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Crises in the lives of schoolchildren

The professional alliance between teacher and therapist as a diagnostic tool in the treatment of critical conditions

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1. Introduction: The hospital school as a place of crisis and transformation

In recent times hospital schools have become very widespread in Germany. Their purpose is to provide patients of school age with lessons that will facilitate a smooth return to their former class after their stay in hospital, even if this has meant an absence of several months. Besides this official task, however, it has been the experience of hospital schools that many students have landed there for psychiatric therapy necessitated by problems with their school-life, and that their eventual reintegration can only be achieved through comprehensive support. Above all, in wards where there are both schoolchildren and young people undergoing psychiatric treatment the curriculum needs to contain much more than just normal school lessons. In difficult cases psychologists and teachers, in consultation with the doctors, must work out a therapeutic strategy which not only meets the crisis, but also reforms the particular student/patient's attitude to schoolwork. Thus the hospital school, on the one hand, has to meet *pedagogical* demands, and on the other can only be effective when these are combined with *therapeutic* intentions. This usually happens through close co-operation with the therapists involved, and implementation follows, for instance, upon consultative meetings.

The temporal sequence by which problem situations emerge in school depends in large part upon mutually intensifying negative influences that have arisen within the pedagogical context, and can no longer be corrected by those involved. Students, teachers and parents are then likely to be at a loss, and at best aware that all attempts at a solution have been ineffectual. Disappointment is rife, and this increases the risk of the situation worsening. A more exact consideration of the „case", in which all relevant parties participate, can, however, bring to light well-proven ways of proceeding and often open up possibilities of placing the whole network of relationships on a new footing.

The high rate of young people refusing to go to school and of school-leavers with no qualifications indicates that parents often do not manage on their own to cope with the conflicts arising in the lives of their children.[1] But on all sides the health of schoolchildren is also giving cause for concern. According to a

1. The level of absenteeism depends upon various, partly regional factors. For example, for the city of Cologne it was found that in the intermediate school („Hauptschul-") sector the number of chronic absentees stood – at the time of sampling – at 15%. A

survey by the Robert Koch Institute in 2008 the rate of chronically ill children and adolescents in need of clinical care lies between 12% and 16%. This situation has not significantly changed since then. Current results of the National Survey of Children and Adolescents (KiGGS) show the distribution of chronic illness in the general school population: „More than 16% of all children and adolescents suffer from some allergic condition, 15% from being overweight, 8% from obesity; about 21% of adolescents show symptoms of mental disturbance, and among all age groups there are many instances of serious health conditions such as diabetes mellitus, heart problems, epilepsy and cancer." (KiGGS, 2014)[2]

In such situations parents themselves are in need of professional help. They are reliant on a piece of „crisis-management by proxy" (Oevermann 1996, p. 82ff.: Oevermann 2000) being performed for them, and this enables them eventually to act on their own with more assurance. Support from teams of professionals, which are part and parcel of the organisation of hospital schools, thus aids the restitution of parental independence, for the demise of formerly successful family routines often leads to the partial loss of the ability to manage things oneself. Of course, the educational and therapeutic guardianship that happens during a stay in hospital can only ever be seen as a temporary stage between crisis and stabilisation. The object of the support is to render itself superfluous. Thus it is possible – even probable – that all those involved in this increasingly problematical social field – and not just the „certified patient" – can benefit from this new view of mental health problems in relation to education.

2. Theoretical background: The working alliance between teacher and therapist and its structural elements.

This study presents a case-profile from a hospital school where therapists and teachers work in close co-operation. This entails the use of a term used to define an approach discussed in the scientific literature – *the professional working alliance between teacher and therapist* (Oevermann, 1996) – in order to generate interpretive perspectives based on the case dynamics. Subsequently the results will be viewed in relation to procedural options that would have been possible, but did not come to realisation.

A major crisis is something that has profound effects upon a people's lives and brings into play every facet of individual existence. Many aspects of both their inner and outer lives are thrown haphazardly into relief in such a situation, and thus in an uncontoured, in other words, diffuse way constitute material for the professional helper. The relationship between client (patient, student) and helper (therapist, teacher) is thus at the mercy of the lack of personal boundaries occasioned by the crisis. At the same time, the helper's contribution to the relationship is one of a *clearly-defined* role, which aids the professional assessment of what support is required. Without specific, expert *containment and ordering* of the client's diffuse lack of any sense of personal boundaries, the re-establishment of independence could not succeed. In order to arrive at the restoration of self-control a particular form of interaction is required, in addition to that between emotional diffuseness and its therapeutic containment. Following on from Freud, Ulrich Oevermann sees the ideal relationship between client and helper as a *professional working alliance*. „Client" here refers either to an individual whose development has not yet reached the stage of personal independence (e.g. infants or primary school children), or to one who is for a certain period *no longer* capable of autonomously managing their own life due to a mental crisis. „Helpers" (teachers, guardians, therapists) are persons with the expertise to facilitate autonomic processes within an autopoietic context. Defining the situation in these terms makes clear that it does not make sense to view the professional territories covered by education and therapy as widely separated from each other, especially when the aim is to engender conscious self-determination within an open-ended developmental context.

chronic absentee is defined as someone who has missed school unexcused more than five times within a period of one calendar year. The rate of absenteeism in secondary and grammar schools („Realschulen" and „Gymnasien") was markedly lower (5-6%). Cf. Weiss 2007, p.52, and on the aetiology and topology of absenteeism, Ricking 2003.

2. This quotation can be found at http://gesundheitsfoerderung.bildung-rp.de/chronische-erkrankungen.html. (site visited: 25.09.14). The Kinder- und Jugendsurvey (KiGGS) is part of the general health monitoring project of the Robert Koch Institute, and its database is updated regularly.

In dealing with crises in the lives of schoolchildren, therefore, the working alliance between teacher and therapist creates the practical possibility of placing the relationships involved in a productive setting that actually addresses the problem. The practice of forming working alliances of one kind or another is already a firmly established component in the training of doctors, psychotherapists and even lawyers: the students in these fields are thus being prepared for the fact that in their professional lives they will be working with people whose independence is, at least temporarily, diminished – in other words, „clients" as defined above. The structure of such a working alliance can be characterised as the inter-penetration of two forms of knowledge:

The various professions „… have at their disposal, on the one hand, a broad base of empirical and methodological knowledge, and on the other they each have a particular style in the way they combine scientific knowledge with the practical and personal relationship to the client. Thus, while the systematic acquisition of knowledge is the basis of any profession, it can only be rendered effective by the learning of 'an art of practical action' (Oevermann)." (Galiläer 2005, p. 95f.)

Future doctors, psychotherapists and lawyers can all extend the scientific and methodological knowledge acquired during their academic training by schooling their understanding of *concrete cases*, thus laying the groundwork for developing the previously mentioned professional style. Both similarities and differences will thus emerge among the cultural profiles of particular professions. For instance, the psychotherapist must have a way of structuring an exploratory conversation different from that of the lawyer, if he is to access and work with the client's deeper, personal levels. Similarly, the aims and methods of both professions diverge, although they both need to penetrate equally far into the details of the client's personal life (the lawyer must be capable of understanding biographically conditioned motivation, in order to mount an effective defence; without trust, in other words diffuse openness within the working alliance, this will not succeed).

Oevermann distinguishes such classical professions from other fields which are semi-professional. Among the latter he includes school-teaching, because it does not provide a structural context for the creation of working alliances. Such a practical context would have a prophylactic-therapeutic style which would be able to respond to the open-ended, dynamic, transforming individuality of the students. Another reason this is missing is, according to Oevermann, because the fully professional culture of „learning from the concrete case" is non-existent.

It follows from this that to restrict the school's task to the two classical disciplines of transmitting knowledge and norms is tantamount to ignoring the true needs of young people. The school – in fact, the individual teacher – has a task, the structure of which can be formulated in theoretical terms. This is to integrate a „therapeutic dimension" into professional life for the purposes of perceiving and, where necessary, correcting psycho-social imbalances in the development of the students (clients). Since students, according to which final exam they take, spend between 12 and 15 thousand hours[3] of their lives in the institution school – an infinitely variable interactional system that partially shapes their psycho-social integrity – this task is an ever-present challenge.[4]

In the classroom elements of diffuseness and clear focus are in play, and coming to terms with them implies an ability on the part of the teacher to distinguish clearly between the student's and his or her own contributions to the situation, and to act accordingly. The student's contributions can be used diagnostically[5],

3. Cf. Rutter et al. (1980) Fünfzehntausend Stunden. Schule und ihre Wirkung auf die Kinder. Weinheim/Basel.

4. In the context of pedagogical practice the therapeutic dimension is directed towards something that is not yet manifest. Rather, it is a potential, a *slumbering possibility* of pathogenic development, that by the very nature of its incompleteness is susceptible in its further course to educational processes and to the massif formative influence of socialisation. With respect to its objectively given therapeutic dimension, therefore, pedagogical action is always *prophylactic action*, since it has the potential of *switching the biography of adolescent students in the direction of psycho-social normality or pathology.*" (U. Oevermann 1996, p.149, italics in original)

5. It is precisely because the teachers enter into full contact with the personal (and contradictory, unreflecting) behaviour of the students that they need diagnostic competence within the field of the pedagogical working alliance. The student becomes a „client" at those times when he reveals the sides of his personality which are incomplete, still capable of development and susceptible to crisis. The teachers – in relation to the prophylactic-therapeutic dimension – have the mandate to use the diffuse aspects of the situation productively for the students. This mandate, however, is limited. Its limits are set by the rule of universal equal treatment, which the teachers must guarantee for all students. They cannot be solely concerned with the problems of one student, but have to make sure that the whole class are making progress in their learning.

while the teacher has the possibility of moving between closeness (diffuseness) and role-specific detachment for the purpose of imparting direction or exercising corrective control. The picture emerging here of a pedagogical-therapeutic working alliance, however, oversteps the simple duality of the expert-client relationship that usually applies in the previously mentioned professions. In the realm of school-teaching it encompasses the individual teacher-student relationship, the collective teacher-student relationship (i.e. to the whole class) and that of both parties (teacher, student) to the parents or guardians. These last cannot be left out of account, because the fledgling independence of the students must be compensated by some form of ultimate responsibility.

3. Larissa: a case profile

The following vignette takes up a case that happened within the setting of a hospital school. Here it should be pointed out that as a rule knowledge of the biographical details relevant to the understanding of a case are at the disposal of the teachers. This information stems from the patient's (student's) medical file, as well as from conversations and team meetings involving teachers, psychologists and doctors.

The data upon which this case-analysis is based were recorded from conversations and other interactions with the patient/student during her stay on the ward, and interpreted by means of a qualitative-reconstructive method.[6] The passages in italics are reproductions of her actual words from an interview conducted at the end of her hospital stay.

Larissa is a class 9 student at a Waldorf school. The recorded interview took place shortly before the end of an almost seven month stay in hospital. She needed hospital treatment on account of severe anorexia. Upon admission, although 1.61m (5ft 3in) tall, she weighed only 37kg (81.5lb).

Just 15, Larissa is the youngest child in her family. She has three sisters (18, 22 and 23 years old) and a 20-year-old brother. Her 18-year-old sister is in class 12 at the Waldorf school and the other two completed their Abitur there. One sister is studying curative education, the other psychology and the brother, having successfully trained as a precision mechanic, is at the time of the interview in process of doing his community service („Zivildienst"). Larissa has been at the Waldorf school since class one and describes it – as a place of learning and play – in superlatives („brilliant", „perfect", „super"). She was apparently a very wild child and in the afternoons had a hard time tearing herself away from the playground. Three of her siblings have left home, the rest of the family live together and both parents have stable jobs. Up until very recently an old lady also lived with them in the house, and the whole family loved her „like a grandmother". This lady has since died of a brain tumour. Larissa's mother was the one who mostly looked after her, right up until her death. In conversations with the family she (the mother) often expressed her regret at the loss of the cherished structure of the household („The family is shrinking and the house getting bigger".)

For the purposes of this profile, however, Larissa's anorexia and the clearly successful course of treatment applied to it will not be the main focus. In the review conducted with her some points emerged, which were significant for her subjective experience of the healing processes. Since lessons on a daily basis are an integral part of the clinical setting, schoolwork was something that was always uppermost in her mind. This reduced the potential for anxiety about her imminent reintegration into every-day school-life.

When Larissa had been receiving instruction in the hospital school for nearly seven months and we had had a number of conversations with her about re-joining her class, she quite spontaneously expressed the wish for a trial period at a grammar school. This is part of the service the hospital school offers: students for whom a change of school, or even school type, is recommended have the option of trying a new one out. For this purpose it has arrangements with local schools. Now, in connection with the case we are considering here the question arises: what prompted Larissa to come to this decision so seemingly out of the blue?

It soon emerged that this spontaneity was more apparent than real. It turned out that Larissa had been brooding for quite some time over things that had been going on in her school shortly before the beginning

6. Oevermann's method of objective hermeneutics was followed.

of her therapy. And now, faced with the prospect of reintegration these memories rose up in her, influencing her feelings and thoughts.

In connection with this it also became clear to her that the diagnosis of her anorexia had taken a long time. The family doctor could not at first make sense of the large fluctuations in her weight. Nor did her parents think they were anything serious. In school it was noticed that Larissa was under the weather, and that this was possibly due to the inception of some illness. The teachers, however, did not address the situation: the student was seldom absent, and if she was, she always had a doctor's certificate; and her attention to her schoolwork had never suffered. She herself thus comes to the conclusion:

L: I'm pretty sure they noticed – they're certainly not stupid, but (.) that's why nobody said anything.

For the record we can say: Larissa had been seriously unwell for months before the beginning of her hospital treatment. A clear diagnosis – according to her file – was a long time coming, and in school there was only a vague impression that this girl had a problem, so it was not followed up.

She also spoke of a second experience she had during her last few weeks of regular school attendance: a classmate had had a car accident and, when she returned to the Waldorf school from hospital, was still in a fragile condition. Larissa describes this as follows:

L: *When she came back she was so much the teachers' pet and (..) for us that was really terrible because (.) they were always making allowances only for her (.) and for her everything (.) I mean, she was given masses of favours (.) I wouldn't want that, coz for us that was really awful and I don't want, like, my friend or others in the class to be put at any kind of a disadvantage because of me (.) I don't want to be treated either as the one with anorexia, that's just stupid (.) And no one in the new school will have any idea that I was in hospital, all except the teachers, but the students won't…*

In this interview extract two closely related motifs come into focus. Illness singles out the person who is ill, and when the wherewithal to react to it professionally is lacking, it can lead to stigmatisation and thence, in some cases, to actions which, on the one hand, are anti-social, and on the other, fail to respect the inner resources of the person concerned. With all their good intentions of being considerate, the teachers – from Larissa's standpoint – disregarded her classmate's own residual ability to do things for herself, and thus too little was demanded of her and she had too many privileges. This was a very subtle observation of the situation on Larissa's part.

Following on from this observation she then comes to speak of herself – her own return from hospital. She anticipates a possible stigmatisation: *I don't want to be treated … as the one with anorexia* .. And in the sentence after that we hear what is probably the actual motive for wanting to change schools:

L: *And no one in the new school will have any idea that I was in hospital, all except the teachers, but the students won't…*

To be able to become part of a school peer-group without any previous „baggage" seems to be the wish that is being expressed here. While it is alright for the teachers in the proposed new (grammar) school to be aware, as professionals, of her former illness, the students should remain uninformed, in order not to disturb the social equilibrium.

Later on in the interview she lays her misgivings completely on the line:

L: *There's no way I want to be treated as some kind of half person, but to be seen as totally normal, just like everyone else (.) taken seriously and not looked on as, like, weaker or something.*

What seems to be going on in Larissa is an inner process of sensing her own capabilities in spite of her illness, and of consciously placing herself in an appropriate social context. The exclusivity of role which she observed in her convalescent classmate, and which was the focus of supportiveness on the part of the teachers, becomes a fundamental problem for Larissa. When teachers collectively cast someone in the special role of handicapped student, while ignoring her readily available capabilities, then for Larissa this is a threat to the subjectively experienced unity of the self. For the teachers, then, seeing her as injured becomes the

guiding principle for their interaction with this student. They no longer perceive her as „normal", and undermine her access to her own personal resources. The intended support, applied non-specifically, turned into its opposite.

If the still healthy aspects of this person had been met and made use of in a spirit of equal treatment for all, then those occasions when she needed special handling would not have been a problem. For due attention should indeed be paid to that side of the person, through the power of which the unhealed aspects can be compensated. It could be objected, that what this is really about is a problem of Larissa's – her chronic need for social acceptance („narcissism"), which is held at bay by her anorexia – and not so much about the proper management of convalescents. We cannot exclude these as possible ingredients in the situation. But: this girl really wrestles inwardly in her honest attempt to find the right way of looking at her questions, perceptions and judgements. Thus, in the interview she also considers whether it might not be sensible to give her own school, the Waldorf school, another try. Could it not be that her negative attitude towards it before her hospital admittance was due to her illness? –

I: *You said that you have changed?*

L: *Yes*

I: *In what way?*

L: *Well, I mean, completely [smiles] from before I went into hospital (.) for the whole way you think, I mean, what you're interested in, like, totally changes, and I'm not sure now whether it had something to do with the school (.) em (.) that towards the end I felt so negative about everything or mostly with my illness. That's why I'd like to just see how things are now.*

In summary we can say: Larissa no longer regards her recollected feelings as representations of pre-established, incontestable reality. She is beginning to become aware of the changeability in the relationships between feelings, thoughts and bodily states, and this is stimulating her to subject her remembered feelings and their assumed meanings to inner scrutiny. The primary effect of this is to bring her into the realm of recovered independence, as far as the impending decision is concerned.

Many students going through serious inner crises are still able to observe themselves and others in a healthy way and to participate in constructive action. Most of those with these healthy reserves carry within themselves a kind of archetype of the ideal pedagogical-therapeutic working alliance. This exists unspoken, and only ever comes to formulation on specific, rare occasions. Without having to think too long, most students can say fairly accurately what was of direct personal help to them, apart from their experience in school or at home. This also seemed to be the case for Larissa. For instance, towards the end of the interview she was asked quite directly how she felt she could best be supported in school. Her answer was:

L: *Oh, you mean, what way would be good for the teachers to react? Yeah, maybe, that they just talk to me about it, or try to solve the problems together with me, or talk to my parents or something (.) Maybe they know more about this kind of thing, like, maybe somebody dying or whatever (.) With these things I reckon when you can see that someone is really not well, why don't they talk to you? That would have helped me, but not in front of the class, rather some time after school.*

here is quite a lot in this simple description: its main thrust concerns the integral components of the pedagogical-therapeutic working alliance, according to which proper support is not a one-way course of action, that emanates from the teachers alone and – when all goes well – has the desired effect on the students; rather, co-operation among all the persons involved is what Larissa is driving at. Here four aspects are significant:

(1) *The teachers' reaction to a well-observed situation*, which comes then to specific expression in the form of (2) *consultation in a safe space*; this subsequently leads to (3) an attempt to solve the problem *„together with me"*, and finally Larissa (4) extends the supportive context to *include the parents*. With this the pedagogical-therapeutic working alliance as a developmental community, capable in principle of working out possible solutions in a case-sensitive, individual way, has been fully delineated. Insofar as the parents may be in

possession of additional knowledge that could shed light on the crisis („*Maybe they know more about this kind of thing, like, maybe somebody dying or whatever*"), they should apprise the teachers of it, and thus contribute to a more precise understanding of the situation.

In the subjective experience of this student are mirrored the characteristics that we distinguished into the two related concepts of „specific role" and „social diffuseness". Larissa experienced in the example of her injured classmate a deficiency in the role-performance of her teachers. The basic principle of equal treatment was not being upheld. Under the circumstances it should have been an aspect of the teachers' role-performance that they paid specific attention to, and particularly in relation to the fact that the girl in question was still quite capable in spite of her handicap. This missing contour in the role-specific aspect of the pedagogical working alliance corresponds in Larissa's experience to a deficiency at the opposite pole – the diffuse aspect of the teacher-student relationship: the perception of a gradually manifesting critical illness remained subliminal for months. The perception could have come clearly out into the open if the teachers had ventured to enquire discreetly into what was happening in the student's personal life, or perhaps have taken up contact with her parents. This did not happen, and the crisis became acute.

This case, as sketched here, looks comparatively harmless. What Larissa experienced in her class community could hardly be described as dramatic compared to other cases. Nevertheless, from the student's perspective everything looks quite different. Here the every-day normality of what was reported leads us to suppose that this type of case could potentially have a high degree of generality. In other words, this inconsequentiality in these key aspects of the professional working alliance could well be a contributory factor to the outbreak of crises in the lives of schoolchildren.

There is still the question of what Larissa finally decided. Going to the grammar school was in many ways a sobering experience, and so was no longer an option. Conversations involving her class guardian, her parents and herself then took place, in the course of which Larissa described in detail those aspects of her school-life she experienced as problematic, and her re-introduction to the Waldorf school was fully discussed. At the same time they put in place a set procedure for teachers, student and parents to follow in the case of a recurrence of the crisis. The reintegration process was an all-round success.

4 Discussion

The case analysis presented here is concrete evidence of the functionality and effectiveness of the structural elements of pedagogical-therapeutic working alliances introduced at the outset. Mental diffuseness, on the one hand, and clearly defined roles, on the other, are fundamental aspects of pedagogical relationships. The former is attention-seeking behaviour and lacks personal boundaries, the latter signals or creates detachment. They can be used both for diagnostic and for pedagogical purposes.

In what follows the attempt will be made to view these fundamental aspects, as they feature in the vignette of Larissa's case, in relation to their social contextualisation. It will be seen that in Larissa's world there arise opportunities for sound observations as well as failures in this regard.

4.1 The starting point: no proper notice taken of Larissa's poor state of health

According to her medical file there were wide fluctuations in Larissa's weight over a whole year. During this period the family doctor was consulted, but he could find no cause for it, especially as there were no obvious signs of mental disturbance in the patient's behaviour. The significance of Larissa's dietary behaviour also escaped her parents: Gorging on sweet things and then the subsequent refusal to eat them combined with occasional vomiting after meals was not investigated, let alone noted, even in acute phases of weight reduction. Only when this process came to a head with a dramatic loss of 15 kilos in four months did it provoke a reaction from the parents. At first they arranged treatment for her as an out-patient, but this did not bring any improvement. In the face of this failure she was finally taken into hospital care. In school her loss of weight was assumed to be due mostly to an increasingly intense participation in sport, for instance,

handball. Since Larissa was not one who liked being absent from school, and any days she missed were always covered by letters and doctor's certificates, the teachers did not intervene.

The process described here makes clear that Larissa's developmental problem – when the anorexia began she was in the middle of puberty – did not meet with adequate awareness in her social milieu. Her own body-awareness seems to have got lost among the ups and downs of her weight fluctuations, and this in turn made it impossible for her to manage the delicate process of regulating her relationship to the world around her. Exactly what effect this pubertal anorexia had from the perspective of the individual self (subjective, physical awareness of the world and of the body) is impossible to say, for Larissa's bodily awareness was described as unproblematical. The changes in her personality could only have been expressed from a second-person perspective (inter-subjective empathy with the bodily processes of others). But this particular reflective process didn't happen. Thus the remit of keeping a careful eye on development and taking note of any signs of crisis that is usually within the provenance of the family, and indeed that of all those directly involved, remained unrealised.

About the reasons for the parents' blinkered attitude one can only speculate; it's possible, however, that they were keen to avoid the thought of illness at all costs, and as a result refused to see its readily observable symptoms for what they were. The diagnostic uncertainty of the family doctor evident in the file cannot be explained without further information. It can be stated, however, that with this the „third-person perspective" (objective observation or measurement of bodily processes) as a means of heading off a possibly pathological condition fell away. If it had proved possible to detect and describe the somatic changes that were occurring and to set them in relation both to Larissa's behaviour and to the natural phase of development she was going through, the reaction to the crisis could have come earlier. All this implies that the „angle of attention" (Bertram 2005, p.103) for the emerging illness was too narrow, and quite evidently conceptually inadequate. This calls up the general question of how the second- and third-person perspectives here outlined might make some diagnostic contribution at the early stages of a pathogenic process. In this connection borrowing certain elements from the pedagogical-therapeutic working alliance model could well be a good idea. For here, in terms of both structure and personnel, the „angle of attention" is oriented towards the dynamics of emerging pathologies, and as such also towards the finding of appropriate treatment (Oevermann 1996, p.149).

4.2 Viewing the illness in retrospect

A good indicator that a crisis has been overcome is, among other things, the degree of freedom the individual has acquired in the examining of formerly compulsive feelings and value-judgements and in re-evaluating them (cf. Sautermeister 2004, p.201). It is generally agreed that the important thing for patients is „the awakening of a mature attitude towards their illness" (Gerlinghoff & Backmund 2000, p.97). A lasting cure is thought to be closely related to the stability of this newly acquired independence. Proof of the recovery of the ability to take charge of the practicalities of one's own life is thus also provided by a retrospective analytical appraisal of the systemic contexts within which the illness developed – biographical, familial etc. In doing this, the individual incorporates into the process of re-evaluation further individuals who contributed in some way to the onset of the illness. The prophylactic effect as regards future recurrences could therefore be to learn from the current therapeutic success. The empirical knowledge arrived at in this way could then form the basis for transformation in the manner of dealing with latent pathologies that might arise later, and with the immediate social milieu.

Retrospective re-evaluations of this kind were evident in Larissa's utterances, and thus constitute evidence of an increase in independence. Looking back, school appeared to her as a field of interaction beset by problems, as well as mixed up in the dynamics of her own pathology. Larissa attempted to objectify the specific causal events that provoked her illness. In doing so she sensed that body and mind both played a role in influencing the course of her illness: *I'm not sure now whether it had something to do with the school that towards the end I felt so negative about everything, or mostly with my illness*. She was intending to test this by planning a new encounter with the same field of experience (the Waldorf school).

Probably the causes of this case of anorexia nervosa are to be sought[7] in Larissa's family situation, which had gone through changes which presumably had not been fully dealt with (the effects of separation crises, siblings moving out, the death of the lodger they had been looking after). At the same time Larissa experienced the behaviour of her teachers as problematical: they should have noticed the state she was in, and have placed this knowledge at the disposal of the relevant professional working alliance – at least this is how she formulates it in retrospect. Lastly, Larissa thus demands of her teachers a mode of action which goes beyond the narrow boundaries of the classical transmission of norms and knowledge, and which takes account of the development of the individual personality, even when it is in a state of crisis. Here what is required are the workings of the second-person perspective.

5 Summary

In the course of human biophysical development crises are essential. They are a structural component of the progress of ontogenesis towards a life of self-determination. When crises in early life take on pathological dimensions, which greatly incapacitate the individual and bring long-lasting negative effects along with them, then the question of what prophylactic measures should be taken becomes acute. Since the pedagogical-therapeutic working alliance model is a dispensation that is functionally dynamic and flexible in terms of personnel, its observational methods can be combined with those of the ecological model discussed here. The important thing then would be to strengthen the second-person perspective within the working alliance. Empathy and communication flow within the triad (of teachers, adolescents and parents) would form the prerequisites for the ability to recognise psycho-somatic patterns, or their case-specific meaning, within a concrete developmental pathway. Since severe juvenile crises such as pubertal anorexia are, according to current views of their aetiology, best regarded as multi-faceted , it is essential to have „an organ" capable of collecting and combining the multiple perspectives that need to be generated. Before hospitalisation as a last therapeutic resort becomes unavoidable, the options offered by the professional working alliance as an informal, practised organ of collective perception could be tried out and possible corrective measures introduced.

7. On the sort of thing that can trigger pubertal anorexia, Henning Köhler points out the following: „A harmonious, warm and protective family life that for years has been consciously devoted to surrounding a child with tender loving care can suddenly all seem in vain, because and event such as moving house has created a deep insecurity." (Köhler 1987, p.57)

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