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THE EFFECT OF SOCIAL CHANGE ON THE BEHAVIOUR  
AND ACADEMIC PERFORMANCE OF SCHOOL-AGE CHILDREN

by

Professor K. Minde\*



INTRODUCTION

Social change can express itself in alterations of the laws and traditions governing societies or groups of individuals. It may also influence an individual through many other ways. For example, it may expedite or slow down his physical or biological development by changes in dietary intake or housing standards; modify his culture or social life through political, economical, technical or religious change, or through shifts in his relationships with newly dominant groups in his society; and finally, it may influence him psychologically as expressed by his physical and mental health.

While it may be fascinating to explore the wide array of phenomena brought about by social change, I as a child psychiatrist am most interested in its effect on the fabric of social and psychological functioning of children and their immediate families. In keeping with the aim of this workshop I shall concentrate particularly on phenomena resulting from rapid social change - since crises in our management of children and families who have experienced dramatic changes are often clinically most urgent and troublesome.

The present paper then is an attempt to summarize available data and to point out possible important variables or problem areas which have not yet been subjected to a systematic study. As Canada has a substantial native population and many ethnic groups, takes in almost 10 000 refugees per year and deals with thousands of foreign students and transient visitors annually, results of studies conducted among these groups will provide one source of data for this paper. In addition, the discussion will include psychological stress factors, as well as factors that counteract stress and will be based on data from both the Western literature and the limited African and Asian literature available to me. Finally, I shall use the material summarized in the report of the WHO expert committee on child mental health and psychosocial development (1977).

A PREVALENCE OF ACADEMIC AND MENTAL HEALTH PROBLEMS IN CHILDREN

Detailed surveys of general populations in developed countries show that the prevalence of persistent and socially handicapping mental health problems amongst children aged 3-15 is about 5% to 15%. Similar figures have been reported from the developing countries (Giel et al., 1981). Children who require special academic assistance because of problems in

\*Professor K. Minde, MD, FRCP, is Director of Psychiatric Research and Professor of Psychiatry and Paediatrics, The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario M5G 1X8, Canada.

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learning range from 10% to 15% in developed countries. Again, there is some evidence that these figures are similar for the developing nations. However, it should be stressed that prevalence figures are necessarily affected by a number of independent factors. For example, they will vary with the cut-off point used in making a diagnosis or by the type of behaviour seen as abnormal in a particular culture. Nevertheless, in general, mental health problems and academic problems are more common in boys than in girls and are more frequent in inner cities than in rural areas or in small towns. They are also three to four times higher in children who have experienced an insult to their brain or have developed epilepsy. This suggests that brain dysfunction is an independent cause of mental illness although the psychosocial stresses, intellectual impairment or cognitive deficits typically associated with it, may contribute significantly to the high degree of psychological difficulties found in the affected children.

#### THE EFFECT OF SOCIAL CHANGE ON BEHAVIOUR

The options available to an organism subjected to rapid social change are limited. According to Berry and his colleagues (1985) individuals or groups can be assimilated to a new social order, i.e. give up their previous culture and pattern of behaviour completely, or can resist change by closing themselves off or separating from the new demands of society, or they can actively fight it. All three types of reactions have been associated with a high degree of "Cultural Stress", i.e. stress resulting from acculturation or adaptation to social change. In practice this stress is shown by symptoms of confusion, anxiety and depression as well as an increase in psychosomatic disorders in adults and by an increase in behaviour disorders and problems in academic functioning in children.

The model which the Canadian Government has favoured to deal with social change is integration. This option implies that specific ethnic groups or populations are encouraged to maintain their traditional culture or language within specific areas in their day-to-day life. This is thought to counteract the above-mentioned symptoms associated with acculturation as well as the feeling of marginality or social fragmentation commonly experienced by outside groups which have to deal with rapid social change. While prospective controlled studies with large populations have not yet been done, it has been documented that children of recent immigrants experience less psychosocial stress when they are allowed to retain aspects of their traditional culture (Berry et al., 1984).

It becomes clear that in general social change is not the cause of social or psychological disorder. It is the failure of the individual or group to adapt to social change which creates symptoms of social or psychological distress. If the data favouring integration over total assimilation or resistance to new social demands are correct, it follows that retaining some links with the original culture could be similarly helpful to the psychological adjustment of the individual child and his family. Practical suggestions relating to this point will be given in the final section of this paper.

What other factors have been shown to moderate the impact of social change and assist adaptation? Studies which examined primarily adult immigrants, refugees or native groups who were exposed to new cultural values and who experienced massive social changes, as well as more general psychiatric epidemiological studies, suggest that the following factors may act as buffers against psychosocial disorganization.

##### (a) Cultural proximity

The less the difference between the two cultures or social systems, the lower the distress associated with moving from one system to the other (Berry & Annis, 1974). Supporting data here come from studies of Canadian native groups and of foreign students at Canadian universities. Thus the acculturation of native Canadians has been found to be related to the basic social organization of the native group. For example, natives who came from a very loosely organized social structure had far more difficulties in adapting to the highly structured Canadian society than did groups whose life style was based on a tighter social structure (Berry, 1976). Features such as a similar climate and a positive evaluation of the food favoured by members of the dominant culture was likewise associated with low acculturative stress (Minde, 1985).

(b) Sex differences

Girls generally show less psychopathology when exposed to external stress. It is not clear why femaleness should be a protective factor against psychopathology and learning problems in children. Rutter and his colleagues (1976) who examined this phenomenon in detail suggest that it may be related to a particular biological variable associated with the female gender. However, there is also evidence that girls report significantly more stress when they move into a new culture or society than do boys. The reasons for this are not clear but it may be that females in general have a greater tendency to subscribe to personal statements such as those used to elicit symptoms or stress (Cawte, 1972). Yet even sophisticated epidemiological studies of West Indian immigrant children in Great Britain (Rutter et al., 1975) and statistics of children attending a child psychiatric clinic in Uganda (Minde, 1977) and being part of a general population survey in the Sudan (Rahim & Cederblad, 1984) found a similar number of girls and boys with clear-cut psychiatric symptomatology.

(c) Cognitive factors

There is a wealth of data which suggest that intelligence and education are protective factors against a wide array of psychosocial disturbances. For example, the stress immigrants experience is significantly correlated with their previous education. The correlations vary from  $-.25$  to  $-.40$  in different studies (Berry et al., 1985). The reason for this association is not clear. One may speculate that individuals who are more intelligent or who have more education have more inner resources available to them and may even view the acculturation experience as challenging. Acceptance by peers, e.g. in the school situation, may also come more easily to children with higher intelligence.

While hard data from developing countries on this issue are not known to me, data on schoolchildren in Uganda give some support to this hypothesis. In a study where I examined 25 secondary school boys who had come to a mental health clinic because of study problems and presented with a variety of psychosomatic complaints also labelled as "brain fog" (Prince, 1960), I found that in comparison with a healthy control group from the same school, "brain fog" youngsters had significantly lower marks. However, they were also on average two years older, but had not failed previous classes more often than their asymptomatic classmates. This suggests that the troubled youngsters had begun their primary schooling at a later age which presumably increased the pressure on them to perform and excel, leading to an increase in psychiatric symptoms (Minde, 1974). The author of a recent Nigerian study on schoolchildren with study problems has come to similar conclusions.

Another protective factor which is also correlated with intelligence is the knowledge of, or familiarity with the language spoken by the dominant group. Thus studies involving foreign students and immigrant children found the ability to speak English or French to be significantly correlated with adaptation to Canada (Minde & Minde; 1975, Berry et al., 1985).

(d) Contact experiences

These include measures of actual relationships with the larger society, such as wage employment or ownership of property for adults or having a friend in school that belongs to the main cultural group in the case of children. Studies of immigrants to Canada and foreign students show that contact *per se* is seen as supportive and is negatively correlated with acculturation stress (Chance, 1965). While this variable appears rather specific to adult immigrants, similar data can also be found in the general child psychiatric literature. For example, children who have experienced more than one caretaker earlier on in life separate more easily from their mothers when they begin school than do children who come from less open family systems. In addition, there is now a substantial literature which documents the important impact the presence or absence of specific social support systems can have on the mental health of adults and children alike. Not surprisingly, there has been a dramatic increase of self-help groups for parents of children with physical or emotional disorders (e.g. cerebral palsy, spina bifida or autism, just to mention a few) in developed countries. I have found group meetings with mothers of retarded epileptic children in Uganda equally effective (Minde, 1974). Such groups can be run by paramedical personnel and provide an important focus for education and support for families who are faced with physically or socially abnormal children.

(e) Patterns of upbringing

There is a great deal of evidence which links variations in the psychosocial development of children with specific qualities of caretaker-child interaction regardless of their cultural background. Children who are rejected or are unwanted or who experience serious family discord (i.e. arguments and disagreements between their parents) show a far higher incidence in delinquency, school failure or conduct disorders. (West & Farrington, 1973). For normal emotional and cognitive development children also need to be stimulated in an appropriate fashion, i.e. they require active experiences and interchange both with adults and their peers. The close relationship between the child and specific caretakers is especially important during the first five years of life as primary attachment relationships are developed during that period. If these are broken or if the primary caretakers are unable to respond sensitively to the children during their early years, basic lack of self-esteem or social competence frequently follows. Even an improvement of parental caretaking later on may not be able to reverse some of these phenomena (Tizard & Rees, 1975).

Children who are reared in institutions and experience multiple changes in parent figures are therefore clearly at risk for psychosocial problems and poor academic performance. Likewise children who are permanently or abruptly separated from their parents because of political upheaval or violence against them are at high risk for psychiatric problems. Follow-up studies by Amnesty International (Cohen et al., 1979) and by other clinicians (Allodi, 1980) showed that even 3 to 6 years after seeing a family member being killed or abducted, 65% to 75% of these children still showed signs of fearfulness and withdrawal, insomnia or aggression.

The loss of the extended family is clearly one of the most disruptive experiences for families in group-oriented societies. In a good number of studies (e.g. Sethi & Sharma, 1982; Sharma et al., 1985) it has been shown that an extended family, at least in India, is a better source of psychosocial support than is a nuclear family. Since parents are obviously the mediators of culture, the stresses they themselves are subjected to because of new social demands will therefore necessarily reflect on their children's functioning.

(f) Poverty

Much has been written about the deleterious effects of poverty on psychological wellbeing and academic performance. In fact, the "War on Poverty" of the 1960s highlighted by the Head Start Program in the United States was conceived as one way to change the social outlook of millions for the better and interrupt the apparently endless cycle of disadvantage. However, more recent work has made it clear that a multitude of stress factors associated with poverty, such as crowded living quarters, family strife or a large number of children, which contribute to a higher rate of psychological disturbance in poor children in Western countries, also increase the risk of psychopathology in the more well to do. Recent studies have furthermore indicated that children who come from poor families but who have good relationships with their parents and live in homes with low family discord, exhibit fewer problems in behaviour or learning during childhood and adolescence. These children also attempt to marry spouses with little psychopathology and in turn do a good job in raising their own children later on (Quinton & Rutter, 1984a and 1984b). In contrast, children who are equally poor but in addition have inadequate parents tend to continue to be troubled during their adolescence and earlier adulthood. They leave school early, have children early with spouses who often show similar inadequacies and end up placing some of their children "in care", thus continuing the cycle of disadvantage so commonly encountered in mental health clinics.

While in the United States early educational intervention has been seen as one avenue towards breaking the cycle of poverty, results up to now have not been encouraging. Only highly structured, very expensive programmes which begin during the first year of life and continue for four or more years, have shown to change severely underprivileged children's intellectual and academic performance during the first decade of their lives (Ramey et al., 1982). Nevertheless, there is no question that a good preschool programme which provides both cognitive stimulation and emotional warmth for young children who live in poverty will further their development and give them a better chance later on (Gottfried, 1984).

(g) Protective factors

Looking at stress factors only inherent to social change provides a one-sided view as many children and families are very successful in coping with a rapidly changing environment. The following section will therefore deal with compensatory factors which may help children and their families to come through stressful experiences unscathed.

1. The number of stresses

It appears that children who are faced with one serious stress (e.g. moving from a village to the city) do not show an increase in psychological abnormalities as long as other things remain constant. For example, if both parents move with the child and remain psychologically close to her/him, and some friends from the village are also moving and if there are no major changes in dietary habits or availability of schooling, the change may be weathered well. Likewise, if a child moves into a relative's house in another village or town because he is closer to the school, he will usually manage well (Minde, 1975). However, if the move to the same relative is brought about by the father's desertion and mother is now depressed, has less money and must go to work, problems are likely to spring up as the child must now cope with at least three stressful events (the loss of father, mother's depression, and the move to a different home).

2. The maintenance of a good relationship with at least one parent or other relative within the extended family.

It has been shown that the risks to mental health which relate to growing up in an unhappy quarrelling family can be significantly reduced if the child can be comfortable with at least one parent or close relative. For example, if a father begins to drink heavily because he has lost his job, and in conjunction becomes irritable and punitive, his children nevertheless do well if they can continue to trust their mother and are supported by her. There are also reports which indicate that children with troubled families who have a good relationship with members of their extended families show little increase in psychiatric symptomatology. This is especially true in developing countries (Minde, 1976; Rahim & Cederblad, 1984).

3. Success or good experiences outside the home

There is good evidence that good schooling can mitigate the effects of a poor home environment. In a series of studies Rutter and his colleagues (1979) have shown that certain schools are able to contain very difficult children and in fact help them to rid themselves of some of their psychological difficulties. Other schools seem to have an opposite effect, i.e. appear to create problem youngsters. This seems especially important in the developing countries where overcrowding and undue competition for good marks often compromise the emotional health of the students (Chintu & Haworth, 1979). While it is not clear what factors within the schools are responsible for the rate of behaviour problems of their pupils, the general spirit of the individual school seems to be an important ingredient. This spirit is, among other things, expressed in the rate of teacher turnover (the fewer turnovers the better the school's mental health record), but not in the class size. Unfortunately, equivalent data from developing countries are not available. In my study of children in three different schools in Uganda, the rate of problem children varied from 10.5 to 24% (Minde, 1975). Since I did not examine many of the factors identified by Rutter and his colleagues as contributory to the incidence of mental health problems, the significance of the difference among the Uganda schools must remain speculative. On the whole, however, we may assume that positive experiences beyond the immediate family will assist the psychological development of any child regardless of his culture or the state of development of its particular society. Schools have an especially important role to play in this regard.

THE EFFECT OF SOCIAL CHANGE ON ACADEMIC PERFORMANCE

All the factors which increase the likelihood of mental health abnormalities can also be responsible for problems in learning. Children who are hungry, or fearful and depressed, or who cannot understand the local language or the language of instruction very well, will obviously be compromised in their concentration and their ability to invest themselves in learning. Good academic performance does not only require a good intellectual ability but a sense of self-worth

and hope for the future. This many children lack when they are confronted with powerful social changes. Since education, as mentioned earlier, indeed is one of the most powerful determinants of good adjustment to social change, problems in learning must be thoroughly investigated if at all possible.

Three basic reasons for poor learning have been identified:

- (1) Children with severe cerebral damage and associated mental retardation will obviously be unable to profit from a normal school programme. Unfortunately, injuries to the brain are far more frequent among the poor, both in the developed and the developing world (Davie et al., 1972).
- (2) Children with serious mental disturbances, especially if they show themselves in stealing, lying, aggressiveness or other activities which hurt others, likewise often show little interest or perseverance in school (Zinkus, 1979).
- (3) There is also a substantial group of children (about 8-12% in the age-group 6 to 12 years) who either have difficulties in concentrating or attending to instructions or have specific learning problems. Children with attentional disorders usually have normal intelligence and when helped to concentrate can understand and conceptualize academic material without difficulties. However, their impulsive and non-reflective cognitive pattern often does not allow them to stop and think sufficiently before they rush into an activity, resulting in poor work habits and a high rate of academic failure (Langhorne et al., 1976).

Children with this problem are called hyperactive or are said to suffer from ADD (Attention Deficit Disorder). This disorder affects about 5-12% of all school-aged children (Miller et al., 1973) and has a boy to girl ratio from 5:1 to 9:1 (Omenn, 1973).

There is no convincing evidence that ADD is caused by social stresses although children who show these symptoms are significantly more vulnerable to any sudden change in their support structure.

While good epidemiological studies on the incidence of hyperactivity in developing countries have not yet been done, Minde & Cohen (1978) have estimated from available data in Uganda that the ratio in that country is between 3 and 5%.

Youngsters who suffer from a learning disability will be able to take in what they should learn (i.e. they can concentrate well) but will fail to process or conceptualize the learning material. Here again, two main groups can be recognized. There are children who display a general reading backwardness, i.e. are two or more years behind in their reading ability as measured by standardized tests. These children often have a low I.Q. (the average I.Q. in one well-controlled study (Rutter & Yule, 1975) was only 80). They also show a high incidence of overt neurological disorders (11%) and usually have abnormalities involving a wide range of neurodevelopmental functions including motor coordination, right-left differentiation, and speech and language involvement. Most commonly, such children come from large families where fathers have a low paying job. Reading backwardness is equally common in boys and girls and affects about 7% of all schoolchildren.

In contrast there is a smaller group of children (about 3.5%) who show a specific reading retardation. These children more frequently have parents or siblings who are also reported to have reading difficulties (35% vs 10% in the slow readers). There are also far more boys than girls (the ratio is about 3.3:1) and have a higher I.Q. (an average of 102 in the study by Rutter and Yule. Their clinical difficulties are also quite variable. For example, they may not perceive minor differences in vowels in spite of excellent hearing or are unable to recognize the inappropriateness of their social behaviour despite repeated instruction. Both reading delayed groups and hyperactive children require special types of teaching or supervision to improve their academic performance; repeating a grade has no positive effect on school performance.

As in problems associated with the mental health of children, it must be stressed again that the physical and emotional wellbeing of parents plays an immensely important part in the school achievement of children and an assessment of poorly learning children should always include an interview with their families. Only when this is done can the differential contributions made by biological and external factors be diagnosed and a comprehensive treatment programme be developed.

#### ADAPTATION TO CHANGE AS A PROCESS

In the previous sections we have discussed some of the variables which can increase or buffer the stress experienced by children and their families who have to adapt to social change. In all these deliberations both the social change and the individuals's response to it was presented as if it occurred suddenly.

However, any adjustment to change is a process which continues for a varying length of time. While mental health specialists have been aware of distinct stages in adaptation following external events such as parental divorce, the loss of a valued person, the diagnosis of a malignancy or the birth of a defective child, social psychologists are now also beginning to talk about specific phases of acculturation. For example, Berry & Kim (1985) in a very recent contribution to a WHO sponsored workshop on the applications of cross-cultural psychology to the promotion of healthy human development, talk about five phases of acculturation. There is said to be a precontact phase, followed by contact, conflict, crisis and finally an adaptation phase. In the contact phase cultural and behaviour exchanges begin, with the now dominant group providing most of the input and in that way increasing the stress experienced by the acculturating group. This may lead to conflict with an ensuing crisis which demands some type of resolution (adaptation). The importance of this model for mental health professionals is the possibility to assess children and their support system in a more ecological fashion. For example, famine victims from Northern Ethiopia, because of their malnutrition, may have had extremely poor physical and mental health before they arrived in camps and possibly were re-settled in the South of Ethiopia with all the ensuing social changes. The enforced change in that situation may thus possibly not lead to a conflict or crisis but to a less stressful existence, as food and provisions are now secured. To maintain a low stress level would nevertheless require that the dominant culture values the characteristics and cultural identity of the newcomers and also offers them active and positive contacts.

In a very detailed study of 250 immigrant children from three different countries two years after immigration to Australia, Taft & Cahill (1978) confirmed some of Berry's hypotheses. Thus Maltese children, two years after immigration to Australia were also rated considerably worse in their learning ability, attitude to learning and general problem behaviour in school by their teachers than one year after their arrival in Australia. This was not true, however, of South American and British immigrant children. Taft & Cahill felt that these differences were due to the different attitude of the children's parents. The Maltese parents disliked life in Australia. They therefore resisted integration which may have led to their children's experience of conflict with Australian institutions.

This data suggests that future research on immigrants and other groups exposed to rapid social change should be more process-oriented. Identifying specific phases of adjustment might also help those concerned with intervention and prevent develop more appropriate techniques.

#### INTERVENTION

Intervening and lowering the stress to the child and his family created by rapidly changing social conditions is a complex undertaking. It is very difficult to scientifically design and evaluate appropriate intervention studies. Yet some stresses, such as the concern about an impending nuclear war acutely perceived by many children in the developed world today (Somers et al., 1985) require very different intervention strategies than do the stresses brought on by a drought or the death of a parent. However, there are nevertheless some general principles of intervention which can be applied in a variety of situations across different cultures.

(1) There is a great need to raise a general awareness that behavioural abnormalities are frequently caused by changes in a child's environment. For example, it would be enormously beneficial if health workers and those in administrative positions everywhere would understand the relationship between social incompetence and inadequate food intake (Graham & Canavan, 1982). It would likewise be useful if teachers could recognize the connections between a learning disability and the solemn defiance of a 10-year old youngster.

In general this implies that we must teach those in contact with children and their families about:

(a) The interdependency of the cognitive, biological, social and psychological development of children. Some examples of this are given above.

(b) The effect particular events may have on the whole fabric of society and its encompassing behavioural manifestations (Bronfenbrenner, 1979). Some recent examples are the changes in the role of women in our society, the availability of cheap birth control techniques or the increase in the divorce rates. These developments have not only made us aware of the need for increased day-care, but have also led to a re-evaluation of traditional concepts of mother-infant attachment, of sequential cognitive development and of the importance of a same sex parent available for successful sexual identification.

The present review obviously cannot discuss the full range of changes which have been required of various societies during the past decade - but each of them can best be understood by using an ecological model.

(2) The effects of sudden or powerful changes in a society should be slowed and buffered for children and their families. This can best be done by keeping in mind that it is always preferable to have few simultaneous changes in any behavioural system. For example, Rahim & Cederblad (1984) in an excellent recent study examined 240 children aged 3-15 in an area near Khartoum which had been investigated in 1965. They found that while the study area had changed from rural to urban since their last inquiry, and the older children indeed showed a lower rate of physical but a significantly higher rate of behavioural symptoms, the total frequency of symptoms was still lower than most developed countries. Rahim and Cederblad felt that this was due to the migration patterns of their sample which saw whole extended families, even parts of villages, settle in the same part of the new area. This would ensure the maintenance of traditional support structures with the associated self-esteem and in that sense provide a concrete example of the benefits of the integration model mentioned earlier on in this paper. Since we know that the behavioural fallout of other social changes, such as divorce, are likewise much easier to take for a child if she/he stays at his/her old home and continues in the same school, the principle of "the least change necessary" should be adopted whenever possible.

(3) Culture specific disorders are rare and most behavioural manifestations of social change are transculturally valid.

Westermeyer (1985) in a recent review of psychiatric diagnoses across cultural boundaries stresses that there are only a few culture-bound syndromes such as Koro or Amok, although the distribution of non-psychotic disorder differs from one culture to another (Nichter, 1981). This has also been my impression while working in Uganda (Minde, 1974b) and would suggest that many basic principles governing interventions in the Western world would be equally useful in other parts of the world if local cultural practices are taken into consideration.

(4) The sensitivity of teachers and health practitioners in diagnosing and treating psychological disorders must be increased. There is good evidence that professionals involved with children are quite poor in diagnosing cases both with psychiatric syndromes and intellectual impairment (Giel et al., 1981). In fact, only 12-29% of psychiatrically and 5-12% of intellectually troubled children were picked up in Giel's WHO-sponsored study encompassing four countries. While WHO has recently published a technical report aimed at helping the primary health care worker to become more sophisticated in mental health issues

(WHO, 1980), much work still needs to be done to help that educational process to go further. One possibility of doing so is to use a manual on child mental health and psychosocial development which was written by five child psychiatrists of four continents for the WHO regional offices of South-East Asia in 1981 (WHO, 1981). This manual, which has a version for primary health care physicians, educators and child welfare workers, is readily available at WHO's Geneva Office and was written so that it could be easily translated into other languages. The content of these manuals would lend itself to be incorporated into the training procedures of both physicians and teachers. However, my personal experiences would suggest that even the most behaviourally committed professionals would lose interest if they do not (a) get rewarded for their interest in mental health matters by their superiors and (b) have regular access to a mental health professional who can assist them in the day-to-day work with difficult children and their families. When such supervision and consultation is provided, a majority of teachers and other child care professionals are quite interested, able and effective in assisting children in their school work and with their psychological problems (Minde, 1976).

(5) The differing quality of care which society is presently providing for individuals of differing social standing and their families should not cause undue alarm. In fact, experience suggests that the interest of special, often socially favoured groups, for mental health services or special academic programmes will in time raise the expectations of other, less advantaged, groups of the population and in that way create the necessary community pressures to introduce the needed services to all (Graham & Canavan, 1982). It should also be remembered that in the developing world the newly educated comprise an especially high risk group for providing poor child care as many of them are frequently very career-oriented and tend to leave their children with poorly paid and uncaring household help (Gatere, 1980).

- (6) Any kind of practical intervention should be based on the principles of:
- (a) Maintaining traditional family ties and support structures.
  - (b) Maintaining the personal autonomy of the involved population group.
  - (c) Providing support structures for existing cultural practices instead of replacing them with new ones.

In practice this means that we should try to keep families together or use family members as parent substitutes when the need arises; create day-care or other part-time alternative support services for working mothers or those not able to look after their children; use self-help groups or other ways of community organization measures which actively involve the families at risk in the search for solutions brought on by social change; and finally build on the strength rather than the weakness of existing structures in our attempts to help those in need of our care.

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