Mental Disorders in Children – What are the Solutions?

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During the post-war history of Germany, the school as an institution has never been as frequently in the focus of the glaring spotlight of society as is the case today. It cannot be ignored that critical comments directed at schools are in the clear majority. Around 80,000 young people leave school every year in Germany without any form of secondary school qualification. The Cologne Institute for Economic Research [iW.KÖLN] recently estimated the follow-up costs of the flawed efficiency of the school system, chiefly as a consequence of the high rate of students repeating a year or dropping out entirely, and came up with an annual figure of 3.7 billion. "The dead end of secondary moderns", "Schools as breeding grounds for violence" or "Pupils of 2010 – between motivation and anxiety about the future" are examples of the headlines confronting us almost daily, suggesting the image of a crisis-ridden school landscape throughout Germany. The start of our specialist conference HOPE with the upbeat title 'The sick child - supported by a network of education and medicine' provides a good opportunity for a more detailed examination from a psychiatric viewpoint of the role of schools in the emergence of mental disorders in children and adolescents on the one hand and on the other hand their recognition of these disorders and the positive influences which they could exert.

A study of literature from the first half of the twentieth century reveals however that criticism of schools is no new topic: in those days, individual pupils in schools appeared to have suffered an equal degree of mental torment as is the case nowadays. This is for example borne out by the soul-destroying experiences and confusions suffered by the boarding school pupil Törleß described by Robert MUSIL in his novel from 1906. Hermann HESSE's novel 'Beneath the Wheel' ['Unterm Rad'] appeared in the same year and Friedrich TORBERG's 'The Pupil Gerber' ['Schüler Gerber'] was published 25 years later. Both books describe the depression culminating in suicide suffered by their youthful protagonists. In HESSE's novel, the young Hans Giebenrath cannot ultimately cope with the exalted expectations of his father, is out of his depth in the intense pressure to achieve at school and finally comes to grief as a consequence of an unhappy first love relationship. TORBERG'S pupil Kurt Gerber is in a similar situation: despite his intelligence, he cannot surmount his weakness in Mathematics or cope with his suffocatingly sadistic class teacher: he falls into a state of ever deeper depression and finally throws himself out of the window in despair.

Frustrated pupils under stress and exhausted teachers suffering burnout – is this phenomenon not an unambiguous sign that school-oriented factors are the ultimate fundamental causes of the increase in the occurrence of conditions such as affective disorders in children and adolescents and depression particularly observed in teachers? Is it ultimately the school system per se with its two sets of actors in front of the class and behind the desks which in the face of the initially described scenario provides a tangible detriment to the quality of life and is an increasing cause of ill health? Or are other factors also to blame?

Looking back over the past 25 years, paediatric psychiatrists as one of several specialised professional groups involved with mentally disturbed or ill adolescents can without doubt confirm the fact that there is a greater demand for their professional help than ever before, irrespective of which region in Germany they are working in and whether they are employed in a practice or a clinic. Annual demand growth rates ranging from 10 to 20 % could be interpreted as evidence for a drastic increase in mental disorders in developmental ages, particularly when considered alongside the fact that the baby-boomer generation has already more or less reached maturity. If we undertake a closer analysis of general illness patterns within the contemporary generation of children and adolescents, the trend has visibly shifted away from chiefly physical disorders to mental disorders in their broadest sense.

Although on the one hand child and adolescent psychiatric clinics are bursting at the seams and waiting periods of several months are unavoidable in practices and outpatient departments for children with psychological disorders, on the other hand we often see excess capacity in classical somatic paediatric clinics – this frequently has the consequence that we have to treat milder psychiatric disorder syndromes under the label of 'psychosomatic disorders' with insufficient funding.

The increase in demand and utilisation of established child and adolescent psychiatric services is however due to a number of different factors. One essential fact is certainly that the quality of detection, diagnosis, therapy and rehabilitation services offered by child and adolescent psychiatry and psychotherapy has increased substantially over the past few years. In Bavaria twenty years ago for example, there were only a few clinics and a handful of specialist consultants: now each administrative district has at least one child and adolescent psychiatric hospital which has been forced to create supplementary wards and outpatient departments in peripheral areas due to high demand. A growing number of specialist consultant practices – regrettably to a large extent centred round urban conurbations – and modern, attractive clinics are frequently able to shorten the customary long waiting times experienced by affected families.

In addition, the extensive media coverage of the endangered mental health of children has led to a greater level of awareness of our specialist field and also to the removal of taboos and threshold fears accompanying a visit to a child and adolescent psychiatrist. Many parents and those professionally involved with children and adolescents displaying behavioural disorders now seek help and support at an earlier stage. As a consequence, child and adolescent psychiatric and psychotherapeutic institutions are increasingly allocated patients with psychological disorders or corresponding dubious symptoms – according to the motto 'supply creates demand'. Many of these disorders were either simply not detected or inadequately treated in the past.

Within this context, the question must be asked whether it is true that nowadays a greater number of children and adolescents display symptoms of mental illness than before. Although epidemiologists have overall not reported a dramatic increase across the entire spectrum of disorders, they have registered the following trend: according to a current BELLA study on the mental health of children and adolescents in Germany, around 18 – 20 per cent of this age group display conspicuous psychological and/or psychosomatic features requiring further clarification, a percentage which has not changed significantly in comparison to studies undertaken 25 to 30 years ago. What is different is that nowadays a long-term therapeutic intervention is considered necessary in one in out of two cases of children with identified disorders compared to one out of four cases in the past.

In a clinical setting, we have the impression that particular disorder patterns are encountered more frequently than in the past. This includes children with circumscribed and frequently combined development disorders, e.g. within the areas of reading and writing or calculation who as a result encounter great diffi culties in school and social isolation; children and adolescents with social behavioural problems chiefly of aggressive and expansive types already visible during the first few years at school; preschool and schoolchildren with a hyperkinetic syndrome and/or an Attention-Deficit/Hyperactivity Disorder (ADHS) which present serious obstacles to their integration within the family, at school and within a social environment; individuals with a substantial history of truancy and also an increasing number of adolescents and even children displaying alcohol and drug abuse at an extremely early stage. With the onset of puberty, an increasing number of mainly girls with anorexic-bulimic syndromes and adolescents with internally or externally triggered forms of aggressive breakdown and/or depressive-suicidal crises are coming to practices and clinics. Generally speaking, a significant overall increase in anxiety-based and depressive illnesses has been registered. In addition, an increasing number of young patients have survived complications arising from premature birth, trauma, malignant or metabolic disorders thanks to advances in paediatric medicine, but as a result harbour the increased risk of subsequent psychological problems. The entire spectrum of disorders listed here which can take many forms and can be observed at different developmental stages have one common factor: they first come to light within a school environment.

Starting school is for 6-year-olds frequently the most profound experience they have ever encountered in their developmental phases. These children are after all at this point emerging from a narrowly defined environment which – depending on their individual family context – was relatively clear, more or less structured but mostly without any form of strict, universally valid performance requirements within an intellectual-cognitive area. From a paediatric-psychological perspective, a relevantly pre-disposed child will soon display cognitive defects and behavioural problems during this new stage in life which takes place in a regimented and achievement-oriented environment: these problems had up till now been disguised or even overlooked in the protected environment of the family or nursery school.

Two case studies of 7-year-old children will provide examples here: in one of the children, an attention-deficit/hyperactivity disorder only came to light when a longer period of concentration and control of impulses was necessary during classroom activity. In the other case, an otherwise linguistically talented girl who had never displayed any problems at the preschool stage developed increasing symptoms of dyslexia towards the end of the first year at school. In both these cases, the school is almost destined to become the location of infantile behavioural disorders and therefore the annoyed and disappointed parents will initially see the school as the cause of these problems – at least until a correct diagnosis has been established and relevant counselling provided on the neurobiological foundations of both disorders. Two mothers of two boys in year four who had been given Ritalin to treat their hyperkinetic disorders asked me for advice independently of one another. By chance, it emerged that both boys were in the same class at school and it was established that four other classmates were also receiving medication for hyperactivity and concentration problems. This class in a school in Upper Bavaria consisted of 34 children who had already had to come to terms with a second change of teacher within a single school year plus intermittent class cancellations and frequent changes of supply teachers.

Maybe this was all just a coincidence. Without going into further detail about my two patients – for one of whom I incidentally prescribed the effective and well-tolerated methylphenidate, a highly suitable medication for this condition – and without being familiar with the other four children on medication, this situation is naturally not representative, but should give parents, teachers and doctors some food for thought. Of course, ADHS can be diagnosed in around 3-4 % of all schoolchildren and successfully treated in an individually tailored therapy consisting of psycho-educational advice, behavioural-therapeutic measures and also with medication. But are doctors too quick in reaching for their prescription pad

without giving sufficient consideration in each individual case to all pathogenic environmental factors – whether in the parental home or at school? This should of course not imply that factors such as crowded classrooms with inconsistent educational supervision or watching TV for several hours a day can in itself be the cause of ADHS. Nevertheless, if these influences are grafted onto the neurobiological vulnerability of a child, this does raise the risk of disorders. Should it therefore not be a matter of course to switch off these accompanying circumstances where possible – in the truest sense of the word – in an effective therapy?

Particularly in a school setting, the conjunction of a disposition to an individual illness and environmental factors aggravating the symptoms can cause a much more complex situation than is the case with ADHS. This holds true for severe psychiatric illnesses such as psychoses or a serious tic disorder like the Gilles de la Tourette syndrome, both of which develop over an extensive period of time. A schoolchild with a combined tic disorder can initially only be detected during an extended preliminary phase through involuntary jerky movements of individual muscular groups and subsequently through the production of explosive noises or words, frequently of an obscene nature. In the absence of relevant knowledge, a teacher's only reaction to this behaviour will be to give the impression that they are able to cope with the miscreant, consider this behaviour to be deliberate and combat it with punishments. Classmates will make fun of this behaviour and isolate their fellow pupil which will only succeed in aggravating these tics.

It is however not always serious neuropsychiatric disorders in a narrow sense of the term, sometimes not even correctly diagnosed, which can bring children within the school environment into a vicious circle, particularly if this situation is not recognised as such. It appears that a considerable number of children and adolescents in all age groups and school types have become victims of bullying. According to findings from the bullying study undertaken by the Munich development psychologist Mechthild SCHÄFER, one in three primary school children has apparently already experienced bullying and at least temporarily felt themselves as victims of psychological pressure or even physical violence at the hands of their schoolmates. In the majority of cases, these studies assign a partial responsibility for this phenomenon to the teacher who appears to display insufficient sensitivity and consistency to the denigration of an individual within these group-dynamic processes. It is therefore expected of teachers that they ensure that a considerate and tolerant atmosphere is created in the classroom and that bullying is categorised as being taboo right from the start which will otherwise be countered immediately through suitable intervention from teaching staff.

These accusations can perhaps be justified in certain cases of bullying. A more detailed analysis of the prehistory of conspicuously emotional adolescents presented to the child psychiatrist by their parents as victims of bullying can sometimes reveal individual causes of their problems which have nothing to do with school, for example over-protective spoiling on the part of the parents or high expectations of fellow classmates despite their own limited and underdeveloped interpersonal and social competence. In my opinion, we must ensure that we do not overburden our schools and teachers with excessive demands and wishes. School representatives are justified in asserting that conflicts in the classroom and the playground are merely a reflection of our society which is frequently characterised by instable family structures and relationships, an egocentric lifestyle and a lack of ethical orientation. In Germany, around 5 – 10 per cent of all school-age children and adolescents display some form of school-evasive behaviour: some only for a few days and others over a period of several months and even longer. In a number of large cities, school absenteeism is a frequently observed phenomenon.

Although it is impossible to pigeonhole school truants precisely, child and adolescent psychiatrists have defined three general group areas: the first group of school truants who steer clear of school whenever possible due to their dissocial development only receives a passing mention here. It is only the second sub-group which displays a fear of school as the underlying motive; excessive demands, bullying by

schoolmates, fear of a cynical teacher or excessive expectations of ambitious parents can in these cases trigger off physical ailments such as headaches or stomach pain and avoidance tactics for attendance at school. We child and adolescent psychiatrists often establish that children with a chronic fear of school within this context have been placed in an unsuitable school form. We see primary schoolchildren for example who due to their intellectual capabilities would be better off in a school for special needs and grammar school children out of their depth who would be far better suited to a secondary modern school. Incidentally, we repeatedly encounter the fear of school phenomenon in the case of the large number of children who have been identified as 'highly gifted', whose potential has been overestimated and who are unable to become integrated in a new class after skipping ahead a year at school.

The third subgroup of school truants, those suffering from a genuine school phobia, are surely the most complicated from an etiological point of view. Here the psychodynamic foundations of the persistent truancy of a child lie in a separation anxiety of which the child is barely aware and the school is actually only a projection screen for this anxiety. Children affected by this phenomenon can display a history of over-protectiveness, overpampering or premature birth and experience their exit from the safe environment of home in which they were the central focus quasi as a loss of control. A further group of adolescents specifically affected by this phobia come from a broken home situation, for example in a close and sometimes symbiotic relationship with a single parent. Occasionally, they can even assume the role of substitute partner in this type of parentified relationship, for example reacting on an equal footing with the mother, and frequently fear subconsciously that while they are at school something could happen during their absence from the home or circumstances could change over which they would have no control. This can lead to truancy in children suffering from school phobia over a period of several weeks or several months and in individual cases even over several years if this condition is not treated effectively.

Mentally ill children – what are the solutions? I have attempted to demonstrate through several significant examples of school-associated disturbance patterns that the institution school can become the stage for a wide variety of behavioural problems and psychiatric illnesses, particularly in a socially precarious era such as today. I find it however completely unreasonable to pin down the school as an institution a priori as being the responsible party, as the pathology of a child normally only develops as a result of the interaction of several harmful factors. It is not right that our schools are overhastily identified as the scapegoats when certain paediatric disorders in actual fact stem primarily from biological causes, deficits in the family and undesirable developments in our society. One-sided accusations would only serve as further discouragement for many committed teachers and ultimately lead to a shortage of young, qualified teaching staff.

If it is observed that individual children and adolescents or particular groups of children are displaying behavioural disorders or symptoms of psychological ailments within a school environment, the relevant school and teachers must become attentive and observant and be able to recognise any causes which could be connected with school. If appropriate, intervention must naturally occur at the earliest possible stage. This requires on the part of schools a relevant education and training for teachers, a sufficient number of sensitive counsellors and school psychologists, functioning managerial structures and a well-organised communication process between school and parents. Child and adolescent psychiatrist who are aware of the importance of the adequate provision of school services as an essential element of treatment within the framework of both inpatient and outpatient therapy in hospitals have a vital diagnostic and therapeutic task to fulfill in these individual cases.

The school at the Heckscher Clinic with a long tradition offering 200 places for inpatient treatment with a current total seven outpatient clinics in different locations is one of the largest clinical institutions for child and adolescent psychiatry within German-speaking countries and is a prime example for the successful cooperation between education and medicine. Alongside 73 doctors, 42 psychologists, a further 33

therapists working in a variety of fields and nursing staff and ward educators, a total of 53 teachers with a wide range of special areas are also involved who teach an average annual total of 650 patient pupils in 23 classes. In addition to a certain number of outpatients, this means that around two thirds of all inpatients (priority is given to longer-term patients) receive schooling in small groups. Tuition is planned individually and is highly differentiated to aid the successful treatment of these young patients. A particular focus of our several-day congress will be on the central importance of a clinic school with specialised staff and areas of expertise within the framework of a therapy concept for a child and adolescent psychiatric clinic.

In an analysis of the causes of psychological disorders in schoolchildren we should ultimately also pinpoint the inherent weaknesses of the educational system and do our best to eradicate them. In brief, this includes the necessity of the early recognition of risk factors and deficits during the nursery school phase prior to starting school and consistent early support in language development, particularly for children from immigrant families. At a later phase, each child should be taught in the school form corresponding best to his or her developmental and intellectual abilities, and should partial weaknesses in specific areas be established, these must be remedied during lessons through specialised support and also be considered in school marking systems. Smaller classes, a more flexible permeability between different school forms and supplementary opportunities for all-day schooling would certainly also help to compensate for certain social inequalities and injustices as well as functioning as a protective factor for the mental health of children and adolescents.

We would only inflict greater harm on our schoolchildren and school teachers if we fell into a state of fundamental pessimism in the face of school tristesse and unfulfilled hopes of reform and would banish a further vital element for a good atmosphere in schools: humour! Perhaps we should take some inspiration from Wilhelm BUSCH? He is famous throughout Germany for his celebrated stories of the infamous schoolboys Max and Moritz who on one occasion caused their pipe of their teacher Lehrer Lämpel to explode with a little help from some gunpowder – nowadays this prank would be categorised as a bomb attack. As a result, the conscientious but hated schoolmaster fell to the ground covered in soot and his pipe was broken, but thankfully survived this attack otherwise unhurt. Wilhelm Busch preceded this fourth prank played by his two young villains with the following verse written in 1865:

Nicht allein am Schreiben, Lesen,
übt sich ein vernünftig Wesen;
nicht allein in Rechnungssachen
soll der Mensch sich Mühe machen;
sondern auch der Weisheit Lehren
muss man mit Vergnügen hören.

Not alone the A, B, C
, Raises man in dignity;
Not alone in reading, writing,
Reason finds a work inviting;
Not alone to solve the double
Rule of Three shall man take trouble;
But must hear with pleasure Sages
Teach the wisdom of the ages.