

Overview of Asian and Pacific Islander Americans

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Asian Pacific American Ethnic Groups

It is only within the past 20 years that the term *Asian American* has been used to refer to a broad selection of ethnic groups. In the late 1960s and early 1970s, scholars engaged in ethnic studies sought a new label to sever ties with past stereotypes that created images of Asians as "exotic" or "inscrutable" Orientals (Takaki, 1987). However, as the Asian Pacific American population grew, the demand to extend analyses beyond a single label also increased.

In 1990 the population of Asian Pacific Americans exceeded 7.2 million, nearly doubling the 3.7 million figure in 1980. A little more than half of all Asian Pacific Americans live in the western United States, although the Asian and Pacific Islander population has also increased in other regions: by 139% in the South and Northeast, and by 97% and 95% in the Midwest and West, respectively. The majority of the Asian Pacific American population live in the states of California, New York, and Hawaii. There was a 127% increase in California's Asian Pacific American population between 1980 and 1990. The largest number of Asian Pacific Americans live in California

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and, at 9.6% of California's population, they constitute the state's second largest minority group, after Latinos. In Hawaii, Asian Pacific Americans constitute 61.8% of the state population.

Overlooked in these figures is the fact that Asian Pacific Americans are often seen as a homogeneous ethnic category. The failure to make distinctions among specific ethnic groups can lead to faulty conclusions about important health needs among Asian Pacific Americans. The necessity of examining the health care issues of specific Asian Pacific American groups (e.g., Chinese, Filipino, Native Hawaiian, Samoan, Vietnamese) is a consistent theme in this book.

The emergence of Asian Pacific American communities demonstrates the diversity of the ethnic groups in the United States. Historical developments help shape the way ethnic groups relate to the dominant group and form the boundaries in which ethnic groups can express their cultural norms. A number of excellent resources are available that document the heterogeneity of the Asian Pacific American experience (see, for example, Chan, 1991; Takaki, 1987). Selected facets of some Asian Pacific American ethnic groups are presented below to illustrate the diversity within the group known as Asian Pacific Americans.

Chinese Americans

Although there are scattered reports of Asians inhabiting parts of the United States as early as 498 A.D., the migration of significant numbers of Asians, specifically the Chinese, began with the California Gold Rush of 1849 (Daniels, 1988). Between 1849 and 1882, more than 275,000 Chinese entered the United States. Of these, more than 90% were male. Initially, the Chinese immigrants worked primarily in mines, but they also labored on the western leg of the transcontinental Central Pacific Railroad, in agriculture, and in service trades. Some researchers have proposed that the Chinese, like other European ethnic groups who immigrated to the United States, were sojourners who intended only to work in the United States in order to make money and then return to their country of origin. However, unlike European immigrants, the Chinese became the first ethnic group to be barred legally from immigrating to the United States, by the Chinese Exclusion Act of 1882. The Chinese Exclusion Act represented, at a federal level, the culmination of anti-Chinese sentiment that had been present throughout many western states

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and localities. Because of the Chinese Exclusion Act, the early Chinese population, consisting primarily of unmarried males, declined until the 1920s.

The advent of World War II marked a change in U.S. policy toward the Chinese. The laws that had excluded Chinese immigration to the United States were repealed in 1943 by the Magnuson Act. The Magnuson Act also set a Chinese immigration quota of 105 per year and allowed those of Chinese descent to be eligible for naturalization. The McCarran-Walter Act of 1952 was a turning point in U.S. policy of discrimination along racial lines in citizenship eligibility. The McCarran-Walter Act allowed the Chinese, and all Asians, to become naturalized citizens of the United States. Because of changes in immigration and refugee policies, between 1960 and 1985 the Chinese American population quadrupled (Kitano & Daniels, 1988).

At the time of the 1990 U.S. Census, Chinese Americans, at more than 1.6 million, were found to be the largest Asian Pacific American group, making up 22.6% of the Asian Pacific American population. Between 1980 and 1990, the Chinese American population doubled, with most of the growth owing to immigration. Currently more than 63% of Chinese Americans are foreign-born (U.S. Commission on Civil Rights, 1992).

Japanese Americans

Early immigration from Japan to the United States and Hawaii commenced in large numbers around 1885 and peaked between 1900 and 1910. The National Origins Act barred Japanese Americans and other Asians from entering the United States after 1924. This immigration pattern created a unique layering of generations that is important to understand when conducting research within the Japanese American community (Fugita & O'Brien, 1991). The Issei, or first generation of Japanese Americans, for example, had a strong sense of nationalism, with a set of social boundaries that distinguished them and other peoples of the world. At the time of the Issei immigration, the Japanese had a single language without significant variations in dialect (Haglund, 1984; Nakane, 1970). In addition, Japan's Constitution and the Imperial Rescript of Education formally stated the uniqueness of its people (Ichioka, 1971). This is a significant point because, unlike many European and other Asian groups who came to the United States during the same

period, the Japanese immigrants did not share problems associated with a national identity.

As with most groups, the sense of a national identity is most salient with the Issei and becomes less so with each succeeding generation (O'Brien & Fugita, 1991). However, it is an error to equate the changes in identity with the lack of a strong identification with the Japanese American community. Japanese Americans have shown the ability to acculturate on many dimensions while maintaining a viable ethnic community. Even if Japanese Americans appear similar to middle-class Caucasians in lifestyles and behaviors, most have not given up their identity and involvement with their ethnic community (Fugita & O'Brien, 1991).

Based on the 1990 U.S. Census, Japanese Americans are the third-largest Asian Pacific American group, with a population of 847,562. In contrast to many other Asian American groups, more than 70% of the Japanese American population were born in the United States. More than 80% of Japanese Americans currently live in the western United States (U.S. Commission on Civil Rights, 1992).

Filipino Americans

Initial Filipino immigration to the United States was markedly different from Chinese or Japanese immigration. Unlike earlier Asian immigrants, who were considered aliens, because of American imperialism in the Philippine Islands Filipinos were considered to be American nationals (Kitano & Daniels, 1988). Between 1903 and 1910, those in the first wave of Filipino immigrants, the *pensionados*, were sponsored by a U.S. government program to attend American educational institutions. In what is considered to be a second wave of immigration, after World War I, significant numbers of Filipinos began arriving in the United States and Hawaii to work in agriculture, a labor niche previously occupied by the Chinese and Japanese immigrants.

The third major wave of Filipino immigration began after the discontinuation of the quota system in 1965 and continues to this day. The Filipino American population increased by 81% from 1980 to 1990. Currently at 1.4 million, Filipino Americans make up the second-largest Asian Pacific American ethnic group. More than 64% of Filipino Americans are foreign-born (U.S. Commission on Civil Rights, 1992).

Korean Americans

There have been three waves of immigration of Koreans to the United States. The Tonghak Rebellion, the Sino-Japanese War, the Russo-Japanese War in the late 1800s and early 1900s, a cholera epidemic, a drought, a locust plague, and famine all created unstable conditions in Korea, which prompted displaced Koreans to migrate to Hawaii to work on plantations (Kitano & Daniels, 1988). Between 1951 and 1964, the second wave of Korean immigration consisted of the wives of Americans who had gone to Korea during the Korean War, Korean children orphaned by the Korean War who were adopted by American families, and students (Kitano, 1991). The largest wave of Korean immigration, which continues today, followed the 1965 Immigration and Naturalization Act.

According to the 1990 U.S. Census, the population of Korean Americans is 798,849, making up 11% of the Asian Pacific American population. More than 80% of Korean Americans are foreign-born, and between 1980 and 1990 the Korean population in the United States more than doubled. Koreans who are currently immigrating to the United States tend to come with their families, and the adults tend to be highly educated.

Pacific Islander Americans

Prior to the 1980 U.S. Census, the populations of the different Pacific Islander ethnic groups, such as the Native Hawaiians, Samoans, Tongans, Tahitians, Guamanians, Fijians, Northern Mariana Islanders, and Palauans, were not presented by ethnic group. However, in the 1980 U.S. Census, the populations of some of the different Pacific Islander groups were detailed. At 211,014 at the time of the 1990 U.S. Census, Native Hawaiians are the most numerous of the Pacific Islanders, followed by the Samoans (62,964), Guamanians (49,345), and Tongans (17,606). Because of the limited scope of this chapter, Native Hawaiians are the only Pacific Islander group we discuss in detail.

Native Hawaiians are the indigenous people of Hawaii, who settled that land more than 2,000 years ago. At the time of Captain Cook's arrival in Hawaii in 1778, the population of Native Hawaiians may have been as large as one million people (Stannard, 1989). With contact from Westerners, tuberculosis, measles, influenza, leprosy, and other infectious diseases decimated the Native Hawaiian

Asians totaled no more than 55 annually during the 1950s, increased from 100 to 1,000 during the 1960s, and ranged from 1,500 to 4,700 during the early 1970s. Vietnamese constituted about 97% of these admissions (Gordon, 1984). However, this migration pattern changed dramatically in the mid-1970s. Beginning in 1975, more than 1.5 million people left their homes in Cambodia, Laos, and Vietnam to escape war, internal political conflicts, and famine. By September 1988, about 900,000 Southeast Asians had relocated to the United States (Rumbaut, 1991). Vietnamese represented 60% of this refugee group and Cambodians and Laotians made up equal proportions (20%) of the remaining people (U.S. Committee for Refugees, 1988). Despite initial efforts by the federal government to settle Southeast Asians throughout the United States, a substantial proportion (40%) now live in California.

Southeast Asians came to the United States in two waves. The first occurred during April 1975 to December 1977, the period following the fall of Saigon. Vietnamese made up this first group of refugees, who were seen as sympathizers with the American and South Vietnamese governments. The second wave of refugees ensued between 1978 and 1980, as political turmoil escalated in Cambodia, Vietnam, and Laos. The Vietnamese escaped in small, overcrowded boats that were often stopped by Thai pirates. Many were tortured, raped, or killed. The people who survived the long journey were forced to remain in camps for months in Malaysia, Singapore, Indonesia, Hong Kong, or the Philippines before resettling in another country (Chung & Okazaki, 1992). Cambodians, Hmong, and Laotians overcame traumatic circumstances to escape their countries. Many of the Hmong and Laotians who eventually resettled in the United States were poor, illiterate, and unfamiliar with Western culture, which made their adjustment to life in the United States even more difficult.

By the 1990 U.S. Census, there were 614,547 Vietnamese, 147,411 Cambodians, 149,014 Laotians, and 90,082 Hmong in the United States. The rates of poverty among Southeast Asian American ethnic groups are high: In 1980 a third of Vietnamese immigrants and over half of Cambodian and Laotian immigrants lived in poverty (O'Hare & Felt, 1991). Given the tremendous increases in Southeast Asian American populations owing to immigration, it is likely that the poverty rates among these groups has also increased substantially.

The brief descriptions of ethnic groups offered above help to demonstrate the different paths Asian Pacific Americans have taken to

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population. From 1778 to 1883, the population was reduced to approximately 40,000 Native Hawaiians. Within this period, the number of foreigners outnumbered Native Hawaiians by more than 10,000 people. Although Native Hawaiians currently total more than 200,000 in Hawaii, there are only 8,000 full-blooded Native Hawaiians left (Ikeda, 1987).

Native Hawaiians evolved a web of cultural values that served as the basis for social relationships. These values imparted a deep concern for unity (*loka'i*) with a living, conscious, and communicating cosmos. The values emphasized harmony with self—*na'au* (feelings), *kino* (body), and *'uhane* (spirit). Equally important was harmony with kin (*'ohana*), elders (*kupuna*), and land (*'aina*). This worldview encouraged supportive interpersonal relationships and low reliance on personal responsibility (Howard, 1974).

The Hawaiian language played an important part in reinforcing this harmonic relationship between the person and the community, nature, and spiritual world. The language was an oral tradition until the missionaries arrived in 1820. An example of the power of this oral tradition came when unfamiliar chiefs met in Hawaii. Chief genealogy was proof of rank, which dictated protocol. When these chiefs met, their *kahuna* or priests would step out and repeat thousands or more lines of poetry related to genealogy. Only after these chants did the chiefs know who had the higher rank and was deferred to. A memory lapse, lengthy pause, or mispronunciation was sufficient for a *kahuna* to be put to death (E Ola Mau, 1985).

In the past two centuries, Hawaiian culture and traditional methods of resolving problems have been devalued through Westernization and capitalism. For example, as important as the Hawaiian language is, it is estimated that there are only 10,000 people who can carry on a conversation in Hawaiian; about 4,000 Native Hawaiians—many of whom are elderly—can speak it fluently. In recent years, Native Hawaiians have recognized the importance of the Hawaiian language in defining culture and community in Hawaii. Language preschools have been established on different islands as one method of making the Hawaiian language prosper once again.

Southeast Asian Americans

Prior to 1975, the number of Southeast Asians migrating to the United States was small. Immigration records show that Southeast

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establish communities in the United States. Next, we explore this diversity further by calling attention to selected demographic features of these communities.

Sociodemographic Characteristics

Sociodemographic factors can provide a general assessment of a community's well-being, because some variables are strongly linked to health status. In this section we explore some differences in demographic characteristics among Asian Pacific Americans groups.

One of the prevailing images of Asian Americans is their phenomenal level of economic success. This stereotype has led to unfortunate policies that attempt to exclude Asian Americans from minority programs (Laura Uba, in Chapter 14 of this volume, discusses this issue in more detail). Equally important, using data based on the U.S. Census, policy makers often conclude that Asian Americans are not at high risk for health problems. However, the image of economic success is not supported under closer scrutiny (Kim & Huh, 1983; Suzuki, 1977). Educational attainment and income levels are often used to support the argument that Asian Americans are doing well. Most Asian American ethnic groups have relatively high levels of education and income compared with the national average, and it is usually assumed that high educational attainment leads to well-paying jobs, high status, and prestigious occupations. For Asian Americans, however, this is often not the case. A high level of education does not necessarily lead to more pay and status. Barringer, Takeuchi, and Xenos (1990) found that Asian Americans do not reap the same benefits of education that whites receive; only for Japanese Americans does the relationship between education and attainment come close to the association found for whites. This is an important finding, because Asian Americans use education as the primary path for social mobility (Sue & Okazaki, 1990).

A close examination of sociodemographic characteristics reveals that some Asian Pacific American ethnic groups may be more at risk for health problems than others. Immigrant status is related to a number of adjustment stressors that are linked to health. A recurring hypothesis regarding immigrants is that they experience more stressors than do native-born individuals. Fabrega (1969), for ex-

ample, argues that migrants encounter stressors that originate from leaving the country of origin, the difficulties of passage, the adaptation process in the host society, and the expectations of social and economic attainment. More recently, investigations on Asian immigrants have documented that migrants are facing many stressors, including those created by the acculturation process, stressful life events, employment, and economic hardships (Kuo & Tsai, 1986; Lin, Masuda, & Tazuma, 1984). Chinese, Filipino, Asian Indian, Korean, and Vietnamese Americans are among the ethnic groups with large proportions who were born in another country.

A consistent finding in the social sciences is the inverse relationship between socioeconomic status and illness (Williams, 1990). Studies provide indirect evidence that economic factors can have pernicious consequences for the health of adults. Poverty status, per capita income, and employment status are often used as indicators of socioeconomic status. Of 17 Asian American groups, 14 have poverty levels above the U.S. average (9.6%). Laotians, Hmong, and Cambodians have poverty levels above 45%. Per capita income is a useful measure of socioeconomic status because it takes into consideration the number of people the household income is intended to support. In 1980 Asian Americans had an average household income of \$6,900, compared with the U.S. average of \$7,400. Only Indonesian, Chinese, and Japanese American groups had average per capita incomes at or above the U.S. average. In 1980, 7% of all Asian Pacific Americans were unemployed. Although the average unemployment rate for Asian Pacific Americans was below the U.S. average (5%), Hmong (20%), Laotians (15%), Cambodians (11%), and Samoans (10%) had unemployment rates in double figures.

Using a general Asian Pacific American category masks the diversity and heterogeneity of different ethnic groups. A global ethnic category can underestimate the health problems of specific ethnic groups or lead to erroneous conclusions about risk factors. Uehara, Bates, and Takeuchi (1993) specifically address the consequences of examining Asian Americans as a single category or as disaggregated ethnic groups. They conducted analyses examining the level of functioning drawing upon data from a large-scale study of adults with serious mental illness in King County, Washington. Because data on level of functioning are used as a basis for resource allocation to community mental health programs in King County, the analysis has had important consequences for program planning.

Public health policy has begun to emphasize a "lifestyle" approach to the study of illnesses and diseases. Activities such as heavy alcohol consumption, inadequate diets, and smoking are often seen as precursors to poor health. However, the focus on lifestyle factors can overlook the importance of social structural factors that are linked to both lifestyle and health problems. It is important to recognize that macro social structures (e.g., an individual's position in the social structure) shape behavior and values that in turn partially explain health behavior. Asian Pacific Americans can ethnic groups differ along a number of socioeconomic status (SES) indicators. As mentioned earlier, SES has a consistently strong inverse relationship with health status. SES position is also strongly related to the conditions of life that promote certain lifestyles (Berkman & Breslow, 1983; Schoenborn, 1986). Thus a focus on changing lifestyles at the expense of ignoring macro SES factors may do little to change the health status of a group (Williams, 1990).

Investigators seeking to establish linkages between social structural position and health status among Asian Americans can benefit from a more systematic research plan (Williams, 1990). First, there is a need to conceptualize and measure dimensions of SES that are most salient in predicting health status. Few studies have explored the social factors that are important in determining social positions and the conditions of life among Asian Pacific Americans. Although empirical investigations can enhance our understanding of the role conventional measures of SES—education, occupation, and income—play in Asian Pacific American communities, more research is required to examine alternative measures of social position that are unique to these communities. This has been a useful strategy in investigations in African American communities. Dressler (1991), for example, demonstrates that darker skin color as a measure of social position is related to hypertension among high-SES African Americans.

Second, social position factors affect individual health through smaller, intermediary structures. In health research, these structures include stress, social support, and attitudes toward health. Lifestyle behaviors such as smoking and alcohol consumption are also considered as part of the linkages between the macro levels and health status. Studies that measure these intermediate structures specify that their linkages with health status and use are critically needed. Stress, for example, is associated with health status, but few studies have examined what stressors are meaningful among

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Uehara et al. first compared Asian Americans as an ethnic category to whites. Asian Americans, on the average, had higher community functioning scores than whites. On the basis of these data, planners might reasonably conclude that fewer resources are required to meet the needs of Asian American consumers. Further analyses suggest, however, that such conclusions would have been premature. When analyses were conducted of specific Asian American groups (i.e., Chinese, Japanese, Filipino, Laotian, and Vietnamese), the results indicated that only the Chinese had higher scores than whites on level of functioning. Thus the investigators were able to demonstrate systematically the actual analytic and programmatic consequences for categorizing Asian and Pacific Islander ethnic groups.

Conceptual Considerations

A number of different paradigms are possible in organizing a book on health issues. One common way is to focus on the general issues of health and discuss specific subpopulations, such as the elderly and children. Another way, the one chosen for this book, is to examine specific illnesses and discuss their prevalence among the population of interest, in this case, Asian Pacific Americans. Because empirical health research on Asian Pacific Americans has been neglected in the past, each chapter could begin with a lament about the lack of data and the problems inherent in conducting health research in these minority communities. Rather than have the chapter authors spend time on these issues, however, we highlight in this chapter some common conceptual and methodological issues scientists confront in conducting research in Asian Pacific American communities. Specific concerns unique to particular areas are discussed in the individual chapters.

Because so little has been published about risk factors and special populations within Asian Pacific American communities, the Asian & Pacific Islander American Health Forum decided to emphasize the prevalence of diseases, with some attention to the issues of health professions and access to care. One problem with this approach is the inadequate coverage given to theoretical issues that help to guide research. Although we cannot adequately address conceptual concerns in this overview, we can raise an issue that is missing from the chapters that follow.

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Asian Pacific Americans. Equally important, we do not know whether the stress-health model is a fruitful avenue of research for Asian Pacific Americans.

Finally, empirical investigations are needed to identify the social psychological processes through which people respond to the social structure. Significant others and the media are some common parties that transmit information to individuals (Hacker, Collins, & Jacobson, 1987). In addition to this relay function, significant others and the media often provide models of health behavior for people. To understand these processes, research on Asian Pacific Americans requires more substantive attention to the types of individuals and media that play significant relay functions among Asian Pacific Americans. For example, the Asian American Health Forum has effectively used health promotion campaigns targeted at ethnic newspapers and radio stations. We need to determine whether other sources of influence are salient in the Asian Pacific American communities. An assessment of the impact of different influences and an understanding of how these processes work in these communities are also needed.

The study of linkages between macro structures and health status and behavior provides a systematic understanding of the context of health and illness in Asian Pacific American communities. Investigations on these linkages provide an alternative to viewing disease as simply a medical problem. The attendance to social and psychological factors can have a significant impact on preventing illness and promoting health in Asian Pacific American communities. It is important to keep this point in mind as one reads through these chapters.

Methodological Considerations

One reason for the lack of empirical studies on Asian Pacific American health issues is that a number of methodological issues must be considered in the research designs, making the implementation of a project complex and costly. In fact, these methodological problems make health research in minority communities more difficult to conduct and administer than health research in predominantly white communities. In this section we provide short descriptions of some common methodological problems that must be considered in health research among Asian Pacific Americans.

Public Records

In public records, such as those of public health clinics, some problems call into question the quality of the data:

1. Diagnostic data from public records are limited by interviewer reliability. Often assessments are made by a number of interviewers. Different interviewers create biases, especially when interviewers must rate clients on a number of dimensions. Some clinicians may be more thorough in their assessments than others, and some patients may describe their problems more openly with some clinicians than with others.
2. Ethnic identification is often problematic from public records. When a client does not provide ethnic information, an interviewer may guess about ethnicity based on the client's last name or physical appearance.
3. Health indicators from public records provide a confounded variable of health status and service utilization. It is well documented that Asian Pacific Americans delay seeking professional care for their health problems; thus they may have more severe problems when they enter health facilities than do whites.
4. Missing data are a common problem in public records, especially data on income, occupational status, and education level. These three variables are important in determining whether differences in health status among groups can be attributed to ethnicity or socioeconomic status.
5. Some variables that are critical in understanding Asian Pacific Americans can health status may not be recorded on health clinic forms, such as primary language, place of birth, and generation.
6. There is uncertainty about the meaning of some information found in public records. For example, suicides are recorded on death certificates by medical examiners or coroners across the country. Aside from the technical expertise of medical examiners or coroners to make this assessment, there are often cultural, political, economic, or religious pressures on a coroner not to label a death as suicide. Asian Pacific Americans may be reluctant to cooperate with a suicide investigation because such a determination would lead to a loss of face for the family of the deceased.

Secondary Analyses

Because Asian Pacific American health studies are difficult to conduct, researchers often rely on analyses of secondary data. In addition

to problems associated with any secondary analysis, two related issues are involved in studies that include Asian Pacific Americans. Most large-scale studies include only small samples of Asian Pacific Americans. Large-scale studies usually weight the data to the population figures of the community or geographic region, or the nation as a whole. These weights may disguise the fact that the Asian Pacific American samples are actually quite small. Small samples do not have sufficient statistical power to detect significant health needs. In addition, complex multivariate analyses are not possible to identify high-risk subgroups. When a large sample of Asian Pacific Americans is collected, they are often collapsed into one category. As described earlier, because Asian Pacific Americans are quite heterogeneous, the use of a general category makes it difficult to assess their health care needs accurately.

Original Data Collection

Three issues are especially salient in the study of the health care needs in Asian Pacific American communities: measurement, sampling, and access in the community. It is well established that culture affects the perception of physical and emotional conditions (Kleinman, 1980; Mechanic, 1980; Zola, 1964). Medical technology can reliably detect physical disease, but cultural factors can constrain the ways individuals define and evaluate their health problems, present their problems to the physician, and seek help for their problems. Without adequate information from the patient, the physician may not be able to detect the disease.

The measurement of health status, especially that relying on survey techniques, has become increasingly sophisticated over the past decade with the development of standardized instruments. Too often, however, researchers have used standardized instruments without also assessing the reliability and validity of these instruments for specific ethnic and racial subpopulations, assuming that concepts and measurements of health and illness are uniform from one cultural group to another (Angel & Thoits, 1987). This assumption is unwarranted, because cultural groups vary in their definitions of normality and abnormality, and these variations affect models of health and illness (Higginbotham, 1984). Some of the factors affected by culture include types and parameters of stressors, coping mechanisms, personality patterns, language systems, and expression of illness (Marsella, 1982). Without proper consid-

eration of these issues, errors are often made in diagnosis, assessment, and treatment.

Manson, Walker, and Kivlahan (1987) assert that some standardized self-rating scales and interview schedules can accurately assess health status among ethnic minorities if they are modified to reflect important aspects of the minority culture and history. In the past, researchers often took this to mean that standardized instruments should be translated into different languages for non-English-speaking minorities. The problems in this process are illustrated by the following anecdote. A major health study translated a standardized instrument from English into Spanish. Shortly after the study went into the field, the researchers noticed that Latinos were scoring very low on one particular question: "How often do you kiss your child?" The researchers were quite puzzled by this response pattern and did not know how to interpret this finding, given that it could be very controversial. After checking and double-checking the original questionnaire, someone thought to check the translation. Instead of asking Latinos "How often do you kiss your child," the translated question read, "How often do you kiss your puppy?"

Most translation problems are more subtle. To avoid these types of problems, instruments are translated back into English. However, translation procedures cannot correct for other measurement problems. Let us give another example. We conducted a meta-analysis of an evaluation study that was intended to improve the self-esteem of Hawaiian children. We examined an instrument that measured self-esteem and that was modified to incorporate the pidgin English that Hawaiian children often use. We reviewed the responses for a sample of children and observed their behavior. We were particularly struck by one girl who had scored poorly on the self-esteem instrument but whose other records showed that she had good grades, received excellent evaluations by teachers, and behaved in a manner that demonstrated a positive sense of self. We took her aside and talked with her. We asked her why she answered no on such items as "My friends like me," "My teacher likes me," and "I do good work." In her best pidgin English, she said, "Eh, I no like brag."

This anecdote leads us to other measurement issues. Besides translation considerations, researchers must be concerned with conceptual equivalence, scale equivalence, and norm equivalence. *Conceptual equivalence* refers to similarities in the meanings of concepts used in assessment. For example, do minorities and whites think of well-being, depression, or self-esteem in the same way? *Scale equivalence*

refers to the use of standard formats in questionnaire items that are familiar to all groups. For example, among well-educated groups, most are familiar with answering survey questions using responses along a scale that includes "strongly agree," "agree," and so on, or with a true-false dichotomy. Recent immigrants or individuals who have not been educated in the Western system may not understand this format, however. *Norm equivalence* refers to the application of standard norms developed in one sample to another group. Because statistical norms are the basis upon which we judge "normal" and "abnormal" or "high functioning" and "low functioning," it is important to understand whether the normative sample is similar to the study group. For example, standards of weight and height developed among whites may not be suitable for Asian Pacific Americans.

Sampling

Sampling is another issue that must be considered in conducting research in Asian Pacific American communities. In selecting a sample, researchers are concerned about the representativeness of the people they choose to interview. Although many Asian Pacific Americans live in certain parts of given cities, substantial numbers do not. In Los Angeles County, for example, 22% of Chinese Americans live in census tracts with 500 or more Chinese Americans. The remaining 78% live in areas not populated by large numbers of Chinese Americans. Although it is easier to select a sample of Chinese Americans from geographic areas where large numbers reside, such a sample may not be representative of all Chinese Americans living in Los Angeles County.

The issue of sampling from small populations has been one of the reasons no large-scale health or psychiatric epidemiological study has been conducted for an Asian Pacific American group. Some researchers have resorted to the use of telephone or ethnic directories to obtain a universe of ethnic populations. However, such sampling frames have their own biases. Elena Yu and William Liu address this sampling issue in more detail and propose several solutions to this problem in Chapter 2 of this volume.

Access in the Community

In addition to enhancing their own careers, health researchers conduct studies in minority communities because they want their

work to have an impact in resolving social problems, guiding policy, or serving as a basis for programs that will improve the quality of life in these communities. Researchers can provide minority communities with needed data that can be used to secure resources for new programs, assess interventions that may be useful, or identify high-risk groups. However, to conduct studies, investigators must rely on the community to provide access to minority samples as well as a laboratory in which to test innovative intervention strategies. Unfortunately, there is often an uneasy tension between researchers and the community. Community leaders often see researchers as exploiters whose studies are divorced from real issues and real-life problems. On the other hand, researchers often view community leaders as compromising the science of the research enterprise. This tension makes it difficult to initiate new research projects in minority communities. If this tension is unresolved, both researchers and the communities are unable to meet their objectives.

Concluding Note

Although this overview has focused on some conceptual and methodological issues in conducting health research, future generations of researchers will need to pay closer attention to theoretical issues. Epidemiological research designs must be incorporated with theory (Mechanic, 1980). This statement is especially appropriate to Asian Pacific American mental health research, where few studies are driven by theoretical issues (Sue & Morishima, 1982). An understanding of the biological, psychological, social, and cultural processes that lead to well-being and illness in Asian Pacific American communities will be accomplished only through a more established link between the theoretical and empirical levels.

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