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Abstract	<p>The Asian-American population in the USA is one of the fastest growing ethnic minority groups in the USA yet relatively little is known about the mental health status and needs of Asian-American youth. Existing research suggests that there are higher rates of depression, anxiety, and suicide among this group. This chapter discusses considerations for addressing the emotional/behavioral needs of this population, to provide a more accurate appraisal of their mental health status and effective treatment plans. Additionally recommendations for the assessment of psychopathology in Asian-American youth are also discussed.</p>	

# Assessing the Asian Child and Adolescent: Special Considerations

[AU1] Judy Ho, Natalia Moss, and May Yeh

## Considerations for Assessing Asian-American Youth

Asian-American youth in the USA are a heterogeneous group originating from approximately 52 different Asian countries from the Asia continent, Southeast Asia, and the Indian subcontinent, with over 100 spoken languages and dialects. These youth originate from different social classes, speak different languages with varying degrees of fluency, practice different religions, and adhere to diverse cultural values (Huang, 1994). One of the fastest growing ethnic/racial minorities in the USA, the Asian-American population has increased at a higher rate than all other race groups in the country, growing by 46 % from 11.9 million in 2000 to 17.3 million in 2010 (Hoeffel, Rastogi, Kim, & Shahid, 2012). Extant research has contradicted earlier notions of Asian-Americans as the “model minority,” and literature has documented various social, educational, health and mental health disparities among this population along with comparable mental

health illness and psychological distress prevalence rates to the general population (see Lee, Lei, & Sue, 2001 for a review). Over 12 % of Asian-Americans live in poverty, higher than the 9.9 % rate of poverty among non-Hispanic whites (US Census, 2010), and the illiteracy rates of Asian-Americans is 5.3 times that of non-Hispanic whites (Le, 2013). Southeast Asians have the highest high school dropout rates in the country, 33 % of Asian-American students in public high schools drop out or do not graduate on time, and 24 % of Asian-Americans over the age of 25 do not have a high school degree equivalent (Le, 2013). Relatively little is known about the mental health status and needs of Asian-American youth, but existing research suggests that there are higher rates of depression, anxiety, and suicide among this group. Thirty percent of Asian-American girls in grades 5 through 12 reported depressive symptoms, higher than the rates reported in White girls (22 %), Latino girls (27 %), and African-American girls (17 %) (Schoen et al., 1997). Seventeen percent of Asian-American boys in grades 5 through 12 reported physical abuse, as compared to 8 % among White boys (Schoen et al., 1997). Further, generational differences and conflict regarding family values and beliefs may cause additional strain, stress, anxiety problems, and behavioral difficulties for these youth. Equally concerning is the evidence that Asian-American families tend to delay professional service seeking even when clinical problems arise (USDHHS, 2001), and Asian-American youth have consistently

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61 demonstrated a higher level of unmet mental  
 62 health needs and lower levels of mental health  
 63 service engagement than non-Hispanic White  
 64 youth (Li & Seidman, 2010).

65 In order to address Asian-American youths'  
 66 emotional/behavioral problems, accurate  
 67 appraisal of their mental health status is essential  
 68 to identifying those who could benefit from psy-  
 69 chological intervention and to designing effective  
 70 treatment plans. There are numerous assessments  
 71 that exist for the evaluation of youth emotional  
 72 and behavioral problems in the USA. However,  
 73 many of these have not been explicitly validated  
 74 on Asian-American youth populations. Most  
 75 existing assessments have demonstrated their  
 76 psychometric properties on predominantly non-  
 77 Hispanic white samples, and their results may not  
 78 be readily generalized to Asian-American youth  
 79 due to varying cultural factors that are salient to  
 80 the psychological development of youth from  
 81 different cultures. Some measures have been  
 82 translated for use with indigenous populations,  
 83 but it is not always clear from existing psycho-  
 84 metric studies whether these translated versions  
 85 have achieved cross-cultural equivalence at the  
 86 individual test item level and/or at the construct  
 87 level. In addition, there is a lack of psychometric  
 88 information regarding how these translated ver-  
 89 sions of assessments that have originated from  
 90 Asian countries might be used with Asian-  
 91 American populations.

92 For example, one cannot assume that a ques-  
 93 tionnaire that is developed and normed on one  
 94 cultural group can be used to assess the same  
 95 construct in another cultural group (Arnold &  
 96 Matus, 2000). When administering any instru-  
 97 ment as part of a clinical assessment, one must  
 98 consider how the respondent may interpret the  
 99 items. This is particularly important if the respon-  
 100 dents are immigrants, nonnative English speak-  
 101 ers, or originate from a culture different from the  
 102 one in which the instrument was developed and  
 103 validated (Gee, 2004). Individuals from varying  
 104 cultural groups may ascribe different meanings  
 105 to symptoms than were intended by the authors  
 106 of the original instrument. For example, symp-  
 107 tom expression has been shown to vary in differ-  
 108 ent Asian-American ethnic groups (USDHHS,

2001; Paniagua, 2000), and several culture-bound 109  
 syndromes have been documented in different 110  
 Asian populations in the DSM-IV-TR (APA, 111 [AU3]  
 2001). For instance, Vietnamese Americans have 112  
 been shown to endorse symptoms of depression 113  
 that include somatic complaints (e.g., pains, poor 114  
 appetite) as well as other symptoms that could 115  
 not be readily translated into an English language 116  
 equivalent (Kinzie et al., 1982). For Asian- 117 [AU4]  
 American youth, symptoms of anxiety may also 118  
 consist of somatic complaints, along with sleep 119  
 disturbance, and poor school performance 120  
 (Huang, 1997). Lack of awareness or attention to 121  
 these potential cultural differences is likely to 122  
 lead to misclassification or underdiagnosis of 123  
 emotional/behavioral disorders in Asian- 124  
 American youth. 125

126 Another important issue to consider that bears 126  
 implications for cross-cultural equivalence is the 127  
 use of multiple informants in the assessment of 128  
 psychopathology in Asian-American youth. 129  
 Weisz, McCarty, Eastman, Chaiyasit, and 130  
 Suwanlert (1997) asserted that the study of youth 131  
 emotional/behavioral problems “is inevitably the 132  
 study of two phenomena: the behavior of the 133  
 child, and the lens through which adults view 134  
 child behavior” (p. 569). The use of several 135  
 reporters for youth psychopathology assessment 136  
 is common for many existing evaluation tools 137  
 (evidenced by the availability of different infor- 138  
 mant forms for the same questionnaire), and the 139  
 information gained in this way is highly valuable. 140  
 However, reports from youth, parents, and teach- 141  
 ers have consistently shown low cross-informant 142  
 agreement (Achenbach, McConaughy, & Howell, 143  
 1987), and the research base suggests that inter- 144  
 informant discrepancies may vary systematically 145  
 by race/ethnicity (Lau et al., 2004). These racial/ 146  
 ethnic differences suggest that there may be 147  
 problems in meeting one or more of the condi- 148  
 tions set forth by Marsella and Kameoka (1989) 149  
 when evaluating cross-cultural equivalence and 150  
 interrater reliability: (1) Linguistic equivalence 151  
 and conceptual equivalence require that raters 152  
 have a shared understanding of the characteristic 153  
 being rated, and an understanding of the range 154  
 of behaviors that are representative of that 155  
 characteristic; (2) Metric equivalence requires 156

157 that raters have a shared metric so that they may  
158 accurately scale behaviors that are related to the  
159 characteristic being rated; and (3) Normative  
160 equivalence requires that raters can determine the  
161 presence and absence of behaviors relevant to the  
162 characteristic being rated.

163 Closer examination suggests that youth–  
164 teacher and parent–teacher disagreements may  
165 be explained in part by cultural differences and/  
166 or racial ethnic biases (Lau et al., 2004). There is  
167 evidence that culture may influence adults’ atti-  
168 tudes toward youth behaviors and the determina-  
169 tion of whether an observed behavior constitutes  
170 a problem necessitating professional intervention  
171 (Lau et al., 2004). For example, consistent with  
172 traditional Buddhist values, Thai parents rated  
173 both undercontrolled problems (e.g., disobedi-  
174 ence, fighting) and overcontrolled problems (e.g.,  
175 shyness, fear) as less serious, less worrisome, and  
176 more likely to improve with time compared to  
177 American parents (Weisz et al., 1988). Another  
178 example utilizes two traditional Chinese concep-  
179 tions emerged from Confucian thought: (1)  
180 “Chiao Shun,” which refers to the Chinese youth  
181 behaving in ways consistent to his or her training  
182 (i.e., teaching the child appropriate conduct by  
183 exposing him/her to explicit examples of proper  
184 behavior and restricting exposure to undesirable  
185 behavior in the context of a supportive, highly  
186 involved, and physically close parent–child rela-  
187 tionship), and (2) “Guan,” which equates parental  
188 care, concern, and involvement with firm control  
189 and governance of the child (Chao, 1994, 2000).  
190 Traditional parents may not view some internal-  
191 izing behaviors on Western assessment scales  
192 such as passivity, obedience without question,  
193 and lack of assertiveness as clinical problems but  
194 rather desired behaviors in their child consistent  
195 with the concepts of “Chiao Shun” and “Guan.”  
196 Similarly, differing views of desired attachment  
197 styles in traditional Japanese families may lead  
198 Japanese mothers to view some internalizing  
199 behaviors as normative and expected in their chil-  
200 dren. For example, the indigenous Japanese concep-  
201 t of “Amae” which refers to relationships that  
202 involve both attachment and dependence (Doi,  
203 1989; Emde, 1992) have been shown in research  
204 to translate to more expressed feelings of sadness

205 due to separation between Japanese mothers and  
206 children than between American mothers and  
207 children (Mizuta, Zahn-Waxler, Cole, & Hiruma,  
208 1996). These findings suggest that concepts of  
209 sadness and loss have different meanings to par-  
210 ents and children in Japan than in the USA, and  
211 can potentially significantly affect assessment  
212 and intervention of attachment and youth emo-  
213 tional problems (Rothbaum, Weisz, Pott, Miyake,  
214 & Morelli, 2000).

215 Complicating the multi-informant assessment  
216 picture are linguistic challenges when assessing  
217 families in which parents may speak only one  
218 language (from their country of origin) profi-  
219 ciently, and in which the youth may speak only  
220 English proficiently or are bilingual. In 2011, the  
221 foreign born from Asia represented over one-  
222 fourth of the total foreign-born population in the  
223 USA (Gryn & Gambino, 2012), which suggests  
224 that a substantial amount of these foreign-born  
225 Asian-Americans are not native English speak-  
226 ers. For these individuals, issues regarding accul-  
227 turation status and relatedly, linguistic  
228 considerations, must be considered when con-  
229 ducting a multi-informant assessment. For exam-  
230 ple, when translated versions are available, is it  
231 appropriate to administer the scale in one lan-  
232 guage to the parent, and in another language to  
233 the youth? When administered in different lan-  
234 guages, how can we ensure that the raters have a  
235 shared, or culturally equivalent, understanding of  
236 the characteristic being rated? If there are inter-  
237 generational differences between the parent and  
238 youth regarding level of acculturation to the  
239 mainstream American culture, these cultural dif-  
240 ferences may affect the determination by the par-  
241 ent and youth of whether a behavior constitutes a  
242 problem necessitating professional intervention.  
243 Specifically, parents who are less acculturated to  
244 mainstream American culture compared to their  
245 child may rate a particular behavior as non-  
246 problematic, whereas their child may rate a par-  
247 ticular behavior as problematic, or vice versa,  
248 leading to larger parent–youth disagreement on  
249 an assessment. Further, if only and English ver-  
250 sion of an assessment is available, would it be  
251 appropriate to request the youth to serve as an  
252 interpreter? If so, how might this affect the

253 validity of the parent’s report of the youth’s  
 254 emotional/behavioral problems provided that the  
 255 youth is hearing these responses and also doing  
 256 the written transcribing when it is a written mea-  
 257 sure? The existing literature is limited in provid-  
 258 ing guidelines on how to handle the above  
 259 outlined issues, particularly with multi-informant  
 260 assessments with children, and the field would  
 261 benefit from more research in this area.

262 The perceptions of adult observers who are not  
 263 part of the nuclear family may be particularly  
 264 subject to the influence of race-related beliefs  
 265 about base rates of youth psychopathology (Lau  
 266 et al., 2004). Teacher expectancies for student  
 267 achievement and classroom behaviors have been  
 268 related to student race (Dusek & Joseph, 1983).  
 269 Teachers may have the tendency to view Asian-  
 270 American youth as model students who are dili-  
 271 gent and respectful, yet passive with low  
 272 assertiveness and poor social competence (Bannai  
 273 & Cohen, 1985; Schneider & Lee, 1990).  
 274 Similarly, teachers may rate overcontrolled  
 275 behaviors such as worry and shyness as more rep-  
 276 resentative of Asian students than students of  
 277 other ethnicities (Chang & Sue, 2003).  
 278 Intergenerational differences may also affect  
 279 youths’ perception of their own behaviors. For  
 280 example, youth from immigrant families may  
 281 adopt dominant American cultural values, norms,  
 282 and behaviors more easily than their parents  
 283 (Szapocznik & Truss, 1978), leading to more pro-  
 284 nounced parent–youth disagreements about youth  
 285 emotional/behavioral problems (Lau et al., 2004).

286 Another crucial issue to contemplate is  
 287 whether syndromes of child psychopathology in  
 288 the USA readily translate to those of various  
 289 Asian cultures. Syndromes, groups of emotional/  
 290 behavioral problems that co-occur, often are the  
 291 bases for clinical assessment, yet may not be sim-  
 292 ilar across cultures. For example, the Achenbach  
 293 scales (e.g., Achenbach, 1991, 1995) utilize syn-  
 294 dromes as organizational units for its subscales.  
 295 Although information on youth psychopathology  
 296 has grown quickly in recent decades, most stud-  
 297 ies have been conducted in Western countries.  
 298 This restricted range of cultures sampled in  
 299 empirical research may limit our cross-cultural  
 300 understanding of psychopathology as findings

301 from Western countries may not generalize to  
 302 other cultures (Weisz, Weiss, Suwanlert, &  
 303 Chaiyasit, 2003). Weisz and colleagues (2003)  
 304 found that some child psychopathology syn-  
 305 dromes may not match up very well between  
 306 Thai and US children. For example, the narrow-  
 307 band syndromes did not show strong concor-  
 308 dance, and only two of the eight broadband  
 309 comparisons showed substantial or almost per-  
 310 fect agreement. Research is limited in this area,  
 311 but if child psychopathology syndromes differ  
 312 systematically across cultures, this would under-  
 313 mine efforts to develop a common classification  
 314 system to be used for all cultures. Relatedly, the  
 315 construct validity of assessment tools developed  
 316 using syndromes from a common classification  
 317 system as a basis may be questionable when  
 318 applied to different cultures. The appropriateness  
 319 of clinical assessments conducted in Asian cul-  
 320 tures using scoring categories developed from  
 321 US samples may also be called in to question.  
 322 Thus, it may be wise to assess syndromal similar-  
 323 ity across cultures before applying the syndrome-  
 324 based categories of one culture to another.

325 Without an accurate assessment of the clinical  
 326 picture, motivating and engaging the youth and  
 327 his/her family for professional services and  
 328 designing and implementing effective treatment  
 329 plans become even more of a challenge for this  
 330 already underserved population.

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## 331 **Recommendations**

332 Many Asian cultural groups prefer more indirect  
 333 ways of communication that involve a combina-  
 334 tion of verbal, explicit, nonverbal, and implicit  
 335 responses. For example, traditional Chinese  
 336 groups tend to rely on indirect, more complex  
 337 methods of communication like indefinite com-  
 338 ments while Westerners tend to adopt direct and  
 339 simple methods (Su, Wang, Fan, Su, & Gao,  
 340 2008). These differences in communication and  
 341 response style may render direct responses to  
 342 face-valid surveys (the majority of most emo-  
 343 tional/behavioral assessment tools) more diffi-  
 344 cult for Asians compared to their American  
 345 counterparts. Further, many Asian groups both in

346 the USA and internationally tend to avoid mental  
 347 health services because of their fear and rejection  
 348 of mental health disorders (USDHHS, 2001).  
 349 Thus, the adoption of a more indirect communi-  
 350 cation style coupled with the stigma against  
 351 mental illness may significantly influence how  
 352 Asian groups respond to items on a face-valid  
 353 mental health assessment. They may be more  
 354 likely to underreport symptoms and this has been  
 355 demonstrated consistently in the literature  
 356 (USDHHS, 2001). Misunderstandings may also  
 357 ensue as symptom expression is often different  
 358 for various Asian groups (e.g., the tendency to  
 359 somaticize symptoms for many Asian groups;  
 360 USDHHS, 2001).

361 The way the items on an instrument are con-  
 362 structed may also alter response patterns for dif-  
 363 ferent Asian groups. For example, many Asian  
 364 languages bear linguistic structure differences to  
 365 English. In Korean, the verb comes at the end of  
 366 the sentence, as do positive and negative valence  
 367 words. Therefore, Korean respondents may give  
 368 more attention to the last portions of sentences.  
 369 In English, the verb does not always come at the  
 370 end of the sentence. Therefore, the way in which  
 371 an item question is structured may inadvertently  
 372 direct an individual's attention towards or away  
 373 from an item's focal content as conceptualized by  
 374 the original test developers.

375 For the reasons above, interviews with the  
 376 youth's primary caregivers may be a very helpful  
 377 supplement, as they may provide information  
 378 regarding the meaning of specific symptoms and  
 379 shed light on how cultural factors may play a role  
 380 in the expression of these emotional/behavioral  
 381 problems. Of course, the information gained by  
 382 adult informants needs to be weighed according  
 383 to what is known from the existing research  
 384 regarding informant disagreements regarding  
 385 youth emotional/behavioral problems and the  
 386 role that culture may play in whether a problem is  
 387 viewed as worthy of clinical attention, and the  
 388 preliminary findings that syndromes established  
 389 with Western samples may not be similar across  
 390 different Asian cultures. For the above reasons, it  
 391 may also be important to assess the acculturation  
 392 levels and/or ethnic identity of both the parents  
 393 and youth in order to gain some additional context

394 around the degree to which each informant may  
 395 ascribe to more westernized conceptualizations  
 396 of psychopathology and syndromes.

397 Overall, an integrative approach should be  
 398 utilized for clinical assessment which combines  
 399 both standard and ethnocultural assessment  
 400 strategies such as the one described by Huang  
 401 (1994). An ecological approach to assessment  
 402 provides multiple sources of data essential to a  
 403 holistic picture of the youth, and combines the  
 404 evaluation of domains of a standard assessment  
 405 (e.g., physical appearance, language, affect, fam-  
 406 ily composition, demographics, communication  
 407 patterns) as well as an ethnocultural assessment  
 408 (e.g., generational status, acculturation level,  
 409 ethnicity and self-concept, migration history,  
 410 salience of ethnicity, history with cultural differ-  
 411 ences; Huang, 1994).

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# Author Queries

Chapter No.: 23      0002114235

Queries	Details Required	Author's Response
AU1	"Judy Ho" has been treated as the corresponding author. Please check if it is ok.	
AU2	(USDHHS, 2001) is cited in the body but its bibliographic information is missing. Kindly provide its bibliographic information. Otherwise, please delete it from the text/body.	
AU3	(APA, 2001) is cited in the body but its bibliographic information is missing. Kindly provide its bibliographic information. Otherwise, please delete it from the text/body.	
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