

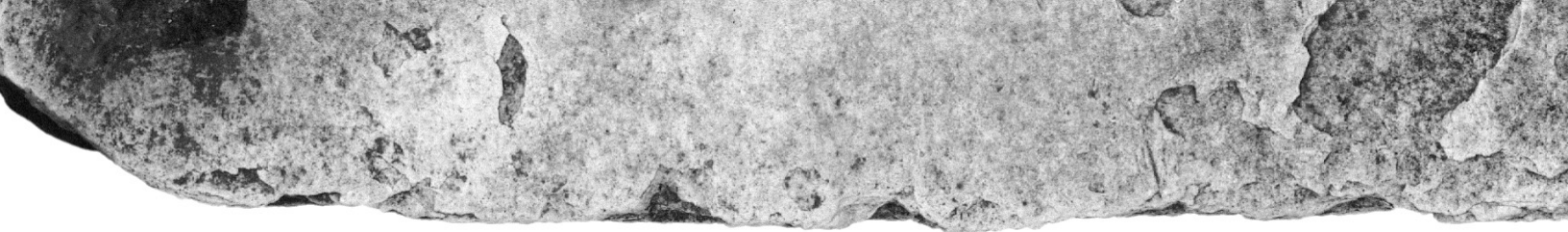
Is schooling good for Aboriginal children's health?

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Abstract

Overseas research has found a correlation between parental schooling and child and individual health, and between literacy levels and population health. Research in Australian Indigenous contexts points to a less straightforward connection. This paper will extrapolate to the Indigenous schooling context from correlational studies that implicate lack of control over destiny and social exclusion in poor health outcomes, with stress hormones being the plausible biological pathway. Alternatively, 'social support' and certain cultural factors have been found to moderate stress. Revisiting data from two classroom ethnographies, I propose that the broader societal picture is reflected in the microcosm of the classroom. A third case study examines how mainstream schooling can empower Indigenous students. The degree to which Indigenous students are culturally incorporated and socially supported within the organisation of the classroom may have significant implications for their health in the longer term. At a broader level, schools that foster mastery through Aboriginal leadership and community development programs may contribute to the health of the whole family in addition to that of the student.





The link between schooling and health

There is extensive research evidence to support the notion that *schooling and literacy* enhance population and individual health. Strong positive correlations have been found between parental levels of schooling and infant and child survival and child health (Caldwell 1993). This body of work proposes that:

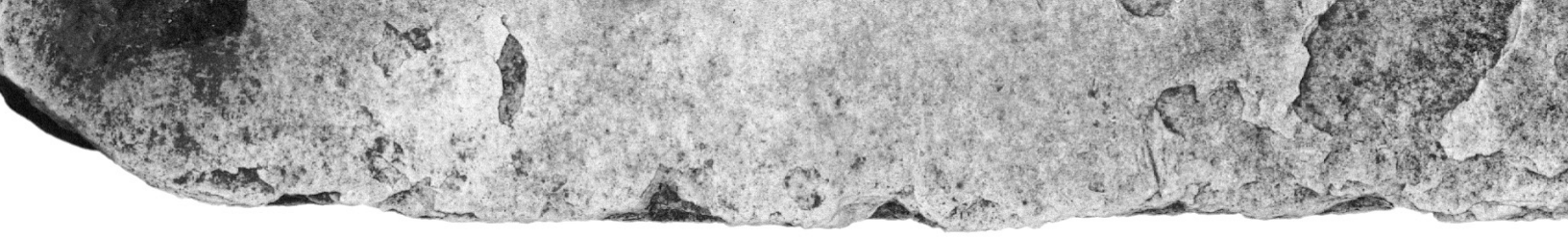
1. schooling promotes modernity and a scientific world view;
2. better-schooled mothers —
 - have more self-confidence and higher expectations of western medicine; and
 - are more assertive in seeking out appropriate health care for their children, and complying with the prescribed medical treatment; and
3. for each additional year of maternal schooling child mortality is reduced 7–9 per cent.

Marmot found that in countries with equivalent gross national products adult mortality is inversely related to levels of adult literacy. Boughton (2000) suggested that a 10 per cent increase in literacy rates could lead to a 10 per cent decrease in child mortality. Evidence associates poor attainment at school with risk of unemployment, perceived social marginality and, at best, jobs that have low status and low control in adult life (Marmot & Wilkinson 1999).

Little research has been conducted into the connection between years of schooling and health with colonised Indigenous populations, and even less regarding Australian Indigenous health (Boughton 2000). The few Australian statistically-based studies do not point to a straightforward connection between schooling and Indigenous health (Gray & Boughton 2001; Ewald & Boughton 2002). It is likely that the impact of colonisation confounds the health–schooling connection.

Colonisation has brought Indigenous Australians low socioeconomic status, racism and social exclusion. These factors have been negatively associated with population health in overseas studies (Devitt, Hall & Tsey 2001), whereas positive correlations have been found for social support and cultural cohesion.

In this paper, I begin by summarising some of the literature that investigates the particular ‘social determinants’ of health that could be seen to characterise the colonisation experiences of Aboriginal Australians. These same factors may militate against any health-promoting effects of schooling. I extrapolate from these international large-scale studies to the microcosm of the classroom, where I focus in particular on the notions of social exclusion and social support. I argue that the specific nature of schooling could make a difference, not only with regard to academic outcomes for Aboriginal students but, in the longer term, with regard to their social and emotional wellbeing and their physical health.





The Societal Context

Social exclusion and health

Social exclusion is one of a multitude of factors that may contribute to the poor health and low life expectancy of Aboriginal Australians, possibly nullifying any positive effects of schooling.

In seeking to explain the current state of Aboriginal health, Mathews, Weeramanthri and D'Abbs (1995) quote Oodgeroo Noonuccal, 'Let no one say the past is dead. The past is all about us and within'. Mathews, Weeramanthri and D'Abbs implicate Australia's history of colonisation, Aboriginal dispossession and marginalisation in the disproportionate levels of poor education, unemployment, poverty, drug abuse and subsequent poor health endured by Aboriginal people today. Colonisation has resulted in a legacy of domination by the majority non-Indigenous society over almost every aspect of Aboriginal life to the extent that institutional structures in law, health, education, social services and the like are all planned around the needs and cultural assumptions of White Australia. Raphael and Swan (1997, p. 17) propose that colonisation has had devastating effects on Indigenous mental health :

The current high levels of loss, traumatic and premature mortality, the separation of children from their families, through family breakup and justice policies, plus continuing racism, disadvantage, and other effects of white colonization, contribute to the present high level of stress.

'Social exclusion' encapsulates the cumulative effect of colonisation on Aboriginal people. It is a term conceptualised in 'social determinants' research. It encompasses the state of economic hardship and the process of marginalisation of groups that result from colonisation. Shaw, Dorling and Davey-Smith (1999, p. 222) cite the explanation given in the European Social Policy White Paper (1994) as follows:

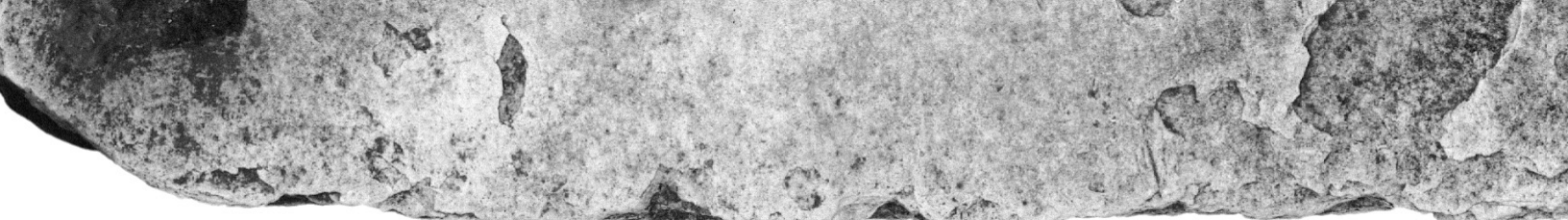
Exclusion processes are dynamic and multidimensional in nature. They are linked not only to unemployment and/or to low income, but also to housing conditions, levels of education and opportunities, health, discrimination, citizenship and integration in the local community.

Social exclusion limits people's access to resources, and to social networks and support. It impedes their access to full social and economic participation, and it imposes enormous stresses on people's daily lives. Australian Indigenous social exclusion is evident in: lack of access to health services; a poor standard of living, including inadequate housing and municipal service delivery; and experiences of racism.

Access to services

Educated professional Aboriginal women, interviewed by Katona and Cahill, felt that the most debilitating influence in their lives was their daily encounter with the cultural domination of non-Aboriginal society, and its impeding of their access to essential health and other services in a rural Northern Territory town where they lived and worked (Katona et al 2002, p. 62).

Anderson (1997) documents clinical processes that work against equitable access to medical services for Aboriginal people with regard to the allocation of therapies for end-stage kidney disease. This includes, for example, inadequate communication between patient and health practitioner, inequitable access to both kidney transplants and dialysis treatments, and lack of accessible information and programs that target prevention strategies. Anderson's study maps a direct connection between discrimination on the basis of Aboriginality and health.



Cunningham (2002) did a retrospective analysis of routinely-collected administrative data from the National Hospital Morbidity Database. She found that, in public hospitals, Indigenous in-patients who presented at the hospital with a sudden or severe symptom were significantly less likely than other in-patients to undergo a subsequent diagnostic or therapeutic procedure, even after adjusting for patient, episode and hospital characteristics. This applied to most diseases and conditions, and is an indication of a systematic difference in the treatment of patients who identified as Indigenous. These findings are consistent with those for African Americans in the USA (Gornick 1999; Williams 1999).

Although the reasons for these disparities in access to health resources have not been thoroughly tested, substantial responsibility is placed with:

- medical practitioners' stereotypical assessments of patient motivation and compliance; and
- the institutionalised culture and practice of health services, including the social and physical structure of health care centres (Anderson 1997; Gornick 1999; Humphery, Fitz & Weeramanthri, 2001).

Cultural issues and distance of treatment from home may also play a part.

Communication access is an issue in the Northern Territory where, up until recently, the lack of an interpreter service for speakers of Aboriginal languages was implicated in detrimental effects on Aboriginal health (Lawrie 1999). Even since the establishment of the Aboriginal Interpreter Service, communication between renal clinic health practitioners and Indigenous clients has been found to be seriously inadequate, limiting the opportunity for patients to make genuinely informed choices in managing their renal disease, and compromising the quality of care (Cass et al 2002).


Standard of living

In residential areas populated predominantly by African Americans, USA studies have found lack of access to municipal services in segregated housing estates, exposure to environmental toxins and poor quality housing correspond with higher rates of infant and adult mortality (Collins 1999; Williams 1999). In Australia, Runcie and Bailie (2000) report serious inadequacies in housing and health infrastructure in Indigenous communities. Hygiene, overcrowding, lack of electricity and running water, excessive dust and lack of protection from the weather are issues for many Aboriginal communities (Maidment 2002).

Racism

Morris and Cowlishaw (1997; p. 3) document the many forms of racism experienced by Indigenous people in Australia. They draw attention to how racism operates in Australia:

Discrimination on the basis of race is abhorred as immoral, and Aboriginal people live in an unprecedented time of formal equality. But there are dramatic disparities in the conditions of life between Aboriginal people and others on every statistical indicator of social well being (see Dodson 1995). Thus, despite the prevailing rhetoric of anti-racism, evidence of the destructive outcomes of racialised inequalities and of racialised marginality is compelling. Racist expression is seen as 'merely offensive but never harmful' (Goldberg 1993:38) but the harm is there for all to see.



Broadly speaking, racism can be defined as

... belief systems concerning characteristic inferiority or superiority associated with group membership; and patterns of behavior that differentially affect the esteem, social opportunities, and life chances of members of racial groups as a function of those belief systems (Rollock & Gordon 2000, p. 5).

Recent research shows a strong connection between individual experiences with racism and ill health.

Rollock and Gordon (2000, p. 6) in a synopsis of research into the *impact of racism on mental health* state, '... racism can erode the mental health status of individual victims and dominate the institutional and cultural mechanisms through which it operates'. This research found that racism generates internal stresses in individuals, resulting in mental health problems. On occasion, it may lead to 'full-blown personal self-hatred' or, more commonly, impact negatively on personal identity. In adults, it can generate coping strategies that restrict their capacity for both 'intra- and inter-group interaction' and ultimately lead to limitations to their lifestyle. Experiences of racism can impact negatively on people's general emotional experiences and expression, and their health and psychophysiology. This may then be transmitted across generations. At the societal level, '... institutionalized racism detracts from the overall capacity of a community to promote the development of its residents'.

Several studies have concluded that racism that is internalised by the victim can: negatively impact on an individual's sense of ambition, self-assertion; erode their sense of self; and lead to depression, anxiety, substance abuse, and chronic physical health problems (Krieger 2000; Miliora 2000; Williams 1999, p. 185). Katona and Cahill reported that the Aboriginal women they interviewed appeared to have internalised racism so that it seriously undermined their sense of self and wellbeing (Katona et al 2002).

With regard to the *impact of racism on physical health*, research suggests that the subjective experience of discrimination provokes particular responses such as anger, cynicism and anxiety that may generate stress which can lead to cardiovascular reactivity, high blood pressure and negative health consequences on both objective and self-reported measures of physical health (Franklin 1998; Williams 1999; Krieger 2000).

The 'control factor'

As with other aspects of social exclusion, low levels of control or mastery over one's own life circumstances have also been found to correlate significantly with ill health (Marmot & Wilkinson 1999). The 'control factor', what Len Syme calls 'having mastery', measures the extent to which a person feels that they can master everyday events and obstacles without these becoming overwhelming. When an individual feels in control of the situation, she or he is better able to handle stress, apparently with less ill health consequences than a person who has less of a sense of mastery (Devitt, Hall & Tsey 2001).

A social gradient is apparent in all industrialised countries, where people lower down the social and economic hierarchy experience more ill health than those above them (Bartley, Blane & Montgomery, 1997). Similarly, for those in employment, high work demands place more stress on those whose work status offers them little room for discretion compared with, say, their managers who have greater latitude. The greater the stress experienced, the more ill health.

These are a few examples of accumulated research evidence that social exclusion — whether on the basis of 'race' and socioeconomic status, among other factors — reduces the extent of control that people have over their lives and, ultimately, impacts on their health and wellbeing.



The health consequences of stress

Social exclusion creates trauma and leads to deprivation in people, and this in turn generates stress. Flinn (1999) documented this process, in his longitudinal ethnographic study of rural Caribbean children, over both the long (ten years) and short (hourly and daily) terms. His study monitored 264 children ranging in age from two months to 18 years. Flinn used the hormone cortisol as a marker of stress. Cortisol, along with the adrenalin hormone, is produced in our bodies to help us cope with both physical and psychological stress.

Flinn measured cortisol levels through saliva swabs taken randomly throughout the day. He found that 'chronically stressed' children had higher average cortisol levels and were ill more often than the control group. Children defined as chronically stressed were those who experienced two or more risk factors, which included:

... parental conflict, mild abuse or neglect, high frequency of reported daily stressors, inhibited or anxious temperament, parent alcoholism, low ... peer friendship ranking, and reported anti-social (theft, fighting, or runaway) behaviors (Flinn 1999, p. 125).

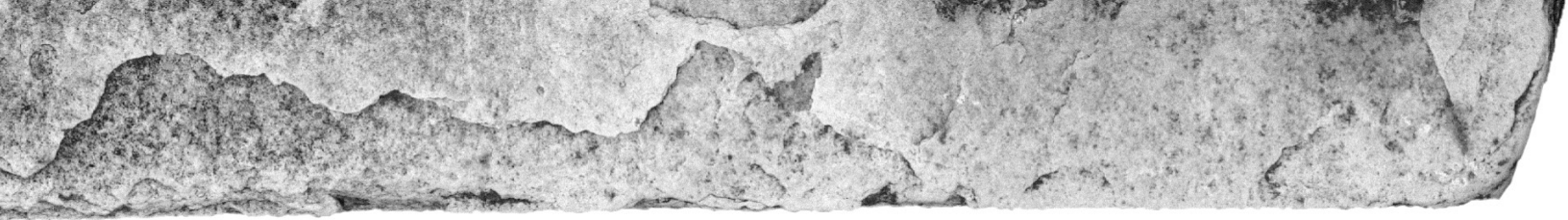
For all ages of children, Flinn found that a traumatic family event such as punishment, quarrelling, fighting or embarrassment corresponded with higher cortisol levels. He concluded that 'family interactions were a critical psycho-social stressor in most children's lives ...' (Flinn 1999, p. 123). Furthermore, he found that there were higher frequencies of illness for three to five days after such a traumatic event than when there had been no such stress event.

Flinn's study is part of a large body of literature which confirms that *psychological stress affects health* (Flinn 1999, p. 124). Stress is believed to be the mediating factor between the social environment and the health consequences.

Other studies indicate that traumatic events are associated with illnesses such as cancer or cardiovascular disease. Such traumas include divorce, death of a close family member, change of address and job loss. The health response is as follows:

Chronic and traumatic stress can diminish long-term health functions, including cellular repair, immune response, and brain expansion. Stress during childhood may be particularly taxing because of the additional demands of growth and development (Flinn 1999, pp. 105–6).

The challenge for medical research has been to expose the actual *biological pathways* by which seemingly remote factors — such as social structure, work, and the social and cultural environment — can impact on the individual psychology, leading to immune responses of the brain and pathophysiological changes and organ impairment. Endocrine and neuroendocrine systems are very responsive to cognitive and emotional experiences that impact on the physiology, producing hormones such as cortisol and adrenalin (Panter-Brick & Worthman 1999). Too great a concentration of these stress hormones can be 'highly pathogenic' (Sapolsky 1999, p.19).



Social determinants theory proposes that elevated levels of stress-generated hormones may:

- suppress the immune system; or
- contribute to the formation of arterial plaques; or
- damage parts of the nervous system.

This may make a person vulnerable to diseases such as diabetes, infectious diseases, heart disease and strokes. In sum, this body of research hypothesises that if a biological stress response is activated too frequently or for too long there is the potential for health costs. However, moderating factors such as individual coping responses and social support appear to underlie social and individual differences in the response to life stressors (Stansfeld 1999).

Moderators of stress

Certain factors have been found to moderate the severity of stress experienced by individuals. This assists them to be more resilient to stressful life circumstances. For example, individual temperament and personality can increase or lessen the impact of stress. Social support has also been found to buffer stress (Stansfeld 1999).

Social support

Stansfeld (1999, p. 155), drawing on the definition of Cohen and Syme (1985) describes *social support* as:

... resources provided by other persons ... [including] information leading the subject to believe that he is cared for and loved, is esteemed and valued and belongs to a social network of communication and mutual obligation (Cobb, 1976).

Social support may be seen as an avenue by which people can regain control of their lives (Syme 1996; Syme 1998 p. 6). Stansfeld (1999, p. 156) depicts the types of social support as comprising emotional and practical support, and negative interaction (see Table 1).

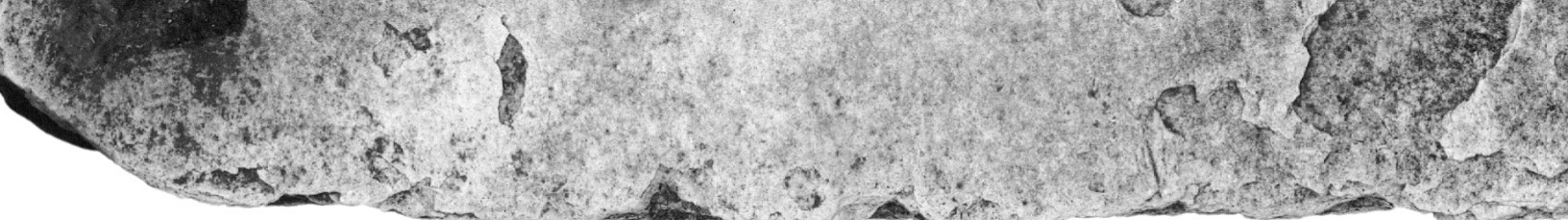
Table 1. Measures of social support

<p>Emotional Support:</p> <p>Informational – information to help in problem solving</p> <p>Self-Appraisal - actions of others that boost one’s self-esteem</p> <p>Instrumental or practical: Offering needed resources, finances, assistance</p> <p>Negative interaction: Fostering dependency or negative self-appraisal</p>
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Source: Adapted from Stansfeld (1999, p. 156)

According to Stansfeld (1999), the kinds of stressful life events that trigger negative health responses include social isolation, school change, job entry, unemployment, bereavement and retirement. The kinds of support that studies have found to buffer the stress effects of these life events include:

- emotional support, such as having someone to confide in;
- social work, which provides access to social services and counselling; and
- the provision of information about services, lifestyle issues and the like.



Those delivering the support may be spouses/partners, relatives, work colleagues or professional service providers. The kinds of health outcomes achieved include improvements in morbidity (illness), mortality (death rates) and levels of mental illness — for example, depression and anxiety.

The actual nature of the support and the person delivering it can trigger different effects on males compared with females, and affect different aspects of health — for example:

- intimate but negative social relationships have been found to have a detrimental impact on health;
- emotional support can buffer the effects of traumatic life circumstances on the incidence of depression; and
- being married is more beneficial to the health of men than to that of women, whereas women benefit more from the emotional support of close friends or relatives (Stansfeld 1999).

Stansfeld (1999) also found that social integration or cohesion can have beneficial effects on health within the whole community to an extent that supersedes even the effects on individual personal relationships. Social cohesion depends on there being:

- mutual trust and respect between different sections of a community;
- substantial participation in communal activities and public affairs; and
- high membership in various community groups.

Cultural Factors

There is also evidence that certain cultural factors may buffer the stress effects of social exclusion, racism or immigration for minority cultural groups. For example, Stansfeld found (1990, p.170) that Italian immigrants to the USA maintained better health where they retained the Italian traditional family-oriented social structure.

But as they became assimilated into the surrounding American culture, where the individual rather than the family and community was considered to be the dominant unit, incidence of coronary heart disease rose.

This was despite improvements in diet and a decrease in smoking.

Factors found also to buffer stress effects include:

- spirituality (Bowen 1998; Jackson & Sellers 1998); and
- a strong sense of cultural identity, family support and association with members of one's own cultural community (Jackson & Sellers 1998; Niles 1999).



Schooling and the Aboriginal Child

The research referred to above, which associates stressful life experiences with long-term physical and mental ill health, has implications for Aboriginal children in urban mainstream classrooms. The following two case studies demonstrate that a teacher can have a profound impact on a child by:

- her relationships with her students;
- the depth of her understanding of their backgrounds;
- her expectations and methods of sanctioning them; and
- the way in which she organises students' learning.

The nature of this impact can range from social exclusion, as in the first case, to social and cultural incorporation, as in the second.

The third case study provides an example of a learning centre that attempts to offer social support simultaneously to the individual student, their family and their community. This holistic approach takes the view that the Aboriginal child's learning will be enhanced if the whole family is included in a program supporting their long-term aspirations and development.

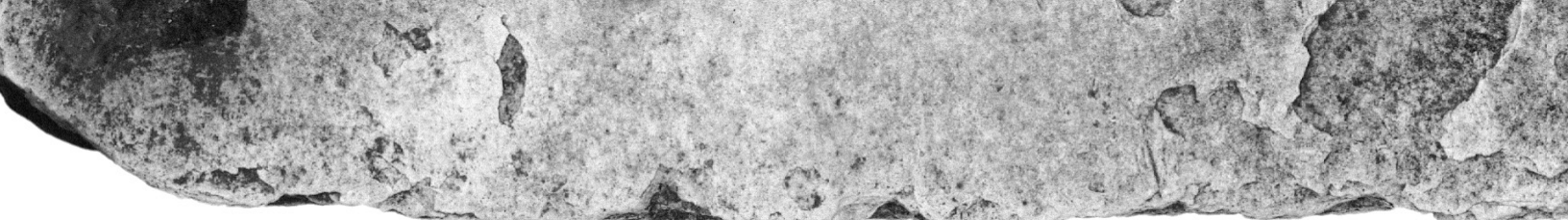
National statistics on Indigenous student participation, retention and attainment rates indicate that mainstream schooling has not been successful in engaging them in learning (Beresford & Partington 2003). A variety of explanations have been offered for this phenomenon. The one proposed here is that the domination of white Australia in the population and societal structures is also reflected in schools. For example, because of structural barriers combined with a small population, Indigenous people are under-represented on school councils and as teachers, curriculum writers, school administrators and government officers. Consequently, it is mainly the perceptions, life experience, priorities and processes of the dominant group that inform school policy and programs. In addition to this, the systemic but largely invisible nature of this domination makes it difficult to identify and expose (Malin & Ngarritjan-Kessarar 1999; Moreton-Robinson 1998).

Case study 1 demonstrates how this process of inadvertent domination can work in the microcosm of the classroom.

Social exclusion in the classroom: case study 1

It is clear that many Aboriginal children find themselves in particularly stressful situations, daily, in the community (Raphael & Swan 1997; Traves 2000) and, as I argue here, also in mainstream classrooms. Everyday, taken-for-granted classroom events can obstruct Aboriginal children's opportunities for learning and be potentially stressful to them. I indicate how and why the accumulation of such events amounts to their social exclusion.

Indigenous Australians have reported experiencing blatant racist episodes in their schooling, and often parents explicitly instruct their children on appropriate ways for dealing with these (see, for example, Malin 1989 and Groome 1988). However, subtler, more systemic forms of racism operate to disadvantage Aboriginal students in schools.



My detailed micro-ethnography of daily life in an urban, early childhood classroom gives a clear picture of how unintentional, invisible racial discrimination can occur. It depicts how an experienced, respected and generally well-intentioned teacher unknowingly discriminated against Aboriginal children in her class in a mainstream urban school.

My previous research (Malin 1997; Malin 1994) found that the seemingly minor oversights, misinterpretations, preconceived ideas and prejudices of an ordinary non-Aboriginal teacher compounded over the year to result in the social exclusion and academic marginalisation of Aboriginal children in her classroom. It is only when small events are monitored, documented and then compounded that the pathways of systemic discrimination are made visible. Of relevance to this paper is the data relating to differential access to precious teacher resources and the accumulated stresses of daily life, which fell disproportionately on the three darker-skinned Aboriginal children in the class.

Access to resources


Videotaped classroom activity documented across a year exposed a pattern of unequal distribution in the amount of emotional support and quality instruction, by the teacher, to the three darker-skinned Aboriginal students in the class when compared with that given to the rest of the students.

Social/emotional resources - Certain teacher actions would communicate to students feelings of warmth and acceptance, including verbal or physical expressions of affection, high expectations, approval and camaraderie. This included the sharing of jokes and personal stories. The allocation of these resources was proportionate to the level of the 'ability groups'. The Aboriginal students, who were over-represented in the 'lowest' group, received the least. In addition, these students received proportionately more punishments than other children. These punishments were primarily in the form of exclusion from the lesson, often sitting facing the wall at the front of the class, and sometimes for actions not punished when done by other children.

Academic resources - Two factors believed to be essential to effective classroom learning are time engaged on an academic (Wittrock 1986, p. 303) and quality scaffolded instruction¹. The three Aboriginal students consistently received less of these than the rest of the class over the year. There were a number of ways that these children received less time on task. These included:

- they were consistently the last to be served by the teacher;
- once served, they had less time for instruction or for independent desk work, because time ran out;
- they spent much time in 'time out' as punishment; and
- they were not allowed to take a reader home for home reading because a book had not been returned previously.

1. *Scaffolded instruction employs strategies such as questioning, theorising, recapitulating, to support students in learning a new concept or solving a problem.*



The quality of instruction offered these students was inferior for the following reasons. These students were placed in an inappropriate ability group, either because their attainment was assessed inaccurately or because they were 'demoted' to a lower group as punishment. The students' attainment had been assessed inaccurately because of miscommunication resulting from the teacher:

- not understanding the students' dialect of Aboriginal English; or
- allowing insufficient response time during questioning.

This was an ongoing problem.

Evidence of stressful events

'Naomi' was a five-year-old Aboriginal student who I closely monitored across a school year. Based on events documented on videotape, through observation, and through teacher and student interviews, it was apparent that Naomi experienced significant stress throughout the year. Many incidents pointed to her *social exclusion*, including the behaviour of other students towards her, particularly after she had received a reprimand: they would make faces at her, move away from her, declare that they would not play with her or refuse her requests to play with them. At times, she would offer the other students food or money in an effort to win their friendship.

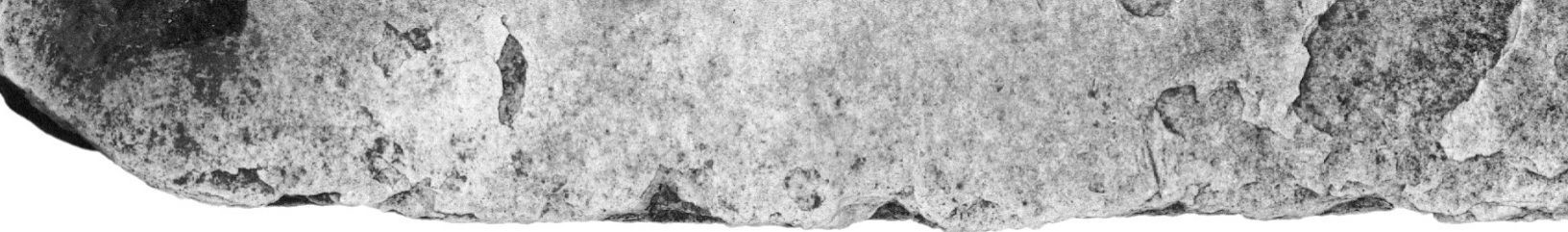
On many occasions, the teacher's behaviour towards Naomi also excluded her. For example, on one occasion, after the teacher did not ratify her correct answers, Naomi asked the teacher if she liked her work. The teacher interpreted these requests as bragging, and ignored Naomi. After being ignored for a sustained period, Naomi retaliated with an angry outburst, telling the three children with whom she had the most positive relations that she hated them and their work. Throughout the year, the teacher ignored or failed to understand Naomi's efforts to share jokes or chat with her.

It was apparent that Naomi lacked credibility with the teacher, who often double-checked on assertions Naomi made about what she had done outside of school. The teacher's low expectations of Naomi resulted in her sending another child on errands with her; and also resulted in her double-checking that Naomi's competent work was indeed her own work. Two years after these events, I questioned Naomi about whether she remembered sitting in 'time out' with her face to the wall. She commented that the experience had been a 'horrible' one for her (Malin 1994; Malin 1997).

Social support versus exclusion

My conceptualisation of inequitable access to resources in the classroom is analogous, although at a micro level, to the much investigated notions of 'social support' and its antithesis, 'social exclusion', which are considered to be among the significant social determinants of health (Brunner & Marmot 1999).

As reported above, the three darker-skinned Aboriginal students had less access to social support, whether practical or emotional, than the other children. At the same time, they received more intensive and frequent negative communications from the teacher. Naomi's experiences of invisibility and lack of recognition and validation of achievements are consistent with the 'invisibility syndrome' often experienced by African Americans. (Franklin 1998, p. 242) This type of experience is stressful and can provoke a range of emotions including disillusionment, anxiety and anger. As stated earlier, these stress responses are thought to be associated with ill health. Clearly, this is evidence of social exclusion.



Shaw, Dorling and Smith (1999, p. 223) explain that *social exclusion* results in the receiving of limited access to resources, not only of the economic kind but also of the resources that come from living within a society — for example, educational opportunities, social networks and social support. Both the receiving of low levels of social support and being socially excluded are associated with higher stress levels. Flinn (1999) found that such factors as punishment, conflict, social exclusion and the like contributed to heightened cortisol levels in children and were associated with an increase in flu and colds.

Given these research findings, it is reasonable to extrapolate that the treatment of these three Aboriginal students, particularly if continued over time, may contribute to their ill health in the long term.

When compounded over a year, the differential treatment of the three Aboriginal students resulted in their receiving less instruction and poorer quality instruction than other children. In a sense, these students' opportunities for academic learning were bartered for their 'good' behaviour, where 'good' behaviour was interpreted differently depending on the respective cultural backgrounds of the students and teacher. This exemplifies a form of institutional racism that is invisible to most of those concerned but creates a situation where Aboriginal students are seen by their peers to be incompetent academically and dissident behaviourally, reinforcing racist stereotypes that are commonly held in the wider society. Furthermore, research evidence now points to the long-term health implications of such exclusionary processes for these children, particularly if they are exposed to such a regime in subsequent years at school. As described, both Naomi's and the teacher's actions are well within the range of what would be considered normal in classrooms today.


A supportive and incorporative curriculum: case study 2

Hudspith's study (1996; 1997) shows a Darwin-based teacher working very differently with her Aboriginal students from the teacher in case study 1. Hudspith's 'Mrs Banks' was loved and respected by the students and their parents, *and* she progressed them academically far beyond their achievements in any of their previous years in primary school. From the perspectives of the principal, her colleagues and the parents, Mrs Banks was considered a good teacher of Aboriginal primary school students. Aboriginal parents said of her:

... you look at [Mrs Banks] and her class and they respect her because she's their teacher, but they respect her because she's like their mother or someone older than them that they respect (Hudspith 1997, p. 99).

[Mrs Banks] had something interesting every day for the kids there and they really wanted to go to school. [My son] talked a lot about school then, and he never wanted to come shopping with me because he was doing something at school and he was really excited about it ... But now [he's not in Mrs Banks' class] he wants to stay home and look after the baby and he's glad to do it because he'd rather do that than go to school (Hudspith 1996, p. 184).

Unlike in my study, the environment of Mrs Banks' class was a *socially and academically supportive* one for the Aboriginal students. They were well-resourced with practical, effective instructional support that advanced their academic learning. Hudspith characterised Mrs Banks' pedagogy as 'visible'—that is, explicit and interventionist. Mrs Banks expected that each of the students would improve their academic skills, and she explicitly communicated this to them. Most of the day was spent on literacy and numeracy. There was little time for videos or physical education, and no free time for colouring or playing activities, yet the students were engaged and enjoyed their work.



In addition, Mrs Banks' students felt confident in themselves, their identities and their abilities. Hudspith characterised Mrs Banks' pedagogy as being 'incorporative' of the student, not only in the class but also in the larger domain of the urban mainstream school. She assisted the children to understand that different teachers have different expectations of children's behaviour, and that they must show respect to all teachers. Other teachers noted that, in the school at large, the behaviour of Mrs Banks' children had improved dramatically from the previous year when they had had a different teacher.

Mrs Banks also fostered links with the children's homes in a number of ways. All the students knew their own and each other's 'country' of origin, and the nature of their relationships with one another. Visitors to the class were commonplace, and they were also situated, relative to the students, according to land and kin. Mrs Banks knew the families well, visited them regularly and continued her contact with them long after the children left her class. Mrs Banks *brought the students' culture into the classroom*, implicitly, in the ways that she used discipline and in the interpersonal interactions that she nurtured. Hudspith writes:

In this way Aboriginality was embedded in the mundane aspects of classroom activities and relationships; Aboriginal identities were tacitly reaffirmed in the taken-for-granted ways in which people related to each other and to the group (1996, p. 105).

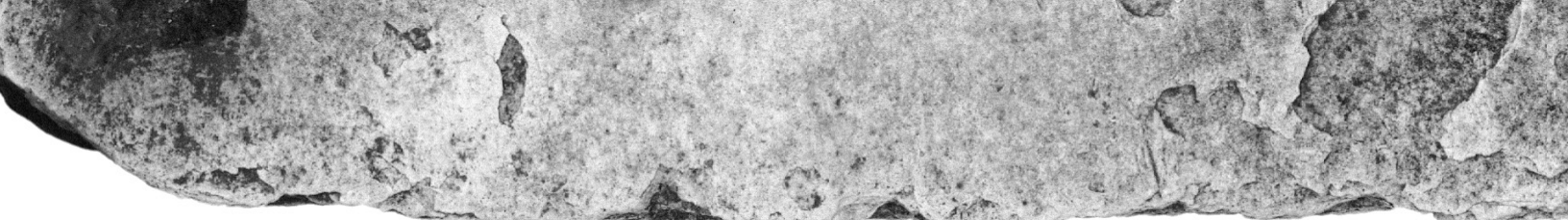
Social and cultural inclusion in Mrs Banks' class extended beyond the class to the school and broader community. In sum, one could extrapolate from these characteristics that schooling for the children in Mrs Banks' class was educationally supportive, enjoyable, relatively stress-free and in the longer term, if sustained, would be health promoting.

A community development and education centre: case study 3

Case study 2 demonstrates that mainstream schooling can function to empower Aboriginal children. Currently, however, this is not the status quo. This is the reason some students have become alienated from the system despite wanting to continue to learn. Irrkerlantye Learning Centre (ILC), the final case study, focuses on students who would have otherwise dropped out of school. I speculate on how the ILC's organisational structure and functioning may contribute to social and cultural cohesion, and support for the Arrernte families involved.

ILC is an Alice Springs-based Eastern/Central Arrernte education and community development program that began as an alternative secondary school for Aboriginal children who lived in the Town Camps and were considered to be 'at risk'. The background of many students is characterised by involvement with the juvenile justice system over issues such as substance misuse, and violent and antisocial behaviours. Clearly, they and their families experience substantial levels of sustained stress.

The ILC secondary-school program offers secondary school-age students mainstream literacy and numeracy curriculum options, and vocational education and training courses. At the ILC, the students' families also have access to vocational education and training courses including horticulture, construction, media, leadership and art.



ILC assists each family to devise a long-term community development plan for their family, and strategies for carrying out that plan through education, training and CDEP (work for the dole) work programs. Descriptions of the ILC by those involved (for example, Traves 2000 and Flynn 2001) suggest that it:

- offers social support to the families;
- focuses on practices that are culturally inclusive; and
- minimises negative communications.

Social support and access to resources

In addition to the ILC's education courses (see above), the centre provides families with ready access to networking and advocacy support with local service agencies — for example, health services, social and emotional wellbeing counselling, and programs focused on women's health and drug dependencies. Breakfast and lunch are provided, as is access to transport, a computer, printer, telephone and office space.

Cultural cohesion

There is reason to believe that ILC fosters cultural cohesion. Flynn (2001, p. 2) reports:

Most of the people attending Irrkerlantye are affiliated with one or other of the four clans who are comfortable working together within the Arrernte social framework. These clans are traditionally associated with lands in Alice Springs and to the east and north of the town.

In her consultations with participants, Flynn (2001, p. 4) found that the ILC was valued for the 'sense of community' that it generated and because it was perceived to be a 'happy and safe environment'. She reported:

The issue of community identity and the physical space to exist is an important one for the Arrernte people of Alice Springs. Urban development means there are less and less places for the type of interaction that is needed to affirm each other in a supportive environment. Various factors have led to the marginalisation of generations of people which erodes family and cultural integrity. The critical alienation experienced by many Arrernte youth and adults over the past five or six years is symptomatic of the chronic stress on communities largely stemming from the reluctance of government agencies to recognise and respect Arrernte people's cultural heritage. Irrkerlantye and Ngarte Mikwekenhe (its corporate body) are addressing the basic human need of family and community well being. (Flynn 2001, pp. 2–3)

Families had expressed the fear that the young people were using Arrernte language incorrectly and were losing their Arrernte culture, and so language and culture learning were being incorporated into the curriculum. They were also reinforced during the regular field trips through which families were reconnecting with their homelands.

It is likely, therefore, that the family focus, cultural cohesion, and 'safe', 'happy' environment referred to above, minimise negative and potentially disempowering interactions that apparently characterise the majority of the young people's experiences in the Alice Springs mainstream community (Flynn 2001).

Preliminary findings from an external evaluation of ILC support the above view. That evaluation also seeks to ascertain the program's success in meeting its goals and obtaining health and/or social benefits for the families (Malin & Maidment, in progress).



Aspects of schooling that promote health

In this paper, I have argued that colonisation has had devastating consequences for the health of Aboriginal people. I have highlighted 'social determinants' research, which points to the likelihood of stress-induced health consequences caused by social exclusion through the lack of equitable access to resources, and the experience of racism and the loss of a sense of control over one's destiny. Alternatively, social support and certain cultural factors — including a shared spiritual affiliation, cultural identity and family support — have all been found to offer some protection from the damaging effects of stress.

Similarly, in overseas studies, years of schooling and levels of literacy have also been positively correlated with the health of a population. Current statistics on Indigenous retention and attainment in Australian schools indicate that schools, in general, are not succeeding in meeting the educational needs of Aboriginal students. Given this background, it is reasonable to suggest that school failure might have long-term negative ramifications for Indigenous health.

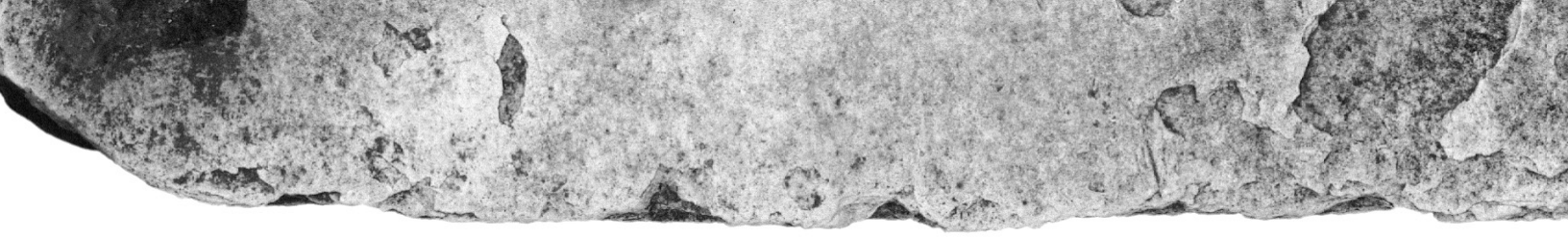
The case studies presented here demonstrate ways that social support can be reinforced or undermined through the organisation of learning and behaviour management in the primary school classroom.

Case study 1 illustrated ways in which fairly commonplace classroom social and academic routines create potentially stressful situations for Aboriginal students, ultimately resulting in their marginalisation within the class. Many of the stressful circumstances documented in this class are equivalent to ones found by Flinn to raise cortisol levels in children and followed subsequently by bouts of ill health. Other studies have found associations between sustained elevated levels of stress hormones, such as cortisol and adrenalin, and physical illness.

I suggest that the positive health effects of schooling found in overseas studies may be cancelled out, in Aboriginal Australian contexts, by the marginalising processes of colonisation that extend into the classroom. The negative consequences of classroom practices are unintended to a large extent, but they are products of Australian institutions being configured to the needs of the dominant non-Indigenous group.

Case study 2 demonstrated how — with specific cultural knowledge, personal knowledge of the families and community, and good teaching skills — teachers can organise their classes around regimes of social and cultural support. In this environment, the students blossomed, their literacy and confidence levels were significantly elevated, and their antisocial behaviour evaporated. We could extrapolate from this that their sense of belonging and of being supported, and their increased levels of confidence at being more academically able, should be health promoting if sustained in the long term.

Because this scenario is not commonplace, many Aboriginal children are alienated from the system. This situation led to the establishment of ILC's holistic, inter-generational community development and learning centre, which is case study 3. The significance of such home-grown, locally-controlled Indigenous schools is underlined by research findings which suggest that the health-promoting process of 'regaining control' is most effective if it begins at the grass roots rather than being imposed from above (Syme 1996; Syme 1998). Whether the 'control factor' comes into play at ILC, in addition to social and cultural support, is being investigated currently, along with the possibility that the centre has contributed to a decrease in juvenile crime in Alice Springs over the past two years (Malin & Maidment, in progress).





Implications for policy and practice

A number of recommendations and policy implications follow from the issues addressed in this paper. For the most part they relate to teacher preparation and in-service education, staffing, variety in models of schooling and further research.

Teacher education

It is clear that teacher education does not prepare teachers sufficiently to teach Aboriginal children. Needed are compulsory units in Indigenous Studies that cover:

- the history of colonisation in Australia;
- the Stolen Generations;
- contemporary social issues, including the latest research evidence on the social determinants of health as they impact on Indigenous Australians; and
- general cultural knowledge about Aboriginal peoples' spiritual, political and economic connections with the land and their kinship systems, for example.

This latter knowledge helps people to understand the devastation caused by Aboriginal dispossession.

Units in Indigenous Education should also be compulsory for undergraduate education students. They should cover topics such as the impact of health on education, and vice versa, in Indigenous contexts.

Important topics for Indigenous Education are classroom management and the organisation of learning, including the issues discussed in this paper about social support and cultural incorporation. Genuine cultural incorporation involves a teacher acquiring considerable knowledge about the local families, and cultural matters that local communities consider to be relevant. It requires involvement of family members in their children's education in every way possible.

Professional development programs covering these issues are also needed for practising teachers, along with encouragement for them to pursue university studies in these same areas.

Indigenous teachers

The implications for staffing arising from this research include the urgent need for a greater Indigenous presence in schools, particularly from the local communities. There has always been a severe shortage of Indigenous teachers and teaching assistants, particularly in urban schools. Turning this around would require increased recruitment efforts on the part of university schools of education.

Retaining Indigenous teachers already employed in the school system has been difficult. This suggests that greater social support is needed for Indigenous teachers. Clearly-articulated career paths may be needed to encourage Indigenous Teaching Assistants either to move into teaching themselves or to take on more responsibilities and influence within schools. Increased Indigenous membership on school boards would help schools to be more responsive to local Indigenous community concerns.



Indigenous education initiatives

Governments' and education departments' support of local Indigenous education initiatives is important. As the variety of schooling options available to Indigenous parents increases, it is likely that Indigenous student attendance and retention will increase also. If a school is to include a community development focus, as does Irrkerlantye referred to above, it is likely to need collaboration in the funding arrangements between health, education, Indigenous community councils and agencies, and correctional services departments.

It would be most beneficial to assemble an internet-based database, which includes directories of the various Indigenous-controlled schools around Australia, including a summary of their organisational structures, aims and objectives, achievements, contact details and funding arrangements.

Further research

Further in-depth research is essential into what is working for Indigenous students in schools, together with a database of research results that already exist. This database needs to be continually updated.

Policy guidelines need to be informed by current research about best practice as opposed to those informed by unevaluated but fashionable trends.

Finally, there is a need for research that investigates the ways in which schools can contribute to improved Indigenous health, in any number of ways. This is of enormous importance in a time when the mortality rate of Indigenous adults is on the increase.



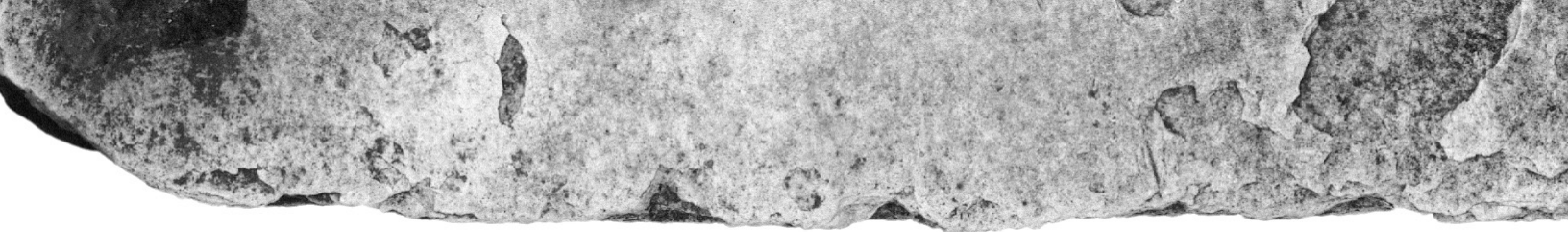


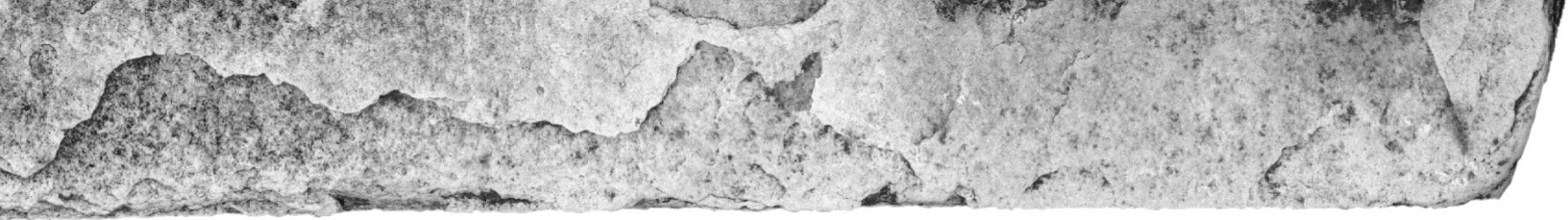
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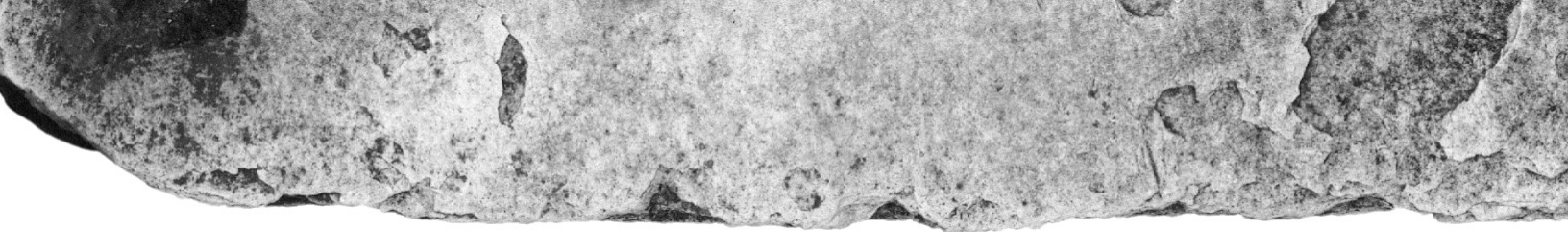
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