Cross-Cultural Formative Assessment

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This article describes some of the issues affecting measures that are translated and/or adapted from an original language and culture to a new one. It addresses steps to ensure (a) that the test continues to measure the same psychological characteristics, (b) that the test content is the same, and (c) that the research procedures needed to document that it effectively meets this goal are available. Specifically, the notions of test validation, fairness, and norms are addressed. An argument that such adaptations may be necessary when assessing members of subpopulations in U.S. culture is proposed.

Keywords: Coping, formative, assessment
Introduction
The prevalence of personality disorders (PD) diagnoses among women and men have increased over the years. (Iwanasa, Larrabee, & Merritt, 2000). Proportional to the peak in PD among women and men, is that of the diagnoses in various ethnic and cultural groups. Unfortunately, this increase may be a result of cultural difference and not a clear indication of a personality disorder. Solomon (1992) discussed how applying clinical diagnoses to ethnic minorities may be detrimental because of cultural differences in the expression of symptomatology, use of instruments and evaluations that are culturally invalid and unreliable, clinician bias and prejudice, and institutional racism.

The need to examine the role of ethnicity in psychopathology in general, and in personality disorders specifically, is of particular importance given the browning of the United States (Iwamasa, et al., 2000). Moreover, the American Psychological Association adopted “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” in 1993, signifying that professional mental health providers must provide effective assessment and treatment interventions to an increasingly diverse population. While progress is currently being made within the development of culture-specific theories of personality and personality disorders, empirical evidence is still lacking (Iwamasa, et al., 2000). Thus, the examination of diagnostic criteria used to diagnose personality disorders among ethnic minorities is important.

We are living in a time of transition. To maintain consciousness during these periods one has to be willing to embrace discontinuity, ambiguity and dissimilarities in all facets of life. For many years America was seen as the melting pot, fusing all cultures and ethnic groups into one gigantic bowl of soup. As the country has evolved so have the concepts. The current school of thought describes the United States as a toss salad, welcoming individual differences and allowing them to maintain their culture – or at least remnants of their heritage. These cultural variations have led clashes in child rearing, schooling, how psychological services are delivered.

Culture
Culture can be defined as the structure and practices that uphold a particular social order by legitimizing certain values, expectations and patterns of behavior; the ideas of a given people at a given time (Tomes, 2004). It is comprised of traditional ideas, related values, and is the product of actions that learned, shared, and transmitted from one generation to the next (Diller, 2004).

Race
While many people use the words race and ethnicity interchangeably, they do so incorrectly. Wilkinson (1993) defines race as “a category of persons who are related by a common heredity or ancestry and who are perceived and responded to in terms of external features or traits.” Moreover, race is seen more as a biological makeup of a particular group. Since this is a biological makeup it is based on heredity and genes and not necessarily the environment.

Ethnicity/ethnic groups
Ethnicity refers to a group that collectively shares a common history, culture, common values, behaviors and other characteristics (Tomes, 2004). Differences in affective, attitudinal, and behavioral patterns across cultures have been termed “ethnic patterns.” (Canino, 2000). Hale-Benson (1982) goes on further to define ethnic groups as “people who have a common
history and generally share a language, a religion, or a racial identity. Each ethnic group forms a sub-culture with its own attitudes and behaviors” (p. 26).

**Cultural Influence**

*Ethnic Identity Behaviors*
As cultures reflect eclectic behavioral patterns, it has become increasingly more important for clinicians to acknowledge a child’s acquisition of basic ethnic group patterns and how he/she belongs to and maintains these behaviors. A number of authors have explored the value of a child’s development based upon their ethnicity (Goodman, 1964; Porter, 1971; Clark, 1965). It has been postulated that children as young as 3 are aware of aspects of their ethnic identity (Porter, 1971). Even in adolescence, ethnic development continues based upon peer groups and peer perceptions (Canino & Spurlock, 2000). The aforementioned aspects are not the only elements critical to a child’s ethnic identity, but cognitive functioning is equally important. It is through cognitive functioning children/adolescents give meaning to their ethnicity and determine how to respond to themselves as well as other outside their group. Their reactions to ethnic stimuli may depend on certain cues emanating in their immediate society. Further, ethnic children/adolescent’s reactions may be affective, perceptual, or cognitive. For some ethnic and culturally diverse children and adolescents, the way individuals outside of their ethnic group perceives them is critically important, compared to other ethnic groups who value intra-ethnic perception. According to research by Gibbs (1989), black children/adolescents tend to use other blacks as a comparison group and not their white counterparts. Further, when a child/adolescent is biracial, a whole different set of norms may arise as he/she affiliates with one race more than the other.

An adolescent’s ethnic identity behavior may be more salient depending on the situation. For instance, some situations, depending on the status of the group and the cultural homogeneity/heterogeneity, the adolescent may respond differently as indicated by their referencing point. Changes in a child’s ethnic awareness may result from changes in cohort or generational groups, varying interactions among influential individuals, and normal developmental changes (Canino, 2000). For example, many third-generation Mexican American children may not know much of their cultural history or their language but may still identify with their ethnic group.

*Cultural Deviance*
Cultural deviance is based out of abnormality of what the culture holds true. Today, especially in the American culture and society, there is somewhat of a consensus that psychoses exist among various ethnic and racial cultures (Devereux, 1961). Further, the manifestations of these disorders are often characterized differently by the members of that culture. The problem facing many societies is how to provide appropriate diagnosis, particularly as it relates to standards of the culture. For example, an American Indian adolescent who is spiritually connected to the earth, may have daily conversations with trees and other inanimate objects. By his culture’s standard, he is practicing traditionally held beliefs. However, according to Western philosophy that prevails in the United States of American, this adolescent may be diagnosed as having a personality disorder.
and quickly medicated as to not become a vagrant to society.

Clearly, more than one type of deviance is likely to exist in any culture. As a result, a person may be singled out based upon some uncharacteristic element that distinguishes him/her from the rest of the same-age individuals. The temperament in children is a common focus of attention in the American culture. It is not uncommon to see parents or guardians with infants and toddlers to hush their children because of the current setting or cultural expectations. In Africa some African tribes (i.e., Zaire), infants are encouraged to cry and yell regardless of the environment, which is indicative of expressing vocal authority of their existence. As the culture and/or community evokes this display of emotion, children are further encouraged as they grow to always “speak their mind.”

How then does a psychologist determine what is due to a true (personality) disorder or what is simply a result of the person honoring cultural norms? Expectations surrounding child development and rearing practices vary as much as their different cultures throughout the world. No one culture or ethnic group can lay claim on the best method to raise a child/adolescent. Yet, the expectation is that a child/adolescent will reflect universal cultural expectations, which initiates the controversy of appropriate diagnosing. Milestones such as vocal expressions, walking without assistance, independence, mastery of fine and gross motor skills acquire different meanings in different cultures.

Cultural norms are additionally influence by the level of acculturation of a given family, even if they are indigenous to the country of interest (Canino & Spurlock, 2000). As a result, language and communication are critical when assessing for any type of disorder. Further, the child/adolescent must be assessed within the framework of their familial and cultural expectations and not those of the majority culture. While some westernized cultures place high value on early accurate vocalizations, other cultures equally value solitude and language development progressing at a slightly slower pace. Therefore, children coming from a less-verbalized background may present characteristics commonly associated with a personality disorder, but in actuality are reflecting cultural norms (i.e., deference to authority).

Non-majority group communication may also signal differences between the majority culture. Parents of Latino and Caribbean children often teach their children to be physically and emotionally expressive. In doing so, it is expected for them to be creative and excited regardless of the situation or conversation of interest. Further, as they attempt to relate to one another or others outside of their culture, they may break the close proximity ruled held by many Americans. On the other hand, Asian American children are less likely to be as expressive and may not even make eye-contact while communicating with another individual, if this person is one of status.

Within the American Indian culture, emphasis customarily placed on non-verbal communication. Personal feelings such as anger and content are no openly expressed (Katz, 1981).

Similar to Latino and Caribbean children, African American children/adolescents are encouraged to be animated and vocal when expressing even the mundane of events or occurrences. During this display of exuberance, one’s
voice may reach high pitch which is often confused with yelling or screaming by westernized standards. As a result, when African American children enter into formal education there are usually several cultural barriers between the school system and the students. As African American children may have been taught to “speak up,” teachers may expect them to acquiesce to their authority. Further, ADHD has proliferated throughout the school community and most of those students being medicated are African Americans (insert some stat). The disequilibrium that has prevailed is simply that of cultural imbalances between teachers’ expectations and culture. While growing up, many children are allowed to act upon their motor skills, but then are cajoled into performing actions that will satisfy their needs and that of their parents/guardians. Transitioning this self-regulation into the classroom becomes another step that is usually countered with much correction in the school system.

**Linguistic/language**

Another aspect of culture is the linguistic skills used by members of various ethnic groups. Language offers not only a means of intra and inter-communication of ethnic groups, but also “cognitive restructuring” of the child/adolescent’s world (Hilliard, 1983). However, it has been found that language can be a common problem in assessing a child/adolescent’s ability or current functioning. For example, “Navajo children usually adopt a slow, methodical speech pattern. When the children pause, Anglo-American teachers often regard this as a signal that they have completed their sentence” (Canino & Spurlock, 2000). This pattern of speech can present similar problems in personality assessment. In the administration of tests such as the MMPI and TAT, individuals are encouraged to respond within a timely matter, in not doing so it may adversely affect their overall score.

**Psychosocial Environment**

There are two environmental and functioning cultural factors that clinicians must consider when assessing children: 1) social support and 2) interpretation of social stressors. Within the Hispanic culture, individuals such as the compadre, comadre, and the priest are called upon when the parents of the child are not able to adequately provide for children due to financial reasons (Paniagua, 2001). Similarly, when trials befall African-Americans, research has supported that they are more likely to confer with the minister or community leader for assistance (Boyd-Franklin, 1989). As a result, these individuals become surrogate parents for the children, at times adapting a new mindset. This aspect of community can be seen further within the Asian culture. The extend family holds significance in childcare, bearing financial assistance, and different levels of community support. As the child/adolescent develops, they encounter more experiences with the “real world” leading them to grapple with multiple perceptions. These perceptions should be carefully screened by clinicians as to not reflect perceptions of racial discrimination or stress resulting from this perception. It is important for the clinician to understand that these types of perceptions can be masked as mental disorder symptoms.

**Healthy Culture**

The residual affects of slavery and racism can be felt today for many African Americans. These hideous crimes have left indelible scars on African Americans and unchangeable background to the American culture. Slavery, then and today, has
tormented socially and psychologically African Americans and now their children. One significant cultural aspect that has emerged for African Americans in particular, is the development of a health cultural paranoia. (Paniaga, 2005). Slavery has led to many African Americans to not only be suspicious of white Americans, but at times doubt their own capabilities, which can mask themselves as personality disorders.

Assessment
Personality disorders have the potential to be diagnosed more than any other Axis 1 disorders due to cultural bias. For example, in many Eastern cultures parents choose and decide whom their child(ren) should marry. The involvement parents have in this decision provides a striking contrast to how Western cultures view marriage partners. In most Western cultures parents tend to offer consultative counsel to their child(ren), but recognize that the final decision rest with the individual person. “The potential for bias may be greatest when the mental health professional comes from a different culture from the person being assessed” (Blum & Pfohl, 1998).

Screeners
Diagnostically based interviews for assessing personality disorders in different cultural groups tend to yield fairly consistent information. The reliability for these instruments is complex and varies. According to Zimmerman (1994) interrater reliabilities are higher for joint compared to separate interviews and interrater reliability of highly skilled versus newly trained interviewers are expected to differ. As evidenced by the reliability, clinicians and they like have considerable power in determining the eligibility criteria of child/adolescent presenting a personality disorder based upon less-sufficiently trained individuals.

An important reason when selecting an instrument for use in diagnosing children/adolescent with personality disorder, is the interview’s organization and/or format. For some instruments, questions may be grouped diagnostically (i.e., DIPD-IV and SCID-II), by topic (e.g., Interpersonal), by version/format (i.e., Parent version, Student Version, Teacher Version). In creating this categorical system, the personality disorder criteria are purporting manifestations of the given personality disorder. This arrangement helps to accurately estimate whether a particular behavior exemplifies a core characteristic of the target behavior (Clark & Harrison, 2001). However, this is a potential weakness to this approach, especially as it relates to children and culture. If a child/adolescent appears to be exhibiting more characteristics for the first two criteria, the clinician may become less objective and develop a positive persona about classifying the child as having a personality disorder without additional probing. It is through the probing that the clinician may uncover cultural information that supports the child’s responses to the interview format and not deviance from the majority held beliefs of the dominant population.

Acculturation
The culture of the child or adolescent is often threatened by the level of acculturation the child has made to a new country, environment, or even social setting. While most clinicians acknowledge that transition for a child/adolescent is difficult, they fail to take the level of acculturation into consideration when diagnosing a child. The process of acculturation may be in itself the focus of
clinical attention. Paniagua (2001) suggest several acculturation scales that can be used to assess children/adolescents. The Brief Acculturation Scale is recommended for clinicians and others who would like to perform a quick assessment of acculturation of children.

This level of assessment also folds over into intellectual functioning and other psychopathologies among culturally diverse groups. The DSM-IV suggests “psychological tests in which the person’s relevant characteristics are represented in the standardization sample of the test or by employing an examiner familiar with the aspects of the individual ethnic or cultural background” (Paniagua, 2001). While this recommendation may be excellent for diagnosis of mental retardation, learning disabilities, etc., there is an inherent problem. Just because a clinician may come from a cultural background similar to the child/adolescent, it does not mean he/she has complete grasp of the experiences of the child. Therefore, it may possible that a lower socioeconomic status (SES) white clinician working with a lower SES African American adolescent may have more in common than a higher SES African American clinician working with a lower SES African American child.

Cognitive Styles

The work of Jean Piaget has been considered a hallmark for understanding cognitive development universally. He gave maturational and biological factors in the development of cognition. While researchers such as Jensen (XXXX) strongly believe that biological aspects play significant roles in cognition, new scholars are acknowledging the importance culture may account for difference among groups. This new era looks at the relationship between one’s culture and the kinds of cognitive skills one develops (Hale-Benson, 1982).

Overdiagnosis

The fear of overdiagnosing is real for many culturally diverse children and adolescents. The prevalence of ADHD can be seen throughout America’s school landscape and the epidemic appears to be worsening as teachers come into contact with multiple ethnic groups and cultures. As a result, clinicians should always be mindful of overdiagnosing of any disorder or pathology. There is an unfortunate tendency clinicians and those that serve a myriad of populations to view pathology in terms of assessment instruments and general lack of understanding (Paniagua, 2005). It is not uncommon to uncover that the assessment instruments used to determine pathology with a culturally-diverse group was normed on primarily Anglo-Americans. These instruments lack cross-cultural validity. The second explanation leading to overdiagnosing, lack of cultural awareness, is almost inexcusable given the cultural explosion within the United States. By having a general lack of understanding and not willing to branch out to discover non-Anglo-American culture suggests an elitist’s mentality. Clinicians who are unfamiliar with practices and beliefs of their multicultural clients may incorrectly diagnosis and report a psychopathology.

Projective Techniques

While projective measures have been used since the early 1930s, their original (and current) use was for members of a familiar culture (Abel, et al., 1987). However, time has revealed that these measures present inaccurate data for less-known groups, or in our case minority populations. Tests such as the Thematic Apperception Test and the Rorschach Inkblot Test provide valid
information, yet they these measures do little to account for cultural representation and individual adaptations made (Abel, et al., 1987). Further, the problem of interpretation is compounded, as demonstrated in the United States of America, by the enormous amounts of immigrants to the country who must adapt themselves (children included) to an unfamiliar role of life. Biases enter as clinicians use their own frame of references as a rubric to make judgments regarding dysfunctional and pathology of children and adolescents.

Reducing Cultural Bias
The DSM-IV made efforts to reduce cultural bias. The first step involves examining the individual in the context of their cultural background. It is important for the clinician to consider the environment to child is being reared in, significant relationships, cultural norms outside of “normal society” perspective, etc. When looking at the criteria for schizotypal personality disorder, “odd” is used to describe various behaviors. The ensuing question should be, “Is the odd behavior consistent/inconsistent with cultural norms and expectations?” If the behavior reflects traditional background elements, then the child/adolescent can not be diagnosed with this personality disorder.

The second safeguard included in the DSM-IV deals with the magnitude the possible disorder places on the child/adolescent. The disorder has to lead “to clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 1994, p.630). The resiliency and adaptability levels of many ethnic minorities in the United States are extremely high. As a result, these individual may employ non-traditional and uncharacteristic functional levels in different environments. While their level of functioning may appear chaotic, eccentric, or uncontrollable, it may not present any clinically significant levels of distress or impairment.

While there is no fairy-tale, culturally free assessment, clinicians should make a concerted effort to employ the least biased assessment strategies. Since there is no culturally-free test, Paniagua (2001) suggests that clinicians select and use strategies appropriate strategies with African American, American Indian, Asian, and Latino clients. For example, when diagnosing person with Dependent Personality Disorder the clinician can no rely solely on tests (i.e., MMPI) to assess the adolescent. The results of this test (and the use of others) could be enhanced with the design of an assessment strategy in which the adolescent could record actual behavior indicative of “dependence” on another person. The additional information would help to tease out what may be more of cultural norms than dependence.

Influencing Treatment
Overall, selected diagnostic instruments minimally, at best, recognize how cultural factors can influence the expression and definition of schizophrenia, affective, and personality disorders.

Conclusion
Determining the presence of a personality disorder in a child or adolescent is a daunting task. Even more so, when the child/adolescent is from a different population than what the measure was normed on or the race of the clinician provides additional concern about the correct diagnosis. As Paniagua (2001) states, “Because all behaviors are learned in a cultural context and presented in a cultural context, accurate assessment, meaningful understanding, and appropriate intervention must attend to the cultural
context.” It is important for clinicians to incorporate some understanding of acculturation and enculturation process in our thinking as it can only benefits the children and adolescents being served.

References


