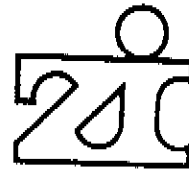


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NATIONAL CASE STUDY

CHILD MENTAL HEALTH AND PSYCHOSOCIAL DEVELOPMENT
IN WEST-GERMANY

Department of Child and Adolescent Psychiatry

by

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1. Demographic data

-1-

Western-Germany has a total area of 248 630 square kilometres.
In 1982 the level of population amounted to 61.6 mio inhabitants, that means, a population density of 248 persons per square kilometre.
In 1981 the age distribution among the population was as follows* (Tab. 1).

Tab. 1: Age distribution

age-group	total	%
0-15 years	10.8 mio	17.6
15-20 "	5.3 "	8.6
20-60 "	34.4 "	55.8
>60 "	11.7 "	11.7

Thus a quarter of the German population (26%) is between 0 and 20 years old.

Usually, the households are supplied with running water and are adequately equipped with sanitary facilities. In W.-Germany to be homeless is defined as to live in improvised or poor housings without any contract. In 1979 about 300 000 up to 1 mio people were estimated to live under such conditions. The official emergency housings usually are supplied with toilets for common use and washing facilities (VASKOVICS et al. 1979).

In 1979 the following rates of immunization (Tab. 2) against infectious diseases were referred (MAI & EHRENGUTH 1981):

Tab. 2: Rates of immunization

tuberculosis	94%
tetanus	92%
diphtheria	87%
whooping cough	21%
polio(oral)	90%
measles	36%

* Unless otherwise provided all figures are taken from the Statistical Yearbook, 1983 or other official statistics.

The basic aims of a health system such as continuous, adequate and available services for all people are in general fulfilled in W.-Germany. Primary medical care including supply with the necessary medicaments is guaranteed. The dense network of health services allows everybody to reach medical care within due time. Although the highly developed and specialized medical centres are indeed concentrated in urban areas, most of them are within easy reach by public conveyance. Besides this most families own a car. In emergency cases the carriage to hospital by helicopter is possible on principle.

In W.-Germany even smaller hospitals have obstrectical wards. That is why even in rural areas deliveries at a hospital with trained personnel are possible. Usually women give birth to their children at a hospital or similar institutions like lying-in hospitals or maternity homes. Home-deliveries are rather seldom although there is a trend to outpatient delivery.

Prenatal care is free. All preventive measures including the frequency of prenatal checkups are left to the discretion of the attending gynecologist. The ordered checkups are completely paid by the health insurance. The guidelines for maternal care suggest at least 10 routine checkups. These checkups should be spread over the normal course of pregnancy so that the women are seen from their doctors every month up to the 8th month of pregnancy and later on every 14 days. According to a survey of TIETZE (1982) women make use of an average of 8 or 9 routine checkups during pregnancy.

All children delivered at a hospital receive care from trained personnel. If complications arise during delivery, a trained pediatrician is always on call to give special care to the newborn. According to a regional study in Baden-Württemberg in 1982 there were 15 000 risk-deliveries (i.e. more than 10%) demanding special care for the newborn. There is an enormous decrease in the use of postnatal follow-up examinations during the first years of life. Whilst the participation in the first two routine checkups carried out in the maternity wards of the hospitals is nearly 100%, the utilization drops from the third follow-up examination onwards and reaches its lowest level of 68,7% at the 8th checkup at the age of 4.

In 1981 625 000 babies were born alive. Out of these 7257 died during the first year of live. Per 1 000 alive born babies as many as 100,7 that weighed less than 2500 g and 6,5 that weighed more than 2500 g died. That means a natimortality of .01%.

The calculated expectation of live for boys born in 1979 runs to 69,9 years and for girls to 76,6 years.

Among the German population we have only a very small number of adult illiterates. Exact figures, however, are missing. It is estimated that there is a significant number of unknown cases among the foreign population. In 1982 4.6 mio foreigners were registered in W.-Germany and the actual number is positively much higher because of the many illegal migrants.

In 1981 the gross national product per capita amounted to 7920 Dollars in average.

2. Sociocultural and environmental factors

As in any other western society in Germany too, social change has taken influence on family structure and family life. Nevertheless the family still is the primary institution of socialization and the basic environmental context of child development. In the last two decades the child rearing attitudes have changed towards a more non-directive and permissive style of education. Yet, in the recent years there is a trend back to a more stringent educational practice taking into account that setting limits is necessary for the further social development of the children.

About 360 000 couples got married in 1981. Since 1950 the rate of marriages decreased from 11 per thousand inhabitants down to 6 per thousand in 1981. In contrary the rate of illegitimate children raised from about 37 000 (6.1%) in 1975 up to 53 000 (8.4%) in 1982. Many of these children live in a "normal" family situation; their parents being unmarried often makes the only difference between them and legal

born children. The consequences of this situation and how it works over the long term remains to be seen.

In 1981 the average age of marriage was for men 29 and for women 26 years. The total number of married couples amounted to 15.1 mio in 1982. About 110 000 couples got divorced. Around 58 000 children under age were afflicted by the divorce of their parents. In about 980 000 families with children under 6 years of age the mother is gainfully employed. This situation applies to 1 150 000 children.

Tab. 3: Statistics of family pattern in 1982

family pattern	total	%
total	22.8 mio	
childless	12.0 mio	
with minors	8.2 mio	
one child	4.2 mio	51.4
two children	2.8 mio	34.8
three and more	1.0 mio	12.7
complete families	12.2 mio	
incomplete families	1.3 mio	

Statistically the mean of children per family is 1.24. Yet, the average German family (according to the given social norms) consists of father, mother and two kids.

Since 1981 interruption of pregnancy is exempted from punishment within prescribed periods and indications. These indications are: medical, eugenic, juristic (after violation) and social indication. Within this range of indications abortions are paid by the insurance funds (yet, it is in discussion to release the insurance funds from paying abortions in cases of social indication). Since this reform passed into law the number of abortions has increased significantly especially on social grounds. The number of registered abortions alone comes to 90 000 cases per year and there is still a not negligible number of unknown cases.

Compulsory school attendance is prescribed by law for the age of 6 up to 16 years. In 1981 as many as 4.7 mio children attended primary and 3.4 mio secondary school. About 1.2 mio students studied at university.

About 340 000 children attend schools for retarded or handicapped children. These schools for special education have classes of a maximum of 20 pupils whereas in regular schools the classes consist of 20-30 pupils. In Germany all one-room schools have vanished even in rural areas. Most smaller schools were integrated within district schools. As a concomitant result of this centralization children of rural areas often have to cope with a long way to school. A multitude of studies deals with the effects of this centralization on the pupils giving room to the discussion of the special stress factors the children are now confronted with.

During the last 20 years the problems of handicapped people and their families increasingly shifted to the focus of public interest. Empirical research is concentrated on the development of instruments for early diagnosis of handicaps and on the evaluation of therapeutic, rehabilitative and supportive measures. In the last decade the spectrum of schools for special education has been enormously extended. By now we have about 2600 schools of this kind including special schools for children with mental retardation, with learning disorders, with behavioral disorders and for children with different forms of physical handicaps. For the present the main emphasis is laid upon the development and evaluation of adequate concepts to integrate handicapped people within everyday life.

In 1981 we had a total number of 5.2 mio handicapped people. The subgroup of severely handicapped children and young adults up to the age of 25 amounts to 278 000, that is .45% of the German population.

The table listed below (Tab. 4) gives absolute figures for different forms of handicaps according to different age groups.

Tab. 4 : Distribution of handicaps by age

handicaps	total (mio.)	age groups			
		4	4 - 15	15 - 20	>25 y.
loss or partial loss of limbs	1.3	127	826	3300	124000
restricted func- tion of limbs	.80	1200	11200	30000	690000
restr. fuction of spine, chest	.79	253	2500	12600	770000
blindness and restr. vision	.21	400	4300	9700	200000
speech disorders, deafness	.17	470	8400	11000	146000
dwarfism and deformations	.09	50	270	900	97000
paraplegia, cerebral disorders, mental retardation	.51	3800	38000	75000	401000
restr. function of intern organs, organsystems	1.92	1900	12900	24000	1880000
others	.64	1300	7400	16000	600000
total	5.27	9500	86000	182000	4990000
%	100	.18	1.6	3.5	95

Like in other European countries unemployment becomes a raising problem in W.-Germany. We are now confronted with more than 2 mio unemployed people. Among these young people are concentrated in large numbers. In September 1982 the official statistics counted 97 000 male and 98 000 female adolescents without employment and, what is worse, without possibility to get any kind of vocational training. In 1983 we had a 12% unemployment quote for youngsters up to 24 years.

Out of the 4.6 mio foreign inhabitants living in W.-Germany as many as 1.3 mio are under age (i.e. 28.4% of the total foreign population).

The magnitude is of Turkish nationality followed by Yugoslavians, Italians, Greeks, Spains and Portugueses. Many foreign workers are separated from their families. They often live in very poor housings compared to their German colleagues.

At present, government policy is to grant no further work-permits to foreign workers and to limit their number as far as possible. The efforts to integrate foreign families within the German society are torpedoed by the existing prejudices and the discrimination within parts of the German population combined with a lack of contact. These problems partly arise from the low social and economic status of foreign people in our society. In return many foreign families refuse to be integrated. As a result about 50% of the Turkish population in Germany and about 15% migrants of other nationality live in a ghetto-like situation.

The large majority of guestworkers arrives in W.-Germany with the determination to return home within the next five years. The fact remains that many of them do not realize their initial plan. In 1977 as many as 40% of the guestworkers had been living in W.-Germany for more than five years and it is to be expected that a large number of them will never return to their native country.

Foreign children up to the age of 3 years are more often in need for hospital care than their German peers. Foreign parents make less use of the routine pre- and postnatal checkups compared to German parents. Contrary to this there is no empirical evidence that foreign children show more psychiatric disorders than their German peers, leaving aside the adaptative difficulties during the early phase of migration. Recent studies (POUSTKA 1983, REMSCHMIDT & STEINHAUSEN 1981) prove that foreign children are as "healthy" as native children. In spite of this fact this group uses child mental health service facilities more seldom.

Foreign workers significantly more often cause industrial accidents compared to German workers. This may be due to the fact that their work often bears more accidental risks.

3. Legislations

3.1 Compulsory age of schooling

Compulsory school age reaches from 6 to 16 years. We have various special schools for learning disabled, mentally retarded and physically handicapped children. Academic failure in primary school leads to an examination of the child to see if a school for special education better meets his learning abilities.

Compulsory school age goes beyond the 9-year-primary-school. After the 9-year-primary-school most adolescents start with a vocational training that in average lasts 3 years and includes vocational school education. The first four years of elementary school are common to all children except those needing special education. After these 4 years comes a first splitting up into primary and different forms of secondary school education.

3.2 Maternal welfare

The given legislations for maternity welfare in W.-Germany comprise the following aspects: pregnant women who work take a normal pregnancy leave - 6 weeks prenatal and 8 weeks postnatal. For this time they receive about \$ 10 a day from their health insurance. The difference to the women's netto income before pregnancy has to be paid by the employer. It is possible to take a prolonged postnatal pregnancy leave going beyond the prescribed 8 weeks. Up to six months after delivery the health insurance pays \$ 10 a day to the young mothers so that they are able to take care of their newborn during this important first period of development. Future legislation, however, is going to reduce these payments to about \$ 7 a day.

3.3 Divorce

By mutual agreement divorce becomes possible after at least one year of separation. After three years of separation it becomes possible even against the will of one partner.

It is provided by law to ask the children whether they want to stay

with their father or mother after separation respectively divorce. It is a fact that young children are not able to decide questions of such great consequence all by themselves, usually they are not able to express their feelings and wishes. Although it is clear that children cannot have the final say, there is an open discussion among experts on how far the child's will has to be respected. In spite of the conflicting views concerning younger children, there is agreement that children past 14 years should be granted a say on their future life.

3.4 Legal capacity and majority

In W.-Germany adolescents attain majority and full legal capacity at the age of 18. Past seven years minors get a limited legal capacity meaning that they are allowed to make contracts in agreement with their parents. Sixteen-year-olds are allowed to get married if their partner has already reached majority (i.e. is 18 or older).

According to criminal law children up to the age of 14 years do not have any criminal discretion. Thus criminal responsibility starts upon completion of the 14th year of life. Between the age of 14 and 18 adolescents are subjected to the juvenile court system. Criminal law relating to juvenile delinquents is chiefly directed on correctional and educational measures. With completion of the 18th year of live adolescents reach full criminal responsibility.

Yet, there is the possibility to submit 18- up to 21-year-olds to the juvenile court system if they are developmentally equal to minor adolescents assuming a probability for later maturing.

3.5 Child protection

If the parents are not able or not willing to guarantee their child's good, it is possible to withdraw parental authority from them by law. Corrective education with a view to the protection of minors can be initiated in both cases with and without the parents' agreement.

Misuse and neglect of children includes mainly physical cruelty but also psychological. Everyone who comes to know about misuse or neglect of children has the duty to give this information to the police

or the youth welfare office . It is supposed that only 5-10% of the cases become registered by police. Thus the estimated number of child abuse respectively child neglect is 150.000 - 200.000 cases annually. Toddlers up to 2 years are most frequently afflicted. The prevalence of sexual misuse of children is difficult to establish for most cases are never brought into public. In most cases family members, relatives, friends or acquaintances are involved and the family tries to hide the incidences.

Children suffering from a form of psychiatric disorder meaning a risk for their own or other's safety can be referred to a closed ward within a psychiatric hospital. It is prescribed by law that they must be heard and seen by a lawyer after admission to hospital. Only court is allowed to decide whether further hospitalization is necessary or not.

In W.-Germany child labour is forbidden by law. Yet, the extent of illegal child labour is not known. During the last years the misuse of children within the scope of pornographic industry has become an increasing problem as well as prostitution of minors. About 10% of the prostitutes are minors and there is an upwards tendency.

3.6 Adoption

Legislations on adoption adhere to both problems, the child's aptitude to become adopted and the parents' qualification to become adopters. It seems necessary to pay more attention to the motivation for adoption; concerning this aspect critical considerations often are missing. Various measures are taken in the forefields of adoption and the parents-to-be are faced with many difficulties. Afterwards, when adoption has been carried out and the parents are confronted with practical problems, they are often left alone. It seems highly desirable to offer these parents the possibility to take advice and support from trained professionals.

In 1981 about 9 000 adoptions have been carried out with aid of the youth welfare offices. And about 70 000 children were given to foster families. It is a fact that foster children often change the families or oscillate between their physical parents, different foster parents

and homes. The missing stability is the main problem connected with fostering. A possible way to manage this problem is to pay more attention to the foster families in the sense of guidance and support.

3.7 Youth delinquency

As already mentioned above, in W.-Germany criminal law differentiates between juvenile (18-21 years) and adolescent (14-18 years) offenders. About 18 700 juvenile and adolescent delinquents were condemned in 1981, these were 50 000 more than 1975.

In youthful offenders the main emphasis is laid upon the correctional component of the criminal justice system. There are many types of community and transitional release programs that have demonstrated value in rehabilitating the offenders. Among these are: probation, halfway houses, work release, prerelease centres. In cases of probation the convicted offender retains his freedom but is subjected to court control and supervision and guidance of a probation officer.

3.8 Social insurance

The affairs of social insurance are regulated by law. Every employee obligatory has to pay his contribution to social insurance according to his income. Unemployed people, as far as they had been working before and thus paid their contribution to the unemployment insurance, receive an unemployment pay proportioned to their last salaries. Unemployed people without a claim for unemployment pay are supported by social welfare.

4. Patterns of health care

In W.-Germany we have both a public and a private health insurance system. Most medical practitioners treat patients from all insurance funds. This means, there is a splitting in many insurance funds but the medical care in general is undivided. In which kind of insurance fund someone is depends on his profession and income. Officials receive a support from the government to pay their medical bills. In general

everybody can afford to go to a doctor or a hospital in cases of illness. We have free choice of physicians.

In 1981 about 76 000 general practitioners, 5100 pediatricians, 5 000 psychiatrists and 249 child psychiatrists were registered in W.-Germany. Early in 1983 we had 22 913 physicians in Baden-Württemberg, that means a doctor per 405 inhabitants ; ten years ago the figure was 566 inhabitants per doctor. Compared with the preceding year the number of doctors has increased in 2,5%. The improvement of medical care in total W.-Germany is mainly due to the growing number of hospital doctors. Their number increased in 61,5% during the last ten years, whereas the number of general practitioners only increased in 28,8%.

In W.-Germany we have 70 child psychiatric in-patient units, most of them offer as well out-patient care. The local public health offices, the federal and the national ministries of health are the main official institutions to govern the health system in its entirety.

Both public and private institutions tie a network of medical care offering diagnostic and therapeutic measures as well as preventive and rehabilitative ones.

The preventive measures start with genetic counseling and are followed by the legal pregnancy leave, the ten pre- and the eight post-natal checkups. This basic system of prevention watching the children up to the age of 4 years would be sufficient if all parents made full use of it; unfortunately, they do not.

Every child going to a kindergarten is seen by a pediatrician, this is a precondition for admission. 3-4year-old children being mentally retarded or handicapped have the opportunity to visit a special kindergarten where they receive special developmental furtherance as early as possible. Children with specific handicaps, for example deafs or blinds receive special early furtherance.

It belongs to the tasks of the public health offices to examine the children before school entrance to make sure that they do not show any developmental delays or severe emotional disorders demanding special treatment. In this school entrance examination physical,

mental and social readiness plays a role.

Unfortunately the public health offices have only an advising function. As a matter of fact there is scarcely any control how far the parents follow the given advice or take the suggested measures.

A lot of institutions and professional groups provide guidance and therapy to disturbed school-age children and adolescents, e.g. educational psychologists, pediatricians, child guidance service facilities, child psychiatric clinics and child psychiatrists. The use of child guidance service facilities is free (of the public ones as well as of those kept up by the churches).

5. Main causes, types and rates of problems

5.1 Emotional and behavioral problems

The different forms of psychiatric and psychosomatic disorders as well as the side-effects of brain dysfunction are the main subject-matters of child psychiatry.

Psychoses - with infantile autism as a subform - rank as the most severe forms of psychiatric disorders. At the moment about 4000 autistic children and twice as much adolescents suffering from a form of juvenile psychosis are living in W.- Germany.

The problems connected with drug abuse represent a central focus in our society. A decay of the heroine prices gave a fresh and bitter impetus to the drug problem. A recent report of the government noted that on an average children have their first contact with alcohol at the age of 13. At the age of 14 the "average adolescent" smokes his first cigarette and at the age of 16^{he} starts with illegal drugs usually offered to him by a friend or a member of his peer group and not - as often supposed - by a professional dealer. About 5% of the adolescents regularly use drugs, 0.4% rank as drug dependent, i.e. about 46 000 persons.

The exact prevalence of psychosomatic diseases is difficult to establish with reliability because the afflicted persons often deny the psychological factors of their disorders (and thus are never seen in psychiatric institutions). Besides psychogenic asthma anorexia nervosa is of particular importance in child and adolescent psychiatry.

Neurotic disorder becomes manifest in a lot of symptoms such as phobia, depression, and obsessive-compulsive symptoms. In a field study CASTELL et al. (1981) found a 1% prevalence rate of neurotic disorders in a general population of 3 to 14-year-olds. Emotional disorders specific to childhood are more frequent (3%, according to CASTELL et al. 1981).

Emotional symptoms are as well seen in the context of adjustment reactions. Suicidal behavior usually occurs in crisis situations, especially in cases of failing coping strategies. In 1981 suicide took the fourth place in the list of causes of death in childhood after traffic accidents, drowning and infectious illness. The rate of suicidal attempts amounts to 14 000 annually.

Tab. 5: Rates of suicides by age group and year

age group	year	inhabitants (x 1 000)	absoulte figure of suicides	suicides per 100 000 inhabitants
0- 9 y.	1979	1778.8	2	0.11
	1980	1678.5	1	0.06
10-14 y.	1979	2548.3	56	2.20
	1980	2443.8	66	2.70
15-19 y.	1979	2650.5	360	13.58
	1980	2720.2	318	11.69
20-24 y.	1979	2354.0	729	30.79
	1980	2461.9	651	26.44

(according to SCHMIDTKE 1983)

According to the field study of CASTELL et al. (1981) disturbances of conduct are present in 1% of the investigated persons.

EICHELSEDER (1977) reported a proportion of 9% hyperkinetic symptoms for all school-age children; the sex relation was 2:1 - twice as much boys than girls. However, EICHELSEDER's figures are taken from teachers' questionnaires. Teachers, however, tend to overestimate these kinds of symptoms especially in the context of school disturbing disorders. With regard to this objection the real prevalence rate is expected to be lower. According to other studies (SCHMIDT et al. 1982, CASTELL et al. 1981) the figure is in the order of 5%.

Except enuresis, encopresis, speech disorders, tics, stereotypies, sleeping and eating disorders, isolated symptoms usually do not incline the development of behaviour disorders needing therapy.

Table 6 summarizes the prevalence rates for different symptoms as determined in several epidemiological studies.

Tab. 6a: Prevalence of enuresis and encopresis according to epidemiological studies

author	year	age	enuresis nocturna	enuresis diurna	encopresis
ESSER	1980	4	8.2 %	11.5 %	1.9 %
		5	5.2 %	3.2 %	1.4 %
THALMANN	1974	7-10	2.6 %		
v. HARNACK	1958	10	4.4 %		
SCHMIDT-KLUEGMANN & SCHERG	1975	10,11	2.7 %	1.6 %	1.7 %
WELDING	1977	2-6	3.9 %		
BOEHNING & GUSIK	1982	3-15	5.6 %		
CASTELL et al.	1981	3-14	0.5 %		

Tab. 6b: Median prevalence of several symptoms as investigated
in epidemiological studies

symptoms	median	number of studies	range
eating disorder	12 %	6	0.5-18 %
sleeping disorder	17 %	7	2 -54 %
hyperkinetic behav.	19 %	7	4 -39 %
poor concentration	24.5 %	6	13 -63 %
poor social relations	7 %	6	1 -34 %
temper tantrums	18 %	3	16 -40 %
depression	9 %	5	2 -15 %
anxiety	12 %	7	1 -37 %
destructiveness	15 %	2	4 -26 %
stealing	5 %	7	1 - 8 %
telling lies	6 %	3	5 -10 %
roaming around	2 %	6	0.5-11 %
tics	5 %	8	3 -10 %
nailbiting	19 %	7	2 -32 %
thumbsucking	5 %	7	2 -11 %
aggression	5.5 %	4	5 -32 %

Since 1958 several epidemiological studies have been conducted in order to provide some information about the overall prevalence of psychiatric disorders ranging from simple behaviour disorders up to severe forms of psychosis. Table 7* gives a view over these studies. A meta-analysis of them leads to a median of 18.5% behaviourally/disordered children and adolescents, i.e. in absolute figures about 2,5 mio. disturbed children and adolescents. Out of these as many as 800 000 urgently need therapy.

There is no evidence for a general influence of sex and age on the prevalence rates. Age differences are only present in the symptoms of sphincter dysfunction. Sex differences, although stated by many authors, are only valid for enuresis, encopresis, developmental speech delay and the hyperkinetic syndrome.

5.1.2 Pathogenic factors

We still have little knowledge about the main aetiological factors in the genesis of behaviour disorders.

The common hypothesis saying that behaviour disorders are more frequently found among children of lower social classes has not been supported, although THALMANN (1974) found a significant correlation

Tab. 7: View over German epidemiological studies

author & year	target population	method of case identification	age	rate of disorder	crit. of case identific.	refusal
WELDING 1977	kindergarten children N=1372	questionnaire for educators	2- 6	13 %	symptoms	missing
ESSER 1980	kindergarten children N=553	interview with mother	4- 5	18 %	symptoms	16 %
KOHLSCHEEN et al. 1975	first graders N=941	teacherinter- view	6- 9	19 %	symptoms	missing
STEUER 1973	primary school children N=621	teacherinter- view	6-12	25.5 %	symptoms	missing
THALMANN 1974	boys N=150	teacher and parent inter- view	7-10	18.7 % 1.3 %	symptoms moderate severe	3.4 %
SCHMIDT et al. 1982	Mannheim children N=292	parent and child inter- view	8	16 %	diagnosis	38.5 %
von HARNACK 1958	Hamburg school children N=1372	clinical examination mother interv.	10	16.3 % 3.7 %	symptoms moderate severe	missing
CASTELL et al. 1981	Bavarian children N=358	interview with mother, clinical examination	3-14	18 %	diagnosis	5 %
BOEHNING & GUSKI 1982	children in day care N=692	questionnaire for educators	2-15	23 %	symptoms	c.31 %

between higher educational level of the father and a decreased rate of behaviour disorders. ALLEHOFF et al. (1983) suggested a non-linear correlation model to explain the interdependence of socioeconomic variables and the rate of behaviour disorders - a viewpoint that deserves further discussion.

Not a single study exists that directly compares the rate of behaviour disorders in urban and rural areas. Yet, the studies of SCHMIDT et al. (1982) in Mannheim and of CASTELL et al. (1981) in rural parts of Bavaria used similar methods and thus are comparable. This comparison yields no difference in the prevalence rates of behaviour disorders between rural and urban areas of W.-Germany.

The relying upon isolated variables showing no relevant influence on the rate of behaviour disorders, VOLL et al. (1982) used a composed measure (Family Adversity Index) of familial and environmental stress factors including the following items:

- father un- or semiskilled worker
- overcrowded housing
- marital discord or divorce
- father: delinquency
- mother: depression and/or neurosis
- child: ever in care

This index proved predictability for behaviour disorders (at least in field studies; SCHIEBER et al. 1983).

THALMANN (1974) stressed marital consens concerning rearing practices as an important factor in the child's development.

SCHMIDT et al. (1982) examined the influence of minimal cerebral dysfunction on the prevalence rates of behaviour disorders. This rate grows from 16 to 40% in cases of brain dysfunction.

Furthermore, long and early hospitalization proved to go along with an increased risk for behaviour disorders. This result is supported by a

study of MARTINIUS et al. (1983) on children with congenital atretic malformations.

Tab.8: View over studies on mental health of guestworkers' children

author	population	method	age	rate of b.disorder
REMSCHMIDT & STEINHAUSEN 1981	children of Greek guest- workers	teacher questionnaire parent interview	8-11	12.8%
	Berlin controls			29.4%
POUSTKA 1983	children of Turkish guest- workers	parent interview	13-14	18%
	of Italian guestworkers	child interview		22%
	German controls			26%

5.2 Mental retardation

Moderate mental retardation is not counted on a national base. School failure combined with learning difficulties often lead to an examination of the pupil's intellectual capacity, that means usually testing the IQ. In this context most cases of moderate mental retardation are diagnosed. Like in other European countries about 20-30% of the German pupils are not able to finish the 9-year-elementary-school with a regular leaving-certificate (Deutscher Bildungsrat 1976). Out of these only 3 % have an IQ between 50 and 80, that means only this minority of school drop-outs does not have the intellectual capacity to pass regular school and should be admitted to a special school for delayed children. Besides intellectual deficiencies there are many other problems demanding special education.

It is difficult to give exact data on the prevalence of severe mental retardation for an official statistic is missing. According to a study of COOPER et al. (1983) learning disability or mental retardation is present in 3% of the school-age children. Out of these 0.8% rank as severely mentally retarded (IQ-score below 50) and 15% suffer from spastic palsy. In 50% mental retardation goes along with injuries of the immature brain.

5.3 Convulsive disorders

Everybody's risk to get a single or repeated seizures is of the order of .05% (MATTHES & KRUSE 1973); this goes coherent with the figures of other European countries. In his recent epidemiological study DOOSE & SITEPU(1983) reported the following distribution of convulsive disorders in a northern region of W.-Germany (Tab. 9).

Tab.9: Cumulative risk for epilepsy in children between 0 up to 8 years of the age classes 1957 to 1966 in Kiel (DOOSE & SITEPU 1983)

year	live births	epilepsy	‰	male	epilepsy	‰	female	epilepsy	‰
1957	3165	17	5.37	1662	9	5.41	1503	8	5.32
1958	3333	17	5.10	1710	10	5.80	1623	7	4.31
1959	3383	24	7.09	1782	13	7.29	1601	11	6.87
1960	3688	31	8.41	1907	22	11.54	1781	9	5.05
1961	3742	19	5.08	1988	11	5.53	1754	8	4.56
1962	3772	23	6.10	1973	15	7.60	1799	8	4.45
1963	3970	22	5.54	2115	19	8.98	1855	3	1.62
1964	4161	33	7.93	2157	20	9.27	2004	13	6.49
1965	4188	30	7.16	2083	13	6.24	2105	17	8.08
1966	4289	19	4.43	2143	10	4.67	2146	9	4.20
Total	37691	235	6.23	19520	142	7.27	18171	93	5.12

DOOSE (1983) examined a sample of 235 epileptic children, 60% boys and 40% girls. Nearly half of these children had their first seizure during the first two years of life.

The following table (Tab.10) summarizes figures on the different kind of convulsive disorders:

Tab.10: Type of seizure(according to DOOSE & SITEPU 1983)

	n	%	♂	♀
Grand mal	159	68	95	64
nonconvulsive generalised seizures	31	13	13	18
absences	25	11	10	15
myoclonic and astatic seizures	4	2	2	2
both	2	1	-	2
partial seizures				
elementary symptomatology	38	16	25	13
complex symptomatology	39	17	28	11
secondarily generalised seizures (incl.drop seizures, "Lennox-syndrome")	11	5	8	3
infantile spasms	18	8	12	6
febrile convulsions	40	17	24	16

The majority of children with convulsive disorders (57%) shows no impairment in their intellectual development. Severe mental retardation is present in 22%. Out of the group of severely mentally retarded patients 70% had their first seizure during the first two years of life. In the group of normally developed children this was the case only in 30%.

The main causes for convulsive disorders are:

1. idiopathic disposition
2. genetical risk factors and congenital metabolic disorders
3. perinatal brain damage
4. posttraumatic brain injuries
5. infectious diseases and brain tumors

6. Delivery of mental health services to children

6.1 Child mental health service system

In W.-Germany the mental health service delivery system is designed as a network. Child psychiatric in-patient units represent the centre of this network. These in-patient units are either independent hospitals or wards within 17 of the university clinics in W.-Germany or smaller units integrated within the general hospitals. The large federal mental hospitals established in the 19th century are the historical roots of psychiatric care in W.-Germany. These federal hospitals still form a part of the German mental health system, yet, their appearance, organization and function has changed. In total we have about 70 child psychiatric in-patient institutions with a bed capacity ranging from 10 to 500 beds (MARTINIUS 1983). Most of these institutions already offer or plan to offer day and/or night care.

Out-patient treatment has proved to be effective and cost-saving in a wide palette of child psychiatric disorders. In any child psychiatric out-patient unit about 500 to 1000 patients are seen annually.

Different professional groups are employed in the field of mental health. In institutions offering in- and out-patient treatment close cooperation of the staff members is of special importance. Child mental health manpower mainly includes the following types of professionals: child psychiatrists, psychologists (esp. clinical psychologists), pediatricians, social workers, nurses, school guidance workers, occupational therapists, educational therapists, physical therapists and many other specialized professions. The concept of mutual help movements and patients clubs is attracting increasing and widespread attention especially in the field of rehabilitation and after-care.

Since the insurance funds have changed their pay-off mode and bear the costs of ambulatory child psychiatric treatment, it is possible to keep up a child psychiatric practice. Yet, in W.-Germany only 25 child psychiatrists run an own practice. This is a quite small number compared to the 249 child psychiatrists registered in W.-Germany.

Most clinical institutions are mainly directed on curative tasks, i.e. diagnosis and therapy. Besides these there are many other institutions concentrating on preventive tasks and after-care. Among these are:

- child guidance service facilities
- rehabilitation centres
- counseling offices within the youth and medical office
- school psychological services
- psychiatrists and psychologists working within the judicial system
- supervisory activities of psychiatrists and psychologists in kindergartens, homes and other institutions
- other guidance and counseling service facilities
(for example in drug and alcohol problems, sexual problems, family problems etc.)

6.2 Methods of treatment

Most child psychiatric disorders can not be seen as having a monocausal origin. Generally a multifactorial causation has to be assumed. Derived from this causation model a multimodal therapeutic approach seems to be indicated in most cases. This multimodal approach includes the following elements of interventions:

- counseling of parents, teachers and other afflicted persons
- psychotherapy of the child and his family
- educational and physical therapy
- drug treatment

Psychotherapy exists in many forms. The most relevant and widespread therapeutic approaches are:

- analytic therapy
- family therapy
- behavioral therapy
- client-centred therapy

Many studies have been conducted in order to evaluate therapeutic approaches and programs for special diagnostic groups, e.g.: EISERT & EISERT, HASELMEYER & PUDEL, LEHMKUHL et al., BEITEL & KRÖNER, FEIERFELL & WENDEL-SPIESS, POUSTKA, DIETRICH - to give just a selection of those published in 1982. Many of these studies used an

integrative approach combining several therapeutic concepts.

6.3. Prevention and rehabilitation

6.3.1 Prevention

The basic problem associated with the field of prevention is the insufficient utilization of the offered measures. Still, preventive thinking is not enough embodied in the German population. Thus more efforts have to be made to provide information and to promote awareness for health problems, equally entitling mental health. This primarily is a task of intensified health education.

Prevention should start before pregnancy. The field of preventive care includes the following aspects:

- family planning and contraception
- genetic counseling
- maternal care
- prenatal diagnosis and supervision
- preparation to delivery (intensified in expected risk deliveries)
- precaution of perinatal injuries
- preparation to parental tasks and neonatal care
- postnatal checkups and supervision of the development during early childhood
- screening of mental disorders
- promoting stable early bondings
- providing creches, kindergartens and day care centres with trained staff
- closer cooperation between the schools and school doctors (medical examinations at school including mental health screenings)
- special training and furtherance for disordered and handicapped children in order to avoid secondary neurotizations (esp. in cases of learning difficulties and speech disorders)

6.3.2. Rehabilitation

Various institutions and organizations are charged with rehabilitative tasks. In W.-Germany we have special rehabilitation centres and workshops. Some of these are specialized on defined target groups like psychotic patients or patients with craniocerebral injuries. Many

institutions, homes and protective workshops are concerned with the care of mentally retarded persons.

The mutual help movement including self-help groups and associations of the afflicted play a major role in the field of rehabilitation, re-integration and after-care.

7. Training

The classic disciplines of mental health are: medicine, psychology, social work and nursing.

Recent degree course schemes for medicine give more room to the training in psychology and mental health. All physicians acquire basic knowledge on psychology during their study of medicine, yet, this is far from being enough. In general medical students are still missing profound knowledge in the field of mental health, let alone practical experience.

Psychologists receive a more intensive training on mental health questions. A specialization on clinical psychology is possible on principle. Yet, it is often criticized that the study is mainly directed on theoretical and scientific skills neglecting the field of practice.

The training of social workers and nurses includes as well psychological lessons, but too little.

Primary and secondary teachers hear about the developmental psychology of the "normal" child, but they have only little knowledge and no experience with disturbed children. This is a very regrettable fact in view of the important role they play for the early detection of problems (teachers and family doctors usually are the first addresses in cases of problems). Teachers for special education, however, receive an introduction into child psychiatry.

7.1 Further education

Physicians have the possibility of a postgraduate medical education in order to become a medical specialist. During this further education especially psychiatrists- and pediatricians-to-be are taught on child

psychiatry. Since 1968 it is possible to become a medical specialist in child psychiatry.

Nurses working in psychiatric wards have the possibility to become a specialist nurse in psychiatry. Yet, this supplementary qualification is no precondition for working in the psychiatric field.

7.2 Continuation training

A voluntary continuation training for all professionals concerned with mental health is possible in many ways, for example: congresses, workshops, Balint-groups, weekend seminars, training courses, lectures etc. Sometimes the psychiatric institutions themselves offer various forms of supervision and continuation training for their staff. Besides this many other institutions and organizations, in particular the therapy and professional associations, care for continuation training programs.

All these trainings, workshops and so on have to be paid by the participants. The participation is voluntary, this means it depends on the individual interest and on the money and time the mental health worker is willing to spend for this.

The most important field of a postgraduate continuation training is that of psychotherapy. Especially training in analytic therapy enjoys great popularity besides behavioural and client-centred therapy. This partly is due to the pay-off regulations of the health insurance, which still privilege psychoanalytic treatment.

8. Special developments and new programs

8.1 Special developments

The Psychiatry Enquête (1975) presented by order of the government designed a dismal sight on the state of mental health care in W.-Germany. Since this time the field has changed. A national program has been started in order to improve mental health care within 14 standard areas of

W.-Germany each comprising 150.000-350.000 inhabitants. The program encompasses the following major aims:

- reduction of in-patient treatment as far as possible
- avoiding rehospitalization
- improved care by improved cooperation
- rehabilitative, re-integrative measures and protection from further loss of abilities
- activation of self-help potentials
- avoiding isolation
- support for the families and other relatives

Included in this national program is the evaluation of the wide palette of mental health service facilities comprising psychosocial counseling, in- and out-patient treatment, special homes and protective workshops for mentally disturbed persons.

Some counties, however, do not participate in that national program, but started own ones laying more stress on prevention and after-care.

In the last years a number of alternatives of full-time institutionalization have evolved, associated with the terms home-treatment, out-patient treatment or day-/night-care. Unfortunately these indeed positive and cost-saving therapeutic approaches are not yet fully accepted by the insurance funds.

Community mental health with all its innovations is another key-word to describe recent developments. To bring the services closer to the users and to provide mobile services are some ideas derived from the community mental health movement.

There is a debate on the pros and cons of schools for special education. In this connection special classes for autistic children are discussed.

In addition, there are different projects and pilot projects working with specific target groups such as delinquents, drug dependents, including a new concern for chronically ill children and their families.

8.2. Self-help associations

In W.-Germany a lot of self-help groups developed and rapidly proliferated during the last decade. Among these the "anonymous alcoholics" are best-known. In 1972 the "anonymous neurotics" and the "emotions anonymous" were established. 6 years later the "emotions anonymous" movement already counted 50 local groups.

Single parents founded groups and many others followed. Meanwhile we have a wide palette of self-help associations, for example of stutterers or chronically ill people (i.e. diabetes, rheumatism, multiple sclerosis, epilepsia etc.). These groups are mainly concentrated on the coping with diseases and concomitant problems. Another group named "action committee child at hospital" struggles for the improvement of the children's psychological situation during hospitalization (MOELLER 1978).

The main characteristics of these self-help groups are: common experience of the members, sharing of personal problems, mutual help and support. In essence, the self-help approach is a-professional, although professionals frequently play a major role in forming and assisting such groups. Nevertheless, the founding of self-help groups partly reflects a disappointment at official institutions and professionals.

9. Suggestions for action in the field of child mental health

The first requirement to improve child mental health in general is a profound training of all professionals dealing with children. This demand applies to mental health workers as well as allied professions. A sharpened eye for beginning disorders in all these professionals (especially teachers and family doctors) is ^{an} essential precondition for early diagnosis and intervention.

By now many disorders (especially speech disorders, developmental delays and behavioral disorders) are diagnosed too seldom, respectively too late. This is a very regrettable fact in view of their trigger function. The different forms of expansive disorders, in particular, are often not diagnosed until the child poses an intolerable problem for

discipline and learning at school.

A second requirement is to increase the utilization of preventive measures such as supervision of pregnancy and early childhood. It is necessary to provide information, to remind parents of their responsibility for their children's development, and to embody awareness for mental health problems among the population - in general tasks of a strengthened health education. Besides this it seems desirable to find ways and means to obligate parents to preventive checkups. By now it still can happen that moderate mental retardation or developmental delays are not seen until the child fails at school. By then, however, valuable time for early intervention has passed.

Special preventive requirements are: an increased concern for unemployed youngsters combined with nationwide efforts against alcoholism and drug abuse during adolescence.

Although the mental health system has changed significantly during the last two decades it is still lacking compactness. One reason for this may be that it does not form an integrated whole in terms of organization. A better local distribution of the given service facilities according to the demands is a major requirement. The service facilities should be in easy reach - in other words: more community psychiatry. Besides this distribution problem, there are various shortcomings of the mental health system. For example, an estimate for W.-Germany formulates a demand of 800 child psychiatrists, this means a lack of 500 child psychiatrists. In addition, it lacks in- and out-patient units.

Concerning the field of therapy, more room should be given to day-/night-care, home-treatment and other forms of out-patient therapy.

Fostering and adoption should be better supervised by trained professionals in order to give support to the families. We must also beware of the misconception to substitute home committal by fostering as a matter of principle. This indeed widespread opinion neglects the fact that foster children are often handed around among foster families, homes and relatives. Thus,

indications in this field have to be carefully considered.

In general it seems necessary to pay more attention to the children's early bondings, for stable bondings are numbered among the preconditions for a "healthy" development. Social change, increasing divorce rates and a multitude of mothers in full-time jobs - all these factors contribute to loosen the family ties.

Another aspect is the economic situation of the family with children. High taxation and increasing rents are a burden to families, particularly large families. Altogether the families' economic situation is in need of improvement.

In view of the wide spectrum of tasks child mental health services are expected to fulfill, a close cooperation between the concerned authorities, institutions and professional groups will be necessary. Especially holding connections with the school should be an essential concern of child mental health services. Two problems are often to be faced in the cooperation of differing professional groups and institutions, these are on the one hand competition rivalries and on the other hand various forms of delimitation policy. Much more efforts are necessary to overcome these problems.

Another problem is the cooperation among rehabilitative institutions, the youth welfare offices and mental health services facilities. Concerning these institutions a better coordination is necessary to make intervention more effective. This especially applies to the problems of cost-bearing - an often complicated and time-consuming procedure .

Finally, I would like to stress the importance of research work. Beside the generally unsolved problems of child psychiatry a lot of questions do exist that have to be answered on ^a regional level in order to allow a sensible organization and a detailed planning of child mental health services.

10. Relevant agencies and organizations

Addresses:

Lebenshilfe für geistig Behinderte e.V.
Raiffeisenstraße 18, 3554 Marburg-Cappel

Diakonisches Werk. Innere Mission und Hilfswerk der ev. Kirche
Deutschlands
Alexanderstraße 23, 7000 Stuttgart

Verband katholischer Einrichtungen für lern- und geistig Behinderte
im Deutschen Caritas-Verband
Postfach 420, 7800 Freiburg/Brsg.

Vereinigung der Heil- und Erziehungsinstitute für seelenpflegebedürftige
Kinder
Habichtswald 1, 3500 Kassel-Wilhelmshöhe

Bundesverband für spastisch Gelähmte und andere Körperbehinderte e.V.
Kirchfeldstraße 149, 4000 Düsseldorf

Deutsche Sektion der Internationalen Liga gegen Epilepsie
Landstraße 1, 7642 Kehl-Kork

Bundesverband der Deutschen Ärzte für Kinder- und Jugendpsychiatrie e.V.
Herzogstraße 89-91, 4000 Düsseldorf

Bundesverband "Hilfe für das autistische Kind" e.V.
Bebelallee 141, 2000 Hamburg

Bundesverband "Legasthenie" e.V.
Gneisenaustraße 2, 3000 Hannover

Bundesarbeitsgemeinschaft "Hilfe für Behinderte " e.V.
Kirchfeldstraße 149, 4000 Düsseldorf 1

Bundesvereinigung "Lebenshilfe für geistig Behinderte" e.V.
Raiffeisenstraße 18, 3550 Marburg

Surveys:

Verzeichnis von Rehabilitationseinrichtungen der Bundesarbeitsgemein-
schaft "Hilfe für das behinderte Kind". Schriftenreihe Bd. 7,
5300 Bonn/Bad Godesberg

Heimschulen und Internate in der Bundesrepublik Deutschland einschließ-
lich Berlin (West). Ein Verzeichnis. Verlag Otto Schwartz & Co,
3400 Göttingen

Drogenberatung - wo? Ein Verzeichnis hrsg. vom Bundesminister für Jugend,
Familie und Gesundheit, 5300 Bonn/Bad Godesberg

Rainer, F., Lorenzen, U.: Verzeichnis von Behandlungseinrichtungen für
psychisch Kranke. Enke, Stuttgart 1979.

References :

- Arzteblatt Baden-Württemberg (1983) 468
- ALLEHOFF, W.H., ESSER, G., SCHMIDT, M.H., HENNICKE, K.: Die Bedeutung der Kooperationsverweigerung für die Interpretationsreichweite einer mehrstufigen kinderpsychiatrisch-epidemiologischen Untersuchung. *Social Psychiatry* 18 (1983) 29-36
- BEITEL, E., KRÖNER, B.: Veränderung des Selbstkonzepts durch autogenes Training. *Z. Klin. Psychol.* 11 (1982) 1-15
- BOEHNING, D., GUSIK, E.: Verhaltensauffälligkeiten bei Kindern. Unpublished manuscript, Berlin 1982
- CASTELL, R., BIENER, A., ARTNER, K., DILLING, H.: Häufigkeit psychischer Störungen und Verhaltensauffälligkeiten bei Kindern und ihre psychiatrische Versorgung. *Z. Kinder-Jugendpsychiat.* 9 (1981) 115-125
- COOPER, B., ORT, M.: Clinical and social characteristics of severely mentally retarded school-age children in Mannheim. In: M.H. Schmidt, H. Remschmidt (eds), *Epidemiological approaches in child psychiatry II*. Thieme, Stuttgart 1983
- Deutscher Bildungsrat: *Sonderpädagogik* 3. Klett, Stuttgart 1976
- DIETRICH, H.: Zur Gruppentherapie bei Kinder. *Praxis Kinderpsychol.* 31 (1982) 9-15
- DOOSE, H., SITEPU, B.: Childhood epilepsy in a German city. *Neuropediatrics* 14 (1983) 220-224
- EICHELSEDER, W.: Studie zur Häufigkeit des hyperkinetischen Syndroms an Münchner Schülern. *Suppl. Pädiat. Prax.* 18 (1977) 93-100
- EISERT, M., EISERT, H.G.: Multimodale Intervention - verhaltenstherapeutische, pädagogische Ansätze und medikamentöse Behandlung beim hyperkinetischen Syndrom. In: H.C. Steinhilber (ed), *Das konzentrationsgestörte und hyperaktive Kind*. Kohlhammer, Stuttgart 1982
- ESSER, G.: Über den Zusammenhang von Verhaltens- und Leistungsstörungen im Vorschulalter (und Grundschulalter). Diss. Universität Mannheim 1980
- FEIERFEIL, R., WENDELSPIESS, U.: Über die Erfassung kinderperzipierter elterlicher Verhaltensweisen und des Selbstkonzeptes des Kindes im Zusammenhang mit einem Elterntraining. *Z. Klin. Psychol.* 11 (1982) 33-44
- von HARNACK, G.: *Nervöse Verhaltensstörungen beim Schulkind - eine medizinisch-soziologische Untersuchung*. Thieme, Stuttgart 1958
- HASELMEYER, F., PUDEL, V.: Klinisch-experimentelle Überprüfung der von Homme entwickelten Methode der "Converants" (verdeckte Reaktionen) und einer neu entwickelten Zerrspiegel-Methode bei der Adipositas therapie. *Z. Klin. Psychol.* 11 (1982) 45-54

- KOHLSCHEEN, G. (with assistance from K. BUFF, R. HELLEMANN): Untersuchungen zur Bedarfsermittlung eines Versorgungssystems für somatisch und psychisch auffällige Kinder und Jugendliche. In: Bericht über die Lage der Psychiatrie in der Bundesrepublik Deutschland zur psychiatrischen, psychotherapeutischen und psychosomatischen Versorgung der Bevölkerung. Bundestagsdrucksache 7/4201, 432-457, Bonn 1975
- LEHMKUHL, G., SCHIEBER, P., SCHMIDT, M.H.: Zur Gruppentherapie Jugendlicher mit Anwendung audiovisueller Verfahren. Acta Päopsychiat. 48 (1982) 323-332
- LEMPF, R.: Gerichtliche Kinder- und Jugendpsychiatrie. Huber, Bern 1983
- MAI, U., EHRENGUTH, W.: Impfschutz und Kinderkrankheiten in der Anamnese von Hamburger Schulanfängern. Hamburger Ärzteblatt 35 (1981) 40
- MARTINIUS, J.: Ambulante und teilstationäre Versorgung psychisch kranker Kinder und Jugendlicher in der Bundesrepublik Deutschland. Z. Kinder-Jugendpsychiat. 11 (1983) 3-12
- MARTINIUS, J., MIES, U., DERA, M., TIESSLER, J.: Psychological development of children after operation for atretic malformations. In: M.H. Schmidt, H. Renschmidt (eds), Epidemiological approaches in child psychiatry II. Thieme, Stuttgart 1983
- MATTHES, A., KRUSE, R.: Neuropädiatrie. Thieme, Stuttgart 1973
- MOELLER, M.L.: Selbsthilfegruppen. Rowohlt, Reinbeck 1978
- POUSTKA, F.: Graduelle Entlassung als teilstationäre Behandlung. Psychiat. Praxis 9 (1982) 155-159
- POUSTKA, F.: Psychiatrische Störungen bei Kindern ausländischer Arbeitnehmer. Habil. Universität Heidelberg 1983
- REMSCHMIDT, H., STEINHAUSEN, H.C.: Psychische Störungen bei Kindern griechischer Arbeitnehmer in West-Berlin. Abschlußbericht für die Stiftung Volkswagenwerk, Berlin 1981
- SCHIEBER, P., SCHMIDT, M.H., DETZNER, M.: Factors influencing utilization of child psychiatric services. Paper presented at the III. European Symposium on Social Psychiatry in Helsinki/Finland, Sept. 12-15th, 1983
- SCHMIDT, M.H., ESSER, G., ALLEHOFF, W.H., GEISEL, B., LAUCHT, M., VOLL, R.: Bedeutung der cerebralen Dysfunktion bei Achtjährigen. Z. Kinder-Jugendpsychiat. 10 (1982) 365-377
- SCHMIDT-KLUEGMANN, R., SCHERG, H.: Verhaltensstörungen bei Viertklässlern im Spiegel einer standardisierten Befragung. Öffentliches Gesundheitswesen 37 (1975) 310-317
- SCHMIDTKE, A.: Zur Prognose und Entwicklung von Suiziden im Kindes- und Jugendalter. Sozialpädiatrie in Klinik und Praxis (1983)
- Statistisches Bundesamt (ed): Statistisches Jahrbuch 1983 für die Bundesrepublik Deutschland. Kohlhammer, Stuttgart-Mainz 1983

STEUBER, H.: Zur Häufigkeit von Verhaltensstörungen im Grundschulalter. Praxis Kinderpsychol. Kinderpsychiat. 22 (1973) 246-250

THALMANN, H.C.: Verhaltensstörungen bei Kindern im Grundschulalter. Klett, Stuttgart, 1974 (2. Aufl.)

TIETZE, K.W.: Epidemiologische und sozialmedizinische Aspekte während der Schwangerschaft. Fortschritte der Medizin 100 (1982) 2031-2032

VASKOVICS, L., WEISS, W., BUBA, S.P.: Stand der Forschung über Obdachlose und Hilfe für Obdachlose. Schriftenreihe des Bundesministers für Jugend, Familie und Gesundheit (Bd. 62) Kohlhammer, Stuttgart, 1979

VOLL, R., ALLEHOFF, W.H., ESSER, G., POUSTKA, F., SCHMIDT, M.H.: Widrige familiäre und soziale Bedingungen und psychiatrische Auffälligkeiten bei Achtjährigen. Z. Kinder-Jugendpsychiat. 10 (1982) 100-109

WELDING, G.: Zur Häufigkeit von Verhaltensauffälligkeiten im Kindergartenalter. Z. Kinder-Jugendpsychiat. 5 (1977) 299-316