Educating Children during Illness as Pedagogy in an Extreme Situation

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Anyone who is ill hopes to recover health. Illness is a temporary situation and not a handicap. An illness can be severe and painful, but ultimately remains an episode whose limitations are merely exceptions to the rule of 'good health'.

Terms and edicts

I have preceded my paper with these colloquial remarks as they have relevance for the work dynamics in a 'school for children who are ill'. The term 'illness' suggests a short-term period which is however not the reality in a school for sick children.

Our profession has nothing to do with pupils who are in hospital for an average period of under a week, for example following a surgical operation; despite varying requirements in the federalism of our education system, all federal states quantify the publicly regulated authorisation for attendance as a 'projected hospital stay of a minimum of four weeks'. This is rarely achieved nowadays, even in the orthopaedic department which was originally the germ cell for the development of the education of sick children.

Nowadays, our area of operation is confined to a few specialised somatic wards including oncology, haematology, nephrology (dialysis) and convalescence wards. I will cover the new focal area of adolescent psychiatry separately below.

Children and adolescents "undergoing inpatient treatment at regular intervals" (KMK, 1998) are however also taught. The total number of days in hospital are added together to produce an annual figure. These children are in most cases suffering from conditions such as diabetes, rheumatism, allergies, cystic fibrosis and renal diseases. In recent times, individual wards at paediatric clinics – also within a day-clinic setting – have begun to focus on these types of perennial patients with chronic diseases. (cf. Michels, 1996 for the statistical increase in this patient group).

This introduces a second term: the chronically ill. These patients do not experience the temporary and episodic nature of illness and in fact experience the exact opposite. Permanently ill patients will have to adapt themselves to the long-term irreversible status of their suffering. Should their ailment be accompanied by life-shortening features, they are also known as terminally ill. Chronic illness but without the threat of a life-threatening condition is a term located within the intersection of illness and a handicap.

Chronic illnesses are disruptions to the concept of life

Living with a handicap is a great burden for both patients and members of their family. Their living conditions are made more difficult, but the circumstances are at least clear. Following initial rebelliousness, denial and euphoric actionism, their resistance is gradually worn down. Although the handicap does not become any easier, patients and others in their close environment begin to accept how to arrange themselves with this handicap and in an ideal case, also reconcile themselves to it.

The situation is different in the case of illness. Here there is no chance of everything calming down; nobody has thoughts of arranging, reconciling or resigning themselves to their fate: instead there is hope and resistance. The illness should disappear as soon as possible and should be no more than a disagreeable episode which should be forgotten as quickly as possible, if possible through a demonstration of the patient's former performance capacity.

These young patients however are suffering from severe, frequently extremely painful and longer-term illnesses. Chronic illnesses cut deeper into the individual concept of life than a scalpel in case of appendicitis, deeper than the fractures treated in the orthopaedic ward, after which it is expected that patients will subsequently be able to walk again.

Patients who qualify for the hospital school are as a rule either ill for long periods or suffer from chronic diseases. "Chronic and psychosomatic illnesses chiefly dominate in the medical histories of children and adolescents in industrialised nations" (Schindler-Marlow in the Rheinische Ärzteblatt, 2007, Vol. 4, p.11). "For this reason, hospital educators observe a high level of stress and fatigue in ward patients. We should however not overlook the fact that this can conceal struggles taking place: struggles of resistance."

Social climate

Children with chronic illnesses and their parents are not only rebelling against life-shortening prognoses; they are also battling against the threatening loss of social inclusion and participation. Although the perniciousness originates from their illness, affected patients frequently feel their personality assaulted by it, not out of invidiousness, but due to a feeling of powerlessness. Schooling in hospital takes place against the background of these types of intra- and inter-psychological processes. I should like to extend this topic by examining the social-psychological context.

The social climate in industrialised countries at the beginning of the new millennium expects individuals to be successful and demands that pupils receive extra encouragement (cf. 'generation barometer' 2009, Allensbach Institute for Demoscopy). "Failure and illness are not part of the picture. Within the employment sector, this is for example borne out by statistical surveys on the low rate of illness. Illness jeopardises social participation. In the world of education, the boom in the establishment of private schools and private tuition centres documents the aspiration for the best possible school qualifications. Failure to gain these qualifications can be compared with a social death sentence. This results in outbreaks of illness being either countered by over-dramatisation or minimisation.

At the beginning of the new school year in 2005 in which numerous federal states had reduced the length of the grammar school career up to Abitur [German university entrance qualification] to 12 years, the weekly magazine 'Eltern' [Parents] ran a title page depicting a child starting primary school with a flag waving out of his satchel reading 'Abi 017' [equivalent: 'A' levels in 2017]. Longer absences from school or repeating a class are simply not included in these calculations and are either ignored or are to be prevented at all costs with the aid of specialists and medication.

In this climate of expectation, teachers of sick children must resign themselves to be considered as the providers of a perfect repair system. Following discharge from hospital, everything should resume as previously without a break. The task of teachers in hospital is therefore frequently misunderstood as 'private tuition on prescription'. These wishes are legitimate and the provision of these teaching staff by the state originated to a great extent from this premise. I quote from a recommendation by the KMK conference in 1998: "Schooling (in hospital) provides pupils with the opportunity to learn successfully despite their illnesses; this reduces fears of falling behind with school work". Problems develop however if the complexity of reality goes far beyond any abstract concepts.

Teaching in consideration of the relationship level

Anyone being taught has confidence in the future. This banal statement has great significance for children with life-threatening diseases and their parents. Half as a joke but also tinged with hopes for a normal life, comments can be overheard in the children's oncology ward such as: "Your teacher is getting on your nerves with multiplication tables, but if she is doing this, it means that she expects you to return to your old school class". Even if our professional experience gives reason to suspect a highly critical progression of disease, we hospital educators will leave such interpretations of prognoses uncommented. We will have to endure that the acceptance of a painfully experienced drop in performance on the part of children and their parents need time to sink in and can be preceded by phases of resistance.

For this reason, we will also accept the substantial volume of teaching material sent from the patient's school as a sign of solidarity and hope that the pupil will return soon, particularly in the initial phase of a longer stay in the clinic. Instead of immediately dismissing the material sent as too strenuous, it is far more helpful to accept it with the words: "It's good that your class is thinking about you and your teacher has gone to such a lot of effort. If you don't manage to get through all the work, I am sure he will understand. I'll let him know how well you have been working here, but will also let him know that you are working under completely different conditions here on the ward and that there can be days when you may not have so much energy for learning. I know from former pupils that their schools accept that they have phases in which they are not able to do any school work at all."

We are only able to teach successfully if we remain aware of the psychosocial context of our pupils' lives. This makes simultaneous demands on our curricular professionalism and our presence on a relationship level. This is the reason for the formulation of my first statement:

I

The consideration of the relationship level is the original element of teaching in hospital and is not a monopoly of the psychological profession. It should however also not be a monopoly of education for sick children.

Teaching staff as a projection screen of resistance

Most children and their parents are glad of some relief from school work, particularly as the onset of an illness initially pushes all other areas of life into the background. Allowance must however also be made for brief and intensive phases of resistance in which the undeniable loss in physical functions must be compensated for through intellectual demands. The careful teacher will not exacerbate this situation through special praise, but will initially simply accept it and will subsequently regret the progressive loss of intellectual competence. This is the point at which it is vital to combat impending resignation.

Hospital educators working with children who have survived illness but whose capabilities will as a result remain restricted, sometimes become the target of negative projection on the part of parents and the patient. The gratitude expressed to the medical system for saving the patient's life can be accompanied by disappointment directed at the teacher due to the limitation of skills, for example if this necessitates a change in the school career involving relocation to a 'lower tier' of the educational system. Children and to an even greater extent their parents need time to redefine objectives on a more modest level. Parents are not only sad to observe the loss of certain functions in their children, but can also experience this situation as a being narcissistic slight to their own ego.

Degenerative processes in these children result in immeasurable disappointment which can be combated by seeking the causes in unqualified helpers or their lack of commitment, for example intellectual functional losses in the teachers. This relieves parents and protects them against the potential unloading of negative emotions onto their child.

Hospital educators should possess a minimum level of psychological skills relating to unconscious mechanisms such as the phenomena identification, projection, transference and counter-transference. For this reason, my second statement is as follows:

II
Hospital educators will make allowance for the phenomenon of transference in their lessons and will be aware that pupils will frequently work off their deficits and anxieties vicariously, also on attachment figures amongst the teaching staff. A controlled counter-transference serves as protection against adverse effects on relationships and will help pupils to undertake further steps towards maturity.

If we teaching staff become the projection screen of resistance, we must remain extremely disciplined and should avoid all affective behaviour. If we react empathically to the threatened loss in ability and nevertheless retain the professional focus on topics related to school, we can provide impulses for parents suggesting alternative schooling methods, unorthodox educational paths and also 'niches' and 'tricks'. This will in the long term reveal new aspects for new concepts of life.

This could sound paradox, but we can best counter psychological irritation if we maintain our role as teacher and educator in front of our pupils. I would formulate this concept in my third statement as follows:

III
It is a help if hospital educators are able to observe and understand. They will however always remain school teachers and their instrument remains didactics built on the foundations of empathy.

The selection of particular subject matter for lessons can trigger off impulses in a similar fashion to therapeutic approaches. The subjects of lessons can serve as a transfer onto a different level into other areas of life. Subjects such as German, religious studies, and social studies provide ideal opportunities for presenting extreme life situations and displaying the possibilities of overcoming these challenges as a normal human experience within the framework of generally familiar cultural spheres.

Tuition as opportunity for the mentalisation of emotions

Lessons incorporating the reality of the pupils' daily lives and responding with examples from our cultural heritage can contribute to the 'mentalisation of emotions' (Fonagy et al, 2004). Young persons can observe a particular emotional state in a literary or musical work which does not necessarily have to meet with our own personal tastes. A mental state of rebellion which is for example reflected in aggressive rock music can be channelled with the aid of cultural stylistic devices.
The possibilities, even in later stages of child development, provided by the phenomenon of emotional reflection through culture is most likely the foundation for the astoundingly successful (self-) educative effects of school culture projects with highly disturbed and difficult adolescents such as the dance project 'Rhythm is it' by Roger Maldoom, Sir Simon Rattle, the Berlin Philharmonic and others (2004).

Young persons are also on the search for emotional reflection within their own creative activities with language, music or art and frequently come very close to statements expressed in high culture. This is illustrated by an example from my own experience in the hospital school:

Herrmann Hesse expressed emotions connected with the topic of 'taking leave' in his poem 'Steps' ['Stufen']. This poem is frequently recited at farewell parties and concludes with the well-known closing appeal: "Courage my heart, take leave and fare thee well!" The seventeen-year-old Nils who following numerous failed relationships and expulsions from schools was retaking his certificate of secondary education in our hospital school at the youth psychiatric unit, made the following statement when writing a text on the souvenir picture of his school: "The topic of taking leave is a topic no-one likes to talk about. It is a feeling of sorrow and loneliness, but also conveys the emotions of making a new start". Nils was leaving school for the first time under normal circumstances since his adolescence: he had been forcibly removed from all previous schools following attacks and negative impulsive behaviour. He found saying goodbye at the hospital school very hard and in previous phases this negative tension would have been accompanied by physical attacks or other destructive behaviour. He had now however – albeit very belatedly – learned to utilise language to express his raw emotions.

IV

Curricular selection supports affect control and mentalisation processes. The content of lessons can also in extreme phases of life provide opportunities for identification and projective relief, thereby encouraging the utilisation of language instead of former raw emotions.

Lesson content can also place experiences of loss and taking leave within a comforting cultural context. An involvement in the experiences of others and a personal exploration of these experiences through individual activities prevents pupils from becoming fixated on their own powerlessness. A week-long project was undertaken in the higher class in the adolescent psychiatric department combining the subjects German, religious studies, art and social studies based on a quotation by Ernst Bloch: "I am. But I do not yet have myself." It is not possible to force the ignition spark of identification, but this can perhaps be triggered off by the provision of the material within the framework of a warm atmosphere. Activities involving cultural material can always encourage the activation and differentiation of retained ego functions.

Accompanied leave-taking of life concepts also in child and adolescent psychiatry departments

The previous examples have led us into the working field of education for sick children which has guaranteed the existence of hospital schools over the last twenty years: the foundation of psychiatric and psychological clinics for children and adolescents. Schools in hospital are to a large extent integrated in these institutions and are increasingly being provided with an infrastructure similar to that of special needs schools with group rooms for smaller classes, specially equipped rooms for certain subjects and separate school buildings.

The transition from teaching primarily somatic patients to psychological patients was initially experienced as a complete change within the professional field of hospital education. Although extreme life-threatening situations and also death were encountered in both medical areas, these originated out of completely different contexts: in the former, the sudden fate of a life-shortening disease and in the latter, self-inflicted injuries and sometimes even attempted suicide.

I should like to demonstrate with three examples from the child and adolescent psychiatric field that the demands made on our educational brief and didactic concepts are not necessarily so different.

Study of changes of school

Within the area of child and adolescent psychiatry, we also experience disappointment in life concepts which have to be altered for reasons of ill health. Psychological disorders can also mean relinquishing hopes, illusions and wishes and we hospital educators will also not always be able to fulfill the parents' expectations of 'extra tuition on prescription'. Additionally, as so many young persons' life plans overlap into the area of educational plans, our help is needed in the careful realignment process towards new objectives. Numerous patients are for example forced to change schools following their discharge from the child and adolescent psychiatric clinics.

A third of all patients discharged from this type of clinic in the federal state of North-Rhine Westphalia subsequently attend a different school; the majority of these pupils also change to a different type of school (cf. Oelsner/ Reichle 2008). This high level of pupils changing schools could indicate that psychological disorders in adolescents are frequently exacerbated and sometimes even caused by the 'wrong type of school'. Hospital educators then 'operate the points' to alter the course of the school career in tandem with the medical system (ibid 2009). As a consequence, the teachers on the wards also become involved in diagnostic tasks which are otherwise undertaken by school psychologist services. Pupils changing schools do not only require our empathy, but also the provision of technical and school-organisational skills, for example the status of relevant legal regulations, probation options, delayed moves into the next higher class and school support (cf. Harter-Meyer 2000).
My statement V is therefore as follows:

V
Reality testing, insight into specific ailments and learning to cope with these situations are all vital support elements in lessons, advisory services and diagnosis within the context of a hospital school. The acceptance of reality also incorporates the acceptance of an illness and certain losses.

Grieving as an integrated didactic objective
The common factor experienced by all those working in our professional field is extreme circumstances. In both in-patient wards and child and adolescent psychiatric clinics, we see young persons and their families equally disappointed, upset and devastated by their prospects in life, as a change of school in the case of psychological disorders nearly always means dropping to a 'lower ranking' system.
Pupils and their families have to undergo a long and frequently painful process in order to come to terms with the fact that they will not be able to achieve their projected ambitions. They are temporarily – and sometimes on a long-term scale – forced to readjust their perspectives of life. Hospital educators on psychiatric wards must also incorporate the grieving process into their work as an integrated didactic objective. This is about an acceptance that a different approach to life will be necessary following establishment of the diagnosis and/or after a traumatic experience. Without this acceptance of limitations and the process of taking leave, there can be no foundation for encouragement and the reorientation of future plans.
Statement VI is therefore an extension of this aspect:

VI
The ability to grieve is an intrinsic objective of lessons and in school career counselling, particularly for pupils suffering from chronic illness. The hospital school nurtures a culture of both taking farewell and encouragement and orientation for the future.

Discussions with parents whose children have irreparably lost particular physical functions through accidents or a tumor are alternately characterised by anger and grief and also rebellion and resignation. These reactions are also experienced within the field of child and adolescent psychiatry, my second aspect. In these cases, the limitations imposed on life are not caused by physical damage, but a psychiatric diagnosis for a child which can radically change its prospects in life. This is naturally not the case for the numerous ADS diagnoses in children of primary school age which can be corrected well through the intervention of child psychiatrists. In contrast, a psychosis or borderline disorder in an adolescent cannot be treated as a short- or medium-term episode.

Examples: Asperger Autism

Some children are admitted to hospital with suspected ADS, obsessive-compulsive disorders, intellectual giftedness or eating disorders for further investigation. In some cases, the disorders of these patients can be diagnosed as comorbid Asperger autism. This can trigger off reactions in these patients as though an irreparable metabolic disease has been established. It is necessary to explain carefully to both parents and pupils that autism cannot be cured through therapy: this empathy disorder will remain, but it is possible to learn how to live with this condition.

In these cases, it is possible to discover special niches off the beaten track of the originally anticipated school career and this process will be undertaken jointly with medical doctors or psychologists. The involvement of the teacher is always essential as the consequences will mean an individual paradigm change in lessons and school life in general. It is ultimately the school system which will prepare the didactic path and social readjustment and make this reorientation tangible in a positive way.

Should other professional groups claim the involvement of the parents through the hospital teachers as their exclusive right – as is occasionally the case – we teachers can make reference to our state mandate. The KMK recommendations (1998) do not only legitimate intervention beyond the confines of mere knowledge transfer, but go as far as to formulate contact with parents as an educational obligation: "Parents and guardians and pupils should be involved in consultation and frequently be supervised over a longer period" (§1.2). "As a consequence, the requirement profile for teaching staff also includes special training in 'conducting discussion', 'counselling skills and the ability for cooperation' and 'information on disease patterns and their possible effects on physical and psychological development'" (§ 8.4). I will summarise these aspects in statement VII:

VII

Parental involvement is an obligatory element of the tuition of sick children: this is one of the required components of the state educational and consultation requirements for hospital teachers.

Toleration of amok problem fields

My third example of extreme situations during lessons in a school in a child and adolescent psychiatric clinic only penetrates the consciousness of our colleagues on rare but spectacular occasions, but must remain a factor which should permanently be kept in mind. This concerns adolescents who are in potential danger of running amok. Ever since the shocking events of Erfurt 2002, Emsdetten 2006 and Winnenden 2009, all teaching staff at schools in child and adolescent psychiatric clinics have been repeatedly alerted to a particular potential field of tension.

Schools in child and adolescent psychiatric clinics are providing tuition in the very same locations in which we would like to see adolescents who could potentially run amok placed preventatively and also treated. These individuals display a profile of an abnormally developed personality with which teachers in schools in child and adolescent psychiatric clinics are familiar: these characteristics include a lack of self-esteem, social isolation, a retreat into an illusory world, a lack of success, fantasies of violence and a high consumption of aggressive media games. For this reason, the hospital school programme includes aspects which are propagated as elements of prevention and therapy for these types of adolescents: the creation and intensification of relationships, social integration, the communication of a sense of achievement, avoidance and processing of insulting situations, the communication of life and training perspectives, the replacement of destructive by constructive solution strategies and the dissolving of manic response forms through socio-culturally recognised fields of reality.

Although it is possible to define the perpetrator's profile so precisely in hindsight, these profiles are nevertheless diffuse and it remains difficult to make a clear forecast in advance. As early as in primary school, there are daily shootings, others' necks are twisted, the world goes up in flames and rulers seize power – all in children's games. Children involved in these types of games cannot be simply excluded from school. Indeed, part of the requirements of education is to enable children to learn to symbolise emotions not in an actual performance, but symbolised through words and cultural channels.

There are no objective scale values which can always unambiguously alert us teachers to what degree of underdevelopment in the ability to symbolise would signify that a particular pupil should be taken out of circulation. Our schools for special needs have indeed been given the responsibility of supervising the catching-up process in this developmental stage. The more progressive a school for sick children is, the greater is the chance of importing this field of tension through our own front door, for example if we are housed in a separate building with its own entrances and the doors are open to the neighborhood to aid the hospital discharge process and the testing reality.

If a school for sick children is to provide space and opportunity for adolescents to reposition themselves, they will also cultivate the school community atmosphere and undertake action. This also brings with it the free movement of persons which however also entails risks, particularly if adolescents discharged from hospital are to continue attending this school during the outpatient transition period, i.e. as 'external pupils'. Not all inpatient pupils who are still too unstable to return to their former schools following discharge from hospital should be 'locked up'.

It is perfectly natural for these adolescents to display behaviour patterns during this phase of extreme stress and irritation which could in hindsight, after a catastrophe, have permitted the identification of the characteristics of a potential perpetrator. The utilisation of exclusion criteria for schools for sick children would however be equal to ignoring a wide range of diagnostic indications within the field of adolescent psychiatry: this is because certain personality deficits of adolescents running amok can also be categorised as comorbid disorders among other less potentially dangerous symptom complexes. What is more, these characteristics are archetypal for certain transition phases of adolescent development and can for this reason be observed in all types of schools. In the clinical pictures seen in our school form, the field of tension is substantially increased.

In our school in Cologne, numerous pupils trigger off vehement discussion in the staffroom as to whether these individuals should continue to attend the school as external pupils. These cases can lead to polarisation and division of opinions, particularly as help for those in danger can also potentially endanger the helpers.

The exclusion of particular pupils from our institution will not solve any problems and would not only constitute a withdrawal of help; the insult of being rejected would only increase their danger to others. These individuals seldom express absolute negative emotions regarding school, but tend more to cultivate a type of love-hate relationship. Disappointment in love demands revenge and narcissistic rehabilitation and these can also be potential motives of a killing spree. If an act of violence actually took place, a possible accusation could be: "How could the school specifically exclude this pupil?" and the media would immediately pounce on headlines such as "Lack of perspectives led to act of desperation". If the pupil had been retained in the school, comments would be the complete opposite: "Why was this ticking bomb not excluded sooner?"

If a particular decision inherently involves a risk, it produces a dilemma which can however be cushioned by an expert network of specialists. This will never provide a failsafe solution, but would certainly alleviate the situation, accompanied by a high degree of sensitivity, caution and responsibility. The dilemma must be recognised and formulated to permit a team decision to be reached after weighing up the pros and cons.

The fact that all previous killing sprees have taken place in conventional schools does not guarantee that hospital schools will be spared this fate. This positive experience can however encourage us to endure the daily pressures of decision-making with confidence. This type of perpetrator profile can be found in all schools, but the probability rate is higher in our own institutions. These adolescents are however here integrated into a treatment system. And no-one can give me the guarantee that while I am calmly addressing this subject in Munich, everything will remain quiet and peaceful back in Cologne. After over twenty years of professional experience with these customers, I can however be fairly certain that institutions devoted to building relationships and confidence – as in our schools in hospital – will not be the prime target of destruction: these schools are particularly felt as a 'secure framework'.

VIII

Attendance at hospital schools can offer pupils with instable personalities a 'secure framework' and a chance to 'build structure'. Aspects of 'containment' influence the planning of the school timetable and allocation to particular learning groups.

The school for sick children as an 'independent form of school' I would like to summarise the educational policy inferences of the above in two concluding statements.

Six years ago in the federal state of North Rhine-Westphalia, we launched a protest when new school legislation would no longer confer on us the status of a 'school for children with special educational needs' after our schools had been included for decades among the group of ten types of special schools in our federal state. This protest had no further result apart from us being conferred the strange special status of an 'independent form of school'. Although we are not greatly enamoured of this title, we have come to appreciate the possibilities which are associated with this term. What and who are we accordingly?

IX

"The school in a psychiatric unit is what it would not have been without its existence".
It is not merely an independent form of school, but an inimitable and indispensable form of school!

This answer remains somewhat vague, but I find it so aptly formulated that I regret that it is not totally original. The first part is my variation on a statement formulated by Heribert Prantl in the German daily newspaper Süddeutsche Zeitung in May of this year in answer to the question "What is the Church?": "The Church is what it would not have been without its existence."

Culture of openness

The success or failure of our work in the schools for sick children depends to a great extent on the degree to which the aspects expressed in the statements can be taken into account. Two prerequisites can however barely be operationalised and demanded as being obligatory. This can only be defined in rather general terms, but this statement is intended to be definitive:

X

Constructive cooperation with all participating professional groups involved with sick children and their parents can only succeed if a culture of openness is nurtured. This involves the acceptance of the specialist authorities by parents and children and vice versa the willingness to place trust in sick children and their parents as 'experts within their own field'.

I remain utterly convinced of one effect after over 40 years of experience with learning groups of handicapped and chronically sick children: all members of a learning social community will benefit from an open attitude towards illness. This effect will overflow into the class which these pupils will attend when they leave the school for sick children. A chronically ill child in the classroom does not have to be a mere burden, but can also provide the opportunity for a better classroom climate. Pupils can become acquainted with abnormalities which deviate from the messages communi-cated by human images in media, modelling and advertising sectors and learn about completely different aspects of life. An altered appearance or deviations from normal life such as the necessity for injections, swift fatigue, exhaustion in sports activities and over-sensitivity in cookery or chemistry lessons will lose all intimations of embarrassment, abnormality and strangeness if pupils observe these experiences in their classmates. Illness as a condition will then not have to be denied as being a part of the life of young people, but will be accepted as a life crisis which can be accompanied by lifelong adverse effects and can affect anyone. (Christoph Ertle, 2002)

Education and humour

One final topic: hospital teachers naturally require academic training and must additionally acquire basic medical-psychological knowledge associated with diagnosis, symptoms and prognosis. The sophisticated superstructure of our work will however only be of use if supplemented by a basic element from a completely different dimension: humour. This is the second element which cannot be made compulsory, but can be hoped for.

XI

Our knowledge will help us to teach sick children and adolescents. Humour will help us to accept and endure their situation and also our own. When we were searching for a name for our school, the names of a variety of scientists were compiled on an initial list. We were however able to convince the city council to accept a name from a completely different area: Johann-Christoph-Winters. Johann-Christoph-Winters was the founder of the locally popular and much loved Hännesches Theatre which is now approaching its 200th anniversary. Winters is the spiritual father of certain figures, two of which will probably also be familiar in Munich: Tünnes and Schäl and Hänneschen and Bärbelchen. Almost instinctively – you could even say 'instinctively out of the population' – he created human types which would identify us everywhere as 'Rhinelander'. Psychology would only at a subsequent point create terms to describe these figures, and nowadays it would be possible to label the stick-puppet figures with psychiatric diagnoses according to ICD 10. These puppet theatre figures typifying an entire region show that there are two possibilities of conceptualising human behaviour: the academic approach and the traditional folk approach: only the second of these can be conveyed with humour. Humour can not only 'pull our legs' but also 'tweak our arms'. I will now do neither of these, but instead simply thank you all for your attention.

I
The consideration of the relationship level is the original element of teaching in hospital and is not a monopoly of the psychological profession. It should however also not be a monopoly of education for sick children.

II
Hospital educators will make allowance for the phenomenon of transference in their lessons and will be aware that pupils will frequently work off their deficits and anxieties vicariously, also on attachment figures amongst the teaching staff. A controlled counter-transference serves as protection against adverse effects on relationships and will help pupils to undertake further steps towards maturity.

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It is a help if hospital educators are able to observe and understand. They will however always remain school teachers and their instrument remains didactics built on the foundations of empathy.

IV
Curricular selection supports affect control and mentalisation processes. The content of lessons can also in extreme phases of life provide opportunities for identification and projective relief, thereby encouraging the utilisation of language instead of former raw emotions.

V
Reality testing, insight into specific ailments and learning to cope with these situations are all vital support elements in lessons, advisory services and diagnosis within the context of a hospital school. The acceptance of reality also incorporates the acceptance of an illness and certain losses.

VI
The ability to grieve is an intrinsic objective of lessons and in school career counselling, particularly for pupils suffering from chronic illness. The school for sick children nurtures a culture of both taking farewell and encouragement and orientation for the future.

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Parental involvement is an obligatory element of the tuition of sick children: this is one of the required components of the state educational and consultation requirements for hospital teachers.

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Attendance at hospital schools can offer pupils with instable personalities a 'secure framework' and a chance to 'build structures'". Aspects of 'containment' influence the planning of the school timetable and allocation to particular learning groups.

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1 The 'Schule für Kranke' ['School for sick children'] is the definition issued by the KMK conference [Federal Standing Conference of the Ministers of Education and Cultural Affairs] in 1998 to describe an independent school form "devoted to the tuition of sick pupils". Thus term replaces other former terms still in colloquial use such as 'hospital school'. In this article, this term also includes alternative organisational forms such as 'hospital schooling' and also 'home schooling'.
2 According to a report published by the German Federal Ministry of Health on 13.7.2009, the level of sickness leave in companies had reached its lowest level during the post-war period with a statistical average of 3.5 days of absence in the first half of 2009. This was reported as being due to a high inhibition threshold out of fear of becoming redundant.
3 According to a report by the German press agency dpa on 15.9.2009, the number of private pupils doubled in Germany between 1987 und 2007.
4 Farewell party at the municipal school for sick children at the University Hospital in Cologne, summer 2009
5 Subsequently, the young patient pupils prepared an exhibition in a museum in Cologne entitled: "Job – why me?" In an interdisciplinary school project, they worked in cooperation with teachers for German, History and Art and also with clinical pastoral care and management services.
6 In large cities with University Hospitals such as Cologne, Essen, Bonn and Münster, the number of pupils changing schools was even higher at a rate of ca. 40 %. This means that in places with a denser and higher differentiated school infrastructure, the opportunities for a change of school were utilised to the full.
7 Hänneschen as the "Jack of all trades" is a hyperkinetic (ICD 10 F 90.1); his roaming permanent girlfriend Bärbelchen displays clear symptoms of school truancy (F 91.2); with Tünnes, the red, bulbous nose is an unambiguous indication of a latent addiction structure (F 10.7) and his companion Schäl is a man who likes to give the impression that he is more than he appears, but shies away from no intrigue, therefore demonstrates symptoms of a paranoid personality structure (F 60.0).