

Cross-cultural Similarities and Differences in Child Behavior Problem Patterns

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In this paper cross-cultural similarities and differences in child and adolescent behavior problem patterns were examined by comparing the Child Behavior Checklist data collected in Korea and the U.S. The Korean CBCL data were from the clinic referred sample of 952 boys and 426 girls between the ages of 4 and 16 and the non-referred sample of 778 boys and 740 girls in the same age range recruited from schools. The U.S data were from the standardization sample for the original CBCL as reported by Achenbach & Edelbrock(1983). The results were as follows. First, comparisons of behavior problem syndromes empirically derived from factor analyses of the Korean and American CBCL revealed considerable similarities, particularly in externalizing syndromes such as Aggressive and Delinquent syndromes. There was less similarity in the pattern of internalizing syndromes such as Anxious and Depressive syndromes. Second, Korean children and adolescents compared to their American peers showed significantly lower scores on the Aggressive and Delinquent scales but significantly higher scores on internalizing scales such as Somatic Complaints, Social Problems and Attention Problems. Third, there was considerable similarity in the type of problems frequently reported by parents from the two countries, but externalizing problems were much more likely to get clinic referral in the U.S. than in Korea. The crossnational differences outlined above were discussed in terms of cultural differences in childrearing practices, criteria for judgment of behavioral deviance, and beliefs and attitudes about mental health problems.

Cross-cultural differences In the prevalence and pattern of psychopathology has been a topic of interest to many psychologists who are interested in the role of cultural factors in human behavior. Theoretically, cross-cultural research is of great significance because it can help us to delineate boundaries of psychological theories and research findings. Since what we know about psychopathology comes from research in western cultures, it is critically important to find out how much of what we know from research in western cultures is culture specific and how much can be generalized beyond the western culture. By attempting to distinguish between culture specific and culture general phenomena, cross-cultural research in psychopathology can provide us with a valuable insight into the contribution of sociocultural factors on human behavior. Cross-cultural comparison of psychopathology is quite important for practical reasons as well because classification systems of psychopathology developed in one culture need to be evaluated for culture appropriateness before they can be used effectively in another culture.

Most of the research on cross-cultural differences in psychopathology has dealt with adults(Al-Isa, 1982; DeRois & Smith,

1984; Draguns, 1982; Marsella, 1979; Singer, 1985) and relatively little attention has been paid to psychopathology during childhood and adolescent years. However, cultural influences in human behavior is likely to start well before the adult years (Weisz, McCarty, Eastman, Chaiysit & Swanlert, 1996). It seems to be particularly important to study cultural variations in psychopathology during childhood and adolescents because the impact of sociocultural factors may be most pronounced during these early years (Weisz et al., 1996).

In the present paper, data on similarities and differences in the pattern of psychopathology of children and adolescents in Korea and the U.S. were presented as a way to examine how cultural factors shape the ways that psychopathology gets expressed. Specifically, similarities and differences following three aspects of child psychopathology were examined; 1) the behavior problem syndrome patterns ; 2) the overall prevalence level of common behavior problem syndromes in the clinic-referred and non-referred group; and, 3) the likelihood that different types of child behavior problems get referred to mental health clinics.

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The data reviewed in the present paper are from a series of studies on the child behavior problems in Korea using CBCL(Oh, Lee, & Hong, 1991; Oh, & Lee, 1990a; Oh, & Lee, 1990b; Lee, Oh, Hong,& Ha, 1991; Oh, 1994; Ha, Oh, Lee, & Hong, 1995; Oh, & Ha, 1996). Use of common instrument, namely CBCL, made it possible to make cross-cultural comparisons of the data collected in Korea and the U.S.

I . Comparison of Behavior Problem Syndrome Patterns in Korea and the U.S.

Child behavior problem syndromes empirically derived from factor analysis of the CBCL data from Korean children were compared to what has been reported for the U.S. children as a way to study how cultural factors influence the pattern of psychopathology in children.

Method

Participants 582 boys and 252 girls between the ages of 6 and 11 who visited 14 psychiatric clinics(6 from general medical centers and 8 private psychiatric clinics) in Korea participated in the study. They were recruited over a 2 year period with the cooperation of the child psychiatrist in each clinic. There were no restrictions in terms of clinical diagnosis except that cases with known organic impairment or children who were specifically referred for evaluation and treatment of mental retardation or language

development delay were excluded. Thus children with a variety of clinical diagnoses were included in the study. Although it is difficult to ascertain whether they constitute a representative sample of children with behavior problems in Korea, sampling from multiple clinical sites and few restrictions in the recruitment process suggest that the present sample is likely to be a good approximation of the representative sample.

Measure The Korean CBCL, a translated version of the Child Behavior Checklist(Achenbach & Edelbrock, 1983; Achenbach, 1991) was used to collect data on child behavior problems in Korea. After two waves of translation and back-translation by a Korean-English bilingual translator, comparability of each item in the English and Korean CBCL was checked and items with any discrepancy were reviewed and retranslated, if necessary. A preliminary study was conducted to check on the validity of the translated instrument with the Korean sample, and the results suggested that it can discriminate the normal and clinic-referred group with accuracy comparable to its American counterpart (See Oh & Lee, 1990a, 1990b, 1990c for details).

Procedure The Korean CBCL was handed out to all parents of the children who visited the 14 participating psychiatric clinics during the 2 year recruitment period. The parents were asked to fill out the CBCL as part of the initial diagnostic

evaluation. In the majority of the cases, it was the mother who filled out CBCL(87.8% for boys and 87.7% for girls). Of the Korean CBCL data returned, those cases that met the exclusion criteria mentioned above were excluded and the remaining data were subjected to factor analyses in order to empirically derive syndrome factors.

Analysis Following Achenbach & Edelbrock (1983), principal components analyses were performed on the CBCL items reported for at least 5% of the sample. Orthogonal rotations on varying numbers of factors to

identify the most robust were performed; from the different rotations, the one comprising the most representative versions of the factors that repeatedly recurred in the rotations was selected. From the varimax rotation chosen, the factors that 1) remained most intact throughout the various rotations, and 2) had at least 6 items with loadings greater than .3 were retained. For the Aggressive factor, the largest factor, items with loading greater than .40 were retained. The analyses were conducted separately for boys and girls in order to examine gender differences in the pattern of

Table I. Empirically derived CBCL syndrome factors in Korea and the U.S.: clinical group age 6-11

Korean CBCL		the U. S. CBCL	
male	female	male	female
aggressive	aggressive	aggressive	aggressive
-	provocative	-	cruel
hyperactive	hyperactive	hyperactive	hyperactive
delinquent	delinquent	delinquent	delinquent
social withdrawal	social withdrawal	social withdrawal	social withdrawal
emotional lability	emotional lability	-	-
somatic complaints	somatic complaints	somatic complaints	somatic complaints
obsessive-compulsive	-	obsessive-compulsive	-
-	depressed	depressed	depressed
sex problem/psychotic	-	-	sex problems
-	schizoid-obsessive	schizoid-anxious	schizoid-obsessive
-	immature	-	-
-	-	uncommunicative	-

source: Oh, Lee, & Hong (1990a)

behavior problem syndromes.

Results

Table 1 presents the behavior problem syndrome factors empirically derived from the Korean CBCL data. The U.S. syndrome factors for the same age groups reported by Achenbach & Edelbrock (1983) are also presented for comparison.

There was considerable similarity in the child behavior problem syndromes obtained in the two countries. Core syndromes such as Aggressive, Somatic Complaints, Social Withdrawal, Attention Problems, Delinquency were obtained in both countries. Furthermore, item composition of each of these syndromes was also quite similar, particularly in the externalizing problem factors, as evidenced by the high correlation between each pair of U.S. and Korean syndrome factor.

There was, however, an interesting difference in the factor analytic results of Korean and U.S. CBCL data; that is, a factor unique to the Korean boys and girls emerged, which accounted for about 4% of the total variance. The factor, tentatively named Emotional Lability, appears to represent a mixture of internalizing and externalizing problems. The items presented in Table 2 suggest a strong negative emotional undertone and passive expression of negative feelings. For boys, the factor is correlated highly with the Depressive ($r=.81$), and moderately with the Aggressive ($r=.65$), and Uncommunicative ($r=.65$) factor,

while for girls, it is highly correlated with the Aggressive ($r=.92$), and moderately with the Depressive factor ($r=.65$).

Discussion

The considerable similarity in the empirically derived behavior problem syndromes in Korea and the U.S. suggest that adjustment difficulties in children are likely to be expressed in similar ways across different cultures. Despite apparent differences in cultural heritage and values in the two countries, when children do show behavior problems, their problems are likely to take similar forms and organizations. This is particularly true of the so-called "core behavior problems" such as aggression, delinquency, attention problems, somatic complaints and social withdrawal, which are likely to have similar meanings in various cultures. Verhust, Achenbach, Althaus & Akkerhuis (1988) also reported cross-cultural similarity in behavior syndrome scales in his study with Dutch children.

The Emotional Lability factor which was obtained in the Korean CBCL data, but not in the U.S. data suggests that cultural context does have an influence on how behavior problems are organized. In Korean culture where expression of emotions, negative emotions in particular, is discouraged, children are likely to learn alternative ways to deal with them. The mixture of internalizing and externalizing symptoms in the Emotional Lability factor

Table 2. Items with factor loading higher than .30 on the Emotional lability factor

Boys		Girls	
88. Sulks a lot	(.66)	88. Sulks a lot	(.63)
87. Moody	(.56)	86. Stubborn	(.57)
86. Stubborn	(.52)	87. Moody	(.56)
45. Nervous	(.49)	45. Nervous	(.50)
75. Shy	(.44)	95. Hot temper	(.45)
89. Suspicious	(.40)	109. Whining	(.45)
95. Hot temper	(.39)	68. Screams a lot	(.43)
46. Nervous movement	(.37)	14. Cries a lot	(.42)
27. Jealous	(.37)	27. Jealous	(.41)
112. Worries	(.35)	46. Nervous movement	(.40)
99. Concerned about neat, clean	(.35)	89. Suspicious	(.34)
109. Whining	(.34)	19. Demands attention	(.34)
14. Cries a lot	(.33)	22. Disobey at home	(.32)
50. Fearful, anxious	(.32)	3. Argues a lot	(.31)
110. Wishes to be opposite sex	(.30)		

source: Oh & Lee (1990a)

Note: Factor loadings are presented in the parentheses.

suggests that attempts to suppress or hide negative feelings are at times "unsuccessful", resulting in passive-aggressive behaviors. For boys, underlying emotions appears to be sadness and depression as indicated by the high correlation between the scale and the Depressive factor; for girls, it is primarily aggression and anger as the high correlation with Aggressive factor indicates.

II. Prevalence of Common Behavior Problem Syndromes in Korea and the U.S.

Cross-cultural similarity in the overall organization of behavior problem syndromes does not mean that sociocultural factors play a minimal role in child psychopathology. It is quite likely that overall prevalence level of each of these syndromes is different depending on the cultural values and attitudes. Behavior that

are in conflict with important values are likely to be strongly discouraged by various socialization agents, resulting in low prevalence. For instance, in collectivistic cultures such as Korea where respect for authority and social conformity is emphasized, behaviors such as aggression and delinquency are likely to be less prevalent than in cultures with individualistic orientation. In order to test the hypothesis, the mean score of each CBCL clinical scale for the Korean and U.S. sample was compared.

Method

Participants 762 boys and 411 girls between the ages of 4 and 11 years were selected from the pool of 1478 clinic referred children whose CBCL data were used in the factor analytic study in order to match the age range of the U.S. clinic sample reported by Achenbach(1991). In addition, 778 boys and 740 girls in the same age range were recruited from 15 local preschools and elementary schools to serve as the non-referred group. Children who were reported to have had mental health services for behavioral or emotional problems were excluded from the non-referred sample.

Measure The Korean CBCL was used to collect data from Korean sample. For cross national comparison, the revised CBCL/4-18 (Achenbach, 1991) syndrome scales were used to calculate means for the Korean sample, which were then compared to the

U.S. data reported by Achenbach (1991). Tests of significance for the differences in the mean scores of the Korean and the U.S. sample were done using the SD reported by Achenbach (1991).

In order to assess the adequacy of the CBCL 4-18 subscales as clinical scales for Korean children, CBCL data for 1184 Korean boys and 901 Korean girls between the ages of 6 and 11 were scored using both the Korean CBCL factor scales derived from the Korean CBCL data and the American CBCL/4-18 clinical scales, and correlation for scores of each pair of scales similar in content were calculated (Ha, Oh, Lee & Hong, 1995). The correlations ranged from .94 (Aggressive scale) to .70 (Sex Problems-Psychotic scale) for boys, and .99 (Somatic Complaints scale) and .79 (Social Withdrawal) for girls. The high correlations suggest that CBCL/4-18 clinical scales can be used to score the Korean CBCL data without losing much clinical information.

Results

Mean scores on the CBCL/4-18 clinical scales for the Korean clinic-referred and non-referred children are presented in Table 3 (boys) and Table 4 (girls). Data for the U.S. children reported by Achenbach(1991) are also presented for comparison.

In both the Clinic-referred and the Non-referred groups, the Korean and American children did not differ significantly in the total behavior problems score. However, t-test for each of the subscales

Table 3. Means scores on American CBCL/4-18 scales : Korean and American boys 4-11

Scales	Clinic referred			Non-referred		
	Korea(N=762) Mean(SD)	U. S.(N=582) Mean(SD)	t	Korea(N=778) Mean(SD)	U. S.(N=582) Mean(SD)	t
WITHDRAWN	4.3(3.4)	4.1(3.3)	1.087	1.8(2.1)	1.8(1.9)	0.000
SOMATIC COMP	2.4(2.8)	1.7(2.2)	5.132**	1.5(2.0)	0.8(1.3)	7.804***
ANX/DEPRESSED	6.5(4.6)	7.9(5.8)	-4.786**	3.5(3.3)	3.1(3.1)	2.290**
SOCIAL PROBLEM	6.4(3.7)	4.7(3.0)	9.298***	2.5(2.2)	2.0(1.9)	4.486***
THOUGHT PROBLEM	2.2(2.4)	1.9(2.0)	2.497**	0.6(1.1)	0.5(0.9)	1.842*
ATTENTION	9.6(4.8)	8.2(4.4)	5.556*	3.9(3.2)	3.3(2.8)	3.677***
DELINQUENT	2.8(3.0)	4.3(3.3)	-8.586***	1.5(1.8)	1.6(1.7)	-1.047
AGGRESSIVE	13.0(7.5)	16.6(8.8)	-7.915***	7.0(5.4)	8.2(5.8)	-3.888***
SEX PROBLEM	0.9(1.4)	0.5(1.1)	5.865***	0.5(0.9)	0.1(0.5)	10.430***
TOTAL PROBLEM	53.9(25.5)	54.5(26.6)	-0.417	26.3(18.9)	24.2(15.6)	2.912**

source: Korean data: Ha, Oh, Lee & Hong (1995)/ U.S. data: Achenbach(1991)

* $p < .05$, ** $p < .01$, *** $p < .001$

Table4. Means scores on American CBCL/4-18 scales: Korean and American girls 4-11

Scales	Clinic referred			Non referred		
	Korea(N=411) Mean(SD)	U.S.(N=619) Mean(SD)	t	Korea(N=740) Mean(SD)	U.S.(N=619) Mean(SD)	t
WITHDRAWN	4.6(3.7)	4.6(3.4)	.000	1.7(1.9)	2.0(2.0)	-2.817**
SOMATIC COMP	3.1(3.3)	2.3(2.8)	4.043***	1.6(2.2)	1.0(1.6)	5.807***
ANX/DEPRESSE	7.5(5.2)	8.5(5.6)	-2.930**	3.5(3.3)	3.4(3.3)	0.556
SOCIAL PROBLEM	6.3(3.9)	4.9(3.2)	6.050***	2.4(2.1)	1.9(1.7)	4.850***
THOUGHT PROBLEM	2.1(2.3)	1.8(2.1)	2.123*	.5(1.0)	.5(1.0)	.000
ATTENTION	8.6(4.8)	7.3(4.6)	4.328***	3.4(3.0)	2.5(2.5)	6.032***
DELINQUENT	2.2(2.3)	3.3(3.1)	-6.528***	1.0(1.3)	1.2(1.4)	-2.709***
AGGRESSIVE	11.6(7.3)	14.2(8.7)	-5.180***	6.4(5.1)	7.0(5.2)	-2.137*
SEX PROBLEM	.9(1.3)	.6(1.2)	3.739***	.4(0.9)	.2(.5)	5.167***
TOTAL PROBLEM	53.0(26.7)	52.1(27.3)	0.525	24.0(17.8)	23.1(15.5)	.996

source: Korean data: Ha, Oh, Lee & Hong (1995)/U.S. data: Achenbach(1991)

* $p < .05$, ** $p < .01$, *** $p < .001$

revealed interesting cross-national differences. Cross-national comparisons of 9 pairs of subscale mean scores revealed significant differences at .05 level with the exception of Withdrawn (for both Clinic-referred and Non-referred boys and Clinic-referred girls), Delinquent (for Non-referred boys), Thought Problem and Anxious/Depressed scales (for Non-referred girls). In the Clinic-referred and Non-referred Group, Korean children (both boys and girls) showed significantly higher mean scores than U.S. children on the Somatic Complaints, Social Problems, thought Problems and Attention Problems scales. In contrast, in the Clinic-referred Group, U.S. children (both boys and girls) showed significantly higher mean scores on the Anxious/Depressed, Delinquent, and Aggressive scales, while in the Non-referred Group, the only scale where U.S. children showed a higher mean score than Korean children was the Aggressive Scale.

Discussion

The statistical significance of the cross-national differences needs to be interpreted with caution because of the large sample sizes involved. However, consistency in the pattern of the cross-national differences merits further interpretation. The finding that Korean children, both the clinic-referred and non-referred general population group, showed a higher level of somatic complaints

is quite consistent with what has been found with Korean adults (Kim & Kim, 1984). It has been suggested that Koreans have a tendency to express their psychological distress through physical symptoms because of the strong cultural emphasis on the need to suppress negative emotions such as anger and sadness (Kwon, 1996).

The higher level of Social Problems and Attention Problems might be related to the Korean cultural value emphasizing academic achievement and interpersonal harmony. Since social problems and attention problems are most likely to interfere with academic achievement or interpersonal harmony, Korean parents are more sensitive to these problems and thus more likely to report them as problems.

The lower mean scores of Korean children compared to the U.S. children on the Aggressive scale suggest that the Korean traditional value emphasizing respect for the authority and social conformity still remains a strong influence in socialization of Korean children. The cross-national difference in the Anxious/Depressed and Delinquent scale was significant in the Clinic-referred Group, but not in the Non-referred Group, suggesting the possibility that the difference might be due to cultural differences in referral practice. Namely, in the U.S., anxiety, depression or delinquent behaviors are considered appropriate reasons for referral to mental health clinics, while they may not be considered so in Korea. Such a

Table 5. 20 Most and Least Referable Problems in Korea: Age 6-11 Male Sample, with Referability Index-Modified(RI-M) for each problem

Most Referable			Least Referable		
Type	Problems	RI	Type	Problems	RI
	Strange behavior	1.30	I	Needs to be perfect	- .11
	Speech problem	1.19	E	Prefers older kids	- .06
	Fears school	1.09		Asthma	.01
	Not liked	1.05		Concerned with neat, clean	.03
	Is teased	1.02		Doesn't eat well	.07
	Repeats actions	.96	E	Alcohol, drugs	.09
E	Truancy	.89		Stores up unneeded things	.12
E	Vandalism	.88	I	Skin problems	.13
	Suicidal thoughts	.84	E	Argues a lot	.15
	Doesn't get along	.84	E	Jealous	.16
I	Stares blankly	.80		Overweight	.17
I	Withdrawn	.80		Acts like opposite sex	.17
	Plays with sex parts in public	.80		Allergy	.18
	Acts without thinking	.78	I	Stomach aches	.20
	Wets during day	.77		Eats too much	.21
	Acts too young	.77	E	Shows off	.22
	Nervous movements	.77		Sleeps little	.22
E	Destroys others' things	.71		Talks, walks in sleep	.22
	Plays with sex parts too much	.71	E	Braggs	.24
E	Steals at home	.70		Sleeps much	.24

N=1009 (Clinic=408, General=601)

Type I=Internalizing Problem/ Type E=Externalizing Problem as defined in CBCL/4-18 by Achenbach(1991)

cross-national difference in the referral practice might result in the higher level of anxiety, depression, and delinquent behaviors in the U.S. clinic-referred children.

III. Referability of behavior problems in Korea and the U.S.

Cultures differ in the ways that behavioral deviance is dealt with. For instance, in certain cultures such as U.S.,

aggressive and delinquent behaviors are seen as mental health problems and thus commonly referred to mental health clinics (Kazdin, 1987). On the other hand, there are cultures where such problems are seen as disciplinary problems and thus handled as such. Similarly anxiety problems might not be recognized as mental health problems in certain cultures, but rather considered as something to be simply tolerated or overcome on one's own. The differences between Korea and the U.S. in the overall level of CBCL clinical scales described above suggest that attitudes and beliefs about mental health problems as reflected in the clinic referral practice need to be looked at.

Recently Weisz & Weiss (1991) proposed the concept of referability as a way to examine cultural attitudes concerning mental health problems and interventions. Operationally defined as the frequency with which the problems is reported as the presenting complaints at mental health clinics relative to the frequency of the problem in the general population, Referability Index (RI) is a useful way to look at how mental health problems are responded to in a given culture. From their analyses of referability of 118 child behavior problems in the U.S. and Thailand, Weisz & Weiss(1991) reported that undercontrolled problems are more referable than overcontrolled problems in the U.S. but not in Thailand, indicating differences in the cultural attitudes about types of problems appropriate for clinic referral.

The primary objective of the present study is to assess the likelihood of various child behavior problems to get clinic referral in Korea. Of particular interest is the effect of problem type on the likelihood of clinic referral for behavior problems in Korea, and how it might differ from what has been reported from the U.S. and Thai data.

Method

Participants The clinic group included 576 children (408 boys and 168 girls) between the ages of 6-11 years. They were randomly selected from a pool of 894 clinic-referred children whose CBCL data were available. The general population sample consisted of 1192 children (601 boys and 591 girls) in the same age range as the clinic sample. They were recruited from 9 elementary schools in Korea with the cooperation of the school system. For both the clinic and the general population sample, there were approximately equal number of cases for each age within each gender, so that each age is equally represented in the sample.

Measure CBCL data for the Clinic-referred and the Non-referred children from the general population were used to calculate the frequency of each CBCL in the clinic-referred group relative to the frequency of the same problem in the general population. Following the procedure that Weisz & Weiss (1991) used to calculate the Referability Index (RI), logit, a natural

Table6. 20 Most and Least Referable Problems in Korea: Age 6-11 Female Sample, with Referability Index-Modified(RI-M) for each problem

Most Referable		Least Referable		
Type	Problems	RI	Type Problems	RI
	Fears school	1.43	Asthma	- .06
I	Withdrawn	1.13	I Needs to be perfect	- .01
	Speech problem	1.08	Doesn't eat well	.02
	Wets during day	1.06	Concerned with neat, clean	.03
	Repeats actions	1.04	Overweight	.03
	Suicidal thoughts	1.02	Allergy	.06
	Not liked	1.01	E Prefers older kids	.07
E	Runs away from home	1.01	Sleeps much	.08
E	Truancy	1.01	E Threatens people	.09
	Harms self	1.00	E Jealous	.11
	Strange behavior	.99	Thinks about sex	.14
	Plays with sex parts in public	.95	Talks, walks in sleep	.14
	Doesn't get along	.90	E Argues a lot	.14
E	Destroys others' things	.86	Stores up unneeded things	.16
	Wets bed	.78	Cruel to animals	.17
	Is teased	.77	Hears things	.18
I	Unhappy,sad,depressed	.76	Thumbsucking	.19
I	Nausea,feels sick	.76	Wishes to be opposite sex	.20
	Sex problems	.75	I Skin problems	.22
E	Steals at home	.73	Trouble sleeping	.22

N=759 (Clinic=168, General=591)

Type I=Internalizing Problem/ Type E=Externalizing Problem as defined in CBCL/4-18 by Achenbach(1991)

log of an odds ratio (i.e., the log of the probability of presence or absence of a particular problem as reported by parents) for each of the 118 problems in the Korean CBCL was calculated separately for the

clinic-referred group and the non-referred group; then the logit for each problem in the non-referred group was subtracted from the logit for the same problem in the clinic group, which was then divided by two. The

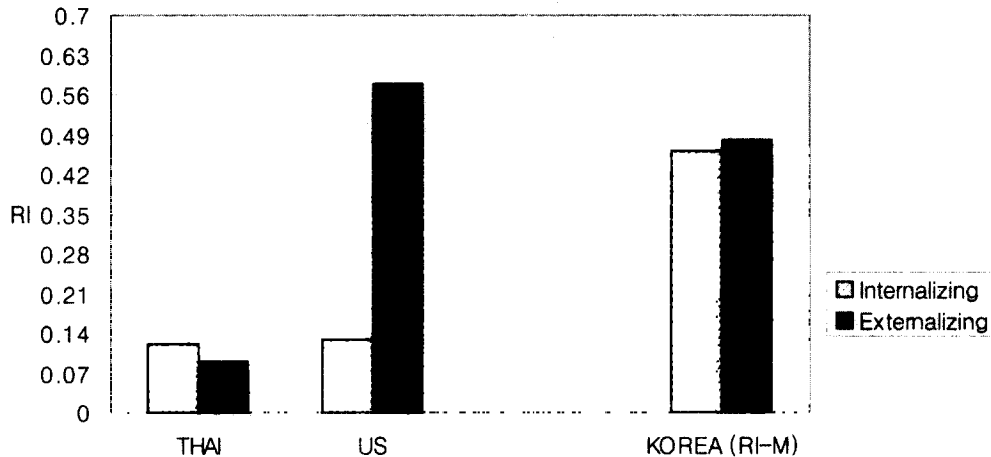


Figure 1. Culture X Problem type interaction :
Thai, United States, & Korea

Source; U.S. & Thai data; Weisz & Weiss (1991)

statistic is assumed to have meaning analogous to the Referability Index proposed by Weisz & Weiss (1991), and thus named Referability Index- Modified(RI-M).

Results and Discussion

20 highest and 20 lowest RI-M CBCL items are listed in Table 5(boys) and Table 6 (girls). High RI-M items, in general, tend to be of more serious psychopathology, suggesting that RI-M values do have some clinical validity.

When the CBCL items were classified into externalizing and internalizing problems according to Achenbach's (1991) classification, there were 4 externalizing

problems and 2 internalizing problems in the list of 20 high referability items for boys; for girls, 4 externalizing and 4 internalizing problems. The rest of the high referability items were of severe developmental difficulties. In contrast, in the U.S. data, out of 20 most referable items, 12 were externalizing problems, suggesting that externalizing problems such as aggression and delinquency are much more likely to get referred to mental health clinics in the U.S. than in Korea(Weisz & Weiss, 1991). Comparing the Referability Index-Modified(RI-M) for internalizing and externalizing problems, there was no difference in the RI-M for the two types of problems in Korea, while in the U.S.

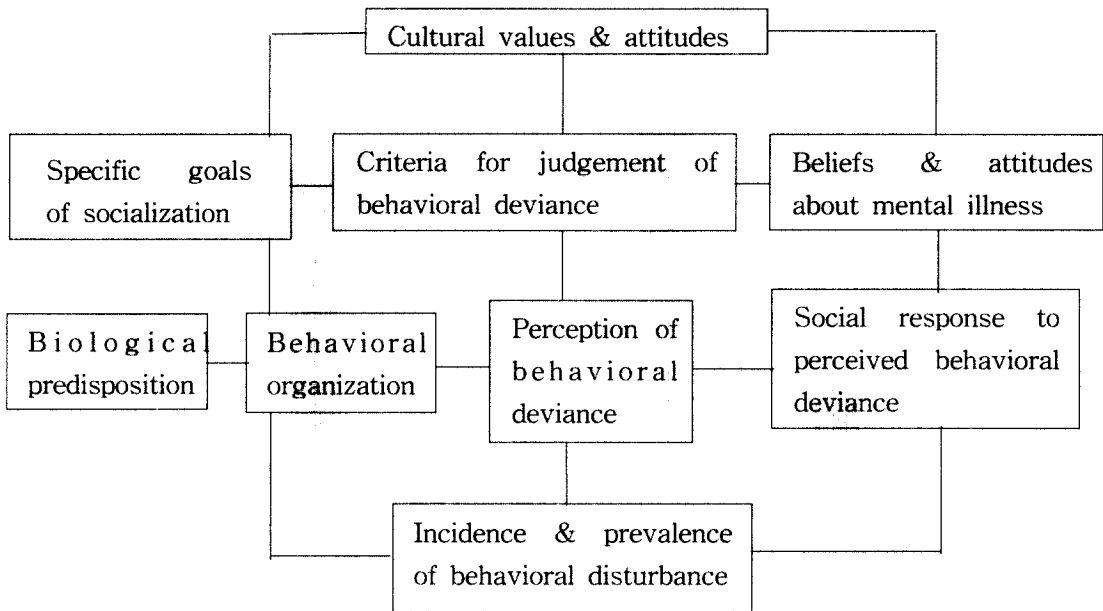


Fig.2 Conceptual model for cultural influence on behavioral disturbance

undercontrolled problems(i.e., externalizing problems) were reported to be significantly more referable than overcontrolled problems(i.e. internalizing problems) (Weisz & Weiss, 1991). Weisz

& Weiss (1991) also reported that in Thai, like in Korea, there was no significant difference in the referability of internalizing and externalizing problems.

The cross-national differences in the relative "referability" of different types of problems suggest the possibility that depending on the referral practice, certain types of problems might get over-

under-represented in mental health clinics. For instance, the higher level of externalizing problems such as aggression and delinquency in the U.S. clinic referred group compared to Korean group might be partly due to the fact that externalizing problems are much more likely to get clinic referral in the U.S. than in Korea or Thai. Thus, referral practice is still another path through which cultural values and attitudes influence psychopathology.

General Discussion

Culture influences the pattern of

psychopathology through diverse pathways. Thus it is important to start with a conceptual model of the diverse pathways of cultural influences when one attempts cross-cultural comparison of psychopathology. Oh(1994) has proposed a conceptual model for cultural influence on behavioral disturbance which attempts to describe several pathways through which cultural factors might operate.

The model, schematically presented in Figure 2, is based on the assumption that the study of psychopathology has to deal with two aspects; 1) the behavior itself, and 2) the lens through which the society views the behavior, make judgment as to its normality and determines what to do about it. Culture undoubtedly has direct and indirect influences on both aspects.

First, cultural values and attitudes play an important role in determining specific goals of socialization, which, in turn, shapes predominant patterns of adaptation. During the process of socialization, behaviors are encouraged or discouraged according to cultural values and attitudes. As Draguns (1973) suggested, "psychopathology within a given culture might be an exaggeration or a caricature of the socially shared and prevalent patterns of adaptation." For instance, in cultures where emotional expression is valued, spontaneous expression of feelings will be encouraged or rewarded by various socialization agents such as parents or teachers. In contrast, in cultures where emotional control is emphasized, overt expression of feelings will be discouraged,

resulting in a general tendency toward emotional inhibition. The idea that culturally modified values and attitudes directly influence the incidence of psychopathology, facilitating some and suppressing others, have been presented as the problem-facilitation model(Weisz, Suwanlert, Chaiyasit & Walter, 1987).

Second, culture also provides a set of criteria against which behaviors are judged to be normal/deviant. Cultures may vary in behavior norms so that a behavior considered to be within a normal range in one culture may be considered deviant in another culture. Similarly, cultures may also vary in the level of threshold for behavioral deviance. Behaviors that infringe upon values important to the culture may have lower threshold so that a slight deviance is perceived as a problem. On the other hand, people might be relatively less sensitive to the behaviors that are less important to the culture. In the case of children and adolescents, it is quite important to appreciate the role of different threshold because unlike adults, children rarely refer themselves for mental health services and teachers or parents often play a critical role in determining the clinic referral process. The adult-distress model proposed by Weisz et al. (1985) as an alternative to the problem-suppression-facilitation model emphasized the role of adult's perception in such judgment process.

Third, cultural beliefs and attitudes about behavioral deviance also influence how the society deals with it, once it is recognized.

The types of behavioral disturbance believed to have serious consequences are more likely to elicit concern and thus to get clinic referral. On the other hand, problem believed to be transient are less likely to be taken seriously. The clinic referral process is influenced by cultural attitudes about professional intervention for mental health problems so that psychopathology might be under- or over- represented in mental health clinics depending on the clinic referral practices in a given culture. In this respect a simple comparison of clinic data across cultures can be misleading if not interpreted cautiously because the clinic referral process itself is heavily influenced by cultural attitudes about the nature of mental health problems and proper intervention methods for them.

The conceptual model outlined above can be used to interpret of the observed cross-cultural differences in child behavior problems in Korea and the U.S. described above. Most commonly mentioned Korean values include collectivistic orientation and respect for authority and social harmony. Although rapid changes in values are occurring in recent years, these values are still deeply entrenched in the Korean culture. Korean childrearing emphasizing these values are likely to lead to 1) suppression of behaviors violating social norms, which will lead to low aggression and delinquency, and 2) facilitates emotional dependency and excessive concern about evaluation from others, which may lead to high social anxiety, and 3) facilitates

emotional and behavioral inhibition, which, in turn, may lead to difficulty with expressing negative emotions, and high prevalence of alternative ways of expressing emotional distress such as somatization. The observed cross-cultural differences are quite consistent with the prediction. They are also in agreement with what has been reported for Korean adults. For instance, somatization is a common pattern of dealing with negative feelings among Koreans as Hwa-Byung, a syndrome unique to Koreans, exemplifies (Min, 1989). Alcohol abuse is another prevalent problem among Koreans, which is interpreted as a way to deal with repressed emotions (Kwon, 1996).

The Korean values emphasizing behavior control, social harmony, and high achievement, are also likely to lower tolerance for behaviors which interfere with these values, thereby leading to overreporting of such problems by adults. The higher level of attention problems and social problems among Korean children are likely to be in large part due to difference in the "distress-threshold" level, particularly when adult reports are used as the information source. Finally, due to low availability of mental health facilities for children and adolescents in Korea and low public awareness that child behavior problems can be helped with psychological intervention, many child behavior/emotional problems with the possible exception of severe developmental disorders do not get referred in Korea. Thus, aggressive behavior which is one of the most common reason

for referral to mental health facilities in the U.S., are seen less frequently in the clinic in Korea partly due to different cultural attitudes about appropriate intervention for the problem.

The above findings strongly suggest that when cross cultural differences in the prevalence are examined, it is important to consider multiple channels or processes through which culture might operate. Not only cultural values directly facilitate or suppress specific patterns behaviors, threshold for perception of deviance, and the referral practice of psychological problems are also important aspects of cultural influences on psychopathology. Thus interpretation of cross-cultural difference in the prevalence of psychopathology need to take into account these processes.

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아동 청소년 문제행동 양상의 횡문화적 비교

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본 연구에서는 문화적 요인이 아동 청소년 문제행동의 양상에 미치는 영향을 조사하기 위하여 한국에서 수집된 CBCL의 자료를 Achenbach 와 Edelbrock(1983)이 보고한 미국 CBCL자료와 비교하였다. 한국의 자료는 만 4세-16세 연령의 임상군 남아 952명, 여아 426명, 그리고 동일한 연령의 정상군 남아 778명, 여아 740명으로부터 수집된 자료가 분석되었다. 그 결과, 첫째, 한국 임상군 CBCL자료의 요인분석을 통하여 구성된 문제행동 증후군들은 미국의 CBCL 증후군들과 공통되는 부분이 많았다. 또한 공격성, 비행 등의 외현화장애 증후군에서는 한국과 미국의 문항 구성이 매우 유사한 반면, 우울 불안등의 내면화 증후군의 경우는 한국과 미국의 문항구성이 차이를 보였다. 둘째, 한국 아동 청소년집단은 외현화증후군에서 미국 아동 청소년보다 낮은 점수를, 그리고 내면화증후군에서는 상대적으로 높은 점수를 보였다. 셋째, 미국과 한국의 부모들이 빈번하게 호소하는 문제들은 대체로 일치하였으나, 미국의 경우는 외현화 문제가 전문기관에 의뢰될 확률이 한국보다 상대적으로 높았다. 이러한 문제행동 양상에서의 문화적 차이는 양육방식의 차이, 탈의 판단기준, 그리고 정신건강문제에 대한 믿음과 태도의 차이와 관련시켜 논의되었다.