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Adult Attitudes toward Over- and Undercontrolled Child Problems: Urban and Rural Parents and Teachers from Thailand and the United States

John R. Weisz,* Somsong Suwanlert,† Wanchai Chaiyasit,† Bahr Weiss‡ and E. W. Jackson§

Abstract—In a study of adult attitudes, urban and rural parents and teachers in Thailand and the U.S. made judgments about two children, one with overcontrolled problems (e.g. shyness, fear), one with undercontrolled problems (e.g. disobedience, fighting). Consistent with previous literature, Thais (vs Americans) rated problems of *both* types less serious, less worrisome, less likely to reflect personality traits, and *more* likely to improve with time. Urban–rural differences and parent–teacher differences had negligible impact. The findings suggest that certain cultural differences in adult attitudes toward child problems may be robust across parents and teachers and across urban and rural settings.

Keywords: Child psychopathology, overcontrolled and undercontrolled problems, adult attitudes, cross-cultural differences

Introduction

Research on psychopathology is actually the study of two phenomena: (1) the behavior of individuals; and (2) the lens through which society views that behavior. As Draguns (1973) has noted, whether an individual's behavior constitutes "psychopathology" may depend on the attitudes, expectations, and prevailing patterns of adaptation within

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*University of California, Los Angeles, California, U.S.A.
†Mental Health and Child Guidance Center of Bangkok, Bangkok, Thailand.
‡Vanderbilt University.
§University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, U.S.A.

Requests for reprints to: John R. Weisz, Department of Psychology, Franz Hall, UCLA, 405 Hilgard Avenue, Los Angeles, CA 90024-1563, U.S.A.

the society where the behavior occurs (see also Marsella, 1979). A particular form of behavior may be deviant in one society but quite acceptable in another. Because identical behavior may be viewed—and responded to—differently in different cultures, it is important to make culturally-mediated attitudes a focus of research on psychopathology.

This is especially true for *child* psychopathology. In contrast to adults, children rarely consider themselves disturbed and rarely refer themselves for treatment. Instead, parents and teachers most often play these roles, in effect determining whether children receive mental health care. Thus, the degree of concern adults experience in response to a child's problems often determines whether intervention will follow (cf. Walker, Bettes & Ceci, 1984; White, 1982). Child problems not considered serious *by adults* are not likely to receive clinical attention, even if they are very distressing to the child. Given the central role played by adults, it is important to know which factors influence their level of concern. One such factor may be culture.

This possibility was explored in a recent study (Weisz *et al.*, 1988) comparing adults' attitudes in Thailand and the U.S. The study focused on child problems within the two most common empirically derived syndromes: overcontrolled problems (e.g. anxiety, social withdrawal) and undercontrolled problems (e.g. disobedience, aggression) (for reviews see Achenbach & Edelbrock, 1978; Quay, 1979). The research design was based on a "threshold model" of cultural influence. In this model, one hypothesized effect of culture is to set adult thresholds for distress over child problems, influencing whether the problems are considered serious and what actions are taken in response. In the Weisz *et al.* (1988) study, adults in urban areas of Thailand and the U.S. responded to vignettes describing two children, one with overcontrolled problems, one with undercontrolled problems. For each child, the adults rated the seriousness of the problems, their own likely level of concern if they were the child's parent, or teacher, and the likelihood that the child's behavior would improve with time. The adults also indicated which child had a greater need for help from a specialist. The findings included several main effects of culture: Thai adults rated both over- and undercontrolled child problems as less serious, less likely to be a source of adult concern, less likely to reflect personality traits, and more likely to improve in time, than did American adults.

These findings supported a *general form* of the threshold model, i.e. the notion that cultures may differ in their threshold for child problems generally. The results were interpreted in the light of certain Thai Buddhist teachings (see Jumsai, 1980; Suvannathat, 1979)—for example, (1) everyone experiences dissatisfaction or unhappiness; (2) every condition is in flux, and nothing will remain as it is; and (3) an individual's behavior does not reflect an enduring personality. Such teachings, if taken seriously, might mitigate adults' distress over child problems. A child's unhappiness, while certainly not desirable, might at least be viewed as a universal to which all are subject [see (1) above]; and a child's misbehavior might be less distressing if adults believe that it is certain to change [see (2) above], and that it does not reflect an enduring personality or trait [see (3) above]. Moreover, it was argued that American adults' greater concern over child problems may reflect the sensitizing effect of their greater exposure to child psychology through academic courses and the media.

Surprisingly, the findings offered no support for a *pattern-specific form* of the threshold model suggested by much of the literature on Thai and American culture. The pattern-specific form is the notion (discussed in Weisz, 1989; Weisz *et al.*, 1988) that cultures may differ *differentially,* with certain types of child problems arousing greater concern in some cultures than in others (see Draguns, 1973, "caricature" model). For example, prominent Thai researchers have maintained that in Thai society, partly because of Buddhist influence, "quietness, politeness, and inhibition are both expected and accepted [in children]" (Sangsingkeo, 1969, p. 292), and that such overcontrolled behavior is much less distressing to adults than are aggression and other undercontrolled behavior (e.g. Gardiner, 1968; Gardiner & Suttipan, 1977; Suvannathat, 1979). This literature seems to suggest that for Thai adults, more than U.S. adults, undercontrolled child problems may be more distressing than overcontrolled problems. Yet, the findings of Weisz *et al.* (1988) offered no support for the pattern-specific form of the threshold model: there were no significant interactions of culture with problem type. Despite the literature, Thai adults were *not* more likely than American adults to regard undercontrolled problems as more serious than overcontrolled problems.

Perhaps the previous literature has been misinterpreted, and there really are no pronounced differences between Thai and American adults in their relative concern over these two broad styles of problem behavior. On the other hand, there is one alternative possibility that bears close scrutiny, because it has significant implications for many kinds of cross-cultural research on popular attitudes: traditional cultural differences may be more likely to be found in rural areas than in urban settings. The sample in the Weisz *et al.* (1988) study included only urban subjects. It is possible that the traditional cultural differences noted in the literature are mitigated by the influence of urban living, which has a homogenizing influence on adults of different cultures. For example, life in Bangkok and its suburbs (the source of all the Thai subjects in Weisz *et al.*, 1988) involves considerable exposure to western people and media, and thereby to western attitudes and lifestyles. For example, urban Thais have ready access to American and British television programs portraying a distinctly western view of childhood and family life.

It is possible that such influences limit the relevance of comparisons between *urban* people of different cultures by rendering them less "cross-cultural". Traditional differences between cultures may be more pronounced in rural areas, where cultural traditions have been less threatened by outside influence. One way to address this possibility is to structure cross-national comparisons which include both urban and rural groups in each national sample, assessing whether the impact of culture varies with urban vs rural setting. This was done in the present study. We compared samples of urban *and rural* parents and teachers from Thailand and the U.S. We reasoned that interactions (e.g. on ratings of "seriousness") involving culture and urban vs rural setting would suggest that the previous findings of Weisz *et al.* (1988) were not clear-cut indicators of "cultural differences", but were instead artifacts of the all-urban samples employed in that study. By contrast, an absence of interactions involving the urban–rural factor would be taken as evidence that the cultural differences discussed in the previous study were robust across urban and rural settings.

Method

Experimental design and subjects

In the 2 (culture) × 2 (urban–rural) × 2 (group—i.e. parents vs teachers) × 2 (over- vs undercontrolled problem) × 2 (sex of child) × 2 (context information) × 2 (order) experimental design, problem was a within-subjects factor. Thai and American parents and teachers read two vignettes; one described a child with overcontrolled problems, and the other undercontrolled. Half the adults received vignettes about boys; half received girl vignettes. For half, the overcontrolled child was placed in context A (see below), and the undercontrolled child in context B (see below); for half, this pairing was reversed. We counterbalanced order; half received the overcontrolled vignette first, half received it second.

U.S. recruitment. U.S. parents and teachers of elementary school children were recruited through schools in the mid-Atlantic area. We randomly selected (from statewide school directories) nine urban schools (from four states) and five rural schools (from three states); following U.S. census procedures, we classified areas as urban vs rural, based on whether available statistics indicated a population density greater or less than 200 per square mile. We gave $100 to the Parent–Teacher Association of each participating school. We provided each school with our own selections of teachers and parents to be included. Teachers were chosen randomly from the faculty roster. Parents were chosen randomly from the pupil roster—e.g. parent of the fourth child on Mrs X's class roster. One constraint was that the adults selected should not be teachers or parents of children in special education programs for the mentally retarded, physically handicapped, or emotionally disturbed. Some 103 teachers participated, an 89% return rate (i.e. we asked 116 to take part); 101 parents took part, an 87% return rate.

Thai recruitment. Thai parents and teachers were from 10 randomly selected urban schools in the Bangkok area and 20 randomly selected schools in rural areas (i.e. population density < 200 per square mile). Teachers and parents were randomly selected from each shool, using the U.S. method (above). The reading required for vignettes led us to include only adults who had at least a primary school education. The 110 teachers who participated represented a 92% return rate; the 111 parents who took part also represented a 92% return rate.

Sample demographics. Demographics of the national samples reflected characteristics of the respective populations. Mean age was slightly higher in the U.S. sample than the Thai sample (means 37.93 and 36.45; SDs 7.94 and 7.44, respectively; $p < 0.05$) (Americans wait later than Thais to have children). U.S. subjects reported more years of education than Thais (means 15.41 and 14.63; SDs 2.62 and 2.68; $p < 0.01$). There was also a significant gender difference (93% vs 79% females in U.S. and Thai samples, respectively; $p < 0.001$). As for religion, 95.5% of the Thai sample described themselves as Buddhist; most in the U.S. subscribed to Christianity or Judaism (87%), or no religion (9%) ($p < 0.0001$).

Materials and procedures

Each adult received a three-page packet. Pages 1 and 2 each contained a vignette, then questions, concerning a 9-year-old school child. We used a school setting (instead of home) to minimize Thai–U.S. differences in setting-specific role expectations for children. On page 3, the adult was asked to compare the two children (below).

In each packet one vignette described a child with overcontrolled problems, the other with undercontrolled problems. Over- and undercontrolled problems were empirically derived from principal component analyses of the Child Behavior Checklist (see Achenbach & Edelbrock, 1983). Overcontrolled vignettes contained eight problems loading on that factor for boys and girls aged 6–11: arguing, cruelty to others, getting into fights, disobedience in school, lying, physically attacking people, teasing, and threatening. Undercontrolled vignettes contained eight problems loading on that factor for boys and girls aged 6–11: dependency on adults, fear of going to school, nervousness, anxiety, refusal to talk, shyness and timidity, sadness and depression, and worrying.

The over- and undercontrolled problems were embedded in either Context A or B. *Context A* noted that the child (a) works well alone and takes pride in accomplishments, and (b) cooperates during team games, but (c) makes sub-ability-level grades, and (d) needs special help from the teacher almost every day. *Context B* noted that the child (a) tries hard once an activity has been started, and (b) has one close friend, but (c) gets left out of group activities, and (d) has fallen behind the class in most subjects.

These contexts were designed to provide the kind of information mix that adults confront in real life, and to permit a check on whether adults actually attend to contextual information when judging the seriousness of child problem behavior.

After each vignette, questions were posed using 7-point Likert scales. Of interest here were: (1) "How serious is this child's problem?"; (2) "If you were this child's parent, how worried would you be about his (her) behavior?"; (3) "If you were this child's teacher, how worried would you be about his (her) behavior?"; (4) "Do you think this child's behavior will improve in a year or two?"; and (5) "Compared to other primary school students in general, how unusual is this child?" Open-ended questions followed, two of which are of interest here: (1) "What do you think is the major cause of this child's behavior problems?"; and (2) "What methods could be used at home to assist this child?" Finally, page 3 asked, "Comparing the two children you just read about, which child has a greater need to be taken to a specialist for counseling or help?"

Translation procedures. All materials underwent three waves of translation into Thai and back translation into English. One wave involved a professional translation agency; two waves involved two bilingual psychologists and a bilingual anthropologist. Translators aimed for conceptual equivalence and culturally appropriate content across languages, and for simplicity of wording within each language.

Coding for open-ended questions. For open-ended questions coding systems were developed. Answers regarding "the major cause" of the child's problems were classified as: (1) medical/biological; (2) faulty child-rearing, socialization, or teaching; (3) environmental stress; (4) child personality traits or psychodynamic processes (e.g. internal conflicts); (5) sociological (e.g. living in slums); (6) typical developmental (e.g. "just the way children of that age behave"); (7) diagnosis only (e.g. "the child has a conduct disorder"); or (8) other. Proposed interventions were categorized as: (1) medical or biological (e.g. drugs); (2) behavioral (e.g. reinforce good behavior); (3) verbal (e.g. "talk to the child", "reassure him"); (4) educational/academic; (5) social support; (6) religious or moral training; (7) punishment; (8) more thorough evaluation; or (9) other. To assess reliability, two coders independently coded 100 responses. Across all the category systems, kappas ranged from 0.91 to 0.98, with a mean of 0.94.

Results

Vignette-specific ratings of seriousness, distress, and prognosis

The first analyses focused on ratings of the seriousness of the problem behavior, how worried the adults would be as the child's parent or teacher, unusualness of the behavior and likelihood of improvement. All analyses were $2 \times 2 \times 2 \times 2 \times 2 \times 2 \times 2$ (culture $\times$ setting $\times$ adult group $\times$ sex of child $\times$ problem type $\times$ context combination $\times$ vignette order) repeated measures ANOVAs, with problem type (over- vs undercontrolled) as a within-subjects factor. To protect against chance findings, we applied a Bonferroni correction (Neter, Wasserman & Kutner, 1985); this set alpha at 0.0008.

Context combination effects. There were no significant vignette order effects, but vignette context interacted with problem type on the seriousness, parent worry, teacher worry, and improvement questions (all $ps < 0.0001$). In general, component simple effects and lower order interactions were stronger when the overcontrolled child was in Context A and the undercontrolled child was in Context B. The effects suggest that the adults read the vignettes carefully, weighing not only the problems but also the informational context into which those problems fit. While this is useful to know, the specific context effects were of little theoretical interest, and are not described further here.

Culture main effects. Strong main effects of culture were found for all five questions:

all five $Fs > 24$, all five $ps < 0.0001$. As Fig. 1 shows, Thais, compared to Americans, rated the problems (both over- and undercontrolled) as less serious (means 4.37 and 5.64; SDs 1.63 and 1.23), less worrisome to a parent (5.11 and 5.99; SDs 1.57 and 1.13) or teacher (4.79 and 5.83; SDs 1.63 and 1.14), less unusual (4.18 and 4.80; SDs 1.67 and 1.33), and *more* likely to improve with time (5.06 and 3.74; SDs 1.62 and 1.73).

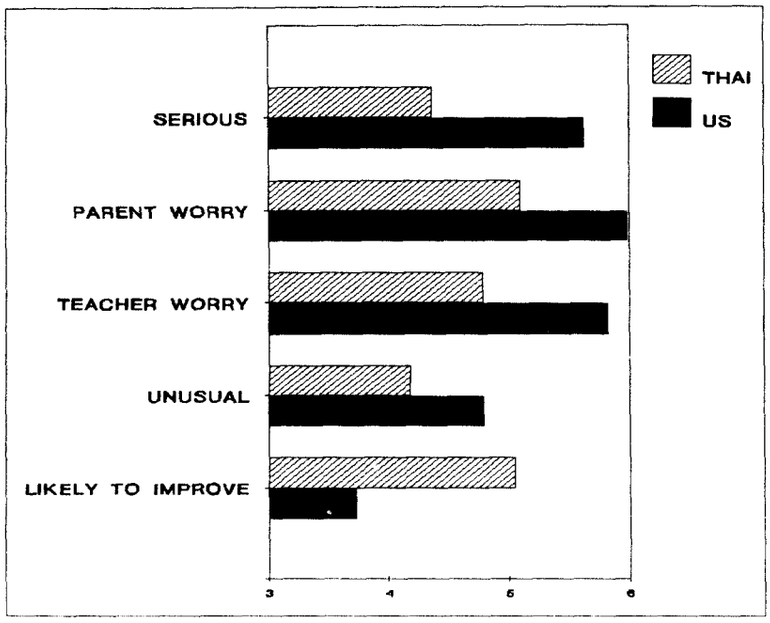

Fig. 1. Thai and American adults' answers to five questions about child problems (over- and undercontrolled combined). The numbers reflect mean ratings on Likert scales ranging from 1 to 7.

We considered two artifactual interpretations of the culture main effects. First, might Thais simply give lower ratings than Americans on Likert scales? Evidently not, since Thais gave *higher* ratings than Americans on the improvement question. Second, might Thais be prone to give more moderate or "middling" ratings than Americans? Contrary to this possibility, the standard deviations of the Thai and U.S. samples shown above reveal that, except for the improvement question, Thais actually showed slightly *more* variability than Americans.

Problem type main effects. On all but the unusualness item, the problem type effect was highly significant, all $Fs > 37.00$, all $ps < 0.0001$. Undercontrolled problems, relative to overcontrolled, were rated more serious (means 5.28, 4.68; SDs 1.48, 1.64), more worrisome to a parent (5.79, 5.28; SDs 1.34, 1.50) and a teacher (5.54, 5.04; SDs 1.41, 1.56), and less likely to improve (4.10, 4.75; SDs 1.83, 1.71).

Controlling for demographic differences between cultures. To test whether the significant main and interaction effects involving culture might have been influenced by age or educational differences between the two samples, we reran our analyses twice, including age, then education as the first term in the model, thus statistically eliminating the two demographic effects. All tests of the culture main effect remained significant beyond the 0.001 level in both eliminating tests.

Need for treatment: over- vs undercontrolled problems

Next we focused on the question asking whether the over- or undercontrolled child had "a greater need to be taken to a specialist for counseling or help". We used a 2 × 2 × 2 × 2 × 2 × 2 (culture × setting × adult group × sex of child × context × over- vs undercontrolled) log linear analysis, with alpha at 0.001. There was a significant context effect, χ^2 (1, $N = 371$) = 19.31, $p < 0.0001$; with the overcontrolled child in context A and the undercontrolled child in B, 72% of the adults chose the undercontrolled child, but with the contexts reversed, 49% did so. There was a marginally significant culture × adult interaction, χ^2 (1, $N = 371$) = 6.79, $p < 0.01$. Thais who chose the overcontrolled child were more likely to be parents than teachers; the reverse was true for Americans. Finally, there was a marginal main effect of culture, χ^2 (1, $N = 371$) = 6.61, $p < 0.01$. Americans were about equally likely to choose the overcontrolled child (46%) and the undercontrolled child (54%); Thais, by contrast, were more likely to choose the undercontrolled child (66% vs 34%).

Controlling for demographics. We reran these analyses with age, then education included as continuous effects in separate models. With cross-national differences in age and education thus controlled, the only notable change was that the marginal effect of culture on need for treatment was reduced to nonsignificance (both *p*s > 0.07).

Judgments about etiology and proposed interventions

Next we focused on adults' judgments as to the causes of the over- and undercontrolled problems. We used 2 × 2 × 3 × 3 (culture × setting × adult group × etiology) log linear analyses, with alpha at 0.001. We used only the three high frequency categories: (1) faulty child-rearing, socialization, or teaching, (2) environmental stress, and (3) personality trait–psychodynamic explanations. For both the over- and undercontrolled child, only the culture main effect was significant, both χ^2s > 15, both *p*s < 0.001. Thais, much more than Americans, attributed both problem patterns to faulty child-rearing, socialization, or teaching. We applied the same type of log linear analysis to adults' proposed interventions for the over- and undercontrolled children, but we found no significant effects.

Controlling for demographics. We controlled for age and education by re-analysing, including those two variables as direct, continuous effects in separate models. The two main effects of culture were both reduced to nonsignificance (both *p*s > 0.03).

Discussion

When Thai and American adults made judgments about the same patterns of over- and undercontrolled child behavior, they evidently viewed the behavior from different perspectives. The most pronounced Thai–U.S. differences support the general form of the threshold model described in the Introduction: across the various judgments about how serious, unusual, and worrisome over- and undercontrolled problems are, Thai adults expressed less concern than Americans.

In addition to this overall cross-national comparison, we compared urban *and rural* samples from both countries. This allowed us to test whether cross-national differences

like those found for the urban samples used by Weisz *et al.* (1988) would be tempered by interactions of culture with urban/rural setting. Such interactions were not found here. Instead, we found no evidence of any culture × setting interaction. This suggests that the cross-national differences reported in Weisz *et al.* (1988) are robust across urban and rural settings. Moreover, the absence of culture × adult group interactions suggests that the cross-national differences in adult attitudes reported here are relatively consistent for parents and teachers in the two cultures.

As for the culture main effects identified here, they appear consistent, in part, with Suvannathat's (1979) conclusion that Thai adults tolerate broad variations in child behavior, and are consistent with some basic tenets of Thai Buddhism as well (Daksinganadhikorn, 1973; Jumsai, 1980; see Introduction). The findings may also reflect an American sensitivity to child problems generated by extensive exposure to child psychology in the media. In addition, the results may reflect the premium Thais place on being *choei choei,* i.e. not being overly emotional or easily upset. Finally, it is possible that some of the Thai–U.S. differences reflect cross-national differences in the *true* significance of child problems. For example, perhaps Thai children who show behavior problems actually *are* more amenable to change than American children who show similar problems.

There was virtually no support for the pattern-specific variant of the threshold hypothesis. The only support was a trend that emerged from the forced-choice treatment priority judgments. Asked which child was more in need of help, Thais were marginally ($p < 0.01$) more likely than Americans to choose the undercontrolled child. The finding is consistent with the notion that Thais are more likely than Americans to be distressed by undercontrolled child behavior, and more likely than Americans to consider inhibited behavior acceptable (see Sangsingkeo, 1969; Suvannathat, 1979; Suwanlert, 1974). However, the marginal level of the finding raises questions about its reliability.

The present findings may help us interpret recent data on child problem prevalence in clinic and general population samples among Thai and American children. In a survey of child clinic referral problems in the U.S. and Thailand (Weisz, Suwanlert, Chaiyasit & Walter, 1987a), overcontrolled problems were more often noted among clinic-referred Thai youth than among their American counterparts; undercontrolled problems were noted more often among American than Thai youth. Such findings might have resulted from Thai–U.S. differences in the actual prevalence of over- and undercontrolled problems *and/or* from Thai–U.S. differences in adult judgments as to what types of child behavior warrant referral. The present findings support the former interpretation and cast doubt on the latter. Indeed, the present findings suggest that Thai adults may be, if anything, slightly more likely than Americans to refer children for *undercontrolled* problems. Thus, the Weisz *et al.* (1987a) findings may reflect Thai–U.S. differences in true problem prevalence rates. This is further supported by epidemiologic findings from Weisz *et al.* (1987b) showing higher levels ($p < 0.005$) of overcontrolled problems in random samples of Thai children relative to random samples of U.S. children. (There was no significant Thai–U.S. difference in undercontrolled problems.) Moreover, Weisz *et al.* (1987b) found that four of the eight problems included in the overcontrolled vignettes in the present study were significantly more prevalent in Thai than American children (all ps < 0.001), whereas

none of the eight was more prevalent in American than Thai children.

One practical implication of the present findings is that child problems may be less likely to stimulate help-seeking by Thai adults than American adults. Studies of other Eastern cultural groups indicate that the Chinese in Canada (Lin, Tardiff, Donetz & Goresky, 1988) and the Japanese in Hawaii (Kinzie & Tseng, 1988) keep psychological problems within the family longer, prior to referral, than do their Caucasian counterparts. The same may be true of psychological problems among Thai people, at least with respect to child problems, and the present findings on adult attitudes would help provide an explanation. As appears to be the case with the Japanese (see Kinzie & Tseng, 1988), it may be that Thais tend to believe (and perhaps correctly so) that their family support systems can provide the help individual members need to resolve most psychological problems. The present findings do not clearly establish such a conclusion, but they do suggest the possibility as a target for future research in this area (see e.g. Weisz & Weiss, in press).

Overall, the findings suggest strong cross-national differences in adult attitudes toward child problems, differences not significantly qualified by problem pattern (over- vs undercontrolled), by adult group (parent vs teacher), or by setting (urban vs rural). It is possible, however, that the absence of interactions involving problem pattern, adult group, and setting resulted in part from the relatively high level of severity of the two problem patterns described in the vignettes—i.e. with eight potentially significant problems included in both the over- and undercontrolled vignettes. The severity of the two collections may have pushed adults in both cultures to make such high ratings as to disguise subtle interactions with other factors. Indeed, it is possible that there was a ceiling effect on some of the scales (e.g. parent worry and teacher worry). In future research, such possibilities could be addressed by varying vignettes on severity. In this and other ways, investigators should continue to test the robustness of the cross-cultural differences identified here.

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