Therapeutic Child Care

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Introduction

This paper is about therapeutic child care. My understanding of what this means was acquired during my 27 years at the Cotswold Community. I was privileged to work with two excellent Consultant Psychotherapists: Barbara Dockar-Drysdale for 18 years and Paul Van Heeswyk for 9 years. I learnt a huge amount about management and the creation of an appropriate staff culture from Richard Balbernie, Isabel Menzies Lyth and Dr Eric Miller. My practice was supported and developed as a result of understanding and discussing the work of D W Winnicott with Mrs Drysdale and others. I also drew on the work of Bettelheim, Redl and Wineman and many others.

Throughout this paper I will be referring to therapeutic communities. See Appendix 1 (below) for a definition by David Kennard, which I find particularly useful.

I will also be constantly referring to emotionally unintegrated children. It is not within the scope of this paper to cover all the causal factors and all the elements which will lead to recovery. See Appendix 2 (below) for an overview of these matters.

What Is Therapeutic Child Care?

Barbara Dockar-Drysdale, in a paper entitled "*The Difference Between Child Care and Therapeutic Management*", points out that it is possible to look after children very well without being emotionally involved, and in fact says that such involvement is often criticised. However, she did not believe that therapeutic management could be achieved without considerable involvement. It is necessary for the grown-up to be able to feel one's way into the child's shoes. Bruno Bettelheim said that even the most disturbed behaviour has a certain logic if you

can see it from the child's perspective. She goes on to say that the differences between child care and therapeutic involvement are best seen by comparing the two kinds of work within the framework of everyday life. For example, child care workers know a lot about food and just what children need to keep them well; therapeutic workers in residential work, while aiming to provide a balanced diet, are tuned in to the emotional needs of the child where food is under consideration.

Emotionally unintegrated children find sharing incredibly difficult. At mealtimes, this could become a large anxiety, i.e. will there be enough? This anxiety can be exacerbated in institutions as a result of food cooked in large quantities, especially if a pie or cake has to be divided into many portions. The anxiety can be helped if children have individual pies or cakes, one which is entirely their own. The meal is thought about from the perspective of the emotionally disturbed child which is the essence of therapeutic child care.

In his paper "*Residential Care As Therapy*", Winnicott describes certain key features that are essential for residential care to be therapeutic.

1. Reliability

When residential work is therapeutic, the children live in the private lives of the workers. For me this means that the residential workers don't just switch off when they are not working. There is a degree of emotional involvement. Reliability is important because most of the children who we work with have been brought up in an environment which was chaotic, either generally or at a particular time, or both. The chaotic environment for the child means unpredictability. Unpredictability means that the child must always expect trauma and the central area of the personality, what Winnicott calls the true self, must be hidden away where nothing can do it either good or bad. The tantalising environment produces mental confusion and the child may develop along the lines of always being confused and never organised. We describe these children as restless, with no power of concentration and they do not persevere. Actually they will spend their lives hiding something which could be called a true self. Nothing will feel real to the child or essentially important or truly a manifestation of the self. Such children may find a solution in compliance, with violence always latent, sometimes manifest. Behind the acute mental confusion lies the memory of unthinkable anxiety when, at least once, the central core of the self, the true self, was found and wounded. Such anxiety is physical and is intolerable to the individual. This

can lead to such children having panic rages and they may need to be physically held through this.

It is essential that we know and realise that the children who carry the memory of something like this around with them are not the same as children who, because they were well cared for in the beginning, do not have this hidden threat always to be reckoned with. In residential care, reliability can, over a long period of time, undo quite a severe sense of unpredictability and a great deal of the therapy of residential care can be understood in these terms.

2. Holding

By this we mean both the physical and emotional holding as seen most clearly during infancy, by the parents and then gradually the wider extended family. If residential care needs to provide holding of this very early kind, then the task is extremely difficult. Residential care as therapy lies in the fact that the child re-discovers, in the children's home or foster family, a good enough holding situation which got lost or broken up at a certain stage. When the child begins to feel hopeful, the symptoms include stealing and violence and claims on time and attention, that would be unreasonable to meet, except in terms of the recovery of that which is lost, which is usually the claim of the very small child on the parents. In this context, whenever we hear the term attention-seeking behaviour, as if it is consciously manipulative, we should reframe it as attention-needing.

3. A Non Moralistic Attitude

The therapy done in a residential setting has nothing to do with a moralistic attitude. There is no linking of symptomatology with sin. The idea of evil does not have a place in therapy. Vindictiveness should have no place whatever in child care and residential work. Grown-ups should recognise they are merely further along the continuum of emotional development than children, but far from perfect specimens. We also have a lot to learn.

4. No Gratitude

In therapy you are not expecting gratitude. Any parent who expects a baby to be grateful is looking for something false. Children find that a thank you is a part of compliance and puts people in a good temper. In making use of the therapy we provide, they are going to be a nuisance and wear us out. That is the essential

nature of therapeutic work. There is no easy path. This can be one of the hardest things for new staff members to cope with. Our best efforts can be rubbished. Make the most of occasional acts of reparation, eg, a cup of tea.

5. Nuisance Value

It is very much a part of the therapy of our work that when children do well they discover themselves and they become a nuisance. They go through phases in which violence and stealing are the manifestations of hope. In the case of almost every child receiving therapy in a residential care setting, there must be a phase in which the child becomes a candidate for the role of scapegoat. "If only that child could be got rid of we would be alright". This is the critical time. "At such time", Winnicott tells us, "Your job is not to cure the symptoms or to preach morality or to offer bribes. Your job is to survive." In this setting, the word survive means not only that you live through it and that you manage not to get damaged, but also that you are not provoked into vindictiveness. If you survive, then and then only, you may find yourself used in a quite natural way. You might even occasionally hear the word "thank you", but you will have certainly earned it because you have been trying to do something that should have been done when the child was at an early stage of development and has been lost through untoward breaks in the continuity of the child's own home life. You must have a proportion of failures and this again is something you have to survive in order to enjoy the occasional success. From my point of view, residential care can be a very deliberate act of therapy done by professionals in a professional setting.

The Development Of The Capacity For Relationships

Therapeutic child care must encourage the capacity to make relationships. We know that the capacity to develop lasting and meaningful relationships develops in accordance with the opportunity of the child, especially the very young child, to form secure attachments. The good ordinary family gives an excellent opportunity where the young child is likely to form a focal, intense attachment. He forms other important, although less intense, attachments with others in the family and gradually his attachment circle extends, as he grows older. Moreover the people in his circle of attachment also have attachments to each other which are important to him for identification. He not only loves his mother as he experiences her, but identifies with his father loving his mother and extends his concept of the male loving the female. For the most part institutions have dismally failed to replicate that pattern. This was certainly true of larger institutions in which all staff indiscriminately care for all children, and prevented child/adult attachment.

A small unit with firm boundaries comes closer to the family model. In a small, group setting, it is possible to provide something nearer to a focal carer by assigning children to a single staff member for special care and attention. For example, the importance of bed time for deprived children, of outings like dental and medical visits, playing together, working with distress and problems, having a special relationship with a child and his family together, if he is still in contact with his family. Add to this the staff developing psychoanalytic insight, and even severely emotionally damaged children can start to recover.

The small group gives a good setting for the adults to form meaningful relationships with each other. This not only again provides good models of attachment behaviour, but also facilitates a child being re-assigned to another staff member when necessary. The work is not only more rewarding but will also be more stressful. In the large institution, multiple, indiscriminate care taking can be seen as a defence for the staff against making meaningful contact with any one child and his family, a contact which frees the child's expressiveness and makes the carer more fully in touch with his distress and problems, as well as his joys. This links in with Winnicott's view that as a disturbed child feels hope, he must become a nuisance to his main attachment figure.

Bion has described the importance for the infant's development of his mother's capacity for reverie – that is how she takes in his communications, contains, and ponders over them intuitively, but not necessarily consciously, and responds to them in a meaningful way. It is particularly important in relation to fear and distress, that the mother can take in his projections and return them to the infant in a more realistic and tolerable version. The function of reverie is also important for staff in children's homes. It can be reverie in the individual staff member, or it can be something analogous to reverie in group situations, staff talking things through in an intuitive way together. The communications on which staff must work are often massive and very disturbing and staff in turn need support. Like the ordinary devoted mother, they need themselves to be contained in a system of meaningful attachments if they are to contain the children effectively. They need firmly bounded situations in which to work and they need the support of being able to talk things through in quieter circumstances, away from the core of the children's distress and problems. I think it is vitally important that the staff, as a group, have an external consultant who can help facilitate and contain this process.

Staff Selection & Support

When people applied to work at the Cotswold Community they were invited to visit and stay for several days. The danger was that they would be seduced by the pleasant environment, by the philosophy, by the niceness of the children towards them, and by their own idealised image of a community which could fill something that was missing in their lives. I had to try to get across that the most difficult thing about the work is not coping with the behaviour problems of the children, but their feelings which would surface through doing the work. People who see themselves as basically calm, caring and sensitive, will be shocked by their own anger and hatred. Caring for a sexually abused child can feel hazardous. The child's expectation and previous experience that caring has been sexualised may resonate with the sexuality of the carer, in a complex transference and counter transference dynamic. Damaged and abused children are experts at pressing the buttons in grown-ups. They have had to, to survive. I said to potential workers that whatever you think you have got over from your past, or worked through or put behind you, it would inevitably surface as a result of doing the work. Not the least of which was facing up to the basic assumptions of one's own upbringing, which one has internalised. In the residential group living context, this will be challenged. If the challenge can be accepted, then it can be a tremendous learning experience and enable a good deal of personal growth and self awareness for the grown-up.

I heard Barbara Dockar-Drysdale say that being involved with therapeutic child care was like having a full analysis. In the sense that I have described, this is true, but this is all the more reason for supplying the support and consultation to help the grown-ups cope with this.

Therapeutic Culture

When I first started working at a therapeutic community, I thought I was quite experienced in residential work. I had done all of 3 years in a probation hostel which was not at all psychodynamic, although I had been on a few courses at the Tavistock Clinic. I was confronted by the culture of a treatment environment, which I gradually embraced, but initially really threw me. I will give you some examples of the thinking of a treatment culture which are not common sense, and which are not usually practised nor particularly valued in our society.

1. Depression can be a good thing.
   We are working with children who live in a permanent state of excitement, fending off painful, difficult thoughts. It is going to be helpful for them to begin to

feel sad and depressed. That was new to me and I think it is common currency in our society that if anybody is depressed, they have got to be jollied out it.

2. **Fairness is not about everybody having the same thing, but each according to his needs.**
   In the therapeutic community it was common for each child to have a special thing or adaptation. We would hear occasionally, "*Johnny is getting so and so. I want that*". What we were trying to achieve was a culture whereby it was possible to say, "*Well, that is right for Johnny at this point in time and you will get to have something that is right for you in due course*".
3. **The importance of being the bad object or carrying the negative transference.**
   I had come from a hostel where, in the staff group, if anybody was working a shift and had had a bad time from the clients, the other staff would say, "*I don't know what he is doing wrong. It's alright when we work*", or "*I don't have a problem with this child. I can manage him perfectly. He is fine for me. What is your problem? You don't seem to be able to handle him*" The staff team needs to understand that children will relate to staff members differently and that coping with the hatred that a child invests in you at a particular time is important. In a sense, the team ought to celebrate that you are doing it on their behalf and support you, rather than being in any way critical, implying that you may not know what you are doing and that is why you are getting a bad time.
4. **Stealing is a sign of hope.**
   Hope stems from the need in the young person to look for something through the process of stealing and it is a good sign that he wants to take something from the environment, rather than feeling hopeless. He has identified a need. He is hopeful. Much more worrying is someone who has completely given up and is passive. It is something to work with and I think Winnicott helped us to see "*delinquency as a sign of hope*".
5. **Greed is important and should be respected.**
   Particularly for very deprived and disturbed children to experience feeling greed for a special food can be a stage in getting well. Finding excitement about something that is legitimate rather than anti-social behaviour, which is delinquent excitement.
6. **The concept of the delinquent contract or, "*I will scratch your back if you scratch mine*".**
   One of the delinquent contracts I first faced when I arrived at the Cotswold Community, it was still pretty primitive in those days, was in the house unit we lived and worked in. I suddenly realised that the way the chairs were arranged to watch television was quite extraordinary. It was not a particularly big room and the television was in the corner and there were concentric circles of chairs. But, the front chairs were never filled until certain people came in the room. Or, if

someone else was in them and a particular person came in the room, the other person would get off the chair. I immediately felt in my gut, "*hold on this is not OK*", but then as soon as I had the thought I also had the fear that went, "*how on earth do I tackle this?*" The boys who were getting the others to get out of the chairs had considerable power in the group. Confronting this in the group situation and bringing it out into the open created an enormous rumpus with considerable fury. However, I knew that I had interrupted something important. I had broken the delinquent contract. I still find this a useful concept. I still find many examples of the delinquent contract and not just with children. This links to the important factor in psychodynamic work of using your own feelings as a barometer, not only of how you are feeling, but also what is going on for others, what you are picking up from others.

7. A good day is not a quiet day.
   I had been used to thinking that a good day in the hostel was a quiet day. In a therapeutic community this would mean that the problems had gone underground. We don't want flat calm or things boiling over, but rather gently simmering.

How Do Residential Communities Stay Alive?

I think that one of the very difficult tasks is to learn how to keep and renew the spirit of pioneering work in therapeutic communities. If therapeutic communities rely on charismatic leaders for their existence and drive forward then they are doomed to whither and die with the departure of the original founder leader. Not only that, we know from some of the abuse enquiries that charismatic leaders are somewhat suspect for demanding collusive loyalty, eg, Frank Beck.

Another form of death is for the work to become routinised. In the early days of a new therapeutic community, there can be a tremendous buzz of excitement over the shared goal and vision, a strong 'we' feeling. Often this is at the expense of relationships with the wider world. It is very seductive for a therapeutic community to feel in its early days that we are essentially good, have all the answers, if only the rest of society would catch up. From the outside, therapeutic communities can seem mysterious, inward looking places. Hence the description by Spencer Millam of the Dartington Social Research Unit, &*Therapeutic Communities are places notable for the permanent sound of tinkling glass at the end of long drives*".

Perhaps in the early days of a therapeutic community it is inevitable, and may be essential, to have the split between what is basically good inside, and the bad

outside. However, it is also important to realise this is a quick fix to a 'we' feeling and will not be sustainable. To sustain this the charismatic leader would have to deliver inspirational leadership continuously. Perhaps only the added ingredient of religion might enable this form of leadership to be long lasting.

After something in the region of 4 or 5 years, a therapeutic community will have to deal with the problem of that original missionary zeal beginning to fade. New staff members arrive who are not part of the first days. They will find things established, routines, norms, expectations. This may not be written down, but they will be there. The real test is how to maintain good staff morale as the gloss wears off and the real grimness of the work begins to surface.

At one stage in the history of the Cotswold Community, when we felt the therapeutic culture under threat, Mrs Drysdale and a small group of staff and children tried to define the essential therapeutic principles, by which we tried to live. It was a very positive thing to do but continuously had to be re-worked in order that following generations could own it. (Appendix 3).

To overcome this staleness, the answer is not to find another charismatic leader, which again is the quick fix solution, like a football club changing the manager after a few bad results. I believe the answer lies in keeping the spirit of enquiry alive. The opposite of this is to adopt the attitude that we know what needs to be done, it is just a question of finding minions to put it into practice.

I think therapeutic communities have learnt to work with children who, 20 to 30 years ago, might well have been thought to be too disturbed to be admitted. I hope that the frontiers of knowledge are continuously pushed back so that we can say something similar in 20 years time.

To keep the spirit of enquiry alive, I believe a therapeutic community needs two things.

1. External advisors – consultants – who can monitor, appraise and clinically supervise the work of the therapeutic community. They must not be seduced by the 'we' feeling. They must be a constant source of irritation to their quest to help the therapeutic community stay on task. Residential units provide a rich breeding ground for bad practice being redefined as good practice, by this inward looking 'we' group. Consultants need to see this and challenge it.

2. **An organisational and management framework** that supports the therapeutic task.

The Cotswold Community had to go through a revolution from being a punitive, hierarchical approved school to become a therapeutic community and this took so much more than simply implanting a different philosophy. The whole management structure and organisation had to change to support the therapeutic task. The previous structure would have prevented it. From day one, the Cotswold Community had consultant help from the Tavistock Institute and this helped to change a top-down organisation into a bottom-up one. Staff working directly with the children were now able to be much more effective because they were encouraged to take authority. They had clearly defined responsibilities and could take decisions accordingly, including control of budgets. Adults in the previous regime presented poor, ineffective role models to the boys.

Groups & Structure

One of the most difficult phenomena to work with in group living, with very disturbed children, are group mergers. Emotionally unintegrated children with very undeveloped personal boundaries are especially prone to merger. We think this is because during their babyhood, when they would be emotionally merged with their mother this was traumatically interrupted, rather than the natural and gradual separating out which normally occurs, when the baby is 12-18 months old. When the disturbed child is particularly anxious and fearful he will seek out this merged state. With the children we work with, this is used as a defence against experiencing painful feelings, especially when seeking merger with each other. The mergers we see are often very wild, driven by the search for delinquent excitement. A merged group contains no individuals one can relate to. It is a blob, a mini mob, capable of doing extreme things which the individuals by themselves probably would not do. A merged group is a frightening phenomenon capable of physically attacking someone or doing considerable damage. The only way that I know of preventing a merged group from spiralling out of control, is to have enough adults to take children away from the group until they can calm down and find their own sense of separateness. The alternative strategy is to stand back and allow the merge to burn itself out. This is risky, because mergers have considerable energy, can last a long time and be very destructive towards people and property around them. I find it interesting that in England the Government's guidance on permissible forms of control in childrens homes avoids the problem of groups that become out of control. Their advice is based on an assumption that problems of control occur only in one to one situations. I find this astounding, considering that

residential workers are most often likely to behave inappropriately, as a result of feeling frightened in the face of a chaotic and out of authority group.

The following is a quote from Julia Mikado, a Child Psychotherapist who once worked at the Cotswold Community.

> "In practice the collectively low level of ego functioning in the group meant that I, and other staff members, spent many days and nights attempting to bring boys down from the roof where they had retreated from 'unthinkable anxiety' (Winnicott) in a state of raucous delinquent merger. So, I suppose my first hard won lesson was that you cannot do therapy until you have management boundaries and containment."

When a group is working well together it can be a very positive influence in therapeutic terms. However, the converse is true and I have seen some excellent individual work with children completely undone by being in a very negative, anti-therapy group. One of the attractions for me in moving from the work of a therapeutic community to an organisation that has children placed in much smaller situations, that is in a foster care environment, is that it breaks up the larger group dynamics. I think the problem of the negative influence of the group explains why there has been a downward pressure on the sizes of groups in residential care. This is in marked contrast to the people that I heard, when I started out in my career, boast that they could control 120 boys having a meal together in the dining room of the Approved School. Surely that kind of remote control could only be achieved through fear.

A disturbed, chaotic child needs to be in an ordered, integrated environment to hold all the various bits of him together. In a therapeutic community it is possible for a child to be looked after, to play, to go to school, all in one environment. If there is a problem in one part of his life, everybody knows straight away. For example, if he has had a difficult afternoon in school, the adults who work with him in the evening will know about this and they can continue to work with him on the problem. This is not usually the case in our society where it is possible for a child to have a problem at school for weeks before the parents get to hear about it and vice versa. Disturbed children do not find this containing enough and they exploit it, creating splits between the different groups of adults in their life. A child in a therapeutic community cannot get away with working these splits for long and this is difficult for him or her, confronting him with his problems.

If a person has not developed the capacity to distinguish properly what is inside himself and what is outside, and to control the boundary between them, then he needs to be somewhere where there are clearly defined and simple boundaries in the external environment. The less developed are the former, then the stronger, more clearly defined and less complex must be the latter. In working with disturbed people, there has always to be clear definition with regard to individual's groups and systems, and their boundaries.

In some respects, the therapy is the order of the community and the ego functioning and behaviour of the staff. I think Winnicott is agreeing with this point when he said "*In a sense, all communities are therapeutic in so far as they work. Children have nothing to gain from living in a chaotic group and sooner or later, if there is no strong management a dictator arises among the children.*"

Communication & Play

Time and again we come back to the importance of communication. Emotionally disturbed children need to be helped to communicate how they are feeling. Failure to do this will inevitably lead to the acting out of these feelings in anti-social and violent behaviour. It is important that these children are offered non-verbal models of communication because their ability to put feelings into words is inhibited and some of the unconscious feelings belong to a pre-verbal era in their lives.

The profound benefits of play can be seen most clearly in the lives of those whose capacity to play has been suppressed or distorted as a result of trauma or deprivation. In such cases, play itself can be an extremely effective method of healing, for play, like dreams, serve the function of self revaluation and of communication at a deep level. This is a central premise behind play therapy. Using play as both a vehicle and a cure for psychological distress, Play Therapists aim to break the destructive circularity of that distress. At the Cotswold Community, play was highly valued. One of the central tenets was that play is a vital ingredient in wellbeing. Playing was an essential part of the emotional work that the boys had to do, and this was reflected in the daily timetable, which gives as much to play as to school work. Sadly the pressures of the national curriculum have eroded this.

However, many of the boys were unable to play, or rather their play was as disturbed as they were. Mock fighting often escalated into real fighting;

competitive games could quickly become unbearably stressful; even relatively gentle fantasy play with toys could feel quite threatening to these children, whose own lives had provided so little of the safety and stability that are the necessary pre-conditions for play.

In the Community's highly supportive environment, the boys were given the opportunity to discover a way of playing that was not destructive either for themselves or others. This process of self discovery through play is extremely powerful. The boys were able to regress to the age at which they 'lost themselves' and, as it were, start again. A 13 year old may retreat to the age of a 3 or 4 year old, in which he clings to his teddy bear and uses it to communicate to the world. There is nothing unusual in asking a toddler what teddy would like for tea, but addressing a 13 year old in this way is a poignant reminder of the necessity of childhood play, as necessary to our future wellbeing as learning to walk or talk.

Peter came to the Community when he was 10. He seldom spoke and seemed locked away inside his head from where he viewed the world with unconcealed mistrust and fear. The only clue he gave to his inner state were the pictures that he was constantly drawing. There were several striking features about these pictures; they were always of a town encircled by high thick walls drawn in heavy grey or black crayon; inside the town there were a few buildings dotted about but there were no streets or paths to connect them. On the outside of the wall, a few wiggly roads led to the perimeter of the town but not further, for there were never any gates in Peter's drawings, either into or out of the town.

For a long time Peter's pictures, or maps as he called them, remained unchanged. But very gradually they began to acquire new features. More streets and pathways appeared inside the town, connecting up the different buildings; more roads appeared outside the town too, so that there were now several approach routes; a small gateway appeared on the south side of the town although no roads, as yet, led directly to or from it.

The therapist working with Peter let him discuss the design and detail of his maps without making an attempt to connect them to his psychological state. The turning point came one evening when the therapist came across a bundle of papers tied up in a plastic bag and dumped in the outside dustbin. The bundle turned out to be Peter's latest maps, hurriedly rejected for what they might reveal. And indeed they were revealing. He had drawn a town that resembled the maps of medieval London, bustling and beaming with life and laced with a thick network of roads.

And, most startling of all at the four compass points there were now four gateways permitting access to and from the town. Peter himself recognised this as a turning point, hence his frightened reaction to this brave new role he had discovered. Nevertheless, it signalled the start of his recovery from his psychic wounds and his gradual return to the world.

Symbolic communication is extremely important in therapeutic work with emotionally disturbed children. It is often associated with a child being in a regressed state, that is, being younger than his actual years. The following is an example of symbolic communication between a boy and his focal carer, Steve.

"I first met Jo when he was a small, slight boy, 10 years old, full of fun, very lively and could be experienced by people as a much younger child. He used to spend a good deal of time walking around holding my hand or being carried on my back.

From somewhere he developed an interest in dolphins and whales and, in particular, the killer whale.

At Christmas I gave Jo a cuddly killer whale. He quickly began to take the whale every where with him and it took on a position of great importance for him. This "teddy& was called "Whale" and at times of great distress for Jo, I was able to talk to Whale who could tell me how Jo was feeling, (Jo would use a special voice for Whale when he was talking to me). Whale started to fall ill as my time off approached and on my return would be at death's door and it would take a good deal of care and time to enable Whale to recover. This pattern would repeat itself every time I had time off.

In discussion with Mrs Dockar-Drysdale, our Consultant Psychotherapist, we devised a way of enabling Whale, and hence Jo, to bridge the space of my time away. When I was away Whale stopped eating, so I suggested to Jo that I left a sugar shrimp (a candy in the shape of a shrimp), so that Whale would not go hungry when I was away. This seemed to make the space more bearable and Whale thrived.

One day Jo told me that Whale's name was Winnie, not only had he named Whale but he had also sexed it, Whale, or rather Winnie, was a female. The routine with the shrimp continued and Winnie used to swim happily in the sea while I was away.

One night when I was putting Jo to bed he told me that Winnie was not feeling very well, this confused me as my time off was not due. I asked Jo what was wrong with Winnie and he told me that he could not tell me but that Winnie would whisper it to me. Winnie whispered that she was pregnant. Jo told me that Winnie would need a lot of looking after and that she would let us know when the baby was due. In discussion with Mrs Drysdale, we decided that the lead of Jo and Winnie would need to be followed and that if the outcome was that the pregnancy ran its full term then I would need to produce a baby whale.

The pregnancy lasted a number of weeks and as fortune would have it, I found a baby killer whale one day when out shopping. I had to have the baby whale close at hand at all times in readiness for the birth. Winnie had similar stresses and pains to those that most pregnant women have, morning sickness being particularly evident.

The day of the birth arrived, Jo sent me for hot water and towels as Winnie went into labour, as I returned Jo told me that Winnie needed covering with a towel, which I did, and that her brow needed mopping. When the baby cry started that was my cue to bring the baby whale from beneath the towel. Mother and baby were fine and went for a swim in the sea. Father was never on the scene and was always away swimming in afar off sea. Jo told me that Winnie was only going to have one baby, which was of great significance, as Jo was a twin.

Through this birth we were able to do a great deal of work around the issues of mothers, fathers and Jo's twinship, as well as the difficulties involved in looking after a baby."

The Therapeutic Importance of Food

I will be presenting some clinical material to demonstrate the above assertion. The first example comes from Peper Harow Therapeutic Community and the second concerns the therapeutic care of an individual boy at the Cotswold Community.

The following is an extract from Melvyn Rose's "*Healing Hurt Minds*" (Tavistock/Routledge).

Food

One night the food store behind the kitchen was broken into. No-one admitted to this in the morning meeting. The locks were increased, but the door was broken down nightly; it was lined with steel, but was then totally removed – frame and all – from the wall itself. We then experienced one momentous Community Meeting. Someone hesitantly said that when he burgled houses he always cooked himself a meal. Apparently this was a common activity. He spoke of having wrecked the kitchen, excreted on the carpet. Yet, after a couple of meetings of hysterically recounting such exploits, the group began to sober up. They began to view their behaviour more realistically as bizarre and puzzling. The discussion moved forward. Boys began to talk of their own homes, of material hardship, of depressed mothers who did not cook, with stories of being packed off to buy chips, and then for the first time some expression of their sense of depression about the lack of comfort or standard of care implied by those poor feeding situations so many had experienced. This discussion could perhaps have been developed further than it was, after all, such depriving experiences can influence youngsters for the rest of their lives. The extent of their internal anxiety as to whether they could survive such a denying mother might thus have become more manifest; the relationship of this underlying anxiety to their compulsions to steal, their extreme aggression, their hatred of women, could have been verbalised, and therapeutically some long overdue experience of grief made more certain, because in the group the individuals could carry each other along. But even a group needs enough maturity to be able to tolerate painful insight. How could it obtain that pre-requisite skill? Fortunately, our experienced psychiatrist was able intuitively to suggest the answer. She proposed that we should set a table up at one end of the dining room. It would have bread and butter, jam, tea and milk, and sugar. It would have an electric kettle and mugs, and it would be available day and night. In exchange, it was agreed that the food store would be locked at night and it was not broken into again, not for several years. (Rose, 1987: 149-62).

If, at this point when the boys had described their crazy behaviour, the psychiatrist had made various comments about the parallels between stealing from the food store and stealing from a withholding mother, only more rage would have ensued. Instead, a practical response was made to their implied cry for nurture by the most senior woman present that indicated they could change their delinquent and disturbed behaviour, and also take some responsibility for receiving good food.

The boy's behavioural message had – at it's simplest – told us that they felt desperately deprived and also enraged. When they became able to verbalise and to consider the source of those feelings in the community meeting, they were undoubtedly heard with sympathy. However, the physical response of providing

actual food and drink in a particular place was, most importantly, a symbol. Everyone knew that the issue was not physical hunger but emotional hunger. A symbolic response therefore allowed the boys to accept it at the level of either their adolescent or their infant selves. The symbolic response illuminated the real issue but allowed the youngsters the emotional choice of receiving an insight on their own terms. Furthermore, because their behaviour had been accorded the respect of a real communication once the boys had begun to see more age-appropriate forms of expression, their relationship with the community as a whole began to change. They increasingly accepted that behaviour alone was no longer an appropriate language of communication. They no longer needed to break into the food store.

Food & Delinquency

At the Cotswold Community we 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 was 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 weighed 8lbs when he was born. It was an uncomplicated pregnancy and birth for both mother and baby. At 2 months he was referred to the GP for failure to gain weight – he was then 6.5 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 20.5 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 his 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 of 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".

Aged 14, 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 had obvious connections to his earlier deprivation. It was a way in which he could satisfy a deep seated need in 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 eg, 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 why 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.

Conclusion

I have tried to focus on what I think are the main ingredients of therapeutic child care. Unless all this links up, however, in an integrated environment, the emotionally disturbed child will fall through the gaps. I have drawn mainly from my experience in a residential therapeutic community. For the past year I have worked for ISP (Integrated Services Programme), a child care organisation which provides care in specially trained foster families, education in both mainstream schools and in our own school units, a range of therapies and a team of social workers who case manage each child, ensuring that the appropriate assessments occur and plans made accordingly. It is now clear to me that this integrated approach can be achieved in a non-residential environment. Received wisdom informs us that the most disturbed children need to go to therapeutic communities following numerous breakdowns in family placements. Since joining ISP, I have seen the reverse of this process, where children, who are unable to live in therapeutic group living environments, do well in a foster care placement with a bespoke package of education, therapy and social work. The child is relieved not to be living in a group of other very disturbed children where the contagion factor is high, and feels more contained in a therapeutic family placement.

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