HEALTH RISK ASSESSMENT FOR EIGHT TO TEN YEAR OLD CHILDREN OF HMONG AND VIETNAMESE ETHNICITY

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By

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&
Patricia E. Leads

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Abstract

Health Risk Assessment for School Age Children of Hmong and Vietnamese Ethnicity

By
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Hmong and Vietnamese adolescents represent two minority groups that exhibit an increased prevalence of high risk health behaviors with poor health outcomes. They have decreased access to culturally specific health care, and as a result there is a deficit in sufficient cultural health data due to under-assessed health behaviors [Task Force, Kagawa-Singer, 1996].

Health care providers, including the advanced practice nurse[APN] need to identify high risk behaviors and provide culturally specific care for Hmong and Vietnamese school-aged children before the stage of adolescence. Culturally specific health risk assessments for these two populations are currently not available. Therefore the purpose of this project was to create a culturally specific health risk assessment for Hmong and Vietnamese children, ages eight to ten years, that addresses lifestyle and health behaviors shown to precede adolescent morbidity and mortality.

The Revised Health Promotion Model, described by Pender [1996] provides the framework for the identification of high risk behaviors incorporated into the Cheung-Leads Health Risk Assessment (C-LHRA). Future implications include the use of the C-LHRA as a screening instrument at a future school-based clinic.

We would like to dedicate this project to the following people:

From Pat:

To my loving daughter, Sarah Joyce, whose love gave me the energy and purpose to complete this project and endure graduate school.

&

From Renee:

To my loving husband Denny, whose support and encouragement inspired me to complete this project.

Acknowledgments

This scholarly project would not have been possible without the support and encouragement of our scholarly project committee. This "joint project" was a new and challenging endeavor for all. Our chairperson, Joan Wood, R.N., Ph.D. bravely undertook this joint venture without hesitation, and for this we are both appreciative. Joan, your leadership and encouragement kept us motivated to finish this project.

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From Pat: I also want to personally thank my daughter Sarah and closest friends, Jan, Margaret, Gale and David for your support and time. To Jan and Gale, for the countless hours I cried on your shoulders. To Margaret, for your endless energy in promoting and living the profession of nursing, and to David for the hours spent providing creative ingenuity and polish to this document. Finally, to my daughter Sarah who I treasure. If not for you, I would not have learned what is truly important in this world. For that my sweet girl, I am ever thankful.

From Renee: I would like to thank my husband, Denny, for the love and support you provided to me, not only for this project but throughout graduate school. Your understanding and support gave me the energy to endure a challenging endeavor.

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Introduction

There is a commonly held perception that all adolescents are healthy and at low risk for long-term health complications, or death. However, for many adolescents the opposite is true. There are numerous health surveys and reports that have documented the adverse health status of our nation's adolescents. They have indicated a shift from biological to social etiologies of morbidity and mortality at a disproportionate rate among minority adolescents [Centers for Disease Control (CDC), 1993; Children's Defense Fund, 1997; & Resnick, 1997]. Other trends suggest an increase in the numbers of minority adolescents living in poverty with decreased access to primary care, an increase in the prevalence of ethnic minority adolescents within the U.S. population [Kagawa-Singer, 1996 & Task Force], and mounting evidence in support of the importance of the impact of the social environment on adolescents [Resnick, 1997]. Finally, there is an abundance of evidence which supports the strong adverse influence that risk taking behaviors have on adolescent mortality, morbidity, and future quality of life [Resnick, 1997]. Overall, these trends should alert health care providers of the need for strategies to increase access to primary care, assist in identifying those at high risk, and alert communities and health care providers to the main threats to adolescents' health.

Research findings acknowledge that the main threats to adolescents' health are not sickness or disease, but are certain high risk behaviors and choices that adolescents make on a daily basis [Resnick, 1997; CDC, 1995]. Minority adolescents are at higher risk to exhibit high risk behaviors than their white counterparts, and have poor health status [Blum, 1987]. They have higher teen birth rates, younger ages of death, and

experience morbidity at a younger age [Blum, 1987]. They also have decreased access to primary health care, a barrier which magnifies the poorer health outcomes for minorities.

Overall, the high risk behaviors among our nation's adolescents consist of injuries (intentional & unintentional), substance abuse (drugs,alcohol, & tobacco), and sexually related consequences. All contribute to the majority of mortality and morbidity in this age group and are largely preventable. These high risk behaviors are usually initiated during childhood, persist through adolescence, and have adverse health consequences into adulthood [Pender, 1996]. In particular, minority adolescents experience the consequences of these high risk behaviors at earlier ages [Blum, 1987]. According to Pender [1996], health beliefs, perceptions, and behaviors are established by age ten. Therefore, it is imperative to identify high risk behaviors of minority adolescents during the school-aged years of eight to ten prior to their establishment in adolescence. To prevent the long-term health problems associated with these high risk behaviors, health care providers must implement strategies that identify and reduce high-risk behaviors of all adolescents.

Identifying those at high risk, particularly adolescent minorities can be difficult due to their under-representation in national health data bases [Kagawa-Singer, 1997; AAP]. For some ethnic-minority groups such as the Asian-Americans, the knowledge base is very sparse. In order to remedy this knowledge deficit, researchers and health care providers need to gather more information on these populations. Either culturally specific health risk assessments can be developed, or current mainstream 'white' adolescent health risk assessments can be modified. Either approach would enable the appropriate

assessment of adolescents of different cultures for high risk behaviors [Kagawa-Singer, 1996]. Thus, this project focuses on the assessment of two specific minority groups, the Hmong and Vietnamese, which have been identified as high risk and reflect a lack of adequate health status data [Kagawa-Singer, 1996].

Problem Statement

Hmong and Vietnamese adolescents represent two minority groups that exhibit an increased prevalence of high risk health behaviors with poorer health outcomes. They have decreased access to culturally specific health care, and their health data reflects a deficit due to under-assessed health behaviors [Task Force, Kagawa-Singer, 1996]. Health care providers, including the advanced practice nurse[APN] need to identify high risk behaviors and provide culturally specific care for Hmong and Vietnamese school-aged children before the stage of adolescence. While this care may be provided in a variety of settings, one approach for the APN is to provide primary care within school-based health clinics.

In order to provide this care, the use of culturally specific health risk assessments that assess school-age children for health behaviors is required. Culturally specific health risk assessments for these two populations are currently not available. The purpose of this project was to create a working draft of a culturally specific health risk assessment, for Hmong and Vietnamese school-age children. The assessment addresses lifestyle and health behaviors that research has shown to precede adolescent morbidity and mortality.

Conceptual Framework

The Revised Health Promotion Model [RHPM], Figure 1, described by Pender provides the framework for this project. This model integrates constructs from the social cognitive theory and the expectancy-value theory within the realm of nursing.

The social cognitive theory states cognition, affect, and environmental factors contribute to the initiation of behaviors. The expectancy-value theory states that behaviors are logical and purposeful [Pender 1996]. The underlying assumptions of the RHPM reflect and emphasize active participation the individual must embrace in order to shape and maintain personal health behaviors. The assumptions speak to the person's ability to seek and create conditions of living that allow one to attain full personal health potential [Pender, 1996].

The RHPM has three major categories, i.e., individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcome. Within the first category, individual characteristics and experiences, are the concepts of 'prior related behavior' and 'personal factors'[Pender, 1996]. Prior related behavior has both a direct and indirect effect on the probability for involvement in health-promoting behaviors. Empirical studies demonstrate that the frequency of similar past behaviors are the best predictors of potential future behaviors and that habit formation predisposes one to continue with these behaviors [Pender, 1996]. Therefore, use of the C-LHRA will assist in the identification of high risk health behaviors and allow for intervention to interrupt these behaviors.

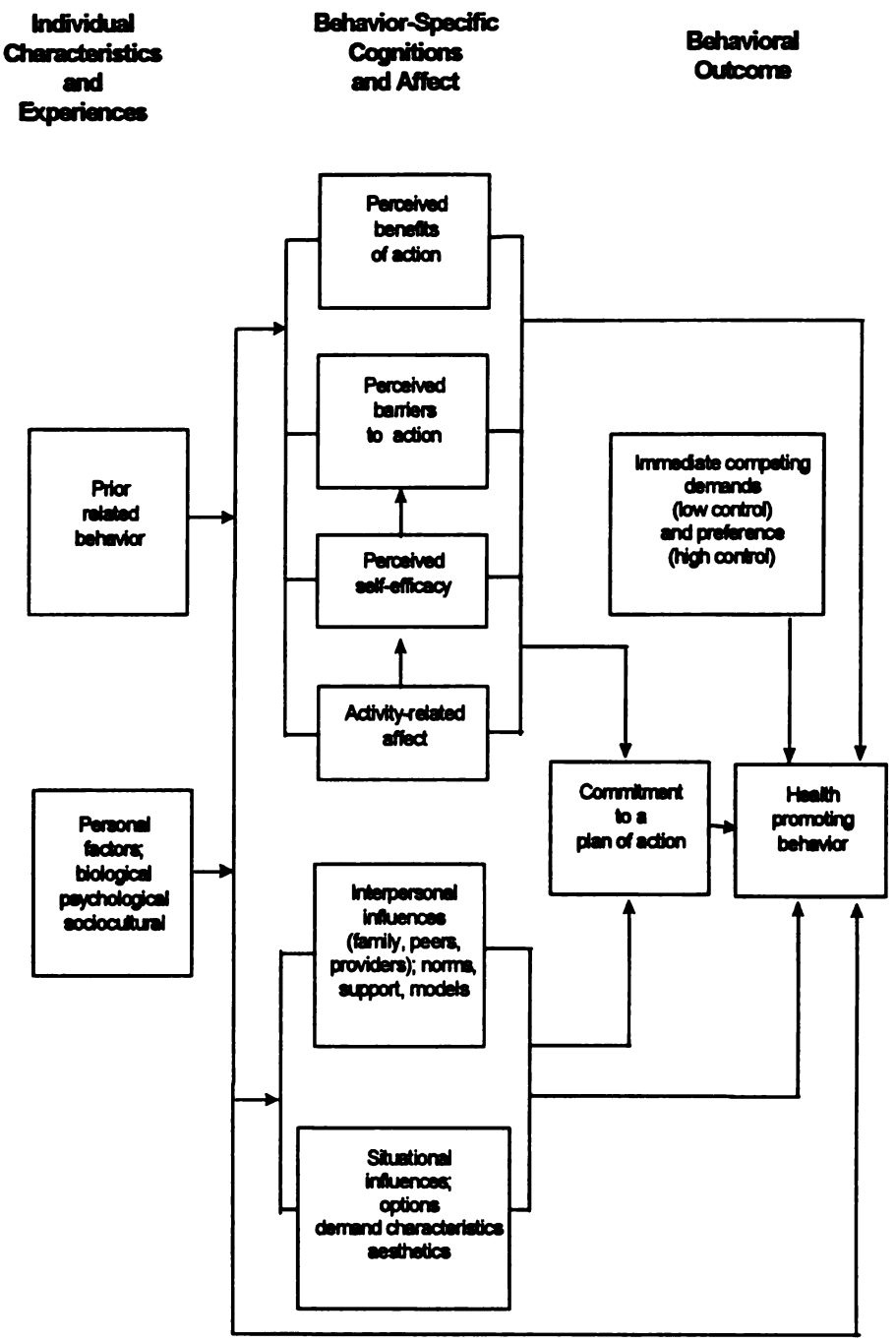

Figure 1. Revised Health Promotion Model (Pender, 1996)

Personal factors include the impact of biologic, psychologic, and sociocultural influences on behaviors [Pender, 1996]. Biologic factors include the individual's age, gender, body mass, pubertal status, menopausal status, aerobic capacity, strength, agility or balance. The psychological factors include, self-esteem, self-motivation, personal competence, perceived health status, and definition of health. Sociocultural factors include race, ethnicity, acculturation, education, and socioeconomic status [Pender, 1996].

The second major category is composed of six concepts: perceived benefits of action, perceived barriers to action, perceived self-efficacy activity-related affect, interpersonal influences and situational influences. These variables combined are considered the category of motivational significance [Pender, 1996]. Within this category these variables are prone to modification through nursing actions and viewed as the critical "core" for interventions. When one decides to engage in a particular behavior, an emotion or affect have influenced that decision [Pender, 1996]. Cognitions, emotions and affect all play an important role in health-promoting behaviors. The belief in a positive outcome is considered to be a necessary condition for engagement in a specific health behavior [Pender, 1996]. The more one experiences perceived benefits from these actions, feels efficacious and capable in relation to an action or skill, the more he/she will engage in the behavior [Pender,1996]. Activity-related affect refers to the subjective feeling a behavior or action stimulates. These feelings occur before, during or after a behavior, and are stimulated by the action itself [Pender,1996].

Interpersonal influences are cognitions that determine behaviors, beliefs or attitudes. The largest impact of interpersonal influences on health-promoting behaviors are families, peers and health care providers [Pender, 1996]. The constructs of interpersonal influences include norms (expectations of significant others), social support (encouragement), and modeling (learned behaviors through observation) [Pender, 1996].

These three interpersonal influences, ie, norms, support, and models, have been identified in previous studies to affect a person's predisposition to engage in health-promoting behaviors. These influences are responsible for the engagement in health-promoting or high-risk behaviors. Behaviors, wishes and inputs from others must be addressed, understood and synthesized into a cognitive representation for a given behavior [Pender, 1996]. Some cultural groups place more emphasis on these interpersonal influences than others. For example, the needs of the family may out weigh the needs of the individual in particular ethnic groups [Pender, 1996].

The third major category, behavioral outcomes is composed of three variables, immediate demands (low control) and preferences (high control), commitment to a plan, and health promoting behavior. Commitment to a plan of action refers to the actual cognitive decision to engage in a specific action. There are two underlying cognitive processes within this variable: the commitment to engage in a specific action at a specific time, and place when either alone or with a specific individual despite competing issues and the identification of strategies to assist in the follow through and reinforcement of the specific action. These two cognitions must be present in order for engagement in a health-promoting behavior to occur [Pender, 1996]. Health promoting behavior is the

outcome in the RHPM. The ultimate goal is attainment of life-long positive health outcomes [Pender, 1996].

Self-care Education Process and Health Risk Assessment

Self-Care Education Process

Imbedded within the category of interpersonal influences are the concepts of self-care education and risk assessment. Though not visually depicted within the RHPM these underlying concepts are important for the health-care provider to understand in order to best deliver appropriate and individualized care. The process of self-care education is a complex and collaborative endeavor.

The self-care education interaction brings together the expertise and knowledge of the health-care provider and the goals of the client (either individual or groups). Within this dyad is mutual assessment of competencies and needs, as well as identification of the environmental and interpersonal support required for learning. Figure 2 outlines the self-care education process described by Pender [1996].

There are many components of the self-care education process. The first step within this process is mutual assessment of health care competencies, strengths and needs. This often is done with a health risk assessment. This assessment is completed early in the process by the client and then reviewed by the health care provider. This recognizes learning priorities, pace and environmental needs for the learning to be successful. Barriers are also identified at this time. Failure to identify and deal realistically with any barrier can result in poor health outcomes or lack of progress towards a self-care goal [Pender, 1996].

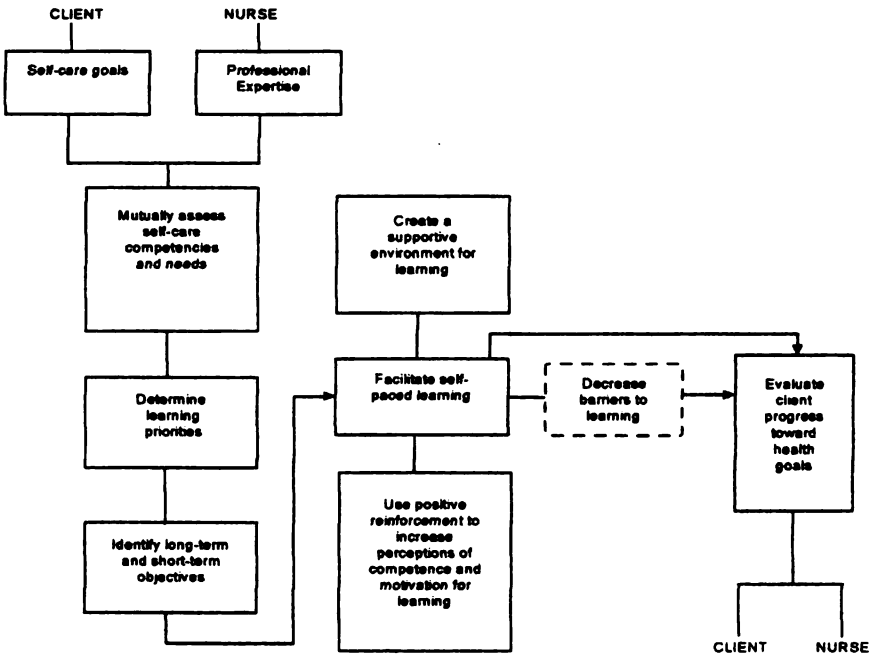

Figure 2. The Self-Care Education Process (Pender, 1996)

The identification of long-term and short-term objectives are important in the self-care education process. Long-term objectives serve as a general guide for learning. Self-paced learning is an important component of the self-care education process. The pace at which a client learns depends on many issues. Personal motivation, perseverance, skill level and learning style all play a role in how one learns. The pace will also vary with the age, health status and educational level the client brings to this process [Pender, 1996]. It is vital to allow the client to set the pace for learning and

maintain control over the learning process. The goal at this step is not the pace of learning but the mastery of skill obtained for self-care and optimal health outcome [Pender, 1996].

Short-term objectives serve as specific actions or steps necessary to master and relate to a long-term objective. [Pender, 1996]. These objectives are in written form and allow the client to recognize their completion via a check mark. This serves as immediate and concrete feedback for the client.

The use of a supportive environment for education is important. A quiet and non-threatening area should be used when education is underway. Group settings or individual education can be done. A combination of group and individual instruction can also be used. This combination method promotes a unique educational setting for clients while allowing efficient use of the health care provider's time [Pender, 1996]. This step influences the person's ability for self-paced learning and either creates a barrier to learning or allows progression for education to occur.

Positive reinforcement is vital for the success of goal achievement. The client, family members and the health care provider all play important roles in positive reinforcement. Praise and compliments enhance feelings of self-care competence for the client. Once learning has occurred, intermittent positive reinforcement strengthens and secures that health behavior over time [Pender, 1996].

As stated earlier, failure to identify and deal realistically with any barrier can result in poor health outcomes or lack of progress towards a self-care goal [Pender, 1996]. Barriers come from a variety of areas. Internal sources such as lack of motivation,

poor self-concept or inadequate skills, or external sources such as lack of family support, or environmental issues influence progress towards a goal. When a lack of progress towards a goal is identified internal and external barriers need to be evaluated [Pender, 1996].

Evaluation of progress is done in collaboration. This process judges whether or not long and/or short term objectives have been met. A combination of evaluation methods reveals the most accurate picture of goal attainment. The overall outcome from the self-care education process is a permanent change in lifestyle [Pender, 1996].

When dealing with groups of people as well as individuals the self-care education process will be unique each time. The individual, as well as the APN brings to the setting a multitude of dimensions; each dimension has its unique life situations, values and behaviors. In order for the education to be meaningful and successful, both must be actively involved. The client brings his/her own expectations and the APN brings knowledge and expertise [Pender, 1996].

The Health Risk Assessment

The health risk assessment is an organized framework utilized by the health care provider to identify health risks for a specific population or an individual. Again, the health risk assessment is not visually depicted within the model of self-care education process, but the concept falls within the domain of the nurse, i.e., APN. The APN utilizes the assessment to assess and identify strengths and areas of growth for the individual. This data then guides appropriate interventions. To be effective, these interventions must be culturally-specific, age appropriate and mutually set.

Health risk assessments are often categorized in general classifications. Pender [1996] identifies six general categories of risk factors. It is generally accepted that risk of disease development increases as risk factors increase. However, the general population data does not accurately reflect an individuals health risk profile [Pender, 1996]. Pender's six categories of risk factors are presented in Figure 3.

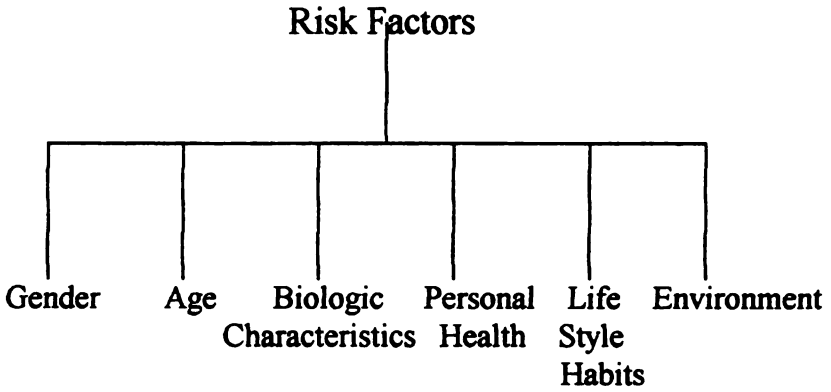

Figure 3. Categories of risk factors (Pender, 1996)

These risk factors provide general categories that can be broken down into specific behaviors which in turn help to identify health risks. For example, an individual's family history of heart disease cannot be altered, but the behavior of smoking can be. The APN can refer and educate regarding smoking cessation and associated cardiovascular health risks. Thus, specific behaviors need to be identified on the health risk assessment in the form of questions and/or statements to which an individual responds [Pender,1996].

The purpose of using a health risk assessment is to identify potential health risks of an individual. The identification of health risk behaviors is the first step in the self-

care education process. This data provides important insight on the health promoting and high risk behaviors of the individual. Based on this information an accurate targeted format of education or counseling can be mutually agreed upon [Pender,1996].

As discussed earlier, the influence of family, culture, and perceived "norms" collectively determine behavior. A health risk assessment that attends to culture, age and the individual's family (ex. involvement from parents), will enable the APN to have accurate data that includes health risk information and becomes the basis for an individualized educational plan. Therefore, the modified Self-Care Education Process within the RHPM appears in Figure 4. This figure visually depicts the relationship between the self-care education process, the health risk assessment and the critical concepts of this project (shaded areas).

Within the self-care education process the C-LHRA can be utilized to mutually assess current high risk behaviors and sociocultural factors that promote or protect against the initiation of high risk behaviors within the context of the Homg and Vietnamese cultures. For instance, perceived connectedness to peers, family, and school provide protection against the initiation of high risk behaviors [Resnick, 1997]. Based on the results of this assessment, the APN can incorporate strategies to increase perceptions of connectedness and competence. These strategies will promote motivation for learning and decrease the potential for high risk behaviors.

This project focuses on the development of a health risk assessment that identifies potential health risk behaviors in school aged children of Hmong and

Vietnamese ethnicity. This information can then be used to identify specific educational programs for these populations as well as identify culturally specific health care services.

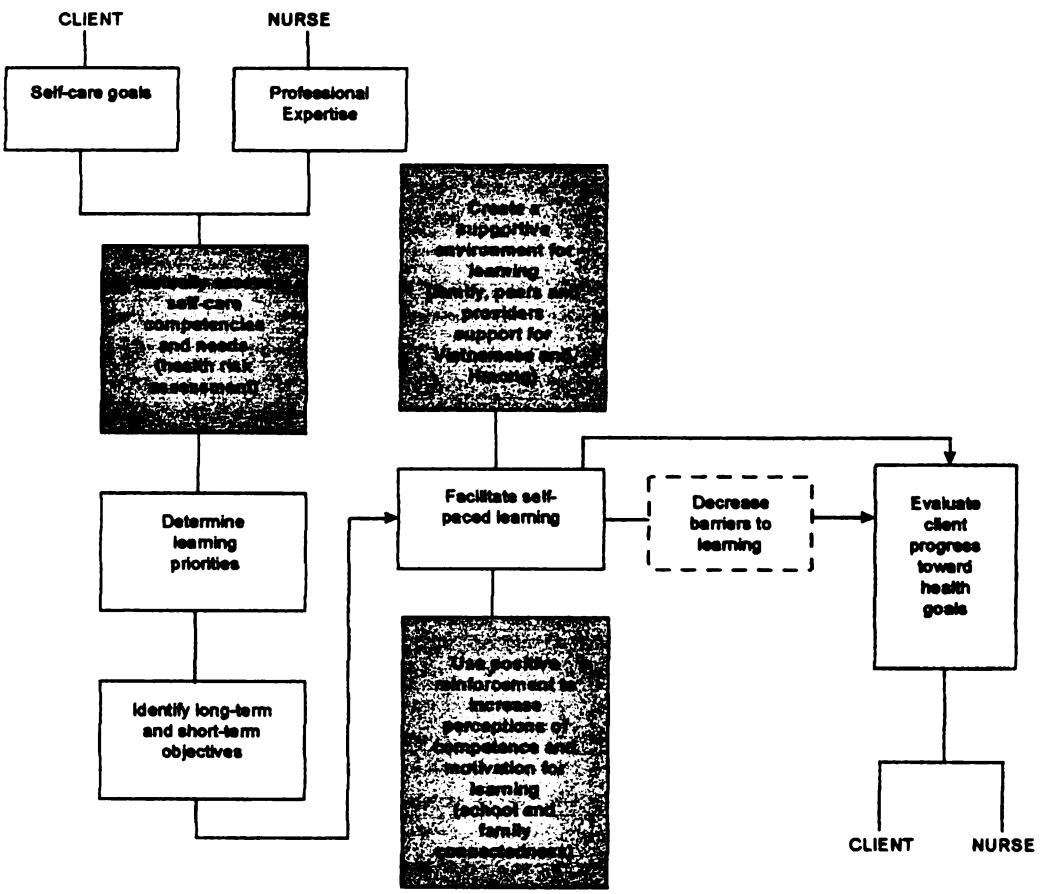

Figure 4. Modified Self-Care Education Process
(Pender, 1996)

Conceptual Definitions

The concepts used throughout this project are health risk assessment, culture, ethnicity, school age children, resilience, connectedness, culturally specific care and primary care. The definitions are as follows:

Health risk assessment refers to an instrument that a healthcare provider utilizes to identify problems or strengths within an individual's health history. The assessment is often structured in broad categories with specific questions within each of the categories. The number of questions can vary. Once the health risk assessment is completed the healthcare provider reviews and evaluates the results. These results may guide the development of an educational program for the individual with similar needs. They may also enable the identification of possible interventions with the client [Pender, 1996].

Culture is defined as a system in which symbols are shared, learned and passed on from generation to generation within a social group [Lipson, Dibble & Minark, 1996]. Culture influences the individual's perceptions and guides interactions with other people. It is a dynamic process that changes over time.

Ethnicity refers to the identity associated within a culture or affiliation [Lipson, Dibble & Minark, 1996].

School age children refers to children eight to ten years of age. This age group often attends an elementary school and are generally in the fourth and fifth grades. The focus on this age group is based on the belief that health-promoting behaviors are established by the age of ten [Pender, 1996].

Resilience is the ability to recover or cope successfully in the face of adversity or significant change [Stewart, Reid, & Mangham, 1997]. This ability changes over time and is enhanced by protective factors within the individual and the environment [Stewart & et.al, 1997].

Connectedness refers to the individual's perceived feelings of love, warmth and caring from parents and teachers the individual believes to be present. This concept is an emerging issue, and necessary to understand the health issues of the young today [Resnick, 1997].

Culturally specific care is defined as the incorporation of the symbols, values and beliefs of a unique culture into the health care of an individual or family. It is a conscious effort on the part of the health care provider to address the cultural aspect of the individual. As the cultural issues are addressed the health outcomes are potentially improved [American Nurses Association (ANA), Executive Summary, 1997].

Primary care is the first level of care provided upon entry into the healthcare system, is provided by a health care provider for a multitude of health problems which individuals and families acquire over a lifetime. This care can be preventive, curative, and/or rehabilitative services, but its intent is to maximize health status and well-being [Starfield, 1992].

Literature Review

The examination of this problem required an investigation of several different areas. The following literature review includes information regarding current adolescent health issues, and the mortality and morbidity of U.S. and Asian American adolescent

populations. The health beliefs/values of the Hmong and Vietnamese cultures, along with factors that promote and prevent the initiation of high-risk behaviors are discussed. Available literature on Hmong and Vietnamese adolescent morbidity and mortality is virtually non-existent. Very little empirical research can be found on the incidence and prevalence of health behaviors of the Hmong and Vietnamese adolescent, and often conclusions for these two groups can only be inferred from health data on adolescents as a whole [Kagawa-Singer, 1996].

Culture provides the blueprint that guides behavior and determines health beliefs and values [Kagawa-Singer, 1996]. It also determines how health risks are defined and identified, and how symptoms are manifested. Once a health problem is identified, the cause attributed to the health problem, the acceptable modes of coping, and the ways of seeking help are dictated by one's culture [Kagawa-Singer, 1996]. According to Pender [1996], heath beliefs, perceptions, and behaviors are established by age ten. Therefore, in order to be effective in reducing the Hmong and Vietnamese adolescent's social morbidity and mortality, health care providers need to address the social etiologies present during the school-age years of eight to ten. When assessing the health behaviors of Hmong and Vietnamese school-age children, it is important to know differences in cultural health beliefs, concepts of health, and values in order to identify and define acceptable behavioral expressions of manifesting these values and beliefs within a cultural context. The APN must be careful to differentiate between traditional practices that individuals associate with cultural identity and behaviors that are high risk and detrimental to health and well-being.

Hmong Health Beliefs/Values

The Hmong strive to obtain balance or equilibrium in their lives in the areas of emotions, relationships, work and relaxation, food intake (hot & cold), and spiritual life [Frye, 1995]. This balance between the mind, body, and soul is equated with health. The Hmong world view is rooted in the ongoing conflict of good and evil forces in a world populated by spirits. The individual is believed to posess many souls in constant danger of being separated from the body[Frye]. Causes of soul loss include loneliness, extreme grief, illness, fright, and violation of body integrity [Frye]. The perceived danger of a separated soul is that it can wander and haunt family members. Therefore, the transgressions of an individual can affect the whole family [Frye]. Hmong believe that an illness is caused by natural or supernatural etiologies. Traditional views of illness include soul loss, spoiled food, hot/cold imbalance, or an attempt by an ancestral spirit to encourage traditional ceremony performance [Lipson, Dibble, & Minarik, 1996]. Natural causes include a shift in the balance of natural forces such as weather. Management of illness includes soul-calling ceremonies, wearing amulets and talismans against spirits, and contacting traditional healers [Frye].

Vietnamese Health Beliefs/Values

The Vietnamese perceive a unity between the mind and the body and equate the unity with health. A high value is placed not only on personal, but also interpersonal and environmental harmony. When an imbalance occurs within any of these three areas, the Vietnamese believe it to be an imbalance between yin

and yang or hot and cold. It can have either physiologic, psychological, or supernatural causes [Kagawa-Singer, 1996; & Lipson, Dibble, & Minarik, 1996]. Supernatural explanations for illness include punishment for personality fault, or violation of a religious taboo [Lipson, Dibble, & Minarik, 1996]. Other causes of illness include spoiled food, selfish desire, and retribution for sin [Frye, 1995]. Mental illness is viewed as a disharmony within an individual and some believe that it is caused by an ancestral spirit come back to haunt them for their bad behavior [Lipson, Dibble, & Minarik, 1996].

Treatment of illnesses includes hot/cold treatment, and coin rubbing [Frye, 1995]. It is the women of the family who are responsible for the care of an ill family member; this includes pampering the family member with daily baths and meals. It is expected that a woman will remain at the bedside of the ill family member, even if hospitalized [Lipson, et. el. 1996].

Central to both ethnic groups are the cultural themes of kinship solidarity, and the search for balance. The individual as a separate entity is subservient to the family's or clan's needs and respect for the elderly characterizes their family patterns. Both kinship patterns are patrilineal with the decision-making residing with the eldest male. Also, a desire for personal and familial self-sufficiency, a strong sense of family obligation, and the use of folk remedies for health care are common to these populations. Children are socialized to be in control of their feelings, needs, and impulses and not disrupt the harmony within the family [Kagawa-Singer, 1996].

Factors Promoting High Risk Behaviors

Factors have been identified at the individual, family, and community levels which place children and adolescents at an increased risk for the adoption of high risk health behaviors and the resulting adverse health outcomes [Stewart, et al., 1997]. For instance, individual-level risk factors are chronic illness, male gender, minority racial status, and anti-social behavior[Stewart, et al., 1997]. Family-level risk factors include separation from parents, exposure to violence, low socioeconomic status, teenage motherhood, and large family size [Stewart, et al., 1997]. The community level of risk factors include poverty, residence in a violent neighborhood, and a deviant peer group[Stewart, et al., 1997]. Overall, these risk factors represent increased stressors for children and adolescents and place them at a greater risk for poor psychological health, physical health, and the adoption of high risk health behaviors associated with adolescent morbidity and mortality.

General Adolescent Intentional & Unintentional Injuries

Specific risk taking behaviors and their consequences contribute to the majority of U.S. adolescent and child (5-14yrs) morbidity and mortality. These risk taking behaviors fall into the categories of injuries (intentional and unintentional), substance abuse (alcohol, drugs, and tobacco), and sexually transmitted illnesses.

Unintentional injuries are the leading cause of death among twelve to twenty four year olds [Waxweiler, R., Harel, Y. & O'Carroll, 1993]. For adolescents, the leading causes of unintentional injuries include motor vehicle accidents, falls, firearms, poisonings, drowning, fires, and burns [Waxweiler, R., Harel, Y. & O'Carroll, 1993].

These risks increase with age in adolescence. The rate for violent injury for 18-19 year olds is almost two and a half times greater than that of 12-15 year olds [Waxweiler, et al. 1993]. Accidents remain the leading cause of death and disability in the school age child and pose a significant health problem for this age group [Van Antwerp, Spaniolo, 1991]. These unintentional injuries have become the leading cause of years of potential life lost before the age of sixty five [Waxweiler, et al. 1993].

Eighty percent of these unintentional deaths occur as a result of alcohol consumption and nonuse of safety belts. Motor vehicle accidents account for 29% of all deaths, in which half are related to alcohol. For adolescents, social and cultural risk factors include social disruption within their environment of home or school, single-parent families, and stressful family situations [Waxweiler, et al. 1993].

Intentional injuries such as, homicide and suicide have been increasing among adolescents, particularly among minority populations [CDC, 1995, & Waxweiler, et al. 1993] . They are the second leading cause of adolescent death in the U.S.. Weapon carrying, physical fighting, and group violence are associated with the most serious injuries [Waxweiler, et al. 1993]. The 1995 Youth Risk Behavior Surveillance Survey [CDC, 1996] revealed that 20% of the 10,904 students surveyed were likely to carry a weapon [Waxweiler, et al. 1993].

Suicide rates among adolescents aged fourteen or younger have increased by 75% over the past decade [Resnick, et al , 1997]. Also, suicide was seriously considered by 24.1% of the 10,904 students surveyed; female students were significantly more likely to have thought about and attempted suicide. For both intentional and unintentional injuries

of adolescents, social and environmental factors have increasingly been identified as etiologies [Blum, 1987]. These factors include: social stressors, the use of alcohol and other drugs, knowledge of the perpetrator by the victim, and the availability of handguns [Blum, 1987].

Hmong Intentional & Unintentional Injuries

Due to the lack of health statistics available on the Hmong population, specific health data on the incidence or prevalence of injuries for adolescents in this population was not found. However, it is known, that due to their refugee experience they are prone to more injuries from disease, physical changes from malnutrition, disabling arthritic and muscular-skeletal conditions, chronic pain, and sensory-cognitive impairments-particularly hearing loss [Frye, 1995].

Intentional injuries, including suicide and suicide attempts through drug overdose has been identified as an area of concern for this population. Suicide has been identified as a frequent coping mechanism when life problems seem overwhelming [Frye, 1995]. Due to the major social and cultural disruption in their environment, Hmong adolescents are at great risk for developing high risk behaviors that result in both intentional and unintentional injuries. The incidents increase as they become more acculturated and lack adequate resources to cope. Therefore, when assessing behaviors of Hmong children and adolescents it is important to note if they have been refugees, and the duration of time from the experience.

Three mental health issues are predominately identified with the Hmong in the literature: post-traumatic stress disorder (PTSD), sudden unexpected

nocturnal death syndrome (SUNDS), and depression [Frye, 1995]. Persistent depression has been identified as the greatest health threat to the Southeast Asian refugee, including the Hmong [Frye]. The degree of loss in their lives has been profound. Their cumulative traumas include years of war, separation from and violent deaths of family and friends, refugee camps, and cultural adjustment to America [Frye]. Hmong adolescents in particular have a high rate of depression and anxiety [Frye]. Excess stress among Hmong adolescents can be accounted for by the stressful events associated with the acculturation process [Kagawa-Singer, 1996]. The acculturation process in many ethnic families is first initiated by the children and adolescents who must adapt to the expectations of the dominate Western culture expressed in school with rules and interactions with peers and teachers [Kagawa-Singer, 1996]. This results in many adolescents leading a double life, one at home and a different one at school. This confusion can lead to feelings of alienation, emotional despair, alcohol and drug use, suicide, and various physical and mental health problems. Often the depression and anxiety are expressed through somatization as a cultural expression of suffering and disequilibrium [Frye]. Commonly encountered psychsomatic complaints include chronic headaches, gastric distress, sleeping disorders, nervousness, and excessive fatigue [Frye].

SUNDS is a bizarre and frightening cultural manifestation of suffering that is especially prevalent among young Hmong men with no apparent cardiovascular risk factors. The syndrome is well documented in the literature; it

refers to young men who die suddenly in the night for no apparent reason [Frye, 1995]. It is characterized by it's nocturnal nature, insomnia, and difficulties with breathing and is linked with anxiety reactions. The Hmong believe that it is an attack by a spirit. Important to note is that SUNDS may be preceded by depression, anxiety, paranoia, and nightmares [Frye]. PTSD is a significant problem; it is prevalent in approximately 50% of the Southeast Asian population, including the Hmong. It is characterized by withdrawal, paranoia, nightmares, flashbacks, and an inability to concentrate [Frye].

Vietnamese Intentional & Unintentional Injuries

Statistics about unintentional and intentional injuries such as accidents and suicide, for the Vietnamese adolescent are not available within the literature and must be inferred from the general adolescent population. The contributors to unintentional and intentional injuries for the Vietnamese vary.

According to Gold [1992] the Vietnamese refugee suffers from medical problems and severe mental health problems. Immigration is known to create serious mental turmoil and distress. Often the psychological distress of this circumstance reveals itself 6-12 months after immigration. Symptoms often are exhibited as depression and anxiety [Stauffer, 1996]. Studies demonstrate Asian refugees and immigrants have extremely high levels of depression, adjustment problems and other mental disorders [Resnick et al , 1997]. The poor emotional health and excess stress of the Vietnamese adolescent places them at high risk for suicidal behavior and other intentional injuries.

A large percentage of unintentional injuries within the general adolescent population, such as motor vehicle accidents, falls, etc. are related to alcohol use. The Vietnamese report a high incidence of alcohol use and view this as an acceptable way to cope with stressful situations [Kagawa-Singer, 1996]. As stated earlier of the general adolescent population, 29% of motor vehicle accidents result in death and half of these accidents involve alcohol. The acceptance of alcohol use as a coping mechanism within the Vietnamese culture places these adolescents at a high risk for unintentional injuries such as motor vehicles accidents.

General Adolescent & Substance Abuse

Substance abuse involving the use of cigarettes, alcohol, and drugs are preventable behaviors that are usually established in youth and extend into adulthood. The use of these substances jeopardizes the physical, mental, and social development during a person's formative years, thereby endangering successful transition from adolescent to adult roles [Blanken, 1993]. Tobacco use among adolescents is the single most preventable cause of death in the United States. Its long-term effects result in causing four out of the five leading causes of death, i.e., cardiovascular disease, cancer, stroke, and COPD/lung cancer; all are significant contributors to the rising health care costs[Marcus, S., Giovino, G., Pierce, J., & Hanel, Y., 1993]. According to the 1995 Youth Risk Behavior Surveillance study [CDC, 1996], 71% of the 10,904 students surveyed had smoked cigarettes and 35% were current smokers. It is also important to note that cigarette smoking has increased among teenagers by as much as two percent per

year for 1992, 1993, 1994 among eighth, tenth, and twelfth grade students [Resnick et al , 1997].

Given that tobacco use is preventable, that initiation of smoking occurs primarily during adolescence, and that regular users find it hard to quit, interventions aimed at preventing youth from initiating smoking are of primary importance [Marcus, S. , 1993]. The study by the CDC [1996] also revealed that 52% of the 10,904 surveyed adolescents drank alcohol during the past month, and that 33% of the 10,904 surveyed reported drinking heavily, or used other drugs during the past month. Even infrequent use of alcohol or other drugs may result in intoxication and acute consequences.

Hmong and Vietnamese Substance Abuse

Substance abuse among the Hmong and Vietnamese has been underestimated, in particular, alcohol and tobacco use [Sue, S., et al. 1996]. Studies found the prevalence of smoking of Hmong males is greater than the rate of the general U.S. male population. However, Asian females have lower smoking rates than the general U.S. female population [Sue, S., & Zane, N., 1996]. This study has found that 35% of male Asians and one percent of the female Asians smoked as compared to 22% and 19% respectively of the general population [Sue, S., & Zane, N., 1996]. No prevalence studies have specifically examined smoking among Asian Pacific Islander youth which includes the Hmong and the Vietnamese populations. It is believed that adolescent smoking patterns follow those observed in their countries of origin and that these studies indicate East Asian men begin smoking at an early age [Kagawa-Singer, 1996]. Vietnamese

report a high incidence of tobacco and/or alcohol use; both are viewed as an acceptable way to cope with stressful situations [Kagawa-Singer, 1996]. Therefore, the APN needs to explore and foster alternative coping strategies by changing the perceived normalcy of these behaviors.

Sexual Activity

The issue of sexual activity has been sighted in the literature as a high risk adolescent behavior that has serious consequences. Specific information on sexual activity of the Hmong and Vietnamese adolescent is not available. As a result conclusions for these two populations must be inferred from the general adolescent population.

Adolescents account for one quarter of the new HIV infections per year, one quarter of all sexually transmitted illnesses per year, and one million pregnancies per year [CDC, 1995]. According to the National Survey of Family Growth [1991], 15- 19 year olds are becoming sexually active at increasingly earlier ages [U.S. Congress, Office of Technology Assessment, 1991]. One third of males and 20% of female adolescents in this survey have had sexual intercourse before the age of fifteen [Rickert, Jay, & Gottlieb, 1990].

The literature indicates that discussion of sexual activity is considered taboo by both the Hmong and Vietnamese cultures. The use of contraceptives and abortion are unacceptable practices for Asian women- especially within the Vietnamese culture. For a Vietnamese woman, a pregnancy out of wedlock would destroy the family name and

bring a lifetime of shame [Aguilar, 1986]. This taboo issue poses a unique challenge for the health care provider. Gold [1992] states to avoid a "conspiracy of silence" [p. 290] direct and specific questions need to be asked to gain accurate health risk data.

Minority adolescent behavior, as all adolescent behavior is motivated by a need to obtain security, self-worth, and a sense of belonging in which culture usually provides the context for these needs to be met [Kagawa-Singer, 1996]. However, when a minority adolescent is confronted with membership in two different cultures, portions of these identities overlap and conflict can develop. The adolescent may believe he/she must choose one culture at the expense of the other [Kagawa-Singer, 1996]. Typically if the minority adolescent does feel rejection from both cultures and they do not have adequate resources to cope, he/she may develop poor health attitudes and behaviors from the excess stress.

Overall, poor emotional health, substance abuse, and excess stress exhibited by the Hmong and Vietnamese populations place them at a greater risk for suicidal behavior and intentional injuries. This is particularly true for the adolescents who are not only experiencing the changes associated with this stage in life, but also are experiencing dual membership in diverse cultures with the high possibility of adopting high risk behaviors.

Access To Primary Care

Access to primary health care is a determinant of health status and is the result of availability, obtainability, and acceptability of health services [AAP, 1994]. An available opportunity to access health care is a key aspect and must be perceived

and actualized by the adolescent in order to reduce morbidity and mortality associated with the high risk behaviors. Adolescents overall represent the largest uninsured group in the U.S., have the lowest physician visit rates with the shortest average duration of 11.6 min per visit., have the fewest return visits, and frequently use the emergency department as their primary source of health care [Lehmann, C, Barr, J., & Kelly, P., 1994]. Populations, i.e., the poor, minorities, and the uninsured represent groups that experience multiple barriers in obtaining primary health care. The lack of access among the culturally diverse is most evident in their poor health care outcomes and large differences in mortality by race [Blum, 1987, Newachech, P., Hughes, D., & Stoddard, J., 1996]. This occurs as a result of delayed and culturally inappropriate health care creating crisis/episodic orientated care. Without the availability of comprehensive health care across the lifespan, health promotion and prevention is not addressed, allowing high risk behaviors to continue.

For minority group children and adolescents the primary barriers are economic, structural, and cultural [AAP, 1994]. Economic barriers include the lack of financial resources to obtain health care services and the lack of health care insurance. The financial barrier to access constitutes the most significant determinant of accessibility [Institute of Medicine, 1993]. Approximately one third of minorities live below the poverty level, and nearly half of the children under the age of six live in a poverty-level household [AAP, 1994]. Adolescent poverty underlies many aspects of adolescent health behaviors [Kagawa-Singer,

1996] and is strongly linked to health status. Adolescents living in poverty in the U.S. are at an increased risk for getting sick, having no medical care, and dying young [Kagawa-Singer, 1996]. Poverty is strongly correlated with indicators of high risk behavior such as, intentional injuries, suicide, substance abuse, and teen pregnancy [Kagawa-Singer, 1996].

A final barrier to health care access is cultural and represents language, perceptions, practices, and beliefs which are different from those of traditional Western medicine. As discussed earlier an important feature in obtaining healthy outcomes is the perception of access by the adolescent and their response to that perception. Perceived cultural and linguistic appropriateness in health care for the Hmong and Vietnamese Asian groups is imperative to ensure healthy outcomes [Kagawa-Singer, 1996]. For instance, most Asian cultures are 'face' oriented which means that an individual's public actions and related sense of social integrity and status directly effect his/her family's loss of face or shame [Kagawa-Singer, 1996]. Certain family problems, i.e., juvenile delinquency, mental health disorders, AIDS, and poverty are considered shameful and likely to bring a loss of face to the whole family [Kagawa-Singer, 1996]. Consequently, many Hmong and Vietnamese adolescents avoid the health services that they need most, i.e., mental health, welfare, and juvenile services. A significant finding is the fact that an Asian adolescent's behavior is considered a reflection of family upbringing [Kagawa-Singer, 1996]. Therefore, parents may delay or refuse using health services for their adolescent if those services represent stigmatized

problems which could tarnish family "face" [Kagawa-Singer, 1996]. As a result Asian adolescents must perceive culturally appropriate access to health care by receiving health care from culturally sensitive providers to increase utilization of these services.

Protective Factors Against High Risk Behaviors

Findings from the National Longitudinal Study on Adolescent Health [Resnick, Bearman, & Blum, 1997] revealed that parent-family connectedness and perceived school-connectedness among adolescents were protective factors against every health risk behavior measure except history of pregnancy. Also, perceived parental expectations regarding school achievement were associated with lower levels of health risk behaviors, and perceived parental disapproval of early sexual activity was associated with a later age of onset of intercourse [Resnick et al, 1997]. Perceived school-connectedness was the strongest protective factor for both boys and girls against acting out behaviors, and second in importance to family-connectedness for the quietly disturbed behaviors [Resnick, 1993].

Stewart et la, [1997] found that the presence of the characteristic, resilience, among disadvantaged adolescents has important implications in preventing the adoption of high risk behaviors. Resilience is defined as the capability to cope successfully in the face of significant change, adversity or risk changing over time and enhanced by protective factors in the individual and the environment. For instance, protective factors identified at the community-level

that fostered resilience among adolescents were positive school experiences, participation in extracurricular activities, perceived opportunities, a positive event before or after a stressor, and finally a positive relationship with an adult [Stewart, et al., 1997]. In addition to community-level protective factors for the adolescent, protective factors at an individual-level were also identified and included having: problem-solving abilities, helpfulness, positive self-esteem, feelings of control over one's life, planning for future events, optimism, and finally social competence [Stewart, et al., 1997]. These findings underscore the importance of schools and adults as primary sources of caring and connectedness for the adolescent.

The latter finding has special significance for the minority adolescent who is experiencing additional stressors due to the acculturation process. Therefore, schools and adults play a vital role in reducing the likelihood of health risk behaviors occurring during adolescence by providing a sense of belonging that may not be provided by other sources such as family or peers. The salience of this connectedness as a protective factor against the initiation of high risk behaviors, strengthens the position that there must be closer collaboration between health and education. This collaboration promotes the well-being and educability of adolescents, particularly those at high risk which includes Hmong and Vietnamese adolescents [Resnick, 1993].

Adolescent Assessment Tools/Instruments

The overall quality of information collected on a national basis is suboptimal with respect to minority group health status and health behaviors. The Institute of Medicine and National Research Council [1992] noted that current surveys are inadequate in addressing the health care needs of the poor, minorities, and those without health insurance. Research has acknowledged that adolescent minority groups have unique health needs [Kagawa-Singer, 1996], however, data that includes specific health behaviors and health status are lacking. This is particularly true for variations among different adolescent minority groups [Kagawa-Singer, 1996]. It is important to note that Asian Pacific Islander group which includes the Hmong and the Vietnamese is the fastest growing minority population in the U.S.. However, little is known about the health status, behaviors, and service needs of Asian Pacific Islander adolescents aged 10-18 [American Academy of Pediatrics, 1994]. It is estimated that by the year 2020 approximately 40% of school-age U.S. students will be Asian Pacific Islander children [Kagawa-Singer,1996]. Which indicates a need not only for culturally sensitive health care providers, teachers, and adults, but also for a culturally relevant data base on health behaviors. This allows for the appropriate development of health care and educational programs.

Various health assessments or tools do exist for the health care provider to utilize when assessing health status and behaviors of adolescents and school-aged children [Tripp-Reimer, Brink, & Saunders, 1984]. However, very few of these health risk assessments/tools exist which address cultural differences and the high-risk behaviors

that precede adolescent mortality and morbidity. Not one specific health risk tool for the Hmong or Vietnamese adolescent was found.

The most comprehensive tool currently used for cultural assessment is George Murdock's [1961] Outline of Cultural Materials. However, it was not devised as a health risk assessment tool for health care providers, but rather for anthropologists wanting to describe a culture group. Also, it does not pertain to adolescents and is more appropriate for group rather than individual assessment [Tripp-Remeimer, Brink, & Saunders, 1984]. A second source that addresses cultural assessment is Brownlee's Community, Culture, And Care: A Cross-Cultural Guild for Health Care Workers [1978]. It too was developed with group assessment in mind and does not pertain to adolescents or high-risk behaviors. Both Brown-Lee's [1978] and Murdock's [1961] cultural assessment tools are so comprehensive that they would be difficult to use in a clinical setting with individual adolescents. While other cultural assessment guides are available, [Leininger,19; Orque, & Bloch, 1983; Kay, 1978] they do not address high risk behaviors of adolescents.

One school-age lifestyle questionnaire was found that addresses the health practices of the school-age child. Three sections ask questions that pertain to health promotion, injury prevention and feelings. This particular questionnaire is meant to be filled out with the assistance of a family member, but the authors state that nurses could use the questionnaire to assess health practices in a variety of settings [Van Antwerp, Spaniolo, 1991]. Two limitations were noted: 1) family and school connectedness are not included, and 2) cultural diversity is not addressed. Though this questionnaire does

address important issues, the focus is health promotion and not the assessment of high risk behaviors.

Two sources within the literature did contain surveys or tools that address the high-risk behaviors that precede adolescent mortality and morbidity [Riggs, & Cheng, 1988; Elster, & Kuznets, 1994]. The first survey, developed by Riggs & Cheng [1988] contains an adolescent health needs assessment for ninth-twelfth graders pertaining to areas of emotional health, substance abuse, sexual activity, and a willingness to utilize a school-based health clinic. This survey tool also had limitations: items related to violence and to cultural diversity were not evident and it pertained more to high school aged adolescents.

The second source, AMA Guidelines for Adolescent Preventive Services (GAPS) developed by the American Medical Association (AMA) [Elster, & Kuznets, 1994], includes twenty four recommendations regarding adolescent preventative services. The recommendations stress prevention of the high risk behaviors that cause adolescent mortality and morbidity; it is appropriate for ages 11-21. However, cultural diversity is not addressed and the cornerstone of guideline implementation is only an annual individual visit with a health care provider [Stevens, & Lyle, 1994]. These two sources contain limitations as mentioned, however, they could be culturally and age appropriately modified.

Discussion

The literature review suggests the need for the development of a school-age health risk assessment for minorities, specifically for school- age children of Vietnamese

and Hmong ethnicity. The five general sections, i.e., intentional injuries, unintentional injuries, substance use, sexuality and perceptions of family and school connectedness, have been identified in the literature review and will be further discussed.

This section will discuss the development process of the Cheung-Leads Health Risk Assessment (C-LHRA), Figure 5, for school age children, eight to ten years old, of Hmong and Vietnamese ethnicity and describe associated outcomes. It was found within the literature that the Hmong and Vietnamese are culturally congruent and exhibit similar high risk behaviors. Therefore, one culturally specific assessment has been created.

The C-LHRA was created with guidance from the principal, and two interpreters from the Center for Language, Culture and Communication Arts (CLCCA) in Lansing, Michigan. The Hmong and Vietnamese interpreters, Mr. Lao and Mr. Taon, respectively gave valuable input into the C-LHRA and guided the cultural appropriateness of items included for this project. The wording as well as the addition and deletion of questions were modified as a result of their input .

The C-LHRA is based upon the original Lifestyle Questionnaire for School-age Children, Figure 6, described by Spaniola and Van Antwerp (1991). The project's authors sought and obtained written permission from Carol Van Antwerp [March, 1998] to modify this instrument. See Appendix B.

No reliability and validity scores were available for the original instrument. However, the authors of the Original Lifestyle Questionnaire for School-age Children completed a test pilot of the questionnaire with five families;

Name_____ Age_____ Grade_____

Directions: Please answer the following questions. Mark your answers with an X under the yes, no or sometimes. Remember there is no right or wrong answer.

Injury	**YES**	**NO**	**SOMETIMES**
1. I wear a seat belt in the car.			
2. I wear a helmet when I ride my bike.			
3. I tell my parents where I am going.			
4. I stay away from lighters and matches.			
5. I have been in a fight in the last two months.			
6. I know there is a gun in my house.			
Feelings			
1. I think it is ok to cry.			
2. I feel like crying all the time.			
3. It is easy for me to fall asleep at night.			
4. I like myself the way that I am.			
5. I have had fun in the last two weeks.			
6. I take a bath at least once a week.			
Substance Use			
1. My family smokes cigarettes at home.			
2. My family drinks beer or wine at home.			
3. I stay away from cigarettes.			
4. I stay away from beer and wine.			
5. My friends smoke cigarettes.			
6. My friends drink beer or wine.			
7. My family uses herbs when I am sick.			
Perceptions			
1. I have a special teacher or friend I can talk to.			
2. I have fun at school.			
3. I visit the doctor when I am sick.			
4. I miss a lot of school.			
5. My family listens to me when I talk to them.			
6. I like my friends.			
7. I have been in the United States two years or more.			
Sexuality			
1. I know about good touch and bad touch.			
2. I have questions about how my body works.			
3. I have a private area to go to so I can be alone.			
4. Someone touched my private area when I said no.			

Figure 5. Cheung-Leads Health Risk Assessment

Date

Child's first name

Child's age Grade

Lifestyle Questionnaire for School-age Children*

Activities that promote health	Yes	No	Sometimes
1. I sleep at least 8 hours every night.			
2. I brush my teeth twice a day.			
3. I visit the dentist every year.			
4. I watch less than 2 hours of TV every day.			
5. I exercise (running, biking, swimming, active sports) one hour every day.			
6. I eat fruits.			
7. I eat vegetables.			
8. I limit my intake of salty snacks and high-sugar snacks.			
9. I have a physical examination every 2 or 3 years.			
10. I stay away from cigarettes.			
11. I stay away from alcohol.			
Injury prevention	**Yes**	**No**	**Sometimes**
12. I wear a seat belt in an automobile.			
13. I look both ways when crossing streets.			
14. I follow bike safety rules.			
15. I stay away from lighters or matches.			
16. I never ride ATVs (all-terrain vehicles).**			
17. I wear a helmet when I go on bike trips.			
18. I swim with a buddy.			
19. I wear a life jacket when I ride in a boat.			
20. I take medicine only with my parent's permission.			
21. I stay away from real guns.			
22. I tell my parents where I am going.			
23. I say "no" to drugs.			
24. Our home has a smoke detector that works.			
25. Our home has a fire extinguisher.			
26. If there is a fire, I know a safe way out of my house.			
Feelings	**Yes**	**No**	**Sometimes**
27. I think it is okay to cry.			
28. I enjoy my family.			
29. It is easy for me to fall asleep at night.			
30. My appetite is good.			
31. I like myself just the way I am.			

**The American Academy of Pediatrics recommends that children do not ride on these vehicles.

Figure 6. Lifestyle Questionnaire for School-age Children

no changes to the instrument resulted. Additional data was collected through the administration of the instrument to 884 children in a variety of settings. The findings lead to the alteration of two questions, which were not specifically discussed in the findings.

Further discussion with the author of the original questionnaire yielded there was not any formal reliability and validity testing done with the original tool. She also stated that there has been further development of this tool, including reliability and validity testing by others. This specific information was not available to the current authors.

Future testing of the C-LHRA for reliability and validity should be done to allow for further development of the instrument. Testing of reliability and validity should follow the tools original intent of one to one administration. Bias can be minimized by consistent administration of the tool to the child, as stated in the guidelines. Face and content validity of the items should be examined initially and changed accordingly.

The C-LHRA is designed to be used as a screening instrument. This instrument uses a pen and pencil format and needs to be administered to the eight to ten year old children of Hmong and Vietnamese ethnicity. Although the impetus of the C-LHRA is for one on one administration, it has future implications for group administration in a variety of settings.

The format of the questions consist of "Yes", "No", or "Sometimes" for response choice. The authors chose this format for two specific reasons; 1) ease

for the eight to ten year old age group can answer the questions. (For instance, this age group has more concrete reasoning ability verses abstract ability needed to differentiate the degrees of meaning associated with the values on a likert scale), and 2) ease of interpretation by the health care provider. (The form is set up so that at a visual glance any response of "No" or "Sometimes" indicates a risk factor requiring further exploration by the health care provider.)

The assessment items contain twenty five questions, divided into the four headings: injuries, feelings, substance abuse, and perceptions. Headings are used throughout the assessment to guide each subgroup of questions and to aid the health care provider in the visual evaluation. The questions are formatted to reflect the reading level of eight to ten year olds, i.e. approximately fourth and fifth grades. The original lifestyle questionnaire and the translators guided the question development for this reading level.

Most of the questions are set up to have a positive response. The cultures of both the Hmong and the Vietnamese support using questions that do not require a negative answer. A positive response should promote their personal comfort for responding and contribute to the validity of the instrument [Thomas, Tumminia,1982].

The categories, injuries, feelings, substance abuse, sexuality, and perceptions represent behaviors that research has demonstrated precede adolescent morbidity and mortality. The perceptions category represents protective factors against the initiation of high-risk behaviors. These categories were based on relevant adolescent literature.

The Items

In the first section, injuries, items one through four, " I wear a seat belt in the car", "I wear a helmet when I ride my bike", "I tell my parents where I am going" and "I stay away from lighters and matches" pertain to the issue of accidental injuries and family connectedness. Accidents remain the leading cause of death and disability in the school age child and pose a significant health problem for this age group [Van Antwerp, Spaniolo, 1991]. When these important health practices are initiated during childhood they have consequences into adulthood. A negative response would indicate the need for further assessment and possible reinforcement of safety practices for the individual and family.

Items five and six in this section, " I have been in a fight in the last two months" and "There is a gun in my house" foster insight into the issue of violence. The category of unintentional injuries includes the use of firearms and fighting in the adolescent age group. The incident of homicide and suicide has been increasing among adolescents, particularly among minority populations and are the second leading cause of adolescent death in the U.S.. [CDC, 1995, & Waxweiler, et al. 1993] . According to Waxweiler (1993), the most serious injuries are related to weapon carrying, physical fighting, and group violence. This also reflects family and school connectedness. According to a study completed by Resnick, Bearman, & Blum (1997), parent-family connectedness

and perceived school-connectedness among adolescents are protective factors against every health risk behavior measure except a history of pregnancy.

An item that reflected conflict at home was deleted from this category due to the reaction from the school interpreters . The question read " There is a lot of fighting at home". They stated that this statement would initiate a "no" response the majority of time, and if the answer was "yes", it would shame the family. Central to both the Hmong and Vietnamese is the strong sense of family obligation and children are socialized not to disrupt the harmony within the family [Kagawa-Singer, 1996].

In section two, feelings, question one, "I think it is ok to cry" refers to the acceptance and expression of feelings. Children are taught to be quiet, honest and polite, and socialized to be in control of their feelings, needs, and impulses [Kagawa-Singer, 1996]. This has important implications for the school-age child who experiences excess stress when attempting to find an identity within two diverse cultures. The acknowledgment and ability to express feelings in a safe environment may improve adjustment and allow integration of the school's Western culture into the culture at home.

Items two, three and six, "I feel like crying all the time", "It is easy for me to fall asleep at night", " I take a bath at least once a week" are directed at the assessment of the issues of anxiety and depression. The lack of personal hygiene potentially reflects a physical symptom of depression. Symptoms related to immigration often are exhibited as depression and anxiety. Studies demonstrate

Asian refugees and immigrants have extremely high levels of depression, adjustment problems and other mental disorders [Stauffer, 1996].

These items also address cultural beliefs as well. Specific to the Hmong is the issue of soul loss. The individual is believed to posses many souls in constant danger of being separated from the body [Frye]. Causes of soul loss include loneliness, extreme grief, illness, fright, and violation of body integrity. Symptoms of soul loss include depression and anxiety [Frye]. By assessing and identifying early signs of soul loss appropriate interventions can be implemented. This will lead to less days off from school and improved adjustment for the child.

Items four and five of this section ,"I like myself the way that I am" and "I have had fun in the last two weeks" reflect and validate the adjustment of the child. Poor emotional health, substance abuse, and excess stress are conditions exhibited by members of the Hmong and Vietnamese populations; these conditions place them at a greater risk for suicidal behavior and intentional injuries. A "no" response would lead to exploration by the APN for appropriate interventions and referrals.

Section three, substance use, includes items one through four, "My family smokes cigarettes at home ", "My family drinks beer or wine at home ", "I stay away from cigarettes", and "I stay away from beer and wine". These questions are intended to directly assess substance use in the individual and family. Direct questioning is needed to adequately assess use. The first item assesses substance use in the family. Research acknowledges that initial experimentation of cigarette

use occurs at eleven years of age, and that access to substances in the home is associated with the increased use of cigarettes and alcohol [Resnick, 1997]. The third and fourth items, directly assess substance use of an individual.

Items five and six, "My friends smoke cigarettes" and "My friends drink beer or wine", allow the assessor to gather information about the peer group of the individual. Research supports that a deviant peer group is a risk factor for the initiation of high-risk behaviors [Resnick, 1997].

Item seven, "My family uses herbs when I am sick" assesses the extent to which a family adheres to traditional cultural practices and if answered with a 'yes' or 'sometimes' prompts further exploration. Although Hmong and Vietnamese cultures share some common cultural themes, there are large variances in the extent to which the cultures are practiced by individual families.

In the fourth section, items one and five, "I have a special older person I can tell secrets to" and "My family members listen to me when I talk to them" assesses the individual's perceptions of his/her connectedness/relationship to adults and their sources of social support. These are consistent with the research which has identified perceived parent-family connectedness as a protective factor against every health risk behavior except history of pregnancy [Resnick, 1997]. Also, perceived caring by teachers accompanied with high expectations of performance have also been found to be protective [Resnick, 1997]. In developing the wording of these items, the interpreters suggested it would be more culturally appropriate to eliminate the words 'adult' and 'mom and dad' and replace them

with 'family member' and 'older person'. These terms would illicit a more accurate response and allow for the inclusion of other adults such as teachers. Within these cultures children view the latter phrases as having a connotation of respect and distance. Therefore, in order to adequately reflect the intent of these items the words were altered.

Items two, four, and six: "I have fun at school", "I miss a lot of school", and "I have friends" assess the individual's perceived school-connectedness. Perceived school-connectedness by an individual has been shown to be protective against the initiation of every high-risk health behavior except a history of pregnancy [Resnick, 1997]. Participation in extracurricular activities was also found to be an indicator of a positive perception of school-connectedness. However, rather than assess the actual activities the authors concluded that these items would adequately and concisely reflect the desires/perceptions that lead an individual to engage in participation. For instance, it was felt that the school-age child does not have as much freedom or availability of extracurricular activities to choose from or participate in when compared to an older adolescent. Therefore, an assessment of perceptions of school-connectedness is more appropriate.

Item three of this section, " I visit the doctor when I am sick" assesses the family's access issues related to Western medicine. This question provides the opportunity for further exploration of the use of traditional health practices if a

negative answer is obtained. It will also help identify additional needs or possible referrals.

Item seven, "I have been in the United States two years or more", pertains to the length of time the individual has been in the U.S. This reflects the refugee experience and the stresses that occur with adjustment. It has been found that the incidence of depression and anxiety are highest during the first two years of immigration [Stauffer, 1996].

In the fifth and final section, issues related to sexuality and the potential for future high risk behaviors of sexual activity include acquiring HIV, sexually transmitted illnesses, and teenage pregnancy are explored. Items one and four, "I know about good and bad touch" and "Someone touched my private areas when I said no" assess the child's awareness of appropriate touch and physical boundaries. Lack of knowledge of appropriate physical boundaries provides cues to the health provider of potential violated boundaries or inhibition towards sexual activities. Lack of boundaries may precede early sexual activity. Item two, "I have questions about how my body works", assesses appropriate developmental interest in bodily function. Item three, "I have a private area to go to so I can be alone" assesses the child's perceptions of a private physical area that a child can retreat to, such as a bedroom or own bed. Assessment of these perceptions provides the health provider with insight to the child's boundary development and facilitates further discussion.

Adolescents from all cultures go through comparable physical changes and learn similar developmental tasks. However, considerable differences exist between and within cultural groups in defining acceptable adolescent behavior [Anderson, & Kagawa-Singer, 1996]. Knowing cultural differences leads to a better understanding of the perceptions and rationale behind adolescent behaviors. Therefore, to be effective in identifying and preventing the initiation of adolescent high risk behaviors, these cultural differences have been incorporated into the design of C-LHRA. Appendix A presents the guidelines and a copy of the C-LHRA in the format it would be used by an APN.

Implications

Knowledge of cultural differences leads to an understanding of perceptions and behaviors of people from different origins. For the Advanced Practice Nurse (APN) to be effective in identifying and preventing the initiation of high risk behaviors, cultural differences must be incorporated into school-aged health risk assessments.

In order to prevent the initiation of high risk behaviors, it is imperative to know which factors provide protection against initiation of high risk behaviors, and the risk factors that promote initiation of high risk behaviors. The development of the Cheung-Leads Health Risk Assessment for children ages eight to ten years of Hmong and Vietnamese ethnicity has implications for clinical practice, research and education. The impact of this health risk assessment is discussed in this section.

Research Implications

As a new instrument, the Cheung-Leads Health Risk Assessment (C-LHRA) will need to be evaluated at several levels. A pilot study which addresses reliability and

validity needs to be completed. This will provide valuable information for modification of the C-LHRA.

The utilization of the Hmong and Vietnamese interpreters has provided culturally specific wording and content in the assessment form. Further evaluation of the health risk assessment in the clinical area also needs to be done. The initial administration of the C-LHRA to a group of eight to ten year old children of Hmong and Vietnamese ethnicity, will likely be done by the principal of the CLCCA school. This could be accomplished by discussing its intent with family members at the monthly parental meetings at the school. It is the advice of the authors that a small group, approximately twenty children complete the assessment and that additional changes be done after their feedback. Anticipated results are the restructuring of sentences for clarity and the inclusion of additional cultural items. Other responses could result in the deletion of an item. This initial review may also result in changing the English printed language to the Hmong or Vietnamese printed language. The health risk assessment form will require modification over time.

The issue of sexuality requires consideration in this initial evaluation. The literature indicates sexuality a "taboo" topic and discussions with the principal of the CLCCA school indicated the topic of sexuality inappropriate. The decision to delete this topic lies with the individual and the context which the C-LHRA is utilized. The authors acknowledge the sensitive situation surrounding the issue of sexuality, but recommend completion of the C-LHRA and using the guidelines as designed. This recommendation is based on the literature and the consequences associated with sexual activity.

While the C-LHRA was created for the CLCCA school and it's future school-based clinic, this assessment has potential to be utilized in many settings, i.e., a primary care pediatric office, the public health nurse that does health screening in elementary schools, and elementary teachers. The individual administering the C-LHRA should utilize the prepared guidelines outlines in Appendix A. The use of the C-LHRA as a screening instrument could determine educational programs and referrals. Other areas in the Lansing community, such as the Refugee Center affiliated with the Ingham Health Department, and other Lansing schools, that have contact with the Hmong and Vietnamese populations could also utilize the C-LHRA. Community-wide educational efforts, which foster the use of seat belts and bicycle helmets or discourage the use of cigarettes through anti-smoking campaigns should enhance the educational efforts in the primary care setting [Van Antwerp, 1995].

The APN has the knowledge base to further develop and refine the C-LHRA. The APN as researcher could analyze and tabulate responses from the C-LHRA. Research questions that might arise with use of the C-LHRA include questions that pertain to substance abuse, the perceived family-school connectedness and injury statistics. Questions such as, "What are the injury rates, both intentional and unintentional for children, ages eight to ten, of Hmong and Vietnamese ethnicity?" Are these rates comparable to the U.S. age groups? "What are the perceptions of family-school connectedness in the school-age child, ages eight to ten, of Hmong and Vietnamese ethnicity?." Is it comparable to children of the U.S.? Is there a difference between these two groups? "What is the cigarette and alcohol use by children ages eight to ten, of the

Hmong and Vietnamese ethnicity?". Is it comparable to children of the U.S.? With further revisions to the C-LHRA, potential questions such as "What are the influencing factors for these statistics on injuries, perceived connectedness, and substance abuse?" could be answered.

By collecting data on these specific populations, a community wide data base could be developed. This information could identify health trends specific to these cultures and geographical area expanding upon the limited health data. The appropriate interventions could then be initiated and health outcomes followed. Health outcomes could then be analyzed and trends outlined and interpreted. This allows for efficient health care and improved health for the community. Community wide data bases also allow for the comparison of interventions that are successful and the deletion of interventions that are not effective. Findings could be collected locally by state, and nationally for presentation at local and national conferences, published in journals and possibly accessed via the internet.

Based on the results educational endeavors could be initiated. The C-LHRA could be modified for other populations and questions replaced with more appropriate cultural and age specific statements. This could lead to a larger community-wide data base and promote the collection of critical data for other under-represented minority populations and specific age groups.

Practice Implications

The Advanced Practice Nurse (APN) is in an excellent position to impact minority adolescents adverse health outcomes that are associated with high-risk

behaviors. This is accomplished when the APN plays multiple key roles in the move toward proactive partnerships between schools, families, and health care [Uphold, & Graham, 1993]. Because learning and wellness are inextricably linked, a strategy that unites educational and health care programs has the potential to increase access to health care and provide comprehensive coordinated care and decrease fragmented, crisis oriented care, and cultural barriers. When there is an interdependence between education and health, optimal child wellness and development will occur. Utilization of the C-LHRA is one such strategy which the APN can utilize to assess the health status of Hmong and Vietnamese school-age children. It may reduce access and cultural barriers, and foster the provision of culturally appropriate health care.

The APN acts as an assessor, counselor, educator, and change agent when administering a culturally-specific health risk assessment. For instance, the C-LHRA can also be used as a means to promote discussion between the student and APN, the student and his/her family. In doing this, the APN acts as an assessor in identifying high-risk behaviors both individually and within the context of the family. The APN also assesses self-care competencies and needs. Once high-risk behaviors are identified, the APN acts as an educator by: 1) determining learning priorities, readiness to learn, motivation to change, and 2) providing appropriate health promotional education. The APN as a counselor creates a supportive environment for learning by providing stabilizing support that allows individuals and their families to express concerns and use problem-solving skills. As a result an individual's perceptions of connectedness to school may increase as evidenced by increased school involvement, and thus provide protection against the

initiation of high-risk behaviors. As a change agent the APN promotes healthy lifestyles by collaborating and coordinating activities with the school, family, and individual in an effort to bring about a positive alteration in the individual's health behaviors.

With the administration of the culturally appropriate C-LHRA the APN is able to accurately illicit the child's perceptions and obtain a clearer understanding about his/her participation in certain risk-taking behaviors. This allows the APN to plan interventions that capitalize on the child's perceptions within the context of his/her culture. It is anticipated that this will promote improved health outcomes because the child's knowledge and beliefs are shaped by his/her environment, primarily the family and school. Therefore, the school is an important site for health promotion in which the APN can attempt to reduce high-risk behaviors before they are established in adolescence [Uphold, & Graham, 1993]. The APN can accomplish this by advocating appropriate perceptions and fostering healthy coping strategies to go through the acculturation process. Establishing school and adult/parent connectedness is key to reducing the initiation of high-risk behaviors.

Altering an individual's high-risk health behaviors outside the context of their family can be difficult if the family has strong cultural affiliation. Therefore, there are further implications for the APN to expand a school-based clinic to include the care of the families and the surrounding community. Working with a family as a unit that lives and interacts in a community is imperative to avoid fragmentation of services [Uphold & Graham, 1993].

In the next decade schools will have greater diversity in student populations, as well as an increasingly larger number of children at risk for serious health problems associated with high-risk behaviors. This includes the Hmong and Vietnamese populations, which are among the fastest growing minority group in the United States. The APN holds the expert knowledge and skills to promote healthy outcomes for all adolescents, but particularly minority adolescents who are medically underserved and experience mortality and morbidity at earlier ages. The APN in collaboration with educators can assist minority children to obtain culturally-specific health care that facilitates the establishment of lifelong health behaviors.

Educational Implications

The C-LHRA has implications for APNs who care for school-age children of Hmong and Vietnamese ethnicity. The C-LHRA has been designed as a screening instrument to identify high risk behaviors in a brief period of time, despite the setting. The guidelines provide instruction for use and interpretation of the assessment. See Appendix A for guidelines. No further education for the APN is anticipated at this time.

With completion of the C-LHRA, the APN can review the responses at the initial visit. Anticipatory guidance with issues surrounding adolescence and the acculturation process, along with the development of specific educational programs concerning adolescent health promotion can be initiated based upon these responses. The results from the C-LHRA can be utilized to assess the impact of interventions and specific education with individual clients. Responses from one educational program and clinic visits with anticipatory guidance, could be compared to the same program done six to

twelve months later. The APN as an educator, assessor, and advocate provides the programs necessary for families and the community to remain healthy. Providing programs based on age and culturally specific needs, health outcomes have potential for improvement. This strategy allows the health-care provider to place the individual in proper context and allow for culturally-specific care [Shanahan & Brayshaw, 1995].

The authors plan to explore the possibility of publication of the C-LHRA in a professional journal. This would allow for the disbursement of vital information and support research which fostered the development of the assessment. A brief synopsis of the literature on the health risks of school-age children of Hmong and Vietnamese and the actual C-LHRA would increase the knowledge base for APNs in any setting and potentially impact health outcomes in this specific patient population.

Conclusion

The APN, in collaboration with schools is in a unique position to impact adolescent mortality, morbidity, and future quality of life. Schools and adults, whether it be the APN, teacher, or parent, all play a vital role in reducing the likelihood of health risk behaviors occurring among adolescents by providing a sense of belonging that may not be provided by other sources. The salience of this connectedness as a protective factor against the initiation of high risk behaviors, strengthens the position that there must be closer collaboration between health and education in order to promote the well-being and education of adolescents, particularly among those at high risk, Hmong and Vietnamese adolescents [Resnick, 1993].

APPENDIX A

Guidelines for Using the Cheung-Leads Health Risk Assessment

Prepared by

Renee Cheung RN MSN
&
Patricia E. Leads RN MSN

May, 1998

This C-LHRA has been designed to be utilized as a screening instrument for high risk behaviors of Hmong and Vietnamese children eight to ten years of age. By utilizing these guidelines, the authors of the C-LHRA believe culturally specific health care can be fostered for the Hmong and Vietnamese school-age child by identifying high risk behaviors. Appropriate interventions and referrals would be based on this assessment. The individual utilizing the C-LHRA may be an advanced practice nurse, school nurse, principal, or other qualified designated school personnel.

Currently there are no specific set number of responses that indicate or warrant a particular intervention or referral. The C-LHRA is to be interpreted based on each item's response. Due to the lack of validity and reliability testing of the C-LHRA, items are not be given a "weighted" value. Therefore, each item carries the same value. Any item's response that indicates a high risk behavior warrants further exploration. This includes clarification and validation that a high risk behavior exists. It also includes providing anticipatory guidance and education that supports alteration of high risk behaviors. Future validity and reliability testing may categorize high risk behaviors into low, moderate, and high classifications. It is the attempt of the authors to provide a useful and efficient screening instrument for the identification of high risk behaviors for children, ages eight to ten years, of Hmong and Vietnamese ethnicity.

Injuries

This section is composed of six items which pertain to both accidental and intentional injuries. This category is global to all school-age children.

- Items one through four assess the acculturation process; any "no" response requires further exploration.
- Items five and six relate to the issue of violence. Minority populations, including the Hmong and Vietnamese have a higher prevalence of intentional injuries that surround issues of violence. Any "yes" response requires further exploration.

Feelings

- Items one through six, reflect and validate the adjustment of the child. Poor emotional health, substance abuse, and excess stress are conditions exhibited by members of the Hmong and Vietnamese populations; these conditions place them at a greater risk for suicidal behavior and intentional injuries. The items address cultural beliefs and the stresses of immigration which are exhibited as depression and anxiety. The issue of soul loss is important to the Hmong and may include the symptoms depression and anxiety. By assessing and identifying early signs of soul loss, appropriate interventions can be implemented. The lack of personal hygiene potentially reflects a physical symptom of depression. A "no" response would suggest to the APN the need for further exploration and possible interventions and referrals.

Substance Use

- Items one through four assess substance use of the individual and family. Experimentation with cigarettes occurs at eleven years of age, and access to substances in the home is associated with the increased use of cigarettes and alcohol [Resnick, 1997]. The Hmong and Vietnamese have a high incidence of cigarette and alcohol use within their cultures.
- Items five and six, allow the assessor to gather information about the peer group of the individual. Research supports that a deviant peer group is a risk factor for the initiation of high-risk behaviors.
- For items one, and five through seven any "yes" or "sometimes" response requires further exploration.
- A " no" to three and four requires further exploration.
- Item seven, specifically assesses the extent to which a family adheres to traditional cultural practices, such as herbal use and coining. Any "yes" or "sometimes" response prompts further exploration to further evaluate traditional health practices. The result of this discussion allows for the perception of culturally congruent health care.
- Although Hmong and Vietnamese cultures share some common cultural themes, there are large variances in the extent to which the cultures are practiced by individual families.

Perceptions

- Items one through six, assess the individual's perceptions of his/her connectedness/relationship to adults and their sources of social support. These are consistent with the research which has identified perceived parent-family/teacher connectedness as a protective factor against high risk behaviors. The perceived connectedness is important for the Hmong and Vietnamese refugee because it assesses the adjustment of the child going through the acculturation process. If there is no perceived connectedness there is increased risk for depression, anxiety and high risk behaviors.
- Item seven pertains to the length of time the student has been in the U.S. This reflects the refugee experience and the stresses that occur with adjustment to immigration. It has been found that the incidence of depression and anxiety are highest during the first two years of immigration.

Sexuality

- Items one and four assess the child's awareness of appropriate touch that identifies appropriate boundaries. Lack of knowledge of appropriate physical boundaries provides cues to the health provider of potential violated boundaries. Lack of boundaries may precede early sexual activity.
- Item two assesses developmentally appropriate interest in bodily function.

Sexuality

- Item three also assesses the child's perceptions of private physical area that a child can retreat to, such as a bedroom or own bed. Assessment of these perceptions provides the health provider with insight to the child's boundary development.

Name_____ Age_____ Grade_____

The Cheung-Leads Health Risk Assessment

Directions: Please answer the following questions. Mark your answers with an X under the yes, no or sometimes. Remember there is no right or wrong answer.

Injury	**YES**	**NO**	**SOMETIMES**
1. I wear a seat belt in the car.			
2. I wear a helmet when I ride my bike.			
3. I tell my parents where I am going.			
4. I stay away from lighters and matches.			
5. I have been in a fight in the last two months.			
6. I know there is a gun in my house.			
Feelings			
1. I think it is ok to cry.			
2. I feel like crying all the time.			
3. It is easy for me to fall asleep at night.			
4. I like myself the way that I am.			
5. I have had fun in the last two weeks.			
6. I take a bath at least once a week.			
Substance Use			
1. My family smokes cigarettes at home.			
2. My family drinks beer or wine at home.			
3. I stay away from cigarettes.			
4. I stay away from beer and wine.			
5. My friends smoke cigarettes.			
6. My friends drink beer or wine.			
7. My family uses herbs when I am sick.			
Perceptions			
1. I have a special teacher or friend I can talk to.			
2. I have fun at school.			
3. I visit the doctor when I am sick.			
4. I miss a lot of school.			
5. My family listens to me when I talk to them.			
6. I like my friends.			
7. I have been in the United States two years or more.			

Sexuality			
1. I know about good touch and bad touch.			
2. I have questions about how my body works.			
3. I have a private area to go to so I can be alone.			
4. Someone touched my private area when I said no.			

The Cheung-Leads Health Risk Assessment

Appendix B

To: Carol Van Antwerp, M.S. R.N.C.

From: Renee Cheung, B.S.N.,R.N.
Patricia E. Leads B.S.N., R.N.

Re: Use Of Lifestyle Questionnaire for School-age Children

Date: February 22, 1998

This letter is a request to obtain permission to use and modify your questionnaire presented in the article "Checking Out Children's Lifestyles" in the May/June 1991 MCN The American Journal of Maternal/Child Nursing.

Renee and I are graduate students from the College of Nursing at Michigan State University and are conducting a joint scholarly project that consists of developing a health risk assessment for school- age children of Hmong and Vietnamese ethnicity.

Modification of the Lifestyle Questionnaire will include, altering wording of the questions for cultural appropriateness and using only sections of the questionnaire that includes information related to substance abuse, feelings, and injuries.

Thank You for your time and please respond at your convenience to:

Patricia E. Leads
13066 Apple Tree Lane
Dewitt, Mi. 48820

Sincerely,
Patricia E. Leads
Renee Cheung
Graduate Students, Michigan State University

Pat,

Thanks for your interest in the Lifestyle Questionnaire. You may Xerox the L.Q. form I have enclosed. Best wishes in your studies!

Carol

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