

## **Participatory model of mental health programming: Lessons learned from work in a developing country.**

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### Abstract

Participatory action research provides a framework for conceptualizing the development of mental health programs in schools and communities. A participatory intervention model is best characterized by a collaborative process in which the partners together create interventions to facilitate individual and cultural change. In this article, we describe the application of a participatory model for creating school-based mental health services in a developing country where such services are non-existent. In particular, we describe the process of identifying individual and cultural factors relevant to mental health in the target culture. The article concludes with a discussion of lessons learned with regard to the importance of formative research and collaboration with stakeholders to ensure cultural specificity of interventions, and the potential for participatory action research to contribute to strengthening our commitment to research-based school psychological practice.

Recent trends in school psychology emphasize participation of key stakeholders (e.g., teachers, parents, community members) in addressing the needs of students. For example, school reform efforts reflect a participatory model through the use of a team-based approach (Adelman, 1995; Curtis & Stollar, 1996). Current models of consultation call for collaboration with teachers and families (Christenson & Conoley, 1992; Rosenfield & Gravois, 1996; Sheridan, Kratochwill, & Bergan, 1996). In this article, we propose a participatory intervention model to guide school-based mental health programming. We describe the application of the model in a developing country in which school-based mental health services are non-existent. This example provides the opportunity to examine closely the process of program development through participation of key stakeholders. We conclude with lessons learned from our work in a developing country and discussion of implications for mental health program development and school psychology practice in the United States.

### Participatory Intervention Model

Figure 1 presents a model of program development that is consistent with a participatory action research model (see Nastasi, 1998). A participatory intervention model is best characterized by a collaborative process in which the partners together create interventions to facilitate individual and cultural change. Partners in program development include representatives from constituencies with a vested interest and/ or necessary resources. For example, in school-based mental health interventions, partners are likely to include teachers, school administrators, parents, students, school mental health staff, community mental health agency staff, community leaders, and policy

makers. Partnership is the catalyst for program development and for individual and social-cultural change.

The first component of participatory program development--participatory program design--corresponds to the program design stage of traditional models, that is, the stage during which program goals are identified and the intervention program (e.g., strategies, curriculum) is planned. The process of program development begins with formative research focused upon identifying and assessing individual and cultural variables that are critical to the change process. Data from formative research are used by the partners to identify culture-specific goals and to develop a culture-specific intervention model. In the process of participatory program design, the psychologist-researcher does not present an intervention for acceptance but through dialogue with stakeholders creates an intervention. In the participatory process, all members of the team hold equal status, contribute equally to the generation of ideas and decision making, and work toward consensus. In this way, program acceptability becomes a by-product of program design.

The second component of participatory program development--participatory program implementation--involves the modification of the culture-specific model to fit the needs and resources of specific contexts (e.g., one school) and populations (e.g., inner-city adolescents). From an ecological perspective, adaptation of the program model refers to the creation of an ecological niche: a person-environment fit that enables optimal development and functioning (cf. Bronfenbrenner, 1989). Thus the question becomes, "What modifications are necessary to achieve an ecological niche for the local culture and participants?" Answering that question requires identifying (a) the essential elements of the intervention, that is, those elements that are requisite for achieving program goals, and (b) what modifications are necessary to implement the essential elements within the local context but still preserve the critical components of the intervention. Hence, program implementation also requires collecting data about the needs, resources, values, language, and behavior of the specific target group. This is done in partnership with program participants (those who implement and those who receive the intervention). The assumption is that the better the ecological fit, the greater the likelihood of program acceptability, proper implementation, and sustainability.

To ensure effective program implementation, continuing data collection or formative/process evaluation is necessary. This data collection provides the opportunity to monitor implementation and modify the program to facilitate an optimal fit between the intervention and the participants. Traditional conceptions of program integrity or fidelity require documentation of the extent to which a prescribed intervention plan is followed. In contrast, the focus in participatory intervention is documentation of the program as implemented within a specific context. From a research perspective, the goal is to identify the critical and non-critical elements of the intervention across multiple person- and culture-specific adaptations. Critical elements are those that are linked to target program outcomes. Noncritical elements are those that can vary across contexts or persons to foster acceptable interventions but do not interfere with the achievement of target outcomes.

The third component of participatory program development--participatory program evaluation--involves the documentation of efficacy, that is, examination of the impact of the intervention. This component addresses the question, "What essential changes have occurred in the direction of the program goals?" The response to this question requires assessment of program impact at multiple points in time, throughout and following the intervention process. Hence, target skill level is the standard against which performance is compared throughout the intervention (formative evaluation), immediately following the conclusion of the intervention (immediate outcome or summative evaluation), and at a later point in time (follow-up or delayed outcome). These changes in target competencies are interpreted with reference to the elements of the intervention (documented during program implementation) to determine which intervention components are essential to bring about the desired goals for the specific culture and person(s). Evaluation results are used to make necessary program modifications to enhance success within the local culture as well as to inform intervention theory.

### Developing School-Based Mental Health Services in Sri Lanka

We present findings from the Mental Health Among Sri Lankan Youth project, conducted in Sri Lanka, an island situated in the Indian Ocean south of India. In its initial phase, this long-term project was focused upon developing a school-based mental health care service delivery model through coordination of government-funded health care and education. Project aims included developing culture-specific definitions of key individual and cultural constructs relevant to mental health; assessing within the professional community and youth sectors the needs and resources relevant to promoting mental health of Sri Lankan youth; assessing service provider training potential and needs to plan for establishment of international exchange programs; and building an infrastructure for mental health research, service delivery, and professional preparation. The information presented here was collected during a two-year period during several visits to Sri Lanka.

Sri Lanka provided an opportune context for this work. First, free and accessible medical and educational services are available to the general population. Second, consistent with the developing world more generally, there is limited emphasis on mental health. However, professionals within the country recognize the importance of addressing mental health issues. Third, mental health services are limited due to the shortage of professionals (e.g., less than 20 psychiatrists in a country of 18 million and nonexistent psychological services) and training programs. Fourth, the extensive government-funded educational system provides an alternative context for provision of mental health services to the general population of children and youth. Finally, a well-established (14-year) collaborative relationship between social science and medical professionals from the U.S. and Sri Lanka made this project and extended work feasible. Collectively, these professionals--anthropologists, sociologists, psychiatrists, pediatricians, and a school psychologist--represent universities and non-governmental research and community service agencies from both countries who have extensive experience in school- and community-based health-related research and service.

Preliminary data regarding the need for and provision of mental health services for Sri Lankan youth were gathered during a two-month visit to Sri Lanka in the Summer of 1995. Data sources included informal participant observation, key informant interviews, and collection of artifacts within the local and professional communities. Interviews with youth and young adults participating in the Youth and Sexual Risk Project served as a secondary database (Silva et al., 1997). Informal participant observations occurred in the context of acclimating to Sri Lanka, particularly the Central Province and the professional and university community, and during participation in the Youth and Sexual Risk Project. In addition, unstructured, open-ended interviews were conducted with key informants representing the educational, health, and mental health sectors. These interviews focused on the mental health and educational concerns of psychiatrists, teachers, and administrators of government and non-governmental agencies who provide health and social services, community leaders and community service workers, public health workers, and community members. Artifactual data included national and local documents regarding mental health and educational issues, and popular media (e.g., daily newspaper, TV dramas).

These preliminary data suggested a need for mental health services that would be easily accessible to the general population of children and youth. Professional mental health services other than those provided by the psychiatric community were non-existent and access to psychiatric care was limited given the number of psychiatrists in the country (less than 20). Yet there was evidence of significant need. For example, the suicide rate in Sri Lanka--the highest in Asia and second highest in the world--has increased 500% during the past 30 years. Suicide is highest among young adults ages 20 to 30 (Communication Centre for Mental Health, 1995; K. Tudor Silva, personal communication, July, 1995). Social scientists in Sri Lanka attribute suicide to low self-esteem, difficulty coping with life stressors, and preoccupation with social stigma related to transgression of social norms and alcoholism. Further, the social science community suggests that these variables are more critical determinants than clinical depression, a factor commonly associated with suicide in the U.S. The psychiatric community, in contrast, views depression as a critical predisposing factor.

Concerns among educators in Sri Lanka regarding disruptive classroom behavior have increased since the 1980s (Jayasena, 1995). Prevalent disruptive behaviors observed by Jayasena included noncompliance and defiance of teacher authority, destruction of school property, use of foul language, and verbal abuse of peers and teachers. Frequency and severity of disruptive behavior were greater among students older than 13 years of age, with the most destructive and threatening (to teachers) behaviors occurring among student older than 15 years of age. In addition, discussions with faculty and teachers-in-training at a teachers' training college located in the Central Province revealed a range of social-emotional difficulties among children and youth that interfere with instruction and learning.

Contacts with the social service and educational community and data from the Youth and Sexual Risk Project suggested that stressors associated with mental health difficulties included parental absence (e.g., due to death, divorce, work abroad, parental alcoholism), civil war within the country, economic problems, academic stresses, uncertain future

prospects regarding education and employment, and difficulties in intimate relationships. Furthermore, spousal alcoholism and domestic violence were cited as common problems for women.

Discussions with members of the psychiatric community indicated that mental health services were restricted to community-based psychiatric treatment of moderate to severe problems. Lack of services, shame associated with mental illness, and attempts to address problems within the family constellation hinder treatment of mild mental health problems. Finally, contacts with social scientists, educators, and the psychiatric and social service community indicated a receptive climate for development of mental health services for children and youth within the school setting. A major drawback was the shortage of mental health professionals (particularly, psychologists) to provide services, training, and support to school personnel.

Thus, preliminary contacts within Sri Lanka suggested the need for accessible mental health care for the general population of children and youth and the need for support to educators in addressing the behavioral and social-emotional needs of students. Furthermore, the need for mental health promotion in Sri Lanka's schools was confirmed in a recent report on youth needs and their health problems commissioned by the Family Health Bureau of the Ministry of Health of Sri Lanka and conducted by two prominent psychiatrists from the University of Peradeniya (Abeyasinghe & Ratnayake, 1996). In the report, suicide, alcohol and other drug abuse, sexuality, and aggression were cited as critical mental health issues for Sri Lankan youth. In addition, mental health promotion within schools was cited as a potential solution. Current national school reform efforts provide the opportunity to reexamine the educational mission of the country.

In an effort to gather more detailed information about mental health needs and resources specific to Sri Lankan youth, we conducted formative research in 1996 in the schools within and around Kandy, an urban community in the Central Province. Data from interviews with school staff and students provided working definitions of individual and cultural constructs to guide culturally specific mental health promotion in Sri Lanka. In the next section, we describe the conceptual model that guided the formative research in Sri Lanka.

### Conceptual Model of Mental Health

Critical features of the conceptual model of mental health that guided our work are (a) an ecological-developmental framework for understanding and promoting human development espoused by Bronfenbrenner (1989), (b) focus on both individual and cultural factors related to mental health (cf. Elias & Branden, 1988), and (c) primary prevention of mental illness by promoting personal-social competence as an integral part of education (cf. Nastasi & DeZolt, 1994). Figure 2 depicts this conceptual model. A major assumption of the model is that critical individual and cultural factors influence mental health. That is, mental health status of an individual is influenced by personal vulnerabilities due to personal and family history (e.g., early school failure or family alcoholism, respectively); social-cultural stressors (e.g., community violence, restriction of male-female interaction during adolescence); the extent to which the individual

possesses culturally valued competencies (e.g., academic competence, social skills, athletic ability); culture-specific socialization practices and agents (e.g., family, teacher, media) responsible for promoting the development of competencies; personal resources (e.g., problem-solving skills) for coping with daily stresses and major life changes; and social-cultural resources available to youth (e.g., peers, family, religious leaders) to facilitate coping. This conceptual framework has been applied to the development of mental health programs in schools within the U.S. (e.g., Nastasi & DeZolt, 1994; Nastasi, Varjas, Bernstein, & Pluymert, 1997).

We used the broad individual and cultural constructs from our conceptual model to formulate the following research questions.

1. What is the cultural definition of mental health/personal-social competence and adjustment difficulties in Sri Lanka?
2. What cultural mechanisms and agents are responsible for socialization and development of mental health/personal-social competence?
3. What personal and family vulnerabilities are present in the society?
4. What social stressors do Sri Lankan youth and their families face?
5. What personal resources do Sri Lankan youth possess for coping with everyday and major life stressors?
6. What social resources are available to Sri Lankan youth for coping with everyday and major life stressors?

## Methodology

### *Context*

The target community was the city of Kandy and surrounding communities. Kandy is an urban community in the Central Province of Sri Lanka with a population of approximately 100,000. It is the second largest city in the country and its schools draw students from the urban community and surrounding villages. Some students board in school hostels. Ethnic groups represented in the community include Sinhalese, Muslim, and Tamil. Languages spoken include Sinhala, Tamil, and English. Socioeconomic status of community members ranges from lower to upper class. Occupational classifications reflect a wide range, from unemployed and unskilled laborers to university professors and other professionals. One of the major universities in the country and a regional teacher's training college are located in an adjacent community. Children and adolescents attend government-funded primary and secondary schools. The civil war within Sri Lanka has been responsible for school closings and interrupted school terms in recent years. Although the civil war is restricted to the northern and eastern parts of the country, the adults and children in the Central Province are indirectly affected by this war.

We selected a range of schools with regard to ethnic composition, religious orientation, socioeconomic status, level of resources within the schools, and enrollment size. Five schools had a female-only student population, four were male only, and the remainder were mixed gender. Target students were from 8 to 13 years of age inclusive (corresponding to grades 7 to 12), thereby representing the adolescent population.

## *Participants*

Students and teachers from 18 schools in the Kandy municipality and surrounding areas participated in a series of 51 focus group interviews. Thirty-three (33) groups were conducted with students; 18 were conducted with teachers. In each school, we conducted one focus group with teachers and one to three groups with students to achieve a range of age levels and gender mix in the student groups. In some schools, prefects (school leaders/monitors) were interviewed in separate groups. The typical focus group size was 4 to 6 members, although the range was 2 to 24 (influenced by school-specific logistics). Focus groups with students were typically of the same gender (13 female groups, 16 male), although 4 mixed-gender groups were conducted. Teacher groups were typically of mixed gender, reflecting staff composition. Although we had permission to conduct interviews in 20 schools, time limitations and a bomb scare in one school precluded data collection in two schools. Additional interviews were conducted individually with school principals and teachers/counselors on formal and informal bases.

## Data Collection and Analysis

Focus groups interviews were conducted with adolescent students and teachers to define the following constructs: the cultural definition of mental health/personal-social competence and adjustment difficulties, cultural mechanisms for socialization and development of mental health/ personal-social competence, personal and family vulnerability, social stressors, personal resources for coping with everyday and major life stressors, and social resources available to youth. The purpose of the focus groups was not to get a normative representation, but rather to gather a wide range of data with regard to the definition of key constructs. Respondents were asked to discuss the issues with reference to their cohort group. They were not asked or encouraged to discuss personal issues or experiences.

Interviews were open-ended, semi-structured in format, and guided by a series of questions. (See Appendix A.) Specific questions for the interviews were generated in collaboration with an educational sociologist/teacher trainer and child psychiatrist with experience in schools. Consistent with qualitative research methodology, questions became more focused with the passage of time. Initial questions such as "What is a good citizen?" were dropped in later interviews as responses across groups became redundant (e.g., no new information was provided after several group interviews). Instead the questions focused more upon specific mental health concerns or social-cultural stressors (e.g., Is academic pressure a concern for youth? If so, how does one cope with the pressure? What adjustment difficulties or mental health problems are related to academic stress?). In addition, some group discussions focused on more specific issues; for example, some groups emphasized problems associated with parental alcoholism or parental absence and were willing to discuss the issues at length. In these instances, more indepth questioning about parental alcoholism (or parental absence) was conducted.

Focus group interviews were co-conducted by two researchers (a school psychologist from the U.S. and an educational sociologist from Sri Lanka) in English with translation to Sinhala and Tamil as needed. The content of interviews was recorded in written form

and audiotaped for later analysis. All data were converted to text and entered into a computer. Verbatim written transcripts were recorded during interviews in English and Sinhala with the assistance of two research assistants (a doctoral student in school psychology from the U.S. and a master's student in education from Sri Lanka). Audiotapes provided archival records for verification when needed. Research assistants were responsible for entering transcripts on the computer.

Textual data were categorized initially in the general domains that guided data collection (e.g., cultural definitions, social stressors). In addition, subcategories and additional general categories were generated inductively from the data. (See Appendix B for the coding scheme.) Transcripts were coded by a team of research assistants in the U.S. under direction of the U.S. researcher. The researcher in Sri Lanka was consulted regarding the coding scheme and the categorization of responses to ensure cultural specificity. The content of the categories provided the basis for developing culture-specific definitions of key constructs.

### Findings

The definitions of key constructs that evolved from the interview data are summarized. These definitions represent the range of responses that were evident across all interviews (students, teachers, principals) and do not necessarily reflect a normative or typical characterization. They are meant to serve as catalysts for discussion and mental health program development. Subsequent research is necessary to provide normative data.

#### *Culturally Valued Competencies*

Characteristics of the competent individual encompass several domains--personal, social, behavioral, academic/occupational, and physical (cf. Harter, 1990). The personally competent individual is described as kind, truthful, brave, and understanding. The personally competent person is responsible, thinks independently, accepts and corrects mistakes willingly, leads a peaceful and religious life, and is motivated toward self-improvement. Respondents described the "mentally balanced" individual as one who possesses coping and problem-solving skills necessary for handling stress and defeat, tackling everyday problems, and making thoughtful and justifiable decisions. The life of the well-adjusted person is characterized by a balance of work and play (e.g., "one who does school work properly [and] extracurricular activities properly"). The socially competent person respects and cares for others, provides an example to and guides others (e.g., "in the correct path"), does not impede the well-being of others, and considers others as "brothers and sisters" despite ethnic differences. Such a person has strong family relationships, is loyal to his/her country, performs community service, and helps to develop the resources of the country. The behaviorally competent person is well-disciplined; that is, conducts her/himself in a socially acceptable manner, follows rules, fulfills obligations, is not disruptive or mischievous, and does not create problems for society. The academically/occupationally competent individual is performance-oriented and strives for maximum performance in academics, extracurricular competitions, and occupational endeavors. The physically competent person performs well in sports (e.g.,



rugger, cricket, netball). Physical competence was described most frequently with reference to males.

### *Adjustment Difficulties*

Similar to competencies, adjustment difficulties encompass personal, social, behavioral, academic/occupational, and physical domains. Personal adjustment difficulties included depression, anxiety, moodiness, confusion, and withdrawal. Social adjustment difficulties included neglecting one's obligations; fighting or arguing with peers, teachers or parents; physical or verbal abuse of others; using or abusing drugs; stealing; carrying weapons; and participating in gang activities (e.g., drugs, theft, rape). Behavioral adjustment difficulties included noncompliance (e.g., to school rules), tantrums, aggression, school truancy, and leaving home. Academic adjustment problems included difficulty concentrating, neglecting studies, inability to read or write, and performance anxiety (e.g., related to exams). Physical adjustment problems included a range of stress-related illnesses and sleeping and eating problems.

### *Vulnerability*

Mental health research has documented the importance of personal and family history variables as predictors of mental health problems in adolescence and adulthood. The data on Sri Lankan youth provided evidence of several personal and family history variables that suggest greater vulnerability to mental health problems. Personal history variables refer to individual adjustment difficulties or experiences that predispose one to mental health difficulties. The personal history variables cited by respondents included school failure; use of drugs; teenage pregnancy; homelessness (i.e., living in the streets); physical or sexual child abuse; and lack of family support because of abandonment, rejection, and parental absence or death (e.g., children who are orphaned). Family history refers to the presence of parental or intergenerational mental health difficulties. The family history variables cited by respondents included parental alcohol abuse, physical or sexual child abuse, domestic violence, and parental aggression.

### *Coping Mechanisms*

Personal resources for coping with stress were categorized as emotion-focused (designed to alleviate the emotional impact), problem-focused (designed to address the source of stress), and support-seeking (seeking instrumental or emotional support from others) (cf. Lazarus & Folkman, 1984). Emotion-focused coping strategies specific to Sri Lankans included sleeping, eating, stress-related illness, prayers, isolation, running away (e.g., leaving home), tantrums or pouting, drinking, and suicide. Problem-focused mechanisms included decision making, attempting to change the circumstances, taking preventive measures, asking questions, attempting different solutions and persistence, seeking professional help, and using logical arguments to resolve conflicts. Problem-focused strategies were most often reported by adult respondents. Support-seeking was characterized by (a) seeking of emotional support, for example, discussing problems with parents, teachers, siblings or peers; and (b) seeking of instrumental support such as

seeking academic help from peers or privately from tuition teachers (private tutors). Students indicated a preference for seeking academic help on an individual basis from tuition teachers to avoid peer ridicule. Asking questions in class was considered unacceptable by peers because it wasted class time for those who already knew the answers. These attitudes are closely linked to the emphasis given to academic achievement.

### *Social Stressors*

The major social stressors affecting youth were associated with family problems and academic pressures. Family stressors included financial difficulties, overcrowding (e.g., several families living in one house), parental alcohol abuse, separation from parents, family violence, lack of attention and understanding from parents, parental extramarital affairs, and parentification of child (i.e., child is forced to assume adult responsibilities within the family due to parental absence or neglect). Academic pressures were related to familial and societal expectations for high achievement, the high stakes associated with the country's rigorous examination process (i.e., access to higher education for less than 2% of the population), and the priority given to studies rather than social and personal development during adolescence.

### *Social Resources*

Social resources are available to youth within several social-cultural contexts, including family, school, peer group, and community. Within the family, youth viewed parents as role models and as sources of advice, guidance, instruction, discipline, and emotional support. Relatives, particularly elder siblings, were viewed as important sources of emotional support and advice. Adolescents reported heavy reliance on peers for guidance, instrumental help (e.g., with studies), and emotional support, particularly when adult help was not feasible. School-prefects are older students, typically selected by teachers for their leadership qualities, who assist staff in enforcing school rules. The students in our study identified the school prefect as peer advisor/ supporter, disciplinarian, and liaison to school staff, suggesting that prefects may be important sources of peer support. Teachers were cited as critical for providing guidance, discipline, emotional support, and intervention for academic and personal problems. Intervention by school principals was typically disciplinary in nature, occurred when problems exceeded the teacher's capacity for intervention, and was likely to result in contact between the school staff and parents.

School counselors, poorly trained and minimally accessible, are teachers who received inservice training in counseling during a recent period in which the government was trying to address the need for mental health services. These efforts were considered to be largely unsuccessful. School counselors typically had teaching as well as counseling responsibilities. In some schools, the role of counselor was defined as disciplinarian. For example, in one all-girls school, the counselor was responsible for monitoring the confiscation of love letters, which were against school rules. When love letters were confiscated, students were reprimanded, and parents were brought in to discuss the issue. No form of "counseling" or support was provided to the student; the issue was handled only in a disciplinary manner.

Outside the school, teachers and students were aware of psychiatric services within the health care system, but viewed these services as appropriate for more severe mental health concerns. Respondents most frequently cited examples of psychiatric care that involved prescribing of medication (pharmacological treatment). With regard to academic pressures, community-based private tuition (i.e., private academic instruction) was viewed as a necessary resource, particularly by youth.

Reliance on informal supports through peers, teachers, and elder relatives were necessary given the limited availability of formal supports. Youth indicated a preference for support from parents, but also indicated that some problems could not be easily discussed with parents; for example, those associated with familial problems, parental expectations, or adolescent issues regarding sexuality and heterosexual love. In such instances, youth relied on elder siblings, teachers, or peers. In contrast to their reluctance to discuss family and adolescent development issues with adults, youth respondents indicated that any topic could be discussed with friends. These findings are consistent with those from the Youth and Sexual Risk Project conducted within the same community (Silva et al., 1997). That is, youth and young adults reported difficulty discussing love relationships and sexuality with their parents and indicated a preference for peers as sources of information and support.

### *Socialization Practices*

Respondents indicated that the critical socialization agents (i.e., for transmission of knowledge and cultural norms) within Sri Lanka are family, school, religion, and the media. Schools clearly have a major role in the socialization of youth in Sri Lanka. However, teachers and administrators expressed frustration regarding the limited opportunities to address personal and social development of students due to the emphasis on academics. Such opportunities were restricted to discipline efforts characterized by scolding; physical punishment such as caning, hitting, pulling the child's ears; requiring the child to kneel or stand; assigning tasks such as cleaning the school; after-school detention; and temporary removal from classroom or school. For serious concerns, contact with parents was initiated by the administration. In extreme cases, students were removed from the school permanently. Use of rewards were mentioned infrequently and restricted to tangible items such as school supplies.

### *Cultural Norms*

The norms of a culture include rules, standards of behavior, values, and customs accepted by society, family, school, and community. Reference to peer norms was minimal, although students indicated interest in changing some of the existing adult/societal norms. The norms most relevant to youth are listed in Table 1. Both youth and teachers identified the country's educational system, economic status, and political climate as important influences on the lives of youth. In addition, youth spoke of gender inequity and restrictions on relationships (with adults and peers) as problematic. Norms relevant to adolescent heterosexual interaction were of particular concern to both female and male youth. Specifically, contact between males and females during adolescence and young adulthood is restricted and closely monitored by parents and teachers. Female students

told stories of being reprimanded in school if a teacher observed them interacting with an adolescent or adult male in public, even if the male was a relative (e.g., cousin, uncle). Private tuition (typically conducted in a class format) and community organizations (e.g., volunteer social service agencies) provided some of the few opportunities for young people to interact socially. As noted earlier, one-half the schools in which we worked had single gender enrollment.

With regard to the future, students and teachers provided suggestions for cultural change (see Table 2). Both teachers and youth suggested changes relevant to academic and occupational preparation and opportunities. In addition, youth indicated interest in changing the social-political climate, for example, with regard to various social injustices, class distinctions, and ethnic conflict.

### Implications/Conclusions

The research findings on youth in the Central Province of Sri Lanka provided the basis for discussing mental health issues of youth and for identifying targets for youth development. Following completion of the study, findings were presented in a seminar in July 1997 to a selected group of 40 teachers, university and teacher training college faculty, researchers, provincial education ministry agents, university students, and young adults from the Kandy area. The seminar was conducted by a school psychologist from the U.S. in collaboration with an educational sociologist/teacher educator and psychiatrist from Sri Lanka. The presentation provided the context for discussion of implications of the data and for development of recommendations for action at several levels--classroom, school, province, and professional preparation. The following recommendations for action were identified by seminar participants:

1. Establish smaller school and class sizes to decrease the current ratio of students to teachers (50-60:1) thereby allowing greater opportunities for individual student-teacher interaction and for teachers to develop supportive relationships with students.
2. Educate teachers and parents about the psychological development of children and youth, particularly regarding social-emotional issues.
3. Reduce gender inequity within schools through education of staff and students and changes in school practices/norms.
4. Promote greater school-community-parent collaboration.
5. Reduce the pressure on academic performance, for example, by using alternative forms of evaluation, providing alternative educational routes (e.g., vocational training), and broadening the scope of culturally valued occupations/jobs.
6. Encourage collaboration of the various sectors that provide services for youth, including government agencies (e.g., education and health ministries), religious organizations, nongovernment organizations, schools, parents, and community members.
7. Develop innovative educational practices that focus on student-centered learning (e.g., through active learning, peer-based/mediated learning, and teacher as facilitator of learning).

8. Review and revise professional preparation of teachers to prepare teachers in innovative educational practices and mental health promotion.
9. Provide professional preparation of mental health specialists (e.g., psychologists, psychiatrists, counselors) specific to mental health promotion for children and youth.
10. Develop school-based mental health promotion programs (e.g., curriculum for promoting life skills, and counseling services).

These recommendations reflect several key issues that were evident in the formative data. First, family, school, and community share responsibility for socialization of children and youth. Second, teachers are an important source of social, emotional, and academic support for students; yet, teachers recognize and are frustrated by limited opportunities to provide such support. Third, cultural norms regarding gender roles and academic/occupational success are sources of stress for youth. Schools can play an important role in reexamining and changing these norms. Fourth, professional mental health services are insufficient for addressing the needs of children and youth.

In summary, formative research findings suggest that key stakeholder groups (particularly, adolescents and teachers) are concerned about the social-emotional development and mental health of children and youth. Furthermore, these findings provide specific definitions of culturally valued competencies, socialization practices, and mental health needs and resources. Recommendations from seminar participants reflected their interpretations of findings and contributed to identification of the following foci for future action in Sri Lanka:

1. Promote awareness of mental health needs and encourage partnership among key stakeholder groups, including educators, parents, and policy makers. Involve these stakeholders in the process of addressing mental health needs of children and youth.
2. Reexamine the role of educators and the country's educational system in promoting the general well-being of children and youth. In the context of current educational reform efforts, extend the goals of education to include social-emotional as well as cognitive-academic development. Realizing these goals will require developing school-based programs and preparing school staff (administrators, teachers, and mental health professionals) to implement programs.
3. Reexamine cultural norms that are sources of stress for youth, particularly those related to gender roles, relationships, and academic success. For example, in the context of educational reforms, evaluate the current examination process--based on the British system of Ordinary Level (O/L) and Advanced Level (A/L) examinations--which determines access to higher education and is a major source of stress during adolescence.
4. Examine ways to increase the supply of mental health service providers in the country; for example, through creating positions within schools and communities and developing training programs. The realization of this recommendation, in particular, requires the identification of short- and long-term funding and the establishment of an infrastructure within the country.

Effective action to promote the psychological well-being of Sri Lanka's youth will require the collaboration of the critical socializing agents (school, family, peer, community) with policy makers and youth service organizations/agencies in the identification of goals, development of action plans, and implementation of social-cultural change. The present study represents an initial attempt to gather necessary data on mental health needs and resources of Sri Lankan youth. Continued research is needed to test the proposed cultural definitions on a national basis, to develop normative data on mental health of children and youth, and to develop and evaluate mental health promotion programs for schools, families, and communities.

### Lessons for the Development of Programs in U.S. Schools

Our experiences in Sri Lanka highlight the value of participatory models for developing school-based programs and for guiding school psychology practice. Given that school-based mental health services are nonexistent in Sri Lanka, we have the unique opportunity to examine the development process from its inception. Recently, we have formulated a five-year plan that addresses needs for program development, training, and research in Sri Lanka. In fostering the evolution of school-based mental health services in Sri Lanka, we continue to use a participatory model with involvement of policy makers, government officials, psychiatrists, school psychologists (initially from the U.S.), educational researchers, school administrators, teachers, parents, paraprofessionals, and students.

Identification and training of school-based mental health professionals are considered critical to establishing and maintaining school-based mental health services within Sri Lankan schools. In response to this need, efforts are being made to establish school psychology as a profession in Sri Lanka. This provides an opportunity from the inception to identify school psychologists in Sri Lanka as school-based mental health services providers. In contrast to Sri Lanka, the challenge in the U.S. is to reframe our current strategies. Nevertheless, our experiences in Sri Lanka have taught us some important lessons about using participatory models for program development.

#### *Lesson 1. Formative Research is Critical to the Development of Culture-Specific Programs*

Formative research provides an excellent tool for examining culture-specific definitions of both individual and social-cultural variables. For example, through formative research in Sri Lanka, we identified the academic domain as critical for both understanding and potentially influencing mental health of youth. Academic achievement is both a culturally valued competency and a major source of stress for youth. Our research findings suggest that the high value placed on academic success interferes with other aspects of development (e.g., due to lack of time to devote to social and recreational activities) and contributes to stress-related difficulties (e.g., anxiety, depression). To address these issues, intervention objectives must include helping youth cope with academic stress and addressing cultural norms that contribute to academic pressure.

Given the cultural diversity within the U.S., attention to culturally specific individual and environmental variables is critical to the design of programs that address the needs of the entire population. It is important that we do not conceive of culture too narrowly but instead give attention to culture as defined by the group (sector of society) as well as the individual (e.g., who receives intervention). We propose that culture be defined with reference to factors beyond race and ethnicity, for example, by including gender, age, regional location, socioeconomic status, sexual orientation, and specific family traditions and values.

### *Lesson 2. Collaboration Among Key Stakeholders is Critical to the Development of Culture-Specific Interventions*

Within a participatory model, the members of the culture are key players as both informants and co-researchers. Not only do they provide culture-specific definitions of key constructs, they participate in data interpretation and intervention design, implementation, and evaluation. Hence, the key stakeholders help to ensure that cultural specificity is maintained throughout the process. Furthermore, the involvement of members of the culture in all aspects of programming helps to ensure acceptability and provide an opportunity for sustainability/institutionalization. That is, key stakeholders are likely to take ownership and develop skills for program maintenance.

In developing classroom-based mental health promotion programs, the involvement of teachers and curriculum specialists helps to ensure that the program can be easily integrated into existing curriculum, thereby enhancing teacher acceptability, ease of implementation, and sustainability. For example, in developing such programs in Sri Lanka, we must consider current instructional approaches (primarily didactic), class size (typically, 50 to 60 students), and educational goals (primarily academic). To address effectively the current conditions, it is critical that we work closely with teachers and school administrators.

### *Lesson 3. Action Research Provides a Means for School Psychologists to Integrate Research and Practice*

Action research (described by Nastasi, 1998) parallels the assessment-intervention process that school psychologists engage in as part of routine practice. For example, if we are asked to address the problem of truancy in a high school, we use existing theory and research to generate hypotheses and questions that guide data collection. Then we engage in a formative research process as we gather information/data about truancy rates, characteristics of students who are truant, school policies and procedures for encouraging attendance and addressing truancy problems, students' and teachers' perceptions of the problem, the administrator's view of the problem, and other information we deem relevant. Using those data, we devise context-specific theories (e.g., What seems to explain the truancy problem in this school?) to guide development of a school-specific intervention. Evaluation of the intervention provides evidence of the effectiveness of the intervention and contributes to our general understanding of truancy. The results, at a minimum, inform the psychologist's personal theory and influence truancy policies and

procedures within the target school. With dissemination of results to the scientific community, the results inform theory and research more generally.

#### *Lesson 4. Participatory Action Research is Consistent with Current Models of School Psychology Practice*

Participatory action research is philosophically and methodologically compatible with current notions of best practice. The process of practice as research reflects the well-established model of the school psychologist as databased problem solver, as depicted in the example in Lesson 3. The conception of the school psychologist as action researcher requires an expansion of the well-accepted definition of the scientist-practitioner (or practitioner-scientist). The school psychologist as action researcher not only uses theory and research to guide practice, but participates in school psychology practice as a research process and potentially contributes to the general body of theory and research in psychology and education. Participatory action research is consistent with models of collaborative consultation and team-based decision making that exemplify current models of best practice. In collaborative consultation, for example, we engage teachers in the process of databased problem solving to address the needs of specific students. Similarly, key stakeholders such as parents, support staff, administrators, and community agency staff participate in team-based decision making. Indeed, collaboration with key stakeholders is essential to effective practice by school psychologists.

In conclusion, a participatory model of mental health programming is highly congruent with prominent models of school-psychology practice and offers a mechanism for systematizing practice. We propose that a participatory intervention model, as characterized herein, affords practicing school psychologists the opportunity to engage in best practice, integrate seemingly disparate roles, conduct practice as research, and contribute to the existing body of knowledge in our field. Furthermore, participatory intervention, as a research process, affords a mechanism for bridging the gap between research and practice and between the worlds of the academic and the practitioner.

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## **Table 1**

### *Existing Cultural Norms Affecting Youth in Sri Lanka*

- \* Restricted male-female interaction during adolescence and young adulthood
- \* High levels of respect for elders (particularly family and teachers)
- \* Social and emotional distance between children and their parents, older sibs, and other adults
- \* Restricted freedom and independence of adolescent girls and young women, in contrast to high level of freedom and independence for boys/men (reflected in differences in social/recreational opportunities and supervision by parents/adults)
- \* Parental arranging or approving of marriages
- \* High emphasis on academic achievement (reflected in educational focus, examination process, system of private tuition) with limited opportunities for recreation during adolescence and limited access to higher education and employment
- \* High emphasis on professional jobs (e.g., doctors, engineers)
- \* High emphasis on individual effort and responsibility for personal achievement (i.e., "If you try hard, you can achieve your aspirations.")

## **Table 2**

### *Foci for Cultural Changes in Sri Lanka*

#### *Suggestions from Youth*

- \* Examination process and academic competition
- \* Higher education and employment opportunities
- \* Restrictions on male-female interactions
- \* Ethnic conflict
- \* Injustices in the society
- \* Class/caste differences
- \* Restrictions on leisure time

#### *Suggestions from Teachers*

- \* Examination process and academic competition
- \* Opportunities for alternative educational avenues (e.g., vocational, technical)
- \* Opportunities to address moral and real-life issues

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## **Appendix A**

### *Questions That Guided Focus Group Interviews with Students and Teachers*

#### *Student Interview Questions*

- \* Describe a good (not good) student.
- \* Describe a good (not good) friend.
- \* Describe a good (not good) citizen.
- \* Describe a good (not good) parent.
- \* Describe a good (not good) teacher.
- \* What makes children happy?
- \* What makes children sad/unhappy?
- \* What makes children angry?
- \* What makes children scared/frightened?
- \* What makes children confused?

#### Feelings [Emotions: happy, sad, angry, frightened, confused]

- \* What makes children/youth feel [emotion]?
- \* How can you tell if someone is feeling [emotion]?
- \* How do children/youth express [emotion]?
- \* What can someone do when feeling [emotion]?
- \* What can you do for a friend who is feeling [emotion]?

#### Common Problems (as indicated by respondents early in the interview process)

- \* Academic pressure/failure
- \* Test anxiety
- \* All study/no play
- \* Family is poor
- \* Alcoholic parent
- \* Mother in Middle East
- \* Break up of love affair

#### Questions about common problems

- \* Do youth in Sri Lanka experience [problem]?
- \* How do youth feel in response to or about [problem]?
- \* What effect does [problem] have on youth?
- \* What do youth do about [problem]?
- \* Whom can youth talk to about [problem]?

### *Teacher Interview Questions*

- \* Describe a good/poor student.
- \* What skills/qualities do students need to do well in school?  
How important are social skills? self-assurance?
- \* How do students express emotions?
- \* In what ways do students differ in academic ability? social ability?
- \* Describe a good/poor citizen.
- \* Who is responsible for preparing youth to be good citizens?
- \* Describe a good/poor parent?
- \* Describe a good/poor teacher?
- \* How is discipline handled in the classroom/school? Who has the responsibility for discipline in the school?
- \* What types of rewards are used?
- \* What problems do Sri Lankan youth experience in school? home?
- \* Describe a student who is having problems.
- \* How can you tell a student in your classroom has a problem?  
What would/could you do about it?

## **Appendix B**

### *Coding Scheme for Mental Health Constructs*

**Valued Competencies.** Any reference to competencies valued in the culture (i.e., as defined by the informant or culture). Code also for one of the following categories: (a) personal, (b) social, (c) behavioral, (d) academic/occupational, and (e) physical/athletic.

**Adjustment Difficulties.** Any reference to adjustment problems, mental illness, dysfunction, malaadjustments, lack of competence, or culturally unacceptable behavior. Code also for one of the following categories: (a) personal, (b) social, (c) behavioral, (d) academic/occupational, and (e) physical/athletic

**Vulnerability.** Any reference to factors to factors in the personal or family history that puts the individual at risk for mental health problems (e.g., personal or family history of substance abuse, mental illness, school failure, adjustment problems). Code for (a) family history and (b) personal history.

**Coping Mechanisms.** Any reference to how an individual copes with stress or problems (e.g., what an individual does when he/she is upset). Code also for the following categories: (a) emotion-focused--attempt to alleviate emotional distress, (b) problem-focused--attempt to alleviate the problem/stressor, and (c) support-see emotional or instrumental help from others.

**Stressors.** Any reference to risk factors or stressors present in the social-cultural environments of family, school, peer group, community, and society. Any risk factor/stressor that can potentially impede an individual's development or education or cause psychological distress. The following codes categories were derived inductively from the data: (a) relationships, (b) family, (c) civil war, (d) alcoholism, (e) poverty/economic, (f) academic/occupational, and (g) social/community.

**Resources.** Any reference to resources available in the social-cultural environments that can facilitate coping with stress or address psychological problems. These include (a) social supports from family, peers, and teachers; and (b) professional services from school counselor, psychiatrist, or tuition teacher.

**Socialization Practices.** Any reference to social or cultural factors or contexts (e.g., family, school, peer group, media, religion) that facilitate development or education. Reference to how one becomes socialized according to social-cultural norms.

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