International Research and Practice in Pediatric Psychology: Challenges and New Directions

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International research and practice in pediatric psychology provide an opportunity to learn about children’s health and illness and to share strategies for health promotion and illness prevention across international boundaries. There are many common aspects to children’s health, ranging from biomedical concerns, such as infectious diseases, chronic illnesses, and disabilities, to psychosocial concerns, such as child abuse and neglect. However, contextual and cultural differences are associated with the understanding and interpretation of child health and illnesses across the world. With increasing globalization and the resultant intermingling of cultures, there is much to be gained from a more culturally sensitive approach to the issues of children’s health and illness.

The demand for developing global as well as culturally specific and sensitive measures for evaluating various aspects of children’s health is growing. The necessity to evaluate new treatments involving relatively rare medical and psychological problems, to compare these treatments across cultures, and to monitor the health of diverse cultural and ethnic populations has become salient. To achieve these varied goals, it is often advantageous and relatively easy to use common measures across cultures. For example, pooling data from drug trials may lead to more comprehensive and rapid evaluations of the efficacy of new treatments, rather than relying on studies from one country or culture. Moreover, given the expense involved in developing new measures of children’s health, it is often economically attractive to consider alternatives already available.

However, much caution is warranted when conceptualizing and operationalizing issues of children’s health and illness across cultures. First, it is not appropriate to assume that explanations for children’s health or illness are common across cultures. For example, in India, families often attribute their children’s illnesses to supernatural powers and beliefs such as fate, God’s will, or karma (the cycle of birth and death in which past deeds determine future life forms). Factors considered to be central to Western explanations of illness, such as viruses, bacteria, or behavior, are often disregarded (Kohli & Dalal, 1998). In Korean culture, many people believe that illness among adults or children may be a result of the loss of the mind’s ideal nature (becoming greedy or having too much desire). When the ideal balance is lost, the body may be invaded by harmful spirits, which leads to disharmony between the Yin and Yang (parts of the human body) and causes illness (Kim, 1999). Although these concepts may seem foreign to Western-trained professionals, they often form the spiritual basis of family members’ explanations of their child’s illness and can influence their decisions regarding health-seeking behavior, treatment, and compliance.

Second, the concepts of self-esteem and self-efficacy related to children’s health and illness often have different connotations in Western and Eastern cultures. In Eastern philosophy, the sense of self is group-centered. People often draw on and organize their perceptions about children’s health and illness

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based on their cultural norms. In Western philosophy, the self is more person-centered and behavior is reflective of individual determinants with little or no consideration of group membership. Thus, Western recommendations regarding individual choices to promote health may not be well accepted by families in Eastern cultures unless they are adopted by the cultural group.

Third, strategies for adapting standardized instruments should extend beyond language translation. Translating the words of a questionnaire or interview does not make the questionnaire valid or reliable in another culture. For example, in the translation of the Diagnostic Interview Schedule (DIS) and the Diagnostic Interview Schedule for Children (DISC) from English to Spanish, Canino, Lewis-Fernandez, and Bravo (1997) faced problems finding equivalent Spanish terms and formulating questions so that respondents did not under- or overreport on certain items. When the McCarthy Scales of Children’s Abilities (MSCA) and the Behavioral Style Questionnaire (BSQ) were used with a Jamaican sample, the authors had to make modifications that included the cultural use of certain words and phrases, local pronunciations, and meanings consistent with the country’s dialect (Dreher & Hayes, 1993). For example, the question in the BSQ, “My child splashes hard in the bath and plays actively,” was not relevant in a Jamaican setting where the children often bathe in the local river or standing in a small plastic tub. This question was changed to “My child plays actively” to make it more culturally relevant. Decisions on where the instruments are to be administered (home or clinic), whether an interview or questionnaire technique is to be used (differing literacy levels of families), cultural norms about expression of illness behaviors, the cultural group's perception of the illness, and the method of help-seeking for the illness should be addressed before administration.

Fourth, it is not appropriate to assume that questionnaires and techniques validated in one culture can be applied to another culture without examining their cross-cultural equivalence. There are four levels of cross-cultural equivalence (Butcher & Han, 1996; Triandis, Brislin, & Hui, 1988). Conceptual equivalence is a comparison between the semantic meaning of the items and constructs in the two languages. Construct or item equivalence is a measure of whether individuals in different cultural groups respond to the same item in similar ways. Operational equivalence refers to the relative performance of the instrument when method of adminis-
courage them to adapt to cultural demands and to acquire the health behavioral norms and socialization patterns of their ethnic group (Mindel et al., 1988).

Cultural norms and socialization patterns determine how children and families react to health-related situations (e.g., how they define and interpret their symptoms), how they feel about themselves, and how they respond to treatment. In addition, historical experiences of the ethnic group (e.g., racial prejudice) and culturally determined patterns of dealing with issues of health and illness shape families' lives and play a determining role in their behavior, relationships, and socialization practices when they face health-related situations.

This issue of the Journal of Pediatric Psychology was developed to address some of the challenges associated with investigating children's health and illness across multiple cultures and to provide directions for solving the methodological challenges and incorporating contextual and cultural sensitivity into these issues. The article by Astatke and Serpell describes the difficult process of examining health risk behavior among adolescents in Ethiopia.

Rather than starting with a questionnaire standardized on a foreign population, the authors began with a culturally relevant theory and used an iterative process of qualitative and quantitative methods to examine the applicability of the constructs to risk behaviors among Ethiopian youths. The article by Waters, Salmon, and Wake, investigating the Child Health Questionnaire among parents of children with asthma in Australia, illustrates the care that must be taken in using instruments across cultures, even when the populations share the same language. The authors emphasize the importance of large-scale development work to obtain culture-specific norms for various subgroups.

The three articles by Stewart et al., Quittner et al., and Kromer, Prihoda, Hidalgo, and Wood provide examples of the care that should be taken in applying measures across cultures. Stewart et al. examine glycemic control among children in Hong Kong, illustrating that contrary to findings in Western cultures, authoritarian parenting style was not associated with negative child outcomes. Quittner et al. examine the applicability of a French version of the Quality of Life as applied to children with cystic fibrosis and are in the process of conducting a national validation study. Kromer and colleagues examine the construct validity of the Impact of Family and Functional Status II questionnaires among Hispanic children with asthma in Texas.

The articles by Mobarak, Khan, Munir, Zaman, and McConachie and by Hunter, Jain, Sadowski, and Sanhueza demonstrate the importance of examining family relationships as related to children's health. In the Mobarak article, stress among mothers of children with cerebral palsy in Bangladesh was related to the children's behavior problems and the burden of care. In the Hunter article, mothers in India who were poorly educated and victimized themselves reported an increased incidence of severe discipline practices among their children. Both articles illustrate the importance of considering contextual factors, including parenting and family relationships, in children's health as well the need for cultural sensitivity when operationalizing definitions.

The final article, by Eiser, Hill, and Vance, conducts a systematic review of multiple databases to examine the psychological consequences of surviving cancer and illustrates the importance of conducting international research among low incidence problems, such as childhood cancer.

These articles are a representative sample of the work being conducted in international pediatric psychology and are merely the "tip of the iceberg." There are multiple benefits to sharing information gathered through international pediatric psychology, but much remains to be done to ensure that psychometrically strong and contextually and culturally sensitive methods are used to investigate children's health and illness throughout the world. We hope this selection of articles raises issues about conducting research on pediatric psychology in international settings and provides a benchmark for future work in this increasingly important area.

References


