

A Nutritional Model for Effecting Change in Behavior-Disordered and Severely Emotionally Disturbed Victims of Child Abuse: The Experiences of the Salem Children's Villages

Thomas C. Hartmann¹

For over twenty years in Europe, and for several years in the United States, Salem Children's Villages for abused and abandoned children have been using a nutritional approach as one primary facet of a multi-leveled program for modifying the behavior and personality deficits of emotionally disturbed children and adolescents. The programs have demonstrated considerable success in this area, being the subject of considerable media attention in Europe and the US over the years, and appear to offer a viable alternative to traditional models of caring for disturbed children; This report, while presenting a brief overview of worldwide programs, centers on the experiences of the New England Salem Children's Village in Rumney, New Hampshire.

Broadly speaking, the chief emphasis of Salem is to offer a deinstitutionalized context for children who had previously been residents of, or were headed for, group homes or psychiatric facilities. One component, much like Dr. Karl Menninger's "The Village," is a variety of individual "family"

The New England Salem Children's Trust settings in homes on the property of the Children's Village. Professional housepar-ents, relief parents, and other well-trained staff people provide care and services to the children, who, living in a family-like environment, can (often for the first time in their lives) witness an appropriate role-model for parenting and "normal" home life. The villages are rural, and outdoor activities are encouraged. There is no television; there are horses and other opportunities for self-image enhancing, structured recreation.

A primary therapeutic component is diet. All refined foods are eliminated, and replaced by homemade breads and grain products, and desserts lightly sweetened with molasses, honey, or fruit. All chemical additives, particularly salicylates, are removed. The diet is classified as natural-foods, lacto-ovo-vegetarian, and much of the food is grown locally. Natural salicylates, however, are not removed, and have not caused a problem for those youngsters who have an identifiable salicylate sensitivity. An interesting illustration is the case of 12-year-old Sally:

Sally had been removed from her natural parents at age three, because of severe abuse. A younger sibling had recently died of

'Executive Director & Founder

starvation, which, coupled with several reports of abuse, prompted the action by the state. She was hospitalized for a brief period of time, and then shuffled through a series of foster homes and institutions. Diagnosed as hyperactive and possibly retarded, she was placed on 40 mg Ritalin (10 mg Q.I.D.) daily and spent the past several years in an institution where the primary between-meals beverage snack was Kool Aid (a substance containing large quantities of chemicals suspected of being a causative factor in hyperkinesis). The Ritalin evidently stunted her growth — by age 12 she had not lost her baby teeth, and was unable to perform normal exercises. Diagnostic tests indicated gross motor deficits and a number of perceptual motor difficulties of "unknown etiology" which may also have been associated with infantile malnutrition.

Her behavior was uncontrollable without medication, and even then difficult. She was totally illiterate, and unable to run or swim. Salem was informed upon intake processing that she could not possibly be managed without Ritalin or other medication. The day she arrived, the Ritalin therapy was terminated. Within three months, many of the deficits of the previous six years were overcome. Her level of activity settled down to the norm for her age within the first week, although there were still obvious emotional difficulties. No hyperactivity was evident as long as the diet was controlled. Gross motor coordination has improved to the point where she is running and swimming competitively. Intellectual performance has also shown a dramatic improvement and she has grown five inches in six months. Without the dietary intervention of Salem, it is likely that this child would have remained institutionalized and medicated for the entirety of her adolescence. (It should be noted here that one of the more evident side-effects of Ritalin therapy is retardation of physical and intellectual development. This child's history demonstrates clearly the damage that may be being done to thousands of children because of the indiscriminate use of this drug, prior to or without investigation of nutritional options.)

In addition to sensitivity to exogenous dietary

factors of synthetic origin, Salem has also witnessed milk and sugar sensitivity in some children: 14-year old Johnathon had a history of drug abuse, violence, truancy, sexual acting-out from an early age, and severe learning disabilities. He was also the victim of recurring ear and throat infections, and seemed to constantly exhibit symptoms of non-specific upper-respiratory infection. After having devastated several foster homes, and being removed from one institution, he was placed at Salem. At age 14 he was totally illiterate, not knowing his alphabet, and seemed angry and defiant upon arrival. He had a lengthy history of severe abuse by his parents prior to his first foster placement at age 10.

Johnathon was coded as mildly retarded, with a variety of other "maybe" and "possibly" labels. He craved milk, and would easily drink a gallon a day. Very much like the adolescents that Alexander Schauss studied, his behavior changed radically for the better when placed on a low-milk (one to two glasses a day) and sugar-free diet. (Prior to placement his usual lunch was four or more candy bars and a quart of milk. Breakfast was sugary cereal and milk. Dinner was usually a McDonald's burger and milk, with milk throughout the day.)

In one year, Johnathon had advanced three grades in school, and has had no further trouble with the law. He has taken a leadership role with his foster siblings and encourages appropriate behavior on their part. He has had no further infections or catarrhal difficulties.

Both the New England and Maryland Salem Children's Villages have had success in treating children who were former residents of state-run psychiatric facilities. All the youth in Salem's experience who have come from these facilities have experienced medications as causative factors in a variety of neurological dysfunctions, most notably tardive dyskinesia, delusions and hallucinations (American Journal of Psychiatry, January 1980).

This causative action appears to be the result of phenothiazine inhibition of dopamine transmission, with the body responding by

growing new dopamine receptors in the neostriatum. The primary result of this over-compensation is tardive dyskinesia, which Salem has observed most clearly in one adolescent who was medicated with 1000 mg Thorazine daily, for approximately one year, in a state-run psychiatric facility. Certain nutritional deficiencies have also been implicated in the modification of neurochemical transmission, and reported by Hoffer, First, and others.

The Salem experience with juveniles exhibiting behaviors which are the result of suspected neurological and biochemical dysfunction, either by exogenous or endogenous mechanism, is that a six month to one year period of high-quality, natural foods containing levels of natural vitamins, minerals, enzymes and fiber higher than that of the Standard American Diet (SAD) is sufficient to largely correct these deficits in most cases.

Summary

The nutritional approach appears to be a viable option in treating the biological and psychiatric disorders (as much as they can be separated) of children and adolescents evidencing a variety of possible causative mechanisms. Simple physical problems such as excessive adipose tissue, chronic respiratory system infection, underweight, skin difficulties, dry, brittle hair, and excessive body odor, have all seen beneficial change or complete remission on the Salem diet.

More severe "psychological" disorders such as hyperkinesis, MBD, learning disabilities, "pre-psychotic" states, and "behavior disorders" have also all been amenable to dietary intervention.

It should be stated at this point that the unique and multi-faceted approach of the Salem program to the problems of emotionally disturbed and abused children presents problematic difficulties in ascertaining the true effectiveness, or extent of effectiveness, of any one individual component of the overall therapeutic milieu. To such an extent as is possible, non-dietary factors have been closely examined and separated out of the data presented in this paper. Certainly, however, a

consistent, nurturing, rural and carefully structured environment such as is provided by Salem generates an atmosphere wherein change is facilitated and, indeed, even accelerated. Many of these children, though, have been in professional and highly regarded institutions and quality, loving foster homes before their arrival at Salem. All had failed. The data certainly implicates nutritional factors as playing a leading role in the unusually rapid reconciliation of biological, biochemical, neurological and behavioral deficits resulting from child abuse, malnutrition, and extended amphetamine or phenothiazine therapy.

NOTE: To protect the anonymity of the children presented here, their names and some details not relevant to an investigation of their cases have been altered.

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Sidebar to Article About The Salem Children's Villages

The Salem Children's Villages were started in 1954 in West Germany by Gottfried Mueller, a former prisoner-of-war. There are three such villages in Germany now, with a total population well in excess of 200 children. Additionally, Salem Children's Villages have been started in other European countries and here in North America. In the United States, there are Salem Children's Villages operating in Maryland and New Hampshire, and one in its formative stages in Michigan.

All Salem Children's Villages around the world follow the same dietary program, and have similar living situations for their clients. These include individual family "homes" with foster parents and up to eight children. The food is prepared centrally to assure quality control, and distributed to the various homes so that the living units can eat together as a normal family.

Salem Children's Villages in the United States are a relatively new phenomenon. The Maryland program, set up currently for eight children, has been operating over three years, while the New England Children's Village with

a current population of 14 children — and expanding to 18 within the year — has been in operation for two years.

The success of the New England program (nearly every child they've taken in had been rejected by other institutions in the state, and, of 16 children in the past year, only two have failed to recover as a result of the Salem program and their dietary intervention) has brought about a veritable flood of refer-als from state and private agencies to the New England Salem Children's Village. For every child in placement at least five were turned away for lack of space. Because of this situation, the New England program is currently engaged in an ambitious building program . . . constructing three new children's houses on 137 acres of recently acquired forest land near the present facility. Plans are for a complete "Village" within the next three years, incorporating more children's houses, a grandparents' house, guest facilities, and extensive food production facilities. A free newsletter is available, documenting the progress of the New England program, and containing health information and recipes, and can be obtained by writing to: **The Salem News, P.O. Box 56J, Rumney, New Hampshire, 03266.**