management problems and Gavin was admitted to hospital. There he gained weight rapidly and presented no other problems. A parental management problem was diagnosed.

At 18 months Gavin was again referred to the GP for failure to gain weight and, despite close supervision from the health visitor and GP, it was decided to readmit Gavin to hospital. The hospital felt that he was simply not being fed and was in a starved condition. Again he gained weight rapidly but was discharged by the parents against medical advice. The hospital summarised Gavin's condition as not being fed, probably neglected and largely rejected by his mother.

A third admission to hospital was made when Gavin was nearly 3 years old. He weighed only 20 ½ lbs and was quite passive. He rapidly became more active during his stay, putting on 3lbs in 3 days.

When he was 3 years old he was placed "in care" with foster parents where he improved in all areas, beginning to walk successfully and to play well. He was described as a strong personality with a temper when frustrated. On leaving this placement for adoption the foster parents thought him lively and attractive and were amazed at his lack of disturbance considering his years of deprivation. Inevitably, this emerged later. Gavin was adopted by Mr and Mrs D who had already successfully adopted another child. Gavin continued to make rapid progress, catching up with all his milestones by the time he was five.

At school he presented as a bright but lonely boy. The first real problems came when he was about 10 years old when he was found to be stealing dinner money from other boys. There then followed a period of three or four years delinquent activity, which became increasingly sophisticated, this particularly included theft and shoplifting. He always seemed to be quite surprised at being caught and couldn't think why his behaviour troubled others around him. His only explanation was that he was a "bad boy".

In the middle of 1984 Gavin was placed in care and, after a period of assessment, was referred to the Cotswold Community. Although he settled into the Community fairly well he was virtually unable to trust any of the grown-ups for some considerable time, even over small matters. Smoking was a particular problem for Gavin. He said that he had smoked regularly since he was 7 years old and he continued to go to great lengths to do so in the Community. Whenever he obtained cigarettes or tobacco he would divide it up into little caches that would then be hidden around the estate for later use. He would often wake late at night and go off to get these.

Gavin was provided with a variety of foods and sweets over a period of time to try and help him with the need to smoke but, although these helped to some degree, he said that they were not enough. Investigation and study of his smoking habits made it clear that he was not addicted to nicotine but rather to the oral sensation of smoking. This has obvious connections to his earlier deprivation. It was a way in which he could satisfy a deep seated need himself, thereby not having to risk being let down again by being dependent on someone else to provide for his needs.

Gavin continued to wake at night and found it difficult to fall back to sleep. He often got up and made his way out of the house to a hidden supply of cigarettes. If none existed he would make his way

down to the village pub (some two miles away) and scavenge the dustbins for “dog ends”. At times this journey was made in no more than his pyjamas and a pair of Wellingtons. The path of this journey usually took him past the grown-up who was sleeping in the household, but Gavin had so little trust that he could not bring himself to wake the person to ask for support.

Gavin always felt disgusted by his actions in the cold light of day. He could talk about them to some extent but had no understanding as to why he behaved as he did on these occasions. This night-time disturbance seemed split-off from his day-to-day functioning, which was highly creative e.g. composing classical music and inventing computer programmes. The turning point came one night when he was attempting to get into the kitchen to light a cigarette from the Aga. He was crawling on the floor, past Paul who was “sleeping-in”. Paul was Gavin’s teacher and had increasingly become an important figure in his life. Paul woke to find him there, at first mistaking Gavin’s white socks for the household cat. When he enquired what he was doing, Gavin remained silent for a while – perhaps in the hope that Paul would settle for the cat theory. After Paul enquired again Gavin explained about the cigarette. Paul got up and they went into the kitchen where Paul made them both a drink. For a while Gavin sat in despair. He then began to wonder aloud whey he did it. He wondered about the connection with his early life and adoption and said he knew that when he was little he had not had enough to eat. He asked Paul if he knew anything about his early life. Paul told him what he knew about the periods in hospital and why this had been necessary but that we didn’t know why his mother was not able to look after him properly at that time. Although Gavin dealt with all this in an intellectual way (as a boy with near superior intelligence, this was his chief means of defence) for the first time he was able to cry with Paul. He shortly went to bed and slept soundly.

In trying to make sense of Gavin’s waking and use of cigarettes it occurred to Paul that one aspect of his deprived early life may have been to do with the night feed. Gavin, like all babies, may have woken for a feed that never came, for comfort that never came; maybe his night-time cries were unheeded and unanswered, lost in the blackness of his room. No one came. Maybe eventually in exhaustion, he would fall asleep as he may not have had the means to comfort himself.

Following this line of thought it became clear to Paul that Gavin needed to be given a night feed. Paul decided that Gavin needed to be put to bed with the usual drinks and sweets (to help with his smoking problem) and encouraged to sleep. Then he needed to be woken later in the night, 2.00 am seemed a good time, with something to eat. But what? Gavin had a passion for chicken, so it was decided to give him a piece of roast chicken every night at 2.00 am. Thank goodness for cookers with automatic timers! Once all was prepared this was put to Gavin as something that was going to happen. He thought Paul had gone completely mad and laughed at the very idea of it. However, he accepted the chicken. He proved enormously difficult to wake up most nights; often he would eat one or two mouthfuls and leave the rest and sometimes eat none at all. However, if the chicken was either over or under-cooked or for some reason the person sleeping failed to wake up, Gavin would be furious. This was a good sign that the adaptation was important and that the process had symbolic significance, more important than the chicken itself (Dockar Drysdale, 1968).

This went on for a few months, sometimes with the chicken uneaten and seemingly wasted. One day Gavin said to Paul that he no longer wanted the chicken. He then proceeded to describe how he would like some Weetabix with hot milk and sugar. He told Paul exactly how it was to be prepared: two together in the bowl with sugar and milk put on them, followed by the third Weetabix laid across the other two with more sugar and milk. In this way they produced a rounded mound full of sweet milk! He ate this for a few weeks, still at 2.00 am. He then said to Paul that he no longer wanted the Weetabix but that he still wanted someone to get up and come and see that he was alright, but not

to wake him – just to check he was OK. After this he began sleeping better and the need for nocturnal expeditions decreased dramatically.

We felt that this episode in Gavin's treatment was crucial for his future mental health. The nightly feed helped to convert the delinquent excitement into oral greed. If this had not been achieved he would undoubtedly have reverted to nocturnal stealing as a form of self-provision. He also achieved a greater sense of trust as a result of the commitment displayed by grown-ups willing to get up in the night to meet his need.

Gavin has now made a successful transition away from the Community. He decided not to return to his adoptive family on a full-time basis and is living in "digs" while he trains as a computer programmer.

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