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4. Multicultural Family Assessment

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Assessing individuals who are members of minority or recent immigrant groups creates special and critical challenges for psychologists committed to equitable practices (Dana, 1993). As previous chapters in this volume have shown, the goal of accomplishing valid family assessments is daunting in its own right. Culturally sensitive procedures of family evaluation are, perhaps, even more difficult to conceptualize and administer.

This chapter will examine several issues relevant to expertise in assessing families whose cultural framework differs from the majority of the U.S. population. The topics to be covered include:

1. What is cultural sensitivity?
2. What are the important constructs to assess in families and how might these constructs vary across U.S. minority and recent immigrant groups?
3. How do the most frequently used paper-and-pencil assessment devices appear relative to ethnic diversity concerns?
4. What are some suggestions to promote valid assessment procedures?

Family practitioners rely on valid measurement and interpretations to plan for effective treatments. Families are not diagnosed in the

ways in which individuals are (e.g., personality traits or intelligence), but they are frequent consumers of mental health services. Clients from ethnic minority families present interesting assessment concerns for the practitioner.

CULTURAL SENSITIVITY

Culture is an intricate web of meanings through which people, individually and as a group, shape their lives. Culture, however, does not have absolute predictive power concerning the behavior of members of a group. Further, every culture continues to evolve. It is a set of tendencies or possibilities from which to choose.

Cultural paradigms must be recognized and understood. At the same time, these paradigms must be viewed as broadly comprising cultural tendencies that individual families may accept, deny, modify, or exhibit situationally. Forcing a family or an individual to fit within any preconceived cultural model is not cultural sensitivity—it is stereotyping (Anderson & Fenichel, 1989; Steele, 1990).

An acceptance that certain differences and similarities exist in families across cultural groups characterizes culturally sensitive assessments. These differences are neither good nor bad; better or worse; less or more intelligent. The awareness of this possibility and a flexible repertoire of responses are the important components of multicultural assessments of families.

WHAT IS KNOWN ABOUT HEALTHY FAMILIES?

A growing list of competencies or attributes of families that predict or correlate with positive adjustment for the family has appeared. Some of the important constructs include: good communication skills, excellent problem solving, provision of emotional support, authoritative socialization strategies, provision of child supervision, satisfaction with work, positive orientation toward education, good mental health (or at least the absence of serious psychopathology), no substance abuse, physical affection toward children; successful infant attachment, and good marital or relationship quality.

Successful families are good at managing the stresses within their nuclear or extended group and dealing with the press of other environmental demands. Poverty, unemployment, residence in violent neighborhoods, a history of antisocial behavior in the family, and parental failures in school are all risk factors for family and child adjustment.

Some of the family dynamics just mentioned may present fairly straightforward assessment targets (e.g., where do people live; are

there two responsible adults or an adaptive network of adults to care for children; are the adults employed). Others, however, may be difficult to measure in any family and hard to interpret across cultural groups (e.g., marital quality, socialization strategies, problem solving) (Beavers & Hampson, 1990; Oster & Caro, 1990).

Other chapters in this volume detail assessment issues with majority culture families. The constructs and methods mentioned in those chapters may also be useful with families from many cultures. The application of identical procedures and interpretative norms may, however, result in unreliable and invalid measurement. Results of analyses of minority members' scores on individual personality measures (e.g., Campos, 1989; Dahlstrom, 1986; Greene, 1987; Padilla & Ruiz, 1975; Velasquez, 1992) point out the dangers of using majority culture expectations to interpret minority performance on tests. Such threats to validity are likely to exist at the family level of assessment as well due to differences among family cultural patterns.

MINORITY GROUPS IN THE UNITED STATES

Brief Descriptions

It is common in both everyday language and in professional literature to describe groups of people using "ethnic glosses" (Trimble, 1990–91). That is, most writers (ourselves included) use the terms Native Americans, African Americans, Hispanic Americans, and Asian Americans as if each of these groups contained very similar people (few within-group differences) and were quite different from each other (many between-group differences). Neither of these assumptions is made safely.

Native Americans

The federal government recognizes 517 separate entities of Native American peoples. The states recognize 36 tribes whose members still speak a total of about 149 different languages with many, many related dialects (LaFromboise, 1988; LaFromboise & Low, 1989; Manson & Trimble, 1982). There are about 2 million Native Americans in the U.S. There are many differences among these peoples whose homes range from the arctic regions of Alaska to the deserts of the Southwest and the shores of New England.

African Americans

African Americans account for about 12% of the U.S. population. African Americans tend to share a group identity based on a common historical experience of racism and oppression. Concepts of cultural

orientations and Nigrescence have been used to differentiate individuals within this ethnic group (Cross, 1971, 1978; Thomas, 1971; Parham, 1989; Whatley & Dana, 1989). Four cultural orientations have been described: (a) Afrocentrism; (b) Anglocentrism; (c) bicultural; and (d) marginal. The distinctions refer to an individual's commitment to and pride in traditional African values, or identification with Anglo American priorities, or attempts to be part of both cultures, or finally, to lack a clear commitment to either culture and attempts to survive through cooperation, toughness, suppression of feelings, and a belief in luck and magic (Pinderhughes, 1982).

Nigrescence is a continuum of racial identity that describes an individual's movement from dependence with suppressed rage on white society (i.e., Negromarchy) through steps leading to transcendence that identifies the individual with all of humankind.

Hispanic Americans

By the year 2020 it is estimated that the Hispanic population will grow from 9% of the U.S. total to 15%. There are three major groups of Hispanics (i.e., Mexican Americans, Puerto Ricans, and Cubans). There are, however, another 16 groups of Hispanic Americans that have been identified as ethnic minorities in the U.S. including groups from Central and South American.

The three major groups have different histories of migration to the U.S. and some significant demographic variations among them. Many Mexican Americans came to the U.S. from rural, poverty stricken backgrounds. They arrived with little formal education. In contrast, some groups of Cubans who came were highly educated and relatively affluent. Many of that group thought their stay in the U.S. would be brief. They awaited the overthrow of Fidel Castro in fairly segregated enclaves in southern Florida. (This generalization does not apply to recent waves of poor, mentally ill, and jail inmate Cubans who were probably sent by the Castro government to the U.S.) In contrast, Puerto Ricans (already American citizens) tended to come to New York to find better paying jobs but returned often to their island homes. In fact, the expression Nuyoricans has grown up to describe this group.

Asian Americans

Asian Americans comprise about 32 groups. They represent 4% of the U.S. population and are concentrated in California, New Jersey, Texas, Rhode Island, and Oregon. The primary groups are Chinese, Filipinos, Koreans, Japanese, Asian Indians, and other Southeast Asian groups such as the Vietnamese, Laotians, Cambodians, Hmong, and ethnic Chinese. This Southeast Asian group contains at least an

additional 11 cultural groups. Southeast Asians have a birth rate comparable to Hispanic Americans and are, therefore, a fast growing group in comparison to other Asian groups whose birth rate is lower than Anglo-American rates (Leung & Sakata, 1988).

The different groups have distinct immigration and acculturation experiences. Kitano and Daniels (1988) have done a comprehensive review of these processes. Each group has faced violent racism upon entry to the U.S., which continues today for many of the recent immigrants (Starr & Roberts, 1982).

Most of the research on Asian Americans is based on Japanese and Chinese samples (Morishima, Sue, Teng, Zane, & Cram, 1979; Nakanishi, 1988). The more recently immigrated Chinese and other groups have often arrived in the U.S. with major health problems, as victims of terroristic political persecution, or with overwhelming economic deprivation.

Summary

It should be clear from the previous brief paragraphs that generalizations about our usual ethnic glosses are dangerous. In order to provide some guidance, however, to those wishing to improve their cultural competencies with families it is useful to examine cultural patterns associated with each of these groups. It is also useful to comment on how such patterns may change as families interact with the American host culture. These patterns and changes may be described in numerous ways. For the purposes of this chapter, issues related to family interactions and definition and preferred service providers and systems will be highlighted.

WHO IS THE FAMILY?

The definition of family membership may differ across ethnic groups. Individuals from all the groups mentioned above may describe complicated relationships of obedience, cooperation, respect, and obligation to people beyond a nuclear family. This extended family may include individuals who are not blood relatives especially for Native and African Americans. Assumptions, therefore, about roles in family life and the intensity of various relationships beyond the nuclear family require careful attention (McAdoo, 1979; Myers, 1982; Wilson, 1993).

ROLES IN THE FAMILY

Asian and Hispanic Americans may hold very rigid views about appropriate age and gender roles within families. In particular, Asian American families may be strictly organized with male leadership

and unquestioning obedience to parents and grandparents. Hispanic American families may exhibit traditional values of *machismo* (role of the father to lead, protect, and provide for the family) and *marianismo* or *hembrismo* (role of the wife and mother to be virtuous, nurture the children, and be submissive to her husband's wishes).

Native American families are more difficult to characterize. Individuals may feel responsibility to many people in their community and a traditional respect for elders. In some tribes, women hold visible and influential roles in both tribal governance and family decision making.

African American families, although overtly headed by males, may be best understood by the mother's and other female relatives' leadership. Female children are socialized to be strong and responsible for family welfare (Boyd-Franklin, 1989; Staples, 1988).

Franklin (1993) presents a case study and analysis of the struggles endured by a middle-class African American family man that illustrates the pervasive effects of racism on families. Hersch (1993) examines the experience of two gifted African American children suggesting the same finding that the experience of unremitting racism affects families and individuals in profound ways—often misunderstood by Anglo American psychologists.

Service Provision

Service providers who are unaware of the cultural expectations of each group are likely to have high drop-out rates from therapy and low utilization from minority groups (LaFromboise, 1988). Some illustrations regarding these expectations may be helpful to the reader.

Asian American families may expect deference and careful courtesy from every person involved in a mental health clinic or office. Providers are often expected to meet and greet the family in the waiting room and direct conversation to the oldest member of the family. These families may evaluate providers upon their obvious expertise in terms of credentials, publications, and other accomplishments. Older male providers will have more immediate credibility than younger females.

Native, Hispanic, and African American families tend to value egalitarianism from the service provider. Families may expect the provider to chat with them and be very friendly and cordial. In fact, they may build rapport more readily if the provider has several connections with them (e.g., friend of a friend, relative, known in another capacity). The usual trappings and distance of professionalism may impede the development of a therapeutic relationship (Bailey, 1987; Farris, 1978; Locust, 1986; Samora, 1979). Native American

families expect providers to be respectful, tolerant, accepting of life and other people, family oriented, generous, cooperative, flexible, and to have a sense of humor (Kemnitzer, 1973)! They may respect advisors for the kind of people they are rather than for their specific skills, task orientation, or material possessions (Lewis & Gingerich, 1980).

The Spanish word *simpatia* captures the interactional script expected by some Hispanic Americans and likely useful with Native and African Americans as well. This refers to the providers' tendency to be positive and to avoid negative, competitive, and assertive interactions. Other informative Spanish descriptors of interactional style are *respeto*, *personalismo*, *platicando*, and *ambiente*.

> Respeto, or respect, is accorded by younger to older persons, by women to men, and to persons in authority or higher socioeconomic positions. Personalismo refers to a preference for personal, informal, individualized attention in relationships, including those at work and in politics. Platicando, or chatting, is used to create a warm and accepting atmosphere that is called "ambiente" and is characteristic of personalismo. (Dana, 1993, p. 70)

Therapeutic Issues

Members of each minority group may behave in ways that do not match the expectations of Anglo American providers. Further, these clients' basic understandings of health and illness may be unfamiliar to Anglo American providers.

Behavior

African American men and women and Hispanic American men may speak easily on certain topics to service providers from any cultural background, but may be quite reluctant to discuss personal issues at any meaningful depth. Native Americans, Hispanic American women, and most Asian Americans tend to be very quiet. Their silence might be mistaken for resistance. In fact, they have learned that silence in the face of an authority figure is courteous behavior. Among many Native American groups, lots of talking is generally considered impolite behavior. Asian Americans may expect the provider to learn what is wrong in rather indirect ways and provide directives for change. Rehashing family attempts to solve problems may be seen as disrespectful and useless.

Although African American women are likely to speak for the family no matter who is present, women from the other families tend to defer to the adult men. Even if the women disagree with the men

or have other therapeutic agendas, it is possible these will not be mentioned unless the women are seen alone.

Service providers might expect very long rapport building periods with African and Native Americans. A relationship called *confianza en confianza* (trusting mutual support) must be established for genuine therapeutic alliances to be forged. African and Native Americans have every reason not to trust Anglo-American providers. The provider may have to prove himself or herself worthy over time. This worthiness will be judged not by the usual trappings of expertise (i.e., how many diplomas on a wall) but by the attitudes, trustworthiness, and availability of the provider (Gibbs, 1988; Gibbs & Huang, 1985).

Even well-intentioned providers can fail this test because they have been taught to interpret certain behaviors in ways that are probably not universally correct. For example, some therapists interpret a client's tardiness or unwillingness to engage in future planning as resistance to therapy. Members from the minority groups, however, may not view appointment times as very important. In fact, they may find the lock step office procedures of many mental health service centers to be offensive or, at least, unhelpful. They may be late for appointments and seem unmoved by the fact they have 50 minutes to discuss their difficulties. Such discussion may take significantly longer or be quite brief. The notion that personal relationships are ordered by time periods may seem very foreign to some clients. They may also not connect to future orientations and long-term planning as being relevant to their current difficulties.

African American families may contain some very angry members. The assertive expression of this anger is frightening to some Anglo American therapists. Its suppression, however, is likely to make genuine communication unlikely (Franklin, 1993). A therapist may have to show the street-smart skill of meeting the unwavering, angry gaze of an African American with calmness, compassion, and perseverance.

Understanding of Difficulties

Most dominant culture members understand physical illness as due to biological difficulties. Their understanding of mental illness is likely to be less clear but often they believe that with personal effort their psychological problems can be alleviated. Whatever their understandings of etiology, majority culture members tend to seek professionally trained, expert help when faced with illnesses.

Hispanic and Native Americans may have a more spiritually based understanding of illness. They may believe illness represents

a life that is out of balance because of bad behavior or that evil forces are acting upon the sick or disturbed patient. They may feel more comfortable turning to traditional healers within their own communities to assist them in dealing with illness (Delgado, 1988). Traditional healers often have other jobs (in addition to healing), but still occupy influential positions in many ethnic minority cultures.

Asian American families rarely come to psychologists for emotional or personality problems. Their most frequent use of mental health services concerns vocational and educational counseling (Tracey, Leong, & Glidden, 1986). It is likely they would care for emotionally disturbed family members without professional intervention until such home care became completely impossible (Lin, Inui, Kleinman, & Womack, 1982). Mental illness may still carry a significant stigma in Asian American families representing a failure of the parents to raise children with the appropriate behaviors.

Some Asian Americans may somatize their psychological difficulties. The appearance of physical symptoms due to emotional distress appear commonly in Asian American communities (T.Y. Lin, 1982, 1983, 1990). Neurasthenic reactions may be observed in reaction to a variety of social and personal stresses.

All of the U.S. minorities may have difficulty believing that discussion of difficulties has any value. If their orientations are somewhat external (i.e., the problem is out there and must be fixed by an expert) then Anglo talk therapies appear irrelevant at best. The therapeutic demands for self-disclosure may seem very dangerous given the way most minority groups have been victimized by the dominant culture (Boyd-Franklin, 1993).

Summary and Review

Experts in family assessment may find it useful to pay special attention to a number of issues. A review of existing literature and analysis of our clinical experiences suggest that dominant culture service providers should pay special attention to the following dynamics or constructs. Each of these may vary in ways that make diagnostic impressions based on Anglo-American norms invalid and typical intervention suggestions inappropriate.

Questions about Family Roles

What are the differential expectations toward sons and daughters? Are the son's accomplishments and obedience seen as vitally important to the family's honor and long-term viability? Is the daughter viewed as only a visitor who will someday contribute to her husband's family?

Does the daughter-in-law owe special allegiance and obedience to her mother-in-law?

How influential is the extended family? Is their approval required before decisions can be made?

Are both husband and wife expected to be monogamous? What are the accepted responses toward infidelity?

Are the couple and family comfortable with rigid gender roles? Are the roles complimentary in terms of providing senses of purpose and worth to each member?

How are children to be raised? What are the expectations concerning their behavior in terms of reaching developmental milestones (e.g., toilet training) and in their interaction with adults (e.g., silent, docile, or argumentative and assertive)? What is used to manage their behavior? Considerations of shame and honor may be more powerful than appeals to personal accomplishments or mastery.

How is the family defined? Are there members who are not related by blood or marriage but are nonetheless important sources of support or disturbance?

Personality Factors

Is the family best characterized as optimistic about their abilities to change their situation or pessimistic and fatalistic about their position? Fatalistic world views are common among some minority groups and do not suggest depression or lack of problem-solving skills.

Does the family value independence and individuation or emphasize interdependence? Families may not recognize the value of adult children going off on their own or be impressed by or supportive of individual achievements.

How open is the family? Self-disclosure is valued by mainstream therapists but may be quite offensive to some family members. Because their individual assessments of a situation are considered not important and likely to cause confrontation, talking about personal feelings and opinions may be considered bad manners and irrelevant.

What are the family members' construction of "self?" The Lakota Sioux word *tiospaye* refers to an extended self-concept that includes all family and other relationships necessary for survival. Personal self and needs and rights to become self-actualized may be confusing concepts outside of Anglo American groups.

Belief Systems

How is formal education viewed? Is it seen as equally relevant to men and women? How do family members prefer to learn? Native

American clients report finding informal settings in which they can listen and observe without evaluation or demands for contributions to be the most beneficial.

How powerful is religion or spiritual systems among family members? Sensitivity to religious beliefs is always an important therapeutic issue. This mandate is made more complex by the relative lack of information Anglo American practitioners may have about Native and Hispanic American spirituality and eastern religions.

What is the time orientation of the family? Does a future orientation to problem solving make sense with all families? What are the norms of the family regarding punctuality or scheduling?

How is illness understood? Is there shame? Does a particular symptom represent a punishment? Some Native American groups believed that epilepsy was a punishment for sibling incest. Some Hispanic Americans may believe their difficulties are due to *mal ojo*, that is, an evil curse from another.

Does dominant culture intervention seem relevant to etiological and other cultural beliefs? Should traditional healers from certain groups be involved in treatment programs?

Interpersonal and Interactional Styles

Is rapport and understanding possible if English is used as the second language? Some writers feel that bilingualism is an absolute necessity to really understand what the family is reporting.

What are the parameters associated with personal space? How much touching is considered appropriate? Who can touch whom?

What are nuances of body language? Some Native American groups consider pointing at another to be extremely rude. Some African Americans use what seems to be a signal to move away (i.e., arm and hand waving away from the body) that may actually be an invitation to come closer.

What are the norms of courtesy? Eye contact is sometimes considered to be impolite. In some families only the oldest member should be addressed. How much small talk should be used before (what the service provider considers to be) the session begins? Can first names be used? The safest strategy is to address any older male by a title until given permission to use a first name. How is dress interpreted? Asian Americans may find a casually dressed provider to be unacceptable whereas Native Americans may find those clothed in suits and ties to be too distant to be helpful.

What does yes mean? Among some Southeast Asian immigrant groups a yes means, "I heard you." It does not mean, "I will follow your suggestions."

Does the family value a personal connection to the service provider? In contrast to typical professional norms, some families may want to consult relatives and friends regarding problems. They may come because of knowing the provider in another capacity. The meaning of dual relationships may be difficult to translate to some groups.

Acculturation

All the dynamics suggested in the preceding sections are influenced by the degree to which client families are acculturated to the dominant U.S. culture. Acculturation refers to the learning that occurs among members of minority cultures as a result of their interface with the dominant culture (Padilla, 1980).

Berry (1980) suggested that acculturation occurs in individuals across six dimensions of psychological functioning: language, cognitive styles, personality, identity, attitudes, and acculturative stress. The most obvious measure of acculturation is language. Other signs of increasing acculturation are food preferences, choices of media and entertainment events, knowledge of national history (i.e., which history is known—the new host culture or the original culture), choices of friends for recreational events, and adoption of the norms and values of the host culture.

The level to which minority group members have acculturated to the dominant culture has been shown to have an effect on their mental health status. In general, high levels of acculturation are related to substance abuse, increased risk-taking behaviors, reductions in social support, and general decreases in mental health adjustment ratings (Graves, 1967; Padilla, 1980; Newton, Olmedo, & Padilla, 1982; Szapocznik & Kurtines, 1989).

This finding may appear paradoxical. It seems that current measurement may capture a dimension of acculturation, that is, loss of the culture of origin without ascertaining if another adaptive framework has been developed. Mental health difficulties may arise because individuals have left one system but have little comfort with or acceptance in the other system. African Americans who are described as marginal fit this definition.

Some families may seek professional help because of conflict caused by the discrepancy between the acculturation levels of different generations. Japanese Americans have names for each generation

away from birth in Japan (i.e., issei, nisei, sansei, and yousei). A common conflict within this group is the younger generation's rejection of traditional religious, family, and social norms.

Assessment Approaches

There are multiple strategies for evaluating family functioning and multiple targets to consider. Paper-and-pencil normative tests are not as widely used for families as they are for individual assessment. Interviews, observation, and enactments are more frequently utilized.

CRITIQUE OF EXISTING PAPER AND PENCIL FAMILY ASSESSMENTS

Paper-and-pencil measures may not be the most culturally sensitive methodology a practitioner can employ to assess a family from an ethnic minority culture. Bray (Chapter 3 of this volume) notes that most models of family relationships are based on Anglo middle-class families. As a result, most paper-and-pencil measures used to assess family relationships have not been validated with families from diverse ethnic backgrounds.

Family Adaptability and Cohesion Evaluation Scales

Halverson (Chapter 1 in this volume) describes the Family Adaptability and Cohesion Evaluation Scales (FACES; Olson, Portner, & Lavee, 1985) as the benchmark for family assessment. Unfortunately, the norms for the FACES III do not consider cultural and ethnic diversity. The authors of the FACES suggest a practitioner account for cultural ethnic diversity by having family members complete the scale twice—once in reference to how they perceive the family and again for how they ideally would like their family to operate. Olson et al. (1985) also suggest that completion of the Family Satisfaction Scale (Olson & Wilson, 1982) by ethnic minority culture family members will provide helpful information to a practitioner.

If a practitioner wishes to compare a family to the normative group, however, it must be remembered the FACES norm group may not have included members of the particular ethnic culture. Further, a review of certain items that make up the constructs of cohesion and adaptability may give rise to some concern regarding cultural sensitivity.

Family cohesion is defined as emotional bonding that family members have toward one another. It is measured by items such as:

> Family members feel very close to each other
> Family members feel closer to people outside of the family than to other family members

In our family everyone goes his/her own way
Our family does things together
Family members avoid each other at home
Family members know each other's close friends
Family members consult other family members on their
    decisions
We have difficulty thinking of things to do as a family

Family adaptability is defined as the ability of the marital or family system to change its power structure, role relationships, and relationship rules in response to situation and developmental stress. It is measured by such items as:

Family members say what they want
Each family member has input in major family decisions
Children have a say in their discipline
When problems arise, we compromise
In our family, everyone shares responsibilities
It is difficult to get a rule changed in our family
In our family it is easy for everyone to express his/her
    feelings
Discipline is fair in our family

It seems clear that at least several of these items may mean something in the Anglo American culture and something very different among certain minority families.

Family Environment Scale

Another frequently cited assessment tool, the Family Environment Scale (FES) developed by Moos and Moos (1986), may be used by practitioners to measure the social-environmental characteristics of families from a variety of backgrounds. This scale has been translated into 11 languages including Chinese, French, Korean, and Spanish, which may aid the practitioner who administers it to families with primary languages other than English. In addition, the normative sample includes a small group of Hispanic and African American families. Due to the norming sample not being matched on community size or socioeconomic status, however, the results must be interpreted with caution when used with families from minority cultures.

The FES describes a family's characteristics on the dimension of relationships, personal growth, and system maintenance. The constructs included within these dimensions are cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-

religious emphasis, organization, and control. In name, some of these constructs consider cultural diversity. Because well-constructed norms are not available for minority groups, however, a client's responses may be misinterpreted by a practitioner using the FES for family assessment. Items on the FES that may be problematic include:

> Family members often keep their feelings to themselves
> We fight a lot in our family
> We often talk about political and social problems
> Family members attend church, synagogue, or Sunday School fairly often
> In our family, we are strongly encouraged to be independent
> There is one family member who makes most of the decisions
> Family members strongly encourage each other to stand up for their rights

Like statements on the FACES, the above FES items may have multiple meanings across various minority families.

Other Approaches

Many familiar and innovative methods may be useful with families if a careful analysis is done to insure the methods are congruent with the cultural norms of the family (Patterson, Reid, Jones, & Conger, 1975; Reid, 1978). Parent interview formats have been described by several authors (Aponte, 1976; Fine & Holt, 1983; Friedman, 1969; Golden, 1983).

If family interviewing is impractical, information from the child-administered assessments can also be instructive (Anderson, 1981). For example, the California Test of Personality (Thorpe, Clark, & Tiegs, 1953), Mooney Problem Checklist (Mooney & Gordon, 1950); Offer Self-Image Questionnaire for Adolescents (Offer, 1979); Self-Concept and Motivation Inventory (Farrah, Milehus, & Reitz, 1977) are all general personality tests that have scale scores reflecting family processes.

More specific devices to administer to children include the Behavior Rating Profile (Brown & Hammill, 1983); Child Report of Parent Behavior Inventory (Schaefer, 1965); Child's Attitude toward Mother and Father Scales (Guili & Hudson, 1977); and the Family Relations Test (Bene & Anthony, 1978).

A number of instruments can also be completed by parents to derive information about their child and about their child in the home. Some of these include the Becker Adjective Checklist (Patterson et al., 1975); Revised Behavior Problem Checklist (Quay, 1987); Child

Behavior Profile (Achenbach & Edelbrock, 1991); Eyberg Child Behavior Inventory (Eyberg, Hiers, Cole, Ross, & Eyberg, 1980); and the Parent Daily Report (Patterson et al., 1975).

Another very simple, but useful assessment, goal setting, and monitoring device is an ecomap (Newbrough, Walker, & Abril, 1978). The ecomap graphically represents each system involved with the identified child (e.g., family, church, YWCA, peers, probation) and notes the quality of the relationships among all of the systems. Goals to make the system supportive of change are set and monitored by updates of the ecomap. Essentially, the ecomap turns attention to the qualities of the boundaries surrounding clients as well as to their individual experiences.

Conclusions

Although this brief critique suggests the most frequently cited family assessment tools are not useful for normative comparisons, a therapist may be able to obtain important information under certain conditions. If a measure can be administered in the primary language of the family and the family's priorities match the constructs measured by the instruments, the therapist may use change on the measure following therapy as a means for tracking family members' views on aspects of family life.

INTERVIEWS, OBSERVATIONS, AND ENACTMENTS

Family assessment may be done with the greatest cultural sensitivity and competence using interviews, observations, and enactments. An important axiom to consider is that the solution to any family problem lies within the family's own definition of reality. If practitioners believe this, then a deep understanding of the family ecosystem must be attained before therapists can have confidence in their interpretations and suggestions.

Interviews

An interview format that may be helpful follows. The key ingredients are excellent listening and suspension of personal cultural assumptions. Own up to ignorance when appropriate and ask questions that illustrate an interest in knowing about the family's background.

1. Determine what language should be used. If an interpreter must be used, the person should be one trusted by the family and knowledgeable about nuances in both languages. Even with an interpreter, the validity of the assessment may be compromised.

2. A focus on family strengths will be most respectful. Seeking out family successes and resources is far more useful than trying to determine a psychiatric diagnosis for family members. Many families will not have understandings of difficulties that come close to DSM-IV categories and language difficulties tend to make minority members appear more pathological than they are. In addition, most interventions that will be suggested rely on existing behavioral repertoires. Identification of these is likely to be most critical. For at least these three reasons, an emphasis on strengths is desirable.

3. What are this family's priorities? Service providers make frequent mistakes by assuming what changes are desired by families. Although family therapy may result in clients learning and using strategies modelled or taught by a therapist, therapists should not teach clients to act like Anglo Americans. Therapists aim to make existing systems work within the framework of general understandings of mental health, but must do so with a special sensitivity to cultural variations.

4. What aspects of family life does the family see as important and affecting their priorities? Cause and effect relationships are sensitive to cultural interpretations. It is best to find out what family members believe about how they are involved in problem definition and maintenance before offering an interpretation.

5. What are the family's perceptions of situations and events that affect them? It is common to misconstrue the importance of certain phenomena across cultures. The trust in a therapist will be shattered if a common understanding of what really matters cannot be reached.

6. Check frequently if goals are being met and if services are matching expectations. For example, Sue and Zane (1987) suggest that Asian American clients need some immediate result from therapeutic intervention (e.g., reduction of anxiety, normalization of symptom, relief of depression) for them to continue with services. On the other hand, some Native Americans may take quite a long time before trusting a therapist with important information and may not expect much to change on the basis of their interactions with the therapist.

7. If certain paper-and-pencil instruments must be used, they require scrutiny by culturally aware professionals, community leaders, and family members prior to administration.

8. In contrast to other paper-and-pencil devices (e.g., Moos & Moos, 1986; Olson, Fournier, & Druckman, 1982; Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1982; Olson, Portner, & Lavee, 1989), practitioners might consider careful use of family genograms

(McGoldrick & Gerson, 1985). Genograms focus attention on the complexity of family interrelationships allowing family members to describe the intensity and quality of each of the interactions via graphic representations.

Genograms allow the practitioner and family members to develop hypotheses regarding how a clinical difficulty may be connected to the family system and the evolution of the difficulty over time. McGoldrick and Gerson (1985) provide an interview format that practitioners may find useful. It is a tool for gaining important information from family members about the present living situation, the extended family context, social context, family relationships and roles, and individual issues. Because nuclear and extended family members are included in a genogram, it may be especially suited for use when serving families from minority cultures.

An Illustration

Some of the interpretive pitfalls associated with interviewing minority families may be illustrated by the following. Waterman (1982) suggested a very useful set of questions to use with families who have children with disabilities. Consider each of these from the perspectives of the minority groups described throughout this chapter. (Waterman's questions are paraphrased in italics. Our commentary follows each.)

Do both parents participate with the children? It is a modern Anglo American ideal that both parents have an equitable interaction with their children (especially children with difficulties). Would families from other cultures expect this? Probably not. Who are the caretakers of sick children or children with disabilities in minority families? Can we assume the mother and father of the nuclear family are the most likely ones to shoulder this responsibility?

Are parents overprotective or rejecting or disengaged? What do these terms mean in different cultures? Some Hispanic American girls are never permitted to play out of doors except under the direct supervision of an adult. Is that "overprotective"? Asian Americans may care for their children with disabilities at home and seek help only in the most serious cases. Is that overprotection, rejection, or disengagement? If a child's disability is seen as punishment for family wrongdoings, is that evidence of rejection? Lin et al. (1982) describe a pattern of love, denial, and rejection to characterize Asian American families' reaction to mental illness within the family.

Some Native American families have been seen as rejecting and disengaged toward their children because of the flexible kinship

structure in which adults may informally share responsibility for children and the apparently permissive style of parenting that predominates (Attneave, 1982; Locust, 1988; Medicine, 1981).

Do the parents project their anger on each other or on a child? What are cultural expressions of anger? Will it always be recognized by a therapist? How much anger is normative given experiences of racism and oppression? Is anger the most likely emotion to be evoked by a child with a disability? Perhaps guilt, shame, and dishonor are more typical reactions.

Can the children access the parents appropriately? What levels of interaction are normal for different groups? How do children usually get the attention of adults in their culture? Are they supposed to ask for attention?

Is information kept within subsystems? What are the operative subsystems? Some groups may expect women relatives to speak together about family matters or that male elders will be consulted on all decision making. It may be hard to distinguish triangulation in communication when a therapist is not sure who is supposed to know information in certain systems. Anglo American therapists emphasize the husband-wife dyad as appropriately the most intense in a family. This may not be true for many Asian American families (Tamura & Lau, 1992) in which the mother-child dyad (especially between mother and son) is the strongest.

Is nurture and support available within and across subsystems? What are the cultural norms for support? What does nurturing behavior look like? There may be very high expectations for help from extended families that seem unreasonable to an Anglo American therapist, but very normative to certain groups. Expressions of love may be verbal, or physical, or through tangible gifts or goods. Some groups may find expressions of affection to be irrelevant to the quality of their relationships with each other.

Does each system have time alone with its members? To understand alone, a therapist must understand the conception of self. Dominant culture Americans view self in terms of separateness. Many Asians may see self more holistically, feeling identity as belonging to a group of family members, classmates, or company colleagues. In addition, cultural expectations regarding private times may vary as a function of cultural preferences or as a result of economic pressures. There is no word for privacy in Japanese indicating that at least among traditional Japanese the notion of privacy was not valued (Tamura & Lau, 1992). Families who live in one or two rooms, work 16 hours each day, and are responsible to an

extended family network are not likely candidates for private times between spouses.

Observations and Enactments

Important family functions can be assessed using behavioral observations. Reliability will vary, of course, depending on the particular techniques and time allotted for the observation. Validity will depend on the practitioner's abilities to choose important observation targets and to interpret the meaning the family members ascribe to the behaviors.

Naturalistic observations are often difficult to arrange. Asking the family to enact various scenarios creates some threats to validity, but does allow the practitioner to see family members in action with each other. Family members can be asked to accomplish a task (e.g., plan an outing or decide on a way to manage a child's school problems) during a therapy session. Choice of the task would be dictated by the presenting priorities and culturally relevant information. Practitioners could gain information about communication patterns, problem solving, family roles, and socialization strategies with just these two tasks.

Another facet of using observational data as the basis for assessment is the possibility of obtaining multirespondent information. In addition to getting individual family members' descriptions of family issues, practitioners can often access teacher descriptions of child behavior. Multimethod and multisource assessments may be very useful as long as family norms for privacy and communication are carefully followed. In some families, individual sessions may be necessary to gather impressions because family members may not confront each other directly.

COMMON MENTAL HEALTH OBJECTIVES

Although mental health probably has many different definitions across U.S. ethnic minority groups (e.g., are you in touch with your feelings or do you successfully repress them for a common good?), there are some goals common to all forms of therapeutic intervention (Madanes, 1990). Each of the goals may be reached in diverse ways depending on cultural expressions and preferences. Whatever the cultural group under consideration, therapists who accept these goals are likely to do less harm than those who do not use them as standards.

Therapists should be seeking information and developing interventions that help them to assist their clients to: (a) control their actions so as to be successful in their chosen tasks; (b) control their

thoughts so as to focus their cognitive and emotional energy in productive ways; (c) control violence and anger so that innocent victims are not created and negative cognitive/emotional cycles are avoided; (d) promote empathy so that clients understand the position of others and can choose to use that information if they wish; (e) promote hopefulness in either individual action or collective success—all clients must be able to imagine they will be successful; (f) promote tolerance so that energy can be focused on adjustment and not wasted on hatred of other individuals or groups; (g) encourage forgiveness so that a present or future orientation may be used, thus, allowing for action in the present; and (h) promote harmony and balance that permits a range of human behavior to emerge.

CONCLUSIONS

Careful study of multicultural family measurement issues suggests that culturally sensitive assessment requires broad and deep understandings and a commitment to emic (ideographic/case study knowledge) approaches of assessment. There are many potential sources of confusion when attempting a multicultural practice (Sue, 1991). The most pervasive danger is applying some normative (or etic) constructs to a group without careful validity studies. At this point in time, only emic approaches can be attempted with any safety.

Another problem may be practitioner's beliefs about assimilation versus pluralism (Sue, 1991). Some psychologists may still believe in the melting pot metaphor and expect that ethnic differences will disappear over time. They may assume such homogeneity is preferable to enduring ethnic differences. These practitioners may fear the conflict caused by the clash of cultural norms.

Others believe the differences among the peoples who make up our nation (i.e., a commitment of memory to ethnic group strengths) is what provides the unique and remarkable success of the United States. From this perspective, differences are embraced as complimentary patterns that provide for cultural resilience. Practitioners from this orientation may be interested in acculturation measures as moderators to performance on various psychological tests, but would consider variations among people to be strengths.

Another common cause of confusion, introduced early in this chapter, is a tendency to develop descriptions of group personalities that limit our abilities to recognize individual differences among members of a group. The process of trying to understand minority and recent immigrant groups can inadvertently lead to stereotyping if general statements are confused with personal realities.

Finally, throughout the experience of minority families are the unremitting, humiliating, enraging realities of racism. Those who practice professional psychology must confront racism in their own assumptions and behaviors and learn to identify the effects of racism on their clients. For many of the families who might seek mental health assistance, their everyday life is spent in a toxic environment of hatred, fear, and aggression. We must all be wary of blaming our clients for the environmental stress they endure by using assessment procedures that are insensitive to their contexts.

A challenge of family assessment is to characterize a group of people in meaningful ways. The further challenges of assessing multicultural families are to identify valid targets for measurement and assessment strategies that take into account the costs of being different in the United States of America.

REFERENCES

Achenbach, T.M., & Edelbrock, C. (1991). Revised Child Behavior Profile. Burlington, VT: University Associates in Psychiatry.

Anderson, C. (1981, April). *Family-oriented assessment techniques for school psychologists*. Paper presented at the annual meeting of the National Association of School Psychologists, Detroit, MI.

Anderson, P. P., & Fenichel, E. S. (1989). *Serving culturally diverse families of infants and toddlers with disabilities*. Washington, DC: National Center for Clinical Infant Programs.

Aponte, H. J. (1976). The family-school interview: An eco-structural approach. *Family Process, 15*, 303-311.

Attneave, C. (1982). American Indians and Alaska Native families: Emigrants in their own homeland. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.). *Ethnicity and family therapy* (pp. 55-83). New York: Guilford.

Bailey, E. (1987). Sociocultural factors and health care-seeking behavior among Black Americans. *Journal of the National Medical Association, 79*, 389-392

Beavers, W. R., & Hampson, R. B. (1990). *Successful families: Assessment and intervention*. New York: Norton.

Bene, E., & Anthony, J. (1978). Family Relations Test. London, England: NFER Publishing.

Berry, J. (1980). Acculturation as varieties of adaptation. In A. M. Padilla (Ed.), *Acculturation: Theory, models, and some new findings* (pp. 9-25). Boulder, CO: Westview Press.

Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach*. New York: Guilford.

Boyd-Franklin, N. (1993). Pulling out the arrows. *Networker*, *17*(4), 54-56.

Brown, L. L., & Hammill, D. D. (1983). Behavior Rating Profile. Austin, TX: PRO-ED, Inc.

Campos, L. P. (1989). Adverse impact, unfairness, and bias in the psychological screening of Hispanic peace officers. *Hispanic Journal of Behavioral Sciences*, *11*, 127-135.

Cross, W.E., Jr. (1971, July). The Negro-to-black experience. *Black World*, 13-27.

Cross, W. E., Jr. (1978). The Thomas and Cross models of psychological Nigrescence: A review. *Journal of Black Psychology*, *5*, 13-31.

Dahlstrom, L. E. (1986). MMPI findings on other American minority groups. In W. G. Dahlstrom, D. Lachar, & L. E. Dahlstrom (Eds.), *MMPI patterns of American minorities* (pp.50-86). Minneapolis: University of Minnesota Press.

Dana, R.H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston: Allyn and Bacon.

Delgado, M. (1988). Group in Puerto Rican spiritism: Implications for clinicians. In C. Jacobs & D. D. Bowles (Eds.), *Ethnicity and race: Critical concepts in social work* (pp. 34-47). Silver Spring, MD: National Association of Social Workers.

Eyberg, S., Hiers, T., Cole, K., Ross, A. W., & Eyberg, S. (1980). *Parent-child interaction training*. Charleston, SC: CAMHC.

Farrah, G. A., Milehus, N. J., & Reitz, W. (1977). *The Self-Concept and Motivation Inventory: What Face Would You Wear?* Dearham Heights, MI: Person-O-Metrics, Inc.

Farris, L. (1978). The American Indian. In A. L. Clark (Ed.), *Culture/childbearing/health professionals* (pp. 20-33). Philadelphia: F.A. Davis Co.

Fine, M. J., & Holt, P. (1983). Intervening with school problems: A family systems perspective. *Psychology in the Schools*, *20*, 59-66.

Franklin, A. J. (1993). The invisibility syndrome. *Networker*, *17*(4), 32-39.

Friedman, R. (1969). A structured family interview in the assessment of school learning disorders. *Psychology in the Schools*, *6*, 162-171.

Gibbs, J. T. (1988). *Young, black, and male in America: An endangered species*. Dover, MA: Auburn House Publishing Co.

Gibbs, J. T., & Huang, L. N. (1989). *Children of color: Psychological interventions with minority youth*. San Francisco: Jossey-Bass Publishers.

Golden, L. (1983). Brief family interventions in a school setting. *Elementary School Guidance & Counseling*, *17*, 288-293.

Graves, T. D. (1967). Acculturation, access, and alcohol in a tri-ethnic community. *American Anthropologist, 69*(3-4), 306-321.

Greene, R. L. (1987). Ethnicity and MMPI performance: A review. *Journal of Consulting and Clinical Psychology, 55,* 497-512.

Guili, C. A., & Hudson, W. W. (1977). Child's attitude toward mother and father. *Journal of Social Service Research, 1,* 77-92.

Hersch, P. (1993). Young, gifted and trapped. *Networker, 17*(4), 40-49.

Kemnitzer, L. S. (1973). Adjustment and value conflict in urbanizing Dakota Indians measured by Q-Sort technique. *American Anthropologist, 75,* 687-707.

Kitano, H. H. L., & Daniels, R. (1988). *Asian Americans: Emerging minorities.* Englewood Cliffs, NJ: Prentice-Hall.

LaFromboise, T. D. (1988). American Indian mental health policy. *American Psychologist, 43,* 388-397.

LaFromboise, T. D., & Low, K. G. (1989). American Indian children and adolescents. In J. T. Gibbs & L. N. Huang (Eds.), *Children of color: Psychological interventions with minority youth* (pp. 114-147). San Francisco: Jossey-Bass.

Leung, P., & Sakata, R. (1988). Asian Americans and rehabilitation: Some important variables. *Journal of Applied Rehabilitation Counseling, 9*(4), 16-20.

Lewis, R. G., & Gingerich, W. (1980). Leadership characteristics: Views of Indian and non-Indian students. *Social Casework: The Journal of Contemporary Social Work, 61*(8), 494-497.

Lin, K. M., Inui, T. S., Kleinman, A. M., & Womack, W. M. (1982). Sociocultural determinants of the help-seeking behavior of patients with mental illness. *Journal of Nervous and Mental Disease, 170,* 78-85.

Lin, T. Y. (1982). Culture and psychiatry: A Chinese perspective. *Australian and New Zealand Journal of Psychiatry, 16,* 235-245.

Lin, T. Y. (1983). Psychiatry and Chinese culture. *Western Journal of Medicine, 139,* 862-867.

Lin, T. Y. (1990). Neurasthenia revisited: Its place in modern psychiatry. *Culture, Medicine and Psychiatry, 14,* 105-129.

Locust, C. (1986). *Hopi beliefs about unwellness and handicaps.* Tucson, AZ: University of Arizona

Locust, C. (1988). Wounding the spirit: discrimination and traditional American Indian belief systems. *Harvard Educational Review, 58,* 315-330.

Madanes, C. (1990). *Sex, love, and violence: Strategies for transformation.* New York: Norton.

Manson, S. M., & Trimble, J. E. (1982). American Indian and Alaska Native communities. In L.R. Snowden (Ed.), *Reaching the underserved: Mental health needs of neglected populations* (pp. 143-163). Beverly Hills, CA: Sage.

McAdoo, H. (1979, May). Black kinship. *Psychology Today*, 67-110.

McGoldrick, M., & Gerson, R. (1985). *Genograms in family assessment*. New York: Norton.

Medicine, B. (1981). American Indian family: Cultural change and adaptive strategies. *Journal of Ethnic Studies, 8*(4), 13-23.

Mooney, R. L., & Gordon, L. V. (1950). Mooney Problem Checklist. Cleveland, OH: Psychological Corporation.

Moos, R., & Moos, B. (1986). *Family Environment Scale manual*. Palo Alto, CA: Consulting Psychologists Press.

Morishima, J., Sue, S., Teng, L. N., Zane, N., & Cram, J. (1979). *Handbook of Asian American/Pacific Islander mental health research*. Rockville, MD: National Institute of Mental Health.

Myers, H. F. (1982). Research on the Afro-American family; A critical review. In B. A. Bass, G. E. Wyatt, & G. J. Powell (Eds.), *The Afro-American family: Assessment, treatment, and research issues* (pp. 35-68). New York: Grune & Stratton.

Nakanishi, D.T. (1988). Seeking convergence in race relations research: Japanese-Americans and the resurrection of the internment. In P. A. Katz & D. A. Taylor (Eds.), *Eliminating racism: Profiles in controversy* (pp. 159-180). New York: Plenum.

Newbrough, J. R., Walker, L., & Abril, S. (1978, April). *Workshop on ecological assessment*. National Association of School Psychologists, New York.

Newton, F., Olmedo, E. L., & Padilla, A. M. (1982). *Hispanic mental health research: A reference guide*. Berkeley, CA: University of California Press.

Offer, P. (1979). *The psychological world of the teenager: A study of normal adolescent boys*. New York: Basic Books.

Olson, D. H., Fournier, D. G., & Druckman, J. M. (1982). *ENRICH*. Minneapolis: PREPARE-ENRICH.

Olson, D. H., McCubbin, H. I., Barnes, H., Larsen, A., Muxen, M., & Wilson, M. (1982). *Family inventories*. St. Paul, MN: Social Science, University of Minnesota.

Olson, D. H., Portner, J., & Lavee, Y. (1985). *FACES III*. St. Paul, MN: Family Social Science, University of Minnesota.

Olson, D. H., & Wilson, M. (1982). Family Satisfaction Scale. St. Paul, MN: Family Social Science, University of Minnesota.

Oster, G. D., & Caro, J. E. (1990). *Understanding and treating depressed adolescents and their families.* New York: Wiley.

Padilla, A. M. (1980). *Acculturation, theory, models, and some new findings.* Boulder, CO: Westview Press.

Padilla, A. M., & Ruiz, R. A. (1975). Personality assessment and test interpretation of Mexican American: A critique. *Journal of Personality Assessment, 39,* 103-109.

Parham, T. A. (1989). Nigrescence: The transformation of Black consciousness across the life cycle. In R. L. Jones (Ed.), *Black adult development and aging* (pp. 151-166). Berkeley, CA: Cobb & Henry.

Patterson, G. R., Reid, J. B., Jones, R.R., & Conger, R.E. (1975). *A social learning approach to family intervention, Volume 1: Families with aggressive children.* Eugene, OR: Castalia Publishing Co.

Pinderhughes, E. (1982). Afro-American families and the victim system. In M. McGoldrick, J.K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 108-122). New York: Guilford.

Quay, H. C. (1987). Revised Behavior Problem Checklist. Odessa, FL: Psychological Assessment Resources, Inc.

Reid, J. B. (Ed.) (1978). *A social learning approach to family intervention, Volume 2: Observation in home settings.* Eugene, OR: Castalia Publishing Co.

Samora, J. (1979). Conceptions of health and disease among Spanish-Americans. *American Catholic Sociological Review, 22,* 314-323.

Schaefer, E. S. (1965). Child report of parent behavior. *Child Development, 36,* 413-423.

Staples, R. (1988). The Black American family. In C.H. Mindel, R. W. Habenstein, & R. Wright, Jr. (Eds.), *Ethnic families in America: Patterns and variations* (pp. 303-324). New York: Elsevier.

Starr, P. D., & Roberts, A. E. (1982). Attitudes toward new Americans: Perceptions of Indo-Chinese in nine cities. In C. B. Marrett & C. Leggon (Eds.), *Research in race and ethnic relations: A research annual* (Vol.3, Part 2, pp. 165-186). Greenwich, CT: JAI Press.

Steele, S. (1990). *The content of our character: A new vision of race in America.* New York: St. Martin Press.

Sue, S. (1991). Ethnicity and culture in psychological research and practice. In J.D. Goodchilds (Ed.), *Psychological perspectives on human diversity in America* (pp. 51-85). Washington, DC: American Psychological Association

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 37-45.

Szapocnik, J., & Kurtines, W. M. (1989). *Breakthroughs in family therapy in drug abusing and problem youth.* New York: Springer Publishing Co.

Tamura, T., & Lau, A. (1992). Connectedness versus separateness: Applicability of family therapy to Japanese families. *Family Process, 31,* 319-340.

Thomas, C.S. (1971). *Boys no more.* Beverly Hills, CA: Glencoe.

Thorpe, P., Clark, W.W., & Tiegs, E. W. (1953). California Test of Personality. New York: CTB/McGraw-Hill

Tracey, T. J., Leong, F. T. L., & Glidden, C. (1986). Help seeking and problem perception among Asian Americans. *Journal of Counseling Psychology, 33,* 331-336.

Trimble, J. (1990-1991). Ethnic specification, validation prospects, and the future of drug use research. *International Journal of the Addictions, 25*(2A), 149-170.

Velasquez, R. J. (1992). Hispanic American MMPI research (1949-1992): A comprehensive bibliography. *Psychological Reports, 70,* 743-745.

Waterman, J. (1982). Assessment of the family system. In G. Ulrey & S. J. Rogers (Eds.), *Psychological assessment of handicapped infants and young children* (pp. 172-178). New York: Thieme-Stratton.

Whatley, P. R., & Dana, R. H. (1989). *Racial identity and MMPI group differences.* Unpublished paper, Department of Psychology, University of Arkansas, Fayetteville, AR.

Wilson, M. N. (1993). A view of African American family life: Thoughts and implications for social research and intervention. *Focus: Notes from the Society for the Psychological Study of Minority Issues, 7*(2), 14-15.