Changes in Medical Care during Puberty

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Abstract: Puberty is a period when integrated mental and physical development occurs; and it is a stage that all human beings experience as they mature into adulthood. It is a time of great changes when maladaptive behavior that accompanies psychosomatic disorders may develop. In conjunction with the reduced infant mortality rate in Japan, the occurrence of adolescent maladaptive behavior has become the focus of public attention. The progressive process of school phobia to truancy that accompanies psychosomatic disorders has occurred against a social environment characterized by high matriculation rates and a low birthrate. Having passed through an era of malnutrition and rapidly transiting to an age of excess consumption, Japan has seen the rise of eating disorders (apocleisis and overeating) among adolescent females. Puberty related disorders that were previously restricted to the psychiatric field, have now become common health problems that are treated in the pediatrics field due to their onset among younger children. Moreover, this phenomenon has created individuals who are unable to become socially independent as they grow. Minor disorders such as LD, AD/HD have caused diverse forms of maladaptive behavior to occur during puberty, which stem from environmental changes, notably changes in family and social values.

Key words: Puberty; School refusal; Eating disorder; Family; Children at risk

Puberty is a period when integrated mental and physical development occurs; and it is a milestone in the human developmental process that all of us experience as we mature into adulthood and social independence. It is a period of major mental and physical changes that can be described as period of crisis. Infants mature into socially independent human beings through this process; and puberty is a developmental stage that cannot be bypassed. It is a period of conflicting emotions when children gain a stronger sense of self-awareness in tandem with the growing need to become independent, while simultaneously experiencing anxiety and tension that stem from feelings of dependency. It is a period when they begin to move toward becoming independent of their main social group, namely their families and
the protection that they offer. It is a significant stage of profound physical changes, where a diverse range of puberty related maladaptive disorders may be seen. These symptoms are triggered by the inability to adjust to society and family, and they may be transitory or prolonged, which greatly depends on the background of the children. Thus, the triggering factors may differ according to family background, socioeconomic and cultural conditions. The rapid increase of puberty related maladaptive behaviors is causing shift in the healthcare trend in Japan, and the issues that must be addressed in future are discussed in this paper.

Rise and Fall in Puberty Ages

1. Trend in lower puberty ages

Puberty related maladaptive disorders were largely left untreated in the past because they were not life threatening. When the infant mortality rate in Japan was high, knowledge about puberty was relatively unknown in the pediatric field. Clearly exhibited abnormal pubescent symptoms were referred to the psychiatric department. Following the socioeconomic confusion of the postwar recovery period, malnutrition disappeared, and the puberty age was lowering having their first menstruation at a younger age than their mothers and grandmothers. As Japan entered a period of economic stability, the onset of menstruation shifted from sixth grade to junior high school age group to the fourth grade, and individual differences in physical development have become conspicuous. Thus, together with the unnatural early physical development of girls in the fifth and sixth grades, the contrast of emotional and mental immaturity among junior high girls has been bewildering.

Puberty is a conflicting period of anxiety and dependence stemming from rapid growth; a premature sense of self-awareness, and a desire for independence; and the advent of psychosomatic disorders is seen among many adolescents. Indefinite complaints and autonomic imbalances are complexly intertwined against a period of rebellion and anxiety and trigger school non-attendance, social withdrawal, and eating disorders. Eating disorders that were once considered to be a psychiatric problem have begun to occur in lower aged children and have become commonplace. These are the new trends in recent years that have characterized medical care in puberty.

2. Growing trend toward a longer puberty period

If puberty is defined as a physical, mental, and emotional developmental period leading to social independence, society does not recognize an individual as an independent adult unless he or she becomes socially self-reliant. Thus, in Third World countries, children become socially self-reliant at an early age, despite the fact that they have not reached full physical maturity. They are forced to become self-reliant at an early age to help provide economic support for their families. We are aware of the fact that children in developing countries work to support their families at an age when Japanese children are still in compulsory education. In these countries, the symptoms of psychosomatic disorders in puberty-aged children that are observed in advanced countries are not seen. Medical care is involved in treating life-threatening diseases and countermeasures to combat a high mortality rate. A compulsory educational system is not well developed in these countries and welfare services that provide basic care for children are inadequate.

In postwar Japan, compulsory education was extended from six to nine years. Presently, over 95 percent of the population matriculate to high school and the matriculation rate for universities, junior colleges, and vocational schools is 70 percent. Moreover, in the face of a declining birthrate, social self-reliance has continued to lag because of a prolonged period of parental economic assistance. If the population of young people, including those categorized as “freeters” or temporary workers are
included, the puberty period has increased along with a rise in actual puberty ages. This is a phenomenon that would have been unimaginable in poverty-stricken postwar Japan.

The nurture environment of children has changed greatly in Japan and the number of young people entering puberty showing maladaptive behaviors continues to increase. Although their physical development is superior to their parents or grandparents, many are mentally and emotionally highly immature. There are many youth who refuse to become adults and want to continue to be pubescent. They can be seen at universities and in society at large. It is also not uncommon to hear about young people who want to be treated by a pediatrician.

Maladaptive behavioral problems and future issues that must be addressed in Japan against a background of rapidly changing puberty related medical care will be discussed in the following sections of this paper.

Maladaptive Symptoms during Puberty

1. Truancy

(1) Summary and background history of truancy

Presently, the term, truancy, has become commonplace and the refusal to attend school was first described as “school phobia” in the field of psychiatry in the mid-1950s. School phobia is an obsessive-compulsive disorder and it was seen as the initial stage of schizophrenia. It differs from the truancy exhibited among increasingly younger-aged children in Japan. In the field of pediatrics, the clearly observed symptoms of asthma, autointoxication, abdominal pain, and fever were defined as a psychosomatic disorder. But, the underlying cause of these symptoms was “school refusal”.

During the latter half of the 1960s, the term, “school refusal”, began to be used and the Japanese Society for Child and Adolescent Psychiatry began its debate on whether or not the term denoted obsessive-compulsive disorder. During this period, psychosomatic disorders linked to healthy or borderline children exhibiting low-frequency abnormal behavior was beginning to prevail in the field of pediatrics. Following this period, the term, school refusal, was used for a long period of time and it came to denote a duplication of the symptoms of psychosomatic disorder. Children who exhibited school refusal were diagnosed with autonomic dystonia, chronic illness, or psychosomatic disorder and the issue of school refusal itself was not brought to the fore. The incidence of school refusal tended to increase along with the rise in the matriculation rate to high schools, universities, and vocational schools as explained earlier; and school refusal began to comprise a high share of puberty related maladaptive behaviors. In 1997, the high school matriculation rate reached 95.9 percent and Japan became one of the world’s foremost nations with a highly educated society, in contrast to a rise in school refusal among elementary and junior high school students. The growth in school refusal also gave rise to the issue of qualitative disparities. Because the concept of school refusal in the 1960s and the 1970s differed from present-day ideas, the schools adopted stringent measures and treated students, who found attending school emotionally difficult, or students, who had severe asthma attacks on Monday mornings, and were absent from school for prolonged periods of time. Public schools treated such students as suspended. However, the Ministry of Education, Science, Sports and Culture (presently the Ministry of Education, Culture, Sports, Science and Technology) began to allow such students to graduate despite their extended absence from school, and in the 1980s, a positive form of school refusal was seen — cases of school refusal without physical symptoms or mild cases of initial stage psychosomatic disorders, or cases where students, whose symptoms had disappeared, expressed their desire to be hospitalized rather than attend school.

Subsequently, in 1994, the Ministry of
Education declared that school refusal was not a special illness, but a condition that all students were susceptible to experiencing. It recognized that school refusal was an educational problem and proposed that the term, school non-attendance, be used in lieu of school refusal for students who did not attend school for more than 30 days. This term continues to be used today. In contrast to the past when the term, school refusal, was initially used, parents and children as well as school authorities have come to see this issue as an acute problem. School infirmaries, free schools, and other measures have been implemented to address this problem, and the anxiety, inferiority complex, and tensions that are associated with school non-attendance have decreased.

(2) Transitions in school non-attendance

The majority of students with problems of school non-attendance desire to matriculate to high school. Due to the recent trend toward a declining birthrate, it has become possible for such children to attend high school, although the choices may be limited. In 1988, credit-system high schools that offered part-time educational and correspondence courses were introduced, and from 1993, it became possible for full-time schools to adopt this system as well. In addition, there were students who passed university entrance exams despite never having attended high school. These children had suffered seriously from and overcame the experience of school refusal during their adolescent years.

In contrast, there are many children who matriculate to high school and either quit or take a leave of absence following summer vacation. In recent years, there are cases of junior high school students who progress from school non-attendance to running away from home. This trend is seen among students in the lower grades of junior high school. A major contributing factor is said to be the lowered resistance of parents to the idea of their children not attending school. In the past, the socially isolated child undergoing school refusal had trouble socializing with his peers and disliked leaving his home. But recently, these junior high school children have grouped together and spend the night at each other’s homes. Although they have not run away from home, they do not have established living quarters.

In reviewing the problem of school non-attendance, it must be noted that the concept of school refusal or school non-attendance currently used in Japan does not exist among parents or school authorities in the United States and Europe. Although a mild and infrequent form of obsessive compulsive disorder linked to social phobia that is manifested in the form of school phobia exists, the concept of school refusal is nonexistent. However, dropping out of school, running away from home, drug abuse, pregnancy, and delinquency among adolescents in the United States and Europe have become the focus of concern in their society, and they have become an educational problem. Moreover, there has been a tendency for these problems to occur increasingly among younger-aged children.

Presently, school non-attendance among adolescents in Japan has been on the rise, and it has become a major maladaptive behavioral problem of adolescents. The social structure that contributed to school refusal in the 1970s has greatly changed and values about obtaining higher education have changed among both parents and children. Parental expectations of the child and the pattern of school refusal brought on by domestic violence that stem from parent-child frictions is decreasing. However, when both parents and children lead lives that are independent of the other, in a social background of chronic school non-attendance where children have been freed from the responsibility of attending school, one begins to wonder how they will mature into self-reliant adults.

2. Eating disorders

The DSM-IV of the American Psychiatric Association has classified eating disorders into
three types—anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified. Both anorexia nervosa and bulimia nervosa or overeating were rarely seen in the pediatrics field prior to 1960, and they were regarded as psychiatric disorders. In Japan, due to an inadequate food supply until the 1960s, staple foods were rationed. Although there was hunger, overeating was not seen since an abundance of food did not exist. Thus, until food supply conditions in postwar Japan improved, the Japanese people led a life that was not unlike the war-torn refugee lifestyle that is sometimes seen on television programs. Thus, anorexia nervosa, puberty leanness, and eating disorders which began to be reported in the pediatric field around 1970 is linked to the era of excessive consumption that is synonymous with Japan’s economic development.

Due to a change in the ideal image of feminine beauty from one of health to a prepubescent look, these disorders have been called puberty leanness rather than anorexia nervosa because they are often seen among adolescent girls who restrict their food intake out of an aversion to becoming overweight despite their craving to eat. The disorder began to spread rapidly down the age scale from adult women to university, high school, junior high school, and to primary school girls. Pediatric wards and clinics began to treat primary and junior high school female patients—a phenomenon that had never been seen in the past.

Bulimia nervosa is also often referred to as overeating. In contrast to the almost stoic caloric restriction seen in anorexia nervosa, patients with bulimia nervosa exhibit an excessive appetite where the need to eat is so great that they will resort to eating in secret or even shoplifting food items. It is addictive behavior and the patient becomes overweight in a short period of time. Such cases have decreased in recent years, and many patients control their weight by vomiting and using purgatives and diuretics. When this disorder initially appeared, many patients were hospitalized in emergency wards. The number of cases of repeated apocleisis and overeating is increasing.

The prognosis is varied and although there are cases where recovery is seen in younger patients, there are also cases where the disorder progresses due to parental unawareness of the symptoms. Moreover, it has been reported that when apocleisis and overeating are repeated and become chronic, patients deteriorate mentally, become physically weak and at times die or commit suicide. A ratio of 3 to 6 percent of such cases has been reported in Japan (Nakane1).

In the past, eating disorders were reported to be associated with young women, but recently, there are reports of cases with young men. The desire to be thin remains as a major factor in eating disorders among young female students. In a survey of female university students conducted by the author, about 90 percent of the subjects interviewed responded that they tended to be overweight relative to their height and weight. The results showed that the ideal body weight of nearly all of the respondents fell in the range of leanness.

Eating disorders are typical symptoms seen in puberty, especially girls with borderline personalities who refuse to grow up and tend to be perfectionists. Dysfunctional family relationships have been pointed out as underlying factors, but there is also a need to consider society’s pervasive and pathologic obsession to be thin. Japan evolved from an era of starvation to an era of excessive consumption within a span of 50 years, and eating disorders have tended to occur increasingly in younger age groups.

3. Asocial behavior

The term, asocial behavior, is a vague concept, but DSM-IV has classified it into conduct disorder, oppositional defiant disorder, and disruptive behavior disorder not otherwise specified. But it is difficult to diagnose specific symptoms because asocial behaviors are often an extension of standard social behavior, which
differs for each age group according to culture and era.

The causes of asocial behaviors are not disorders. In the paragraph on oppositional deviant disorders in DSM-IV, it is noted that the criteria for problematic behavior was met when they occurred more frequently in the subject in comparison to the peers in the same developmental stage and age group. Moreover, it is clearly stated that behavioral disorders do not occur only during the course of psychotic or mood disorders.

It has been reported that children who are at slight risk for attention-deficit/hyperactivity (AD/HD) and learning disabilities (LD) that were not defined in this category of disorder displayed asocial behaviors at a higher frequency during puberty. This tendency is especially pronounced in children with AD/HD. Specific asocial behaviors include violence, destructive behavior, shoplifting, stealing, provocative behavior, and arson. Asocial behavior that occurs during puberty are not induced by biologically risky behavior which is naturally innate, but occurs in combination with social factors such as easy access to guns, the degree of drug usage, the collapse of the family relationship, and the safety of the community. Thus, individuals with AD/HD or LD are not dangerous. But educational intervention is required at an earlier stage (childhood) in comparison to problem-free healthy children based on the premise that these disorders are related to adaptation issues that occur during puberty.

Future Issues in Puberty Related Medical Care

1. Anticipated social transitions and problems in puberty

Earlier physical development in lower age groups and social self-reliance at a younger age due to aspirations to achieve higher education has expanded the puberty period. This is a phenomenon that has never been seen in the past Japanese history. Eating disorders and school non-attendance have become common occurrences in less than half a century, and these terms are familiar to all junior high and high school students.

It is generally believed that the illicit drug situation in Japan differs from the United States and Europe due to the country’s strict control of narcotics. But in actuality, high school students are able to obtain illicit drugs easily. Since drugs are used in diet food and beverages, an acutely serious situation that surpasses the harmful effects of smoking and alcohol is surmised.

If incidents that have not surfaced are included, the impact of the Internet on young people has become unfathomable. In the past, group suicides between strangers, who meet through the Internet with the shared desire to commit suicide, were unimaginable. The spread of mobile phones has contributed to the trend toward younger age groups, i.e., from university to high school and junior high school student, in a short period of time. For lonely adolescents, it has become possible to make contact with strangers through the Internet and to obtain information that is not available from parents or schools. In what was once considered a safe environment, Japan is presently undergoing rapid social changes and it is confronting the problems of drugs, sex, diet, AIDS, and suicide. Thus, the scope of puberty related medical care will expand and the country has entered an age where it must provide countermeasures against social pathological factors.

2. Changes in the family structure

Half a century ago, extended families were the norm, but the advent of the nuclear family, a low birth rate, and the rise in working mothers have changed the position of children in the family. Children are born through planning and not by accident. Although kindergartens and primary schools have been integrated, there is a shortage of day care centers and extended maternity and child-rearing leave is needed. However, child-care activities have become
more comprehensive and the motivation to undergo nursery teacher training programs is high. This is good news for both working mothers and children. The current situation is a world apart from working mothers in the past.

But parental abuse of children also exists in society today. In an age when school refusal or eating disorders were rare puberty related problems, parental abuse of children, which has recently become the focus of public concern, also did not exist. Children who are presently in nursery school will go through puberty in the next ten years. Maladaptive behavior does not begin during puberty. It is believed that an immature ego develops through successive childhood experiences and surfaces during an emotionally and mentally unstable development period in puberty.

Conclusion

Puberty is a development stage that all children undergo, but it is also a critical period. They develop a stable sense of social independence through this experience. It is a time when they suffer through feelings of rebellion, loneliness, and emotional and mental anxiety. Thus, social protection and parental support are required during puberty. The situation has been made more complex by major environmental changes that surround them. It is important that parents should be more aware of these circumstances and to accept the fact that their children are mentally and emotionally immature in contrast to their physical development.

REFERENCES