Research and evaluation on programs for Asian American, Native Hawaiian, and other Pacific Islander Populations

The current mental health system has neglected to incorporate, respect, or understand the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing individuals in the criminal and juvenile justice systems.[1]

There is a continuing lack of knowledge as to what constitutes culturally appropriate mental health services for underserved and difficult to access populations, including Asian American, Native Hawaiian and other Pacific Islander (AANHOPI) children, youth, and families. Part of the reason for this is the assumption that "one size fits all" when it comes to program development and implementation. Recently there has been increasing awareness of the need to create programs and interventions that are more culturally sensitive. However, the cultural sensitivity of the evaluation of these programs is often overlooked. Culture should be carefully considered when designing, implementing, and interpreting program evaluation materials. This article focuses on important ways that culture must be considered in the research and evaluation of mental health programs for AANHOPI children and families.

Defining "Asian American"

The growing requirement to implement primarily evidence-based practices (EBPs) in order to receive funding drives the need to delineate different Asian subgroups. It is perfectly reasonable to ask that only effective treatment or intervention strategies be used when offering mental health services to the community. The problem, however, in implementing evidence based practices is "Whose evidence is it anyway?" How do we know if a treatment works for a particular community?

AANHOPI children are frequently missing from mental health program evaluations. When included, their demographic information is often over-generalized. Rarely are ethnicity or generational status considered, and children are merely identified as "Asian American," or in many cases simply "other." Only recently has the "Native Hawaiian or Pacific Islander" designation been included as a category for identification, but usually it continues to be missing altogether.

Research on "Asian Americans or Pacific Islanders" provides only minimal information about the target population, since there really is no such entity as an Asian American or Pacific Islander. There are Chinese, Korean, Vietnamese, Hmong, Filipino, Samoan, Guamanian, and bi- and multi-racial children. There are children who are foreign born, American born to foreign born parents, or who are from families who have lived here for several generations. There are vast cultural differences among these different ethnic groups; a program or intervention strategy that might work for first-generation Americans from Cambodia may have little impact on highly acculturated Filipinos. Research has shown that different men-

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tal health patterns exist among Asian-American subgroups and that several factors, including refugee status, account for these differences.[2]

It would be optimal to evaluate a mental health program or intervention based on its effectiveness among various subpopulations of AANHOPIs; however, this approach can be problematic. A common difficulty is the small number of available subjects within each subgroup—if so few individuals identify with a particular subgroup, researchers cannot generalize to a larger population. This is why researchers oftentimes identify subjects simply as "Asian American" or "Pacific Islander"—they need larger numbers of subjects in order to mathematically measure the effectiveness of a program, and combining the data into larger groups provides a sufficient number of subjects. However, lumping everyone together can limit the usefulness of findings. For example, when investigating the impact of a program designed to decrease the incidence of conduct disorder among Asian-American boys, a Korean whose parents immigrated to Houston five years ago, a youth who was born in Long Beach to parents who were Cambodian refugees, and the son of a bi-racial youth whose father is a third generation Japanese American living in Denver may all be labeled "Asian American male," yet their experiences with the program will be radically different from each other based on their cultural and ethnic backgrounds. Any generalizations made from the results of this evaluation could potentially undermine the effectiveness of the program for a particular population subgroup.

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The "Asian American Experience"

Ideally, when assessing the impact of a mental health program on a particular population, factors such as age, gender, the child's place of birth, parent's place of birth, birth order of child, and primary language spoken (both child and parents), should be considered. However, also important to consider are immigrant or refugee status, and losses due to war or other traumatic events. When assessing for mental health problems in children, it also is important to assess the parents' understanding of mental health and their beliefs regarding the potential causes of the problem. These issues will help shape appropriate intervention strategies. In many instances these factors are at least as important as the specific ethnic group with which the individual identifies.

Likewise, one cannot conduct good research or program evaluation related to AANHOPI children without an accurate picture of the world surrounding the child. This includes a thorough understanding of the parents' current situation and his/her history. The majority (88%) of Asian Americans are either foreign born or have at least one foreign born parent. This alone has tremendous implications for the development, implementation and evaluation of mental health intervention strategies and programs. For example the torture experienced by some Cambodian parents cannot be ignored, nor the traumatic experiences of the Vietnamese, Laotian and Hmong who spent years in refugee camps as they fled the war in Southeast Asia. All is not paradise for Native Hawaiians who continue to face the consequences of the colonization of their land by the United States. Parents' experiences have a profound impact on their children.

Culturally Appropriate Interventions

Assessing the cultural and linguistic appropriateness of mental health services is essential for research and evaluation. This is not an easy task but not an impossible one either. Using key informants, obtaining consultation, working with those who are familiar with the community, and utilizing individuals with the language skills to communicate effectively are all strategies to help assess the cultural appropriateness of a service. In the absence of such effort, what appears as a parent's unwillingness to "comply" with treatment may actually be their reluctance to follow up with culturally and linguistically inappropriate services.

When designing a culturally appropriate intervention, researchers need to consider whether the behaviors observed in somebody from one culture have the same psychological implications as those from a different cultural group. Since the success of a program is often based on evidence of behavior change in a desired direction, it is important to determine whether a particular behavior is linked to particular psychological factors across all cultural groups. For example, the emphasis on collectivism in some Asian cultures may mean that efforts to encourage independence

are not perceived as positively as they are in Western cultures. Similarly, shame, often an accepted emotional response in many Asian cultures, is not as normative in Western cultures and can be perceived as a problematic emotional state. If behavior patterns and symptoms for a particular mental health condition differ across cultural groups, then findings from research that target those behaviors or symptoms will be difficult to interpret.

Cultural Attributions

In many instances, the mental health and the behavior patterns associated with a particular diagnosis are primarily based on Western cultural norms. Unfortunately, unless the relationships between mental health and particular behavior patterns are understood for different cultural groups, psychological diagnoses may result from misleading and erroneous assumptions. Many psychological concepts are universal in human behavior, but how these are manifested behaviorally may be significantly different. For example, Thai children express distress through internalizing problems more than their Western counterparts, leading some researchers to conclude that Thai children, influenced by Buddhist religious ideology, are more likely to exhibit signs of distress in ways that do not disrupt their cultural norms.[3]

Often, assessment and measurement tools are based on specific Western concepts that have few or no parallels with some Asian cultures. Instruments and questionnaires developed for a more Western-oriented population often include questions about behaviors that are linked to psychological factors that have a completely different manifestation in other cultures. The result is that it is not clear whether the standard instruments used to evaluate healthy behavior actually measure similar constructs across cultures. The notion of a culture-free measure is simply an overly broad characterization of human behavior. Since different cultures may have different behavioral manifestations of similar psychological constructs, appropriate measures need to be developed based on each culture.

Culturally Appropriate Evaluations

Analyzing data is important but researchers and evaluators must not lose sight of the fact that the process of data collecting and the content of the questions are equally critical. The use of trained interpreters and translators is one way to address potential language barriers. A standard practice for translating information is to do a forward and backward translation: First, the original question is translated from English into the second language. Then to assess whether the translation still holds the same meaning as the original, a different person must then translate the question back into English. Comparing the newly translated version with the original will help determine if the intent of the question has remained in tact. This takes extra time and resources but is critical to obtaining accurate information.

The next step is to validate the questions with the use of a focus group to assess whether the question is being perceived as intended and is eliciting appropriate information. Translating or interpreting information that does not accurately address

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the concept one wishes to evaluate will only result in inaccuracy in two languages. Another important issue to consider is that the content of the question may not even exist in any language form for some cultures. For example, several Asian cultures have no language equivalents for HIV/AIDS or for many of the high risk sexual behaviors that are associated with its transmission. "Untranslatable" concepts such as these will require a more descriptive definition in order to clarify the construct.

In addition, response options that are frequently encountered in Western cultures may not be comprehensible to members of some Asian immigrant cultures. Likert scales, which typically ask participants to specify their level of agreement with an item, have little meaning with some Asian cultures. For example, the differences between "Never," "Almost never," "Sometimes," "Almost always," and "Always" have few or no language equivalents within most Asian cultures.

Interpretation and Dissemination

Interpreting findings from research and evaluation on mental health programs for different AANHOPI cultures must also be undertaken with caution. Unless a researcher or evaluator is indigenous or well versed in the cultural makeup of a specific Asian ethnic group, findings may prove puzzling and/or the interpretation may be biased by the researcher's perspective. The risk of misinterpretation can be lessened when the research or evaluation process includes consultation with an advisory body consisting of both professionals and lay individuals from the same culture as the research participants. The advisory body serves as a forum for discussion and interpretation of findings, and for deciding which findings should be disseminated and how.

A final question that a researcher or evaluator must ask is an ethical one: Why is the data being collected in the first place? The best interest of the community must be at the core of why the research/evaluation is being conducted. Too often, a community is asked to invest time participating in research, and yet never hears the results of their efforts, and never benefits from the information gathered. Researchers and evaluators must be willing to provide feedback to the community, using their results in ways that promote positive change. Presentations of findings should directly involve parents, youth and other key stakeholders. Failure to respect the community may jeopardize future research efforts.

There is no question that evaluation and research with Asian American, Native Hawaiian and other Pacific Islander populations is a complex process with a unique set of challenges. There are no easy answers, but respecting and understanding the culture and language of the specific population can yield critical information in the quest to improve services for children, youth and families. Failure to identify appropriate questions, use culturally sensitive measurement tools, disaggregate data, or to use proper data collection methods threatens the relevance of study outcomes or findings. This in turn has repercussions for the AANHOPI communities. Funding for community-based organizations may depend on whether or not they can supply evidence of the effectiveness of the programs they implement. Even more importantly, failure to accurately identify what is effective deprives AANHOPI children, youth, and families of opportunities for mental health and thriving.

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