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Child and Adolescent Psychiatric Presentations of Second-Generation Afro-Caribbeans in Britain

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Background. A clinical sample was used to investigate whether second-generation Afro-Caribbean children differed from other British-born children in their psychiatric presentation or vulnerability to risk factors.

Method. Second-generation Afro-Caribbean patients ($n = 292$) were compared with a predominantly white group of patients ($n = 1311$) who lived in the same inner-city area and attended the same child psychiatric clinic between 1973 and 1989. Data on psychiatric presentation and background factors were systematically recorded at the time of the initial clinical assessment.

Results. Afro-Caribbean patients were exposed to more socio-economic disadvantage but less family dysfunction. The ratio of emotional to conduct disorders was lower among Afro-Caribbean than among the comparison patients – an effect that was not evidently due to demographic factors or diagnostic bias. Most risk factors for emotional or conduct disorders had comparable effects on Afro-Caribbean and comparison patients. Psychotic and autistic disorders were disproportionately common among the Afro-Caribbean patients.

Conclusions. Second-generation Afro-Caribbean children differ somewhat from other British-born children in their psychiatric presentation – a difference that has persisted over the 1970s and 1980s and that deserves more investigation than it has received to date.

In a society that is racially, culturally and ethnically diverse, are children from minority groups differentially vulnerable to specific psychiatric disorders or risk factors? To address these questions, we have undertaken a clinical comparison of second-generation Afro-Caribbean[1] children (born in Britain to parents who immigrated from the Caribbean) with other British-born children attending the same psychiatric clinic. Our focus was on Afro-Caribbean children because no other minority group in our sample was sufficiently numerous to warrant analysis.

Guided by the literature, our study has concentrated on the effect of minority status on psychotic disorders, autistic disorders, and the ratio of emotional to conduct disorders. British adults from ethnic minority groups are at an increased risk of schizophrenic or affective psychoses (Harrison *et al*, 1988; King *et al*, 1994); is the same true for children and adolescents? Several studies have reported an increased risk of autism and related disorders among the children of immigrants (Wing, 1979; Akinsola & Fryers, 1986; Gillberg *et al*, 1987); do the features or correlates of autism among the children of immigrants provide clues to the reason for the increased risk? Previous epidemiological and clinic-based studies have found a lower ratio of emotional to conduct disorders in Afro-Caribbean than in white children (Graham & Meadows, 1967; Nicol, 1971; Rutter *et al*, 1974); has this difference persisted? If so, is it attributable to differences between the Afro-Caribbean and comparison groups in social and demographic factors such as unemployment, family size or proportion of single families? Do Afro-Caribbean and comparison children with the same diagnostic label – whether 'conduct' or 'emotional disorder' – have similar or different symptom profiles? Finally, do the recognised risk factors for conduct and emotional disorders in white children have comparable impacts on second-generation Afro-Caribbean children?

1. We have tried to avoid discriminatory language and collective terms that are not acceptable to the relevant communities. If we have failed, we hope that readers will be able to get beyond the barrier of jarring terms by translating them into their preferred terminology.

Method

The study was carried out on patients aged 18 or younger who were referred to the Children's Department of the Maudsley Hospital in south London between the beginning of 1973 (when ICD-9 diagnoses were introduced) and the end of 1989. The study was limited to locally referred children so that both the Afro-Caribbean and comparison groups

were drawn from the same under-privileged area. The local area consists of three inner-city boroughs, each of which has a substantial Afro-Caribbean population, with most first-generation immigrants coming from Jamaica. Group definition and group comparisons were based on data from the standardised item sheets completed on patients seen at the Maudsley Children's Department at the time of their initial assessment. Item sheets cover demographic background, the referral process, family functioning, presenting symptoms, and psychiatric diagnosis (Thorley, 1982); inter-rater reliability is good (Goodman & Simonoff, 1991). Item sheets had been completed for 78.6% of new cases seen during the study period; the likelihood of completion was unrelated to minority status.

Patients

The second-generation Afro-Caribbean group consisted of 292 children or adolescents who were born in Britain and whose parents were both born in the West Indies or Guyana. The vast majority of these Caribbean-born parents were of African rather than Asian or European descent. Though the number of second-generation Afro-Caribbean referrals declined between the 1970s and the 1980s (as the number of third-generation Afro-Caribbean referrals increased), second-generation subjects born in the 1980s were not disproportionately likely to have been born to elderly parents. The comparison group consisted of 1311 children and adolescents born in Britain to parents who were both born in Britain. Though this group included third-generation Afro-Caribbeans, a review of case notes suggested that they accounted for under 5% of our comparison group, i.e. the comparison group was overwhelmingly but not exclusively white.

Measures

The item sheet data available for each subject included multiaxial diagnoses following ICD-9 (Rutter *et al*, 1983). Psychiatric diagnoses (on Axis 1) were grouped for data analysis into the following eight categories to avoid small cell sizes: (1) conduct disorders, including what would now be considered oppositional–defiant disorder; (2) mixed disorders of conduct and emotion; (3) emotional disorders; (4) hyperkinesis; (5) infantile autism and related pervasive development disorders such as Asperger's syndrome; (6) psychotic disorders; (7) other psychiatric disorders; and (8) no psychiatric disorder – most of this group were seen because of psychiatric symptoms that did not reach diagnostic threshold, severe adverse experiences (including abuse and neglect), specific developmental disorders or mental handicap. The case notes covering the first assessment and subsequent out-patient and in-patient contacts were reviewed for all those with diagnoses of psychotic or autistic disorders. When follow-up or further information led to a change in the initial diagnosis, the reformulated diagnosis formed the basis of our classification. Diagnoses on Axes 2 and 3 of the ICD-9 multiaxial scheme (Rutter *et al*, 1983) were used to determine the presence of specific reading retardation and mental handicap.

Other relevant variables extracted from the item sheets fell into four groups. First, there were demographic and background variables: age, sex, parental employment, social class, referrer, type of school, and family composition. Second were psychiatrists' ratings of the presence or absence of 50 symptoms in the year before the first assessment (with dubious or minimal symptoms being counted as absent). Third, subjects were rated as prepubertal or postpubertal on the basis of history and physical examination (including pubertal children in the postpubertal group). Data were complete on at least 94% of the sample for all these three groups. Fourth were the psychiatrists' ratings of the presence or absence of the abnormal psychosocial factors normally coded on Axis 5 of the ICD-9 multiaxial scheme (Rutter *et al*, 1983), e.g. familial over-involvement, mental disturbance in other family members, or discordant intrafamilial relationships. These ratings were only available for 53–55% of subjects; the proportion of missing data was unrelated to minority status. Given this high rate of missing data, and given the difficulty in rating abnormal psychosocial factors reliably (van Goor-Lambo, 1987), we have reported our findings on psychosocial factors circumspectly.

Data were analysed using SAS for Windows, Version 6.08 (SAS Institute Inc.). All χ^2 values for 2 by 2 tables are adjusted for continuity.

Results

Comparability on demographic and other background factors

Though the composition of the Afro-Caribbean and comparison groups did not differ significantly in age or sex, a higher proportion of the Afro-Caribbean group were postpubertal (50% *v.* 42%, $\chi^2 = 5.4$, d.f. = 1, $P = 0.02$), reflecting an onset of puberty six months earlier on average. The significant and near-significant differences in background characteristics between the Afro-Caribbean and comparison groups

Table 1
Background factors in each group

	Afro-Caribbean, %	Comparison, %	Significance
Employment of head of household:			
Non-manual	9	18	***
Unemployed	27	22	(*)
Child lives with:			
Both biological parents	46	55	**
Single parent	36	22	***
Parent and step-parent	8	15	**
Family size:			
Only child	9	14	*
Four or more children at home	32	16	***
Referral from:			
Parent or GP	31	47	***
Education service	36	23	***
Family characteristics:			
Inadequate or inconsistent parental control	25	37	**
Familial over-involvement	7	20	***
Lack of warmth	10	16	(*)
Schooling:			
Special school	15	8	**

Significance of difference in proportion between Afro-Caribbean and comparison groups: (*) $P<0.1$, *$P<0.05$, **$P<0.01$, ***$P<0.001$

are shown in Table 1. The two groups did not differ significantly on the following variables: being fostered or in care; having mentally ill family members; discordant intrafamilial relationships; inadequate or distorted intrafamilial communication; grossly inadequate living conditions; inadequate social, linguistic or perceptual stimulation; stresses in school environment. Though there were substantial changes in background characteristics such as unemployment and family size over the period of the study, the differences between the two groups were stable (with no significant three-way interactions on log–linear analyses involving group, decade and background variables). Given these findings, the sample was analysed as a whole without splitting it by decade.

Table 2
Percentage with particular psychiatric disorders in each group

	Afro-Caribbean, % ($n=292$)	Comparison, % ($n=1311$)
Conduct disorders	34.6*	25.2
Mixed conduct/ emotional disorders	15.4	16.3
Emotional disorders	17.8*	27.1
Hyperkinesis	0.3	1.4
Autism and related disorders	3.4*	0.6
Psychotic disorders	3.4*	0.8
Other	12.8	14.0
None	12.3	14.6

*Diagnosis significantly commoner or rarer than in comparison group (using method of adjusted residuals, see text)

Differences in diagnosis

As shown in Table 2, the proportion of children in the different psychiatric groups varied substantially between the Afro-Caribbean and comparison groups ($\chi^2=43.4$, d.f. $=7$, $P<0.001$). An analysis of standardised residuals (Everitt, 1977) was used to identify which group differences were responsible for this highly significant χ^2 value, and this demonstrated that the Afro-Caribbean group had a significantly higher rate of autistic, psychotic and conduct disorders, and a significantly lower rate of emotional disorders. The proportion with specific reading retardation did not differ between the Afro-Caribbean and comparison groups (8.2% of Afro-Caribbean, 8.5% of comparison, $\chi^2=0$, d.f. $=1$, NS), but there was a difference in the proportion with mental handicap (18.8% of Afro-Caribbean, 11.0% of comparison, $\chi^2=12.8$, d.f. $=1$, $P<0.001$).

Psychotic disorders

Of the ten Afro-Caribbean subjects with psychotic disorders, three had affective disorders (i.e. a bipolar disorder or a unipolar depression with clear psychotic symptomatology), five had schizophrenia, and two had reactive psychoses. Of the ten subjects from the comparison group with psychotic disorders, five had

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affective disorders, four had schizophrenia, and one had a reactive psychosis. For three subjects (two from the Afro-Caribbean and one from the comparison group) the diagnosis of schizophrenia had to be based solely on the symptomatology and history at initial presentation, since there was no follow-up information. For the remaining six subjects with schizophrenia (three from each group) the initial diagnosis was substantiated by the longitudinal course over a follow-up period ranging from two to 17 years.

In both the Afro-Caribbean and comparison groups, only two of the ten subjects with psychotic disorders were prepubertal; all four had affective illnesses. The mean age (s.d.) of subjects at the time of referral for a psychotic disorder was 14.6 years (1.3) for the Afro-Caribbean subjects and 14.8 years (1.1) for the comparison subjects ($t = 0.4$, d.f. = 18, NS). Seven of the Afro-Caribbean subjects and six of the comparison subjects were girls. Of the five Afro-Caribbean subjects with schizophrenia, there was one boy and four girls, whereas all four of the comparison subjects with schizophrenia were boys. Two Afro-Caribbean subjects with psychotic disorders were mildly mentally handicapped: one had an affective psychosis and one had schizophrenia; all the other subjects with a psychotic disorder were of normal intelligence.

Autism and related disorders

Five of the ten Afro-Caribbean subjects with autistic disorders had infantile autism as defined in ICD–9 (Rutter *et al*, 1983), as did four of the eight comparison subjects with autistic disorders; the remaining 50% of subjects in each group had other pervasive developmental disorders. The mean age (s.d.) at referral was 9.4 years (4.1) for Afro-Caribbean subjects and 9.5 years (4.3) for subjects from the comparison groups ($t = 0.1$, d.f. = 16, NS).

Of the ten Afro-Caribbean subjects, two were of normal intelligence (non-verbal IQ $\geqslant$ 70), three were mildly or moderately mentally handicapped (non-verbal IQ between 35 and 69), and five were severely or profoundly mentally handicapped (non-verbal IQ $<$ 35). Of the eight comparison subjects, two were of normal intelligence, six were mildly or moderately mentally handicapped and none was severely or profoundly mentally handicapped. Though the difference between the groups in the rate of severe and profound mental handicap is striking, the results fall short of statistical significance (Mantel–Haenszel χ^2 for trend = 2.6, d.f. = 1, $P = 0.11$). Whereas all the subjects from the comparison group were boys, three of the Afro-Caribbean subjects were girls: one with moderate and two with severe mental handicap.

Table 3
Proportion with emotional disorder† in each group

	Afro-Caribbean proportion (%)	Comparison proportion (%)	Significance
All sample	(52/198) 26	(356/899) 40	***
By sex and age			
boy, aged ⩽12	(14/74) 19	(103/328) 31	*
girl, aged ⩽12	(7/30) 23	(62/146) 42	(*)
teenage boy	(6/45) 13	(79/223) 35	**
teenage girl	(25/49) 51	(112/202) 55	
By referral source			
parents or GP	(24/62) 39	(195/440) 44	
education	(17/77) 22	(86/233) 37	*
other	(11/59) 19	(75/226) 33	*
By era			
1970s	(39/130) 23	(209/562) 37	**
1980s	(22/68) 32	(147/337) 44	
By parental employment			
non-manual	(4/18) 22	(72/143) 50	*
manual	(33/122) 27	(211/557) 38	*
unemployed	(15/58) 26	(73/199) 37	*
By parenting situation			
both biological parents	(28/87) 32	(215/484) 44	*
single parent	(14/77) 18	(80/212) 38	*
parent and step-parent	(2/12) 17	(48/143) 34	

†Denominator is number with any of the three common disorders: emotional, mixed or conduct disorders.
Significance of difference in proportion between groups: (*)$P<0.1$, *$P<0.05$, **$P<0.01$, ***$P<0.001$

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Emotional and conduct disorders

The Afro-Caribbean group had a lower proportion of emotional disorders and a higher proportion of conduct disorders than the comparison group (Table 2). Was this entirely secondary to group differences in background factors? The data presented in Table 3 suggest that this was not the case. The proportion of children with emotional rather than conduct or mixed disorders was consistently lower in the Afro-Caribbean group, even when the sample was stratified by family type, parental employment, decade, referral source, age and sex. In a logistic regression analysis, the difference between groups in type of disorder was still significant after the effects of referral source, parental employment and parenting situation had been taken into account ($\chi^2 = 6.9$, d.f. = 1, $P < 0.01$). The group difference did not narrow significantly between the 1970s and the 1980s ($\chi^2 = 0.3$ for three-way interaction between emotional disorder, group and decade, d.f. = 1, NS).

Afro-Caribbean and comparison children with the same diagnostic label generally had very similar symptom profiles. Rates for the common symptoms are shown in Table 4. The most striking exception to this general rule was the relative rarity of refusal or reluctance to attend school ($P < 0.001$) among Afro-Caribbean subjects with either emotional or conduct disorders. There was no evidence that the relatively low rate of emotional disorder in the Afro-Caribbean group was secondary to a diagnostic bias that led to children with mixed symptomatology being labelled as 'conduct disordered' if they were Afro-Caribbean but as 'emotionally disordered' if they were from the comparison group. Had this been true, Afro-Caribbean subjects diagnosed as conduct disordered would have had more emotional symptoms and fewer conduct problems than similarly diagnosed subjects from the comparison group. In fact, where the two groups differed, the direction was the opposite to that predicted by the diagnostic bias theory.

Did similar risk factors for conduct and emotional disorders operate for both Afro-Caribbean and comparison children? To assess this, we looked at factors that significantly altered the ratio of emotional to conduct disorders in subjects from the comparison group and examined whether they had comparable effects on the Afro-Caribbean subjects. Table 5 shows the odds ratios, for Afro-Caribbean and comparison subjects separately, of having an emotional disorder when a risk factor was present. An odds ratio of more than one indicates that the factor increased the relative likelihood of an emotional disorder. Conversely, an odds ratio of less than one indicates that the factor increased the relative likelihood of a conduct or mixed disorder. Though all the odds ratios are significantly different from 1 in the comparison group, comparable odds ratios are mostly non-significant in the Afro-Caribbean group (probably reflecting the smaller sample size). There were no significant differences in odds ratios between the two groups (as judged by including a two-way interaction term between ethnic group and risk factor in logistic regression analyses),

Table 4
Frequency of common emotional and conduct symptoms by group and diagnostic category

	Emotional disorder		Conduct/mixed disorder	
	Afro-Caribbean, % ($n = 52$)	Comparison, % ($n = 356$)	Afro-Caribbean, % ($n = 146$)	Comparison, % ($n = 543$)
Emotional symptoms				
Refusal/reluctance to go to school	12***	43	5***	20
Anxiety	40	39	2**	11
Depression	52(*)	37	10*	18
Phobias	14(*)	27	3	5
Disturbance of sleeping	29	22	6*	14
Pains of mental origin	8	14	5	7
Suicidal ideas, attempt or threat	8	11	4	8
Conduct problems				
Disobedience/lying	19	15	58	55
Stealing	12	4	42	36
Fighting/bullying	4	4	55***	32
Truancy/staying out late	14	10	31	31
Destructiveness	0	2	19	21
Violent assault	0	0	12***	4

Symptoms commoner or rarer in Afro-Caribbean subjects than in comparison subjects from the same diagnostic group: (*) $P < 0.1$, **$P < 0.05$, ***$P < 0.01$, ***$P < 0.001$

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Table 5
Odds ratio of having emotional rather than conduct or mixed disorders in the presence of particular risk factors

Risk factor	Afro-Caribbean	Comparison	Significance of risk factor x group interaction
Male sex, pre-teenagers only	0.77	0.62*	0.7
Male sex, teenagers only	0.15***	0.44***	0.051
IQ <70	0.45	0.37***	0.8
Specific reading retardation	0.86	0.29***	0.08
Only child	0.41	1.72*	0.07
Four or more children at home	1.02	0.54**	0.11
Not with both biological parents	0.58	0.64**	0.8
Familial over-involvement	2.73	3.08***	0.9
Lack of warmth in family	0.57	0.51*	0.9
Inadequate or inconsistent parental control	0.28*	0.36***	0.7
Discordant intra-familial relationships	0.93	0.59**	0.3

Odds ratio differs from unity: *$P<0.05$, **$P<0.01$, ***$P<0.001$

but differences in the impact of family size and specific reading retardation approached significance.

Discussion

Before discussing our findings, it is important to consider potential limitations of the study. More emphasis is now being placed on the distinctions between race, culture and ethnicity, with these three different groupings being based on biological variables, social variables and self-identity respectively (McKenzie & Crowcroft, 1994). Our grouping did not correspond to any of these three, being based on parental place of birth – an imperfect and ambiguous marker for race, culture and ethnicity. This makes it much harder for us to assess how far the differences between our two groups stem from biological factors, social factors or perceived identity. Parental place of birth was the only variable available to us, but future researchers would be well advised to use multiple independent measures of race, culture and ethnicity.

A major potential limitation of all clinical studies is that they are necessarily subject to unknown referral biases. Our findings should be relatively robust to referral bias, however, since we focused on group differences in the relative rates of different disorders or risk factors. For example, had referrers been twice as likely to refer children with psychiatric disorders if they were Afro-Caribbean, that would have affected the *number* of Afro-Caribbean children referred but would not have affected the *relative rates* of different disorders or risk factors in either the Afro-Caribbean or the comparison group. Similarly, had referrers been more likely to refer children with psychotic rather than conduct disorders, that would have increased the proportion of psychotic children in both groups to similar extents. Our study would have been vulnerable, however, to more complex referral biases, e.g. a greater tendency to refer psychotic children if they were Afro-Caribbean but a lesser tendency to refer depressed children if they were Afro-Caribbean. It seems unlikely to us that this sort of referral bias could have accounted for the findings of four to six times as many psychotic and autistic disorders in our Afro-Caribbean group. Bias could more easily have affected our findings on the common emotional and conduct disorders, but we are reassured by the extent to which these generally mirror the epidemiological (and therefore free from referral bias) findings of Rutter *et al* (1974).

Since our results refer to a group of second-generation Afro-Caribbean children and adolescents seen in the 1970s and 1980s, it is uncertain how far they apply to Afro-Caribbean children and adolescents (mostly third-generation) being seen in psychiatric clinics in the 1990s. However, since our study showed that the Afro-Caribbean and comparison groups differed almost as much in the 1980s as in the 1970s, and since our findings generally mirrored the findings on Afro-Caribbean children seen in the 1960s (Graham & Meadows, 1967; Nicol, 1971), we believe that the group differences are relatively stable.

As a final caveat, we note that the value of our findings depends on the reliability, validity and comprehensiveness of the routinely collected item sheet data on subjects and their families. These data were obtained in a psychiatric clinic that emphasised detailed evaluation and recording of phenomenology, risk factors and diagnoses – all

favouring the reliable and accurate completion of item sheets (Goodman & Simonoff, 1991). We do have reservations, though, about the reliability of the ratings of adverse psychosocial factors (cf. van Goor-Lambo, 1987). Could the validity of item sheet data have been seriously undermined by systematic racial bias on the part of the raters? We think this unlikely, since the picture that emerged from our analyses showed the Afro-Caribbean group to be advantaged in some respects (e.g. with warmer, better regulated family lives) though disadvantaged in others. A more serious reservation is that the routine clinical assessments on which our item sheet data are based may not have included sufficiently detailed enquiries about topics such as racial discrimination that are primarily relevant to minority groups.

In line with previous findings on ethnic minorities in Britain (Harrison *et al*, 1988; King *et al*, 1994), psychotic disorders including schizophrenia were substantially over-represented in our sample of Afro-Caribbean children and adolescents. It is hard to imagine that referral bias alone accounted for our finding equal numbers of psychotic subjects in the Afro-Caribbean and comparison groups in an area where only some 15–20% of the childhood population was Afro-Caribbean (see Inner London Education Authority, 1983; Office of Population Censuses and Surveys, 1993; and South East London Commissioning Agency, personal communication). Could the over-representation of psychotic disorders among Afro-Caribbean children and adolescents have been due to a 'brought forward' effect secondary to earlier puberty? In line with the findings of a recent epidemiological study (Ulijaszek *et al*, 1991), the Afro-Caribbean children in our sample did appear to enter puberty roughly six months earlier than subjects from the comparison group. No group differences in age at referral or pubertal status were evident, however, among the subjects with psychotic disorders. Thus although our sample size was too small to rule out some 'brought forward' effect, our results do not suggest that such an effect is the main reason for the high rate of psychotic disorders among Afro-Caribbean children and adolescents.

The striking over-representation of infantile autism and related disorders in the Afro-Caribbean group is in line with previous findings on the children of immigrants (Wing, 1979; Akinsola & Fryers, 1986; Gillberg *et al*, 1987). The over-representation was not limited to autism-like conditions; classical autism was equally over-represented. Afro-Caribbean children with autistic disorders seemed more likely than their counterparts from the comparison group to be severely or profoundly mentally handicapped, in line with a similar observation by Gillberg *et al* (1987) on the autistic children of immigrant parents. Perhaps the high rate of severe mental retardation reflects a higher proportion of autism secondary to severe environmental insults to the developing brain (including some prenatal viral infections) and a lower proportion of autism due to genetic loading. Family studies could address this possibility.

The low ratio of emotional to conduct disorders in Afro-Caribbean children did not appear to be entirely secondary to group differences in referral source or social background, though our attempts to control for social class and family type may not have fully allowed for the greater social deprivation of the Afro-Caribbean group. Our findings did not suggest that a low ratio of emotional to conduct disorders reflected a tendency to diagnose conduct disorders more readily in the Afro-Caribbean than in the comparison children. Judging from the general similarity in risk factors, the distinction between conduct disorders and emotional disorders seemed to have much the same meaning for the Afro-Caribbean and comparison groups – a conclusion that would be strengthened if the distinction could be shown to have similar implications for natural history and treatment response in the two groups.

Several of our findings on group differences in the common psychiatric disorders deserve particular comment. An earlier epidemiological study suggested that Afro-Caribbean children were particularly prone to school-based conduct disorders (Rutter *et al*, 1974), and our findings suggest that this tendency persisted throughout the 1970s and 1980s. Our study provides no basis for judging whether this can simply be attributed to a mismatch between Afro-Caribbean pupils and a largely white school system, but the issue is of pressing concern for child psychiatrists and educationalists alike and requires further investigation.

Whereas emotional disorders made up a smaller proportion of the common disorders in Afro-Caribbean girls under the age of 13 than they did in girls of the same age from the comparison group (23% *v.* 42%), the group difference was almost obliterated in the teenage years (51% *v.* 55%). By contrast, in boys the difference between groups widened with age. The low proportion of emotional disorders in younger Afro-Caribbean girls may be related to group differences in self-esteem. In a community sample of inner-city children assessed at the ages of 7 and 11, Afro-Caribbean girls typically had strongly positive (and well-founded) views of their own academic competence, whereas white girls typically had unrealistically poor views of their own academic competence (Blatchford, 1992). If the

greater self-deprecation of white girls leads to a higher liability to emotional disorders, why should the group difference narrow in the teenage years? One possibility is that the self-confidence of Afro-Caribbean girls is seriously undermined in these years. Another possibility is that biological effects secondary to puberty in girls swamp the protective effects of positive self-regard.

Refusal or reluctance to attend school was strikingly rarer among Afro-Caribbean children than among children from the comparison group. Could this reflect a tendency to describe school absence as truancy in Afro-Caribbean subjects but as school refusal in comparison subjects? We believe not, since truancy was no commoner in the Afro-Caribbean group. One possible explanation, suggested by the somewhat lower rate of phobias in the Afro-Caribbean group, is that the Afro-Caribbean children were less liable to specific fears or separation anxiety. Another possible explanation, suggested by the lower rate of inadequate or inconsistent parental control in the Afro-Caribbean group, is that the Afro-Caribbean parents were more effective at countering rather than reinforcing any reluctance by their children to attend school. A third possibility is that the Afro-Caribbean parents and children valued education more highly, in line with the finding of Maughan & Rutter (1986) that Afro-Caribbean pupils were more likely to choose to stay on at school after the age of compulsory schooling.

In conclusion, although British-born Afro-Caribbean children generally resemble other British-born children in their psychiatric presentation, the mix of disorders does differ in some important respects – a difference that has persisted over 30 years. The three sorts of disorders that appear to be over-represented in the Afro-Caribbean group – autistic, psychotic and conduct disorders – are those with a relatively poor prognosis, further disadvantaging an already disadvantaged group. Is it possible to prevent this state of affairs persisting for another 30 years? It will be difficult to obtain the scientific evidence to guide appropriate remedial action without further epidemiological studies in areas with a high proportion of children from minority groups. Such studies will need to investigate a wide range of risk and protective factors and to pay adequate attention to the impact of racism; and will need the wholehearted support of the minority groups concerned.

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