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Understanding and Supporting Asian American Youth's Mental Health Within Cultural and Family Contexts

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University of Denver

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Abstract

Mental health problems are a major health issue among East Asian American (EAA) youth. Although previous research has explored the risk and protective factors associated with mental health problems of EAA youth, many studies have employed Eurocentric perspectives, thereby excluding their unique cultural backgrounds, beliefs, and values. To better understand mental health needs and support these youth, further research that identifies different factors associated with mental health problems in their cultural context and assesses evidence-supported and culturally responsive interventions is needed.

This three-manuscript dissertation is presented in three papers. The first manuscript presents an integrative conceptual framework that uses two theoretical frameworks focused on family processes: the triadic model of family process (TMFP) and acculturation gap-distress theory (AGDT). By re-constructing these two theories using a cultural lens approach and integrating them into a new integrative framework, this study identified relevant familial and cultural constructs that influence EAA youth's mental health problems. The second manuscript is a secondary data analysis study that used the TMFP as a theoretical framework to investigate the relationship between key familial factors and EAA youth's mental health problems. Specifically, this study examined whether familial factors—maternal culture-specific symptoms of mental distress (i.e., hwa-byung), family enmeshment, intergenerational conflict, and intergenerational cultural conflict—are associated with youth negative emotionality and whether such youth processes led directly to their depression using path analysis. The third manuscript describes a systematic review and meta-analysis study examining the effectiveness of SFBT in reducing mental health issues and school-related risks among youth of East Asian heritage. Taken together, these three papers offer insights into the factors that negatively affect EAA youth's mental health and the promising role of SFBT in supporting at-risk EAA youth as a culturally adaptive school-based intervention.

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Chapter One: Introduction

East Asian Americans (EAAs) include people who have ancestors from East Asian countries, including China (People's Republic of China), Taiwan (Republic of China), Japan, Korea, Hong Kong, and Mongolia (Bronner & Clark, 2016). This three-manuscript dissertation focused on EAA youth who were born in these countries and immigrated to the United States with their foreign-born parents (i.e., first- or 1.5-generation) or were born in the United States (i.e., second-generation immigrants). In addition, EAA youth addressed in this dissertation were mainly in early to middle adolescence (aged 9 to 17), which is a developmental period featuring elevated risk of mental health problems and vulnerability for long-term maladjustment (American Academy of Pediatrics, 2021; Su et al., 2016).

Previous studies have reported that EAA youth have a higher prevalence of mental health problems compared to youth from other ethnic minority backgrounds (Chung et al., 2003; Greene et al., 2006; Grover & Ghosh, 2014). For example, a national survey reported that about 30% of EAA youth suffer from depressive symptoms, almost twice as high compared to their European American peers (National Institutes of Mental Health, 2015). Moreover, EAA female youth have the highest rate of depressive symptoms and suicide deaths compared to their African American and Latina female

counterparts (Centers for Disease Control and Prevention, 2008). Moreover, this rate was even higher after accounting for immigration-related factors, such as levels of acculturative stressors and generational status (Bulut & Gayman, 2015). It is also worth noting that the rate of depression among EAA youth was higher than that of youth living in East Asian countries (Chung et al., 2003). This finding illustrates that EAA youth mental health problems can be influenced by stress induced by immigration processes and acculturation experiences (Chung et al., 2003).

Despite the elevated risk for poor EAA youth mental health outcomes and overall well-being, what leads to their negative mental health has received much less empirical research. In response to this gap, this dissertation study aimed to examine familial factors and school-based intervention approaches that are positively and negatively associated with EAA youth's mental health problems and school-related outcomes. This research specifically focused on family and school context for the following reasons. First, family and school play a key role in youth development as both social microcosms of the broader society and reciprocally influence individuals and communities (Osher et al., 2014). Second, adolescence has been viewed as an important transitional period during which youth's development of cognitive domains is largely influenced by interactions with parents and peers, which aligns with the Asian cultural virtues of group harmony and collectivism. Finally, and more importantly, family and school feature modifiable factors for potential development of behavioral interventions that would complement therapies to reduce mental health problems among youth (Granic et al., 2003). Findings from this study could provide implications for research and practice

aimed at reducing mental health-related risks among EAA youth and their families and improving their overall well-being.

Organization of Dissertation

This three-manuscript dissertation sought to both synthesize and build on the growing knowledge base by exploring causes associated with mental health problems and developmental outcomes among EAA youth. More specifically, this dissertation advances the theoretical framing of EAA youth mental health problems within family context, identifies the familial risk factors for depression of EAA youth, and synthesizes the treatment effectiveness of SFBT on youth outcomes as a culturally adaptive school-based intervention.

The first manuscript is a conceptual article detailing an integrative model of two theories that focus on family processes: the triadic model of family process (TMFP) and acculturation gap-distress theory (AGDT; Schleider & Weisz, 2017; Telzer, 2010). By combining these two theories into a new theoretical framework through an Asian cultural lens, this paper provides a better framework for understanding youth mental health problems in the East Asian cultural and familial context.

The second manuscript used the TMFP as a theoretical framework to identify conceptually relevant family and acculturative factors associated with mental health problems among EAA youth. Specifically, this study utilized longitudinal secondary data drawn from the Midwest Longitudinal Study of Asian American Families to examine how familial factors from three levels affect youth depression over time via youth negative emotionality. Specifically, this study examined how maternal culture-

specific mental distress symptoms (*hwa-byung*), family enmeshment, intergenerational conflict, and intergenerational cultural conflict can explain youth depression by investigating the mediating effect of youth's negative emotionality.

Finally, the third manuscript involved a systematic and meta-analytic review, assessing the current evidence base for SFBT in the treatment of mental health and school-related problems among youth in school settings. To estimate if SFBT is a promising culturally adaptive intervention for EAA youth, this study synthesized and cross-nationally compared the strength of the evidence supporting SFBT between the U.S. and East Asian (i.e., Chinese, Korean, and Japanese) literatures. Overall, this dissertation study, which incorporated theory, empirical testing, and a reviewing of a promising intervention, contributes to the diversity of research on EAA youth and generated new knowledge for practice and policy to support them and their families.

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Chapter Two: Manuscript One

An Integrative Framework of Family Processes to Predict East Asian

American Youth's Mental Health Problems

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Introduction

During the past 10 years, the East Asian American (EAA) population in the United

States increased from 4.5 million in 2010 to 9.5 million in 2020, making up more than

30% of the Asian American population (U.S. Census, 2020). About 40% of Asian

Americans are EAA, which refers to Asian immigrants who were born in or have

ancestors from China, Taiwan, Japan, and Korea (Bronner & Clark, 2016). The marked

growth of the EAA population has been fueled by recent immigration of EAA

immigrants (Horowitz et al., 2019; Misra et al., 2020), such that 62% of EAAs are

foreign-born (Hoeffel et al., 2012). This rapid population growth also reflects the

increasing number of EAA youth. As the youth population has grown, so too have concerns about their psychological well-being.

Although it has received little attention in research or society at large, EAA youth are at high risk of developing mental health problems, including depression, social anxiety, and somatic complaints (Bulut & Gayman, 2016; Huang et al., 2012; Misra et al., 2020). An emergent body of research has found higher rates of mental health problems among EAA youth compared to other racial groups. For example, compared to Latinx and African American youth, EAA youth have the highest rate of depressive symptoms and suicide deaths (Bulut & Gayman, 2016; Centers for Disease Control and Prevention, 2008). Moreover, the few studies that have examined subgroups of Asian American youth have suggested EAA (specifically Korean) youth report higher rates of social anxiety and fear in peer relationships compared with southeast Asian (e.g., Filipino, Vietnamese) youth (Huang et al., 2012).

The emergence and progression of mental health problems among EAA youth are attributed to various individual experiences and sociocultural environmental factors. Specifically, the risks of mental health problems may be amplified for EAA youth whose families are recently migrated to the United States (Kramer et al., 2002). As immigrant youth acculturate to a new culture, they experience emotional burden and conflicts with their families. Moreover, many EAA youth often take on the role of language and cultural broker to meet their parents' expectations and address their family needs, which can add to their stress and increase mental health problems (Oznobishin & Kurman, 2009; Shih et al., 2019). Further, EAA youth are frequently referred to as a "model minority," which depicts all EAAs as academically successful and healthier than

any other racial minority group (Choi & Lahey, 2006). This racial framing imposed by the dominant culture not only obscures EAA youth's health-related needs and challenges but also places them at greater risk of mental health problems due to stress and pressure to succeed and stress (Shih et al., 2019).

Despite the increasing risk of mental health problems among EAA youth, there is a dearth of conceptual frameworks designed for this group. Because traditional frameworks fail to capture the distinctive cultural values, immigration experiences, and processes unique to EAA youth, this paper articulates a new conceptual framework to provide a more holistic view of EAA youth's mental health problems. This paper integrates two extant theories that focus on family functioning: the triadic model of family process (TMFP) and acculturation gap-distress theory (AGDT; Schleider & Weisz, 2017; Telzer, 2010). TMFP and AGDT were selected because they address family and acculturation as key concepts. Specifically, they: (a) focus on family as a social context, (b) share a common outcome (i.e., youth mental health problems) in the family domain, and (c) are complementary by addressing certain processes in more depth than the other theory does (e.g., AGDT complements TMFP by including the concepts of immigration and acculturation processes). This integrative framework introduces unique family systems and processes in the EAA family context that can better explain EAA youth's mental health problems. This framework can be used to facilitate empirical work on the multidimensional pathways from family process to youth mental health problems and ultimately guide the development of culturally responsive interventions for EAA families.

Literature Review

Family and acculturation are critical concepts in understanding EAA youth's mental health problems. Specifically, family is a critical setting particularly for EAA youth, whose culture is strongly influenced by Confucian values, such as family harmony, filial piety, and respect for older adults (Kim & Cain, 2008).

Drawing on prior literature, TMFP and AGDT are described here, along with explanations and definitions of their constructs. We then explain how these constructs can be adapted to fit the unique cultural values and experiences of EAA youth and families. Finally, an integrative framework incorporating these modified constructs is presented.

Triadic Model of Family Process

TMFP recognizes family as the most crucial context for youth and explores how family-related components jointly influence youth's mental health problems incrementally (Schleider & Weisz, 2017). Specifically, TMFP suggests that youth's mental health problems are determined by family components at three levels: parent, family, and dyad (see Figure 1).

Parent-Level Factors

Parent-level factors refer to aspects of the family process localized in a parent or between parents. For example, parental psychiatric symptoms are a parent-level risk factor that can lead to youth's mental health problems. When parents are continuously exposed to stressful events and high strain in day-to-day life, they experience negative feelings including anxiety, depression, and social isolation (Green et al., 2010; Silverstein et al., 2009). Such problems can not only exacerbate their emotional and

cognitive vulnerabilities but also impede warmth, responsiveness, and monitoring in parenting, thereby undermining children's well-being and development (Goodman, 2007).

Interparental conflict is another parent-level factor linked to mental health problems among youth (Rhoades, 2008). Interparental conflicts can shape negative biases among youth by creating a home environment that is unpredictable and erratic, sensitizing youth to potential threats (Schleider & Weisz, 2017). When youth observe parental emotional difficulties and conflicts, they may view their parents' conflicts as threatening to them or feel that they are unable to cope with the conflicts. Youth may be also overly vigilant regarding parental conflicts, thereby forming a negative attentional bias that induces them to preferentially focus on negative information (Schleider & Weisz, 2017). Such cognitions may bring about self-blame and insecure attachment among youth, which in turn, can lead to mental health problems (Shechner et al., 2014; Teachman et al., 2012).

Family-Level Factors

Family-level factors relate to the family system that includes family functioning and stability (Bowen, 1960). Negative family functioning is marked by family enmeshment, with no boundaries between parents and youth (Gewirtz & Davis, 2014). Specifically, roles and expectations of family members are confused because parents are overly and inappropriately reliant on their children for support and children are not allowed to become emotionally independent (Kerig, 2005). As youth perceive being pulled in by their parents to meet family needs, they have difficulty developing a solid sense of self and attachment to their parents, resulting in unhealthy behaviors (Kerig, 2005).

Family instability is another family-level factor that can negatively affects youth mental health. Youth who experience multiple transitions in family structure may struggle with inconsistent or irregular events (Israel et al., 2002; Ivanova & Israel, 2005). For example, the addition of a stepparent can increase stress among youth as they observe their families adjusting to new routines (Fomby & Cherlin, 2011). Such family transitions can lead to poor emotional adjustment among youth by increasing perceptions of insecurity and weakening the parent–child bond (Feinberg et al., 2000; Shanahan et al., 2008).

Dyad-Level Factors

Dyad-level factors refer to aspects of family process in the parent–youth dyad (e.g., parenting style, relationship quality). Studies have identified different dimensions of parenting styles as dyad-level factors that work differently work to explain youth's mental health outcomes. For example, according to Baumrind's (1971) three parenting typologies (i.e., authoritative, permissive, and authoritarian), authoritative parenting is characterized by parental warmth, reasonable demands, and high responsiveness that are linked to positive youth outcomes. On the other hand, authoritarian parenting, which is marked by maladaptive levels of control and lack of warmth, is associated with negative outcomes of youth (Ballash et al., 2006; Williams et al., 2012). However, studies on these parenting dimensions also noted that the influences of parenting styles on youth may vary according to families' cultural and racial backgrounds (Choi et al., 2013; Choi et al., 2020).

Parental modeling is another dyad-level factor that can contribute to the development of youth's cognitive processes and negative health outcomes. Specifically,

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anxious and depressive modeling, which refers to a parent's tendency to demonstrate negative emotions in front of the child (Drake & Ginsburg, 2012), can determine youth mental health outcomes through parent–youth interactions (Burstein & Ginsburg, 2010). For example, when adverse events occur, parents may model negative cognitions about their behavior to their child (Hankin et al., 2009). Youth who observe parents' attitudes and behaviors are likely to adopt similar maladaptive cognitions and have negative bias toward interpreting events (Bandura, 1977; Burstein & Ginsburg, 2010). Such modeling process and negative bias among youth have been a significant predictor of youth depression and anxiety (Abela & Sarin, 2002; Lau et al., 2002; Schleider et al., 2014).

Although TMFP offers some relevant explanations for youth's mental health outcomes, simply adopting it may not be adequate to understanding EAA youth's mental health problems for two reasons: First, TMFP makes no mention of immigrant families' unique immigration or acculturation experiences. Second, because TMFP is a Western theory, most of its constructs, such as parenting styles and beliefs about childrearing, may not applicable to EAA youth and families (Liu, 2018; Rothbaum et al., 2002). Not acknowledging differences between European American and Asian American cultures and simply adopting TMFP for EAA families could lead to biased perceptions of EAA youth experiences and outcomes. Thus, there is a need to reconceptualize and reinterpret the TMFP's constructs and adapt them to East Asian culture. To better understand the nature of EAA family processes in their cultural context, integrating AGDT with TMFP can help this reconceptualization process and aid the advancement of theory in EAA family research.

Acculturation Gap Distress Theory

Overview: Acculturation

There are two competing perspectives on the nature of the acculturation process: the unidimensional model and the bidimensional model (Laroche et al., 1998; Waters et al., 2010). The unidimensional model of acculturation posits that the process of acculturation occurs along a linear path from being unacculturated to being fully acculturated to the dominant culture (Gordon, 1964; Telzer, 2010). According to this model, acculturation is determined by assessing immigrants' preferences for values, attitudes, and behaviors related to only the dominant culture. In contrast, the bidimensional model of acculturation takes a more inclusive perspective by assessing orientations to both the dominant and heritage culture (Berry et al., 2002; Riedel et al., 2011). In this model, acculturation to the dominant culture does not necessarily entail a proportional loss of heritage-culture characteristics (Rogler et al., 1991; Shin et al., 2017). This approach allows individuals to report varying levels of acceptance and adherence to their heritage and the dominant culture (Berry et al., 2002; Choi et al., 2017). AGDT aligns with the idea of bidimensional model because it assumes parents and children take different views on culture as they are acculturated into mainstream society and motivated to maintain the norms of their culture of origin (B. S. Kim & Abreu, 2001). Depending on which cultural values they adopt from the dominant culture and which they maintain from the culture of origin, significant differences can occur in acculturation patterns between parents and youth (Lui, 2015).

Intergenerational Acculturation Gaps and Family Conflicts

AGDT explains the pathways by which different levels of acculturation between parents and their children cause stress in family relationships that lead to youth

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behavioral problems and maladjustment (Lui, 2015; Szapocznik & Kurtines, 1993). Specifically, parents who move to a new country in adulthood often struggle with adopting to the U.S. culture and persist in lifestyles that align with their culture of origin. On the other hand, youth may be more dominant-culture oriented because they participate in the U.S. culture more and learn English at a faster rate (Birman, 2006). These acculturation differences between parents and youth, known as intergenerational acculturation gaps, can increase family conflicts (Kim et al., 2009; Marsiglia et al., 2014). Although intergenerational conflict is a normative developmental process that may help youth achieve independence, it tends to exacerbate negative family relationships when it occurs with acculturation-based conflicts (Ahn et al., 2008; Rasmi et al., 2016). Intergenerational acculturation gaps also can lead to the dissonance of attitudes, norms, and family obligations between parents and youth, thereby decreasing parental authority and youth's respect for parents. Such family dysfunction, in turn, negatively affects youth's psychological adjustment (Telzer, 2010).

Despite its usefulness in understanding EAA youth's mental health problem outcomes as they relate to acculturation and intergenerational conflicts, AGDT lacks a comprehensive view of youth in the context of their family and the mutual influences between different family subsystems. For example, AGDT focuses on the specific subsystem (parent–child relationship), but not other subsystems of family, such as interparental relationships and parenting practices. Therefore, using AGDT alone may fail to fully encompass the complex interplay between EAA familial components and consequential EAA youth's mental health outcomes.

Cultural Lens Approach in Integrating TMFP and AGDT

TMFP and AGDT can complement each other because they both point to the same concept of youth mental health problems as an outcome but interpret these processes from different perspectives. Where AGDT falls short of incorporating complex and different family-related components that have been established as leading to youth mental health outcomes, TMFP can supplement it by adding family-related level components and processes. Thus, combining elements of the TMFP and AGDT allows for a more nuanced understanding of EAA youth's mental health problems in family contexts than either theory could provide in isolation.

Although we propose an integrative conceptual framework that incorporates key components of TMFP and AGDT, we also use a cultural lens approach (CLA). CLA is a stepwise approach that explores how theories can be adapted to specific cultural groups (Hardin et al., 2014). A part of its stepwise process was used for this paper. Specifically, we followed three out of five steps goals that consist of: (1) articulating central constructs that have been defined in the original theory (i.e., TMFP), (2) identifying the groups to which the constructs have not been applied (i.e., EAA youth and families), and (3) reconstructing the original theory that underlines specific cultural characteristics in a new cultural group. Given the unique patterns and norms of East Asian culture, investigating the applicability of TMFP and AGDT factors in the East Asian context will contribute to understanding the mechanisms through which familial factors and processes can lead to EAA youth's mental health problems.

An Integrative Framework of TMFP and AGDT

The integrative framework combining TMFP and AGDT highlights the interrelated nature of sociocultural and familial contexts (e.g., immigration) and culturally situated interpretive processes that determine developmental domains (e.g., mental health problems) of EAA youth. More specifically, this framework illustrates major family-related constructs that are influenced by immigration or acculturation experiences and are hypothesized to explain mental health problems among EAA youth (Figure 2). Broadly, family-related components from TMFP and the concept of intergenerational acculturation gaps from AGDT are used as possible pathways to explain mental health problems among EAA youth. To illustrate, differences in acculturation components (e.g., cultural values, identification, beliefs toward East Asian or European American culture) between parents and EAA youth can create an intergenerational acculturation gap, which may increase parent–youth conflicts and family instability. Increased intergenerational acculturation gaps can lead to EAA youth's mental health problems through parent-, family-, and dyad-level factors that can work as potential mediators.

Acculturation and Intergenerational Acculturation Gaps in EAA Families

Confronted with the discrepancy of cultural value systems between Asian culture and European American culture, EAA families may be at risk of intergenerational acculturation gaps (Chao, 2002). As AGDT posits, EAA parents and youth might have different preferences regarding culture, such that parents are more oriented to their culture of origin whereas EAA youth might be more inclined to the U.S. culture. These attitudes of EAA youth may be viewed as talking back and considered disrespectful in the East Asian home culture (Juang et al., 2007). Moreover, EAA youth might not only

feel pressured to maintain aspects of their culture of origin enforced by their parents, but also perceive their parents as unsupportive (Kim et al., 2009). Such discordant views in parent–child dyads can be a main source of family conflict (Kramer et al., 2002).

Studies have found different acculturation patterns between parents and youth (Buki et al., 2003; Kim et al., 2013; Liu et al., 2009). For example, Buki and colleagues (2003) found that although parents reported a stronger connection to their culture of origin and had relatively weak ties to American society, the adoption of American culture was more evident and faster among youth (Buki et al., 2003). Furthermore, intergenerational conflicts were associated with EAA youth's mental health problems (Chung et al., 2009; Juang et al., 2012; Roley et al., 2014; Wei et al., 2020). Roley et al. (2014) found that family conflict exacerbated the effects of acculturative stress on youth's depressive symptoms as a risk factor. In Juang et al. (2012)'s study, although everyday conflict between parents and youth (e.g., arguing over schoolwork and household chores) increased over time, acculturation-based conflict was more prevalent among EAA families and associated with EAA youth's mental health problems. Although everyday conflict affected youth's mental health problems, acculturation-based conflict explained youth's mental health problems through reduced family cohesion (Juang et al., 2012). This illustrates how intergenerational family systems and acculturation-based family conflict may be more closely linked to family processes and negative consequences for EAA youth.

Parent-Level Factors and EAA Youth Mental Health Problems

East Asian parents' mental health problems or psychological distress can be a critical parent-level factor. Generally, immigration and adaptation to a new society can

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be major stressors among foreign-born parents (Choe, 2020). Moreover, East Asian cultural values that emphasize family harmony and obligations may serve as common stressors for East Asian parents. Many East Asian parents from middle- and working-class experience downward social mobility and feel socially isolated because they are limited to labor-intensive work and stereotyped as "perpetual foreigners" in the United States (Choe, 2020; Kim & Cain, 2008). Such experiences limit their time and energy to parent effectively at home, thereby increasing parental psychological problems (Qin, 2008). In previous studies, parental stressors and psychosocial problems were associated with depression and anxiety among EAA youth (Yasui et al., 2018), and these associations were stronger for youth whose parents were less acculturated (Kim et al., 2006).

Interparental relationship quality is another parent-level factor that can contribute to EAA youth mental health problems. Interparental conflicts can often arise when East Asian parents face the challenge of redefining gender roles and attempting to maintain traditional East Asian patriarchal family structures (Xia et al., 2013). Specifically, East Asian mothers may have additional stress due to maintaining a household while simultaneously working outside of the home. Furthermore, the downward social mobility of men in the process of immigration can threaten East Asian fathers as the male head of household (Kim et al., 2007; Xia et al., 2013). This instability, with added stress and frustration, may push EAA fathers to attempt to reassert their control over the family, which can lead to interparental conflicts (Park et al., 2019; Suarez-Orozco & Qin, 2006). Such family environments might compromise EAA youth's confidence in their parents as a secure base, which can contribute to their mental health problems.

Family-Level Factors and EAA Youth Mental Health Problems

Family instability is a family-level factor that can lead to negative mental health outcomes for EAA youth. The immigration experience can destabilize a family structure over time, because it requires parents and youth to adopt different patterns of interaction and roles that may conflict with well-established patterns of their home countries (García Coll & Magnusson, 1999). Parent–youth enmeshment, which refers to a role reversal in the family, can be an example of destabilized family structure. Because East Asian parents do not often have many relationships with U.S.-born people in their social network, they rely on their children as the best available source of access to receive information about American society (Huang et al., 2012). As a result, EAA youth serve as "language brokers," which requires them to become translators and interpreters for their parents in settings such as the doctor's office, legal situations, and during parent–teacher interviews. Taking on the role of addressing family needs while navigating pressures related to "fitting in" can lead to the emergence of social and mental health problems among youth (Trickett & Jones, 2007). Studies have also found that EAA youth who struggled with translating, interpreting, and solving family issues (i.e., childcare and housework) reported higher rates of depression and anxiety (Qin, 2008; Yeh, 2003).

Dyad-Level Factors and EAA Youth Mental Health Problems

Among dyad-level factors, parental modeling of attribution can be associated with EAA youth's mental health problems. Attribution is derived not only from personal traits, but also in partly from culture (Tamis-LeMonda & McFadden, 2010). For example, people from individualist cultures, such as Western culture, tend to make

positive attributions by making inferences about adverse events due to situational factors

(Tamis-LeMonda & McFadden, 2010). This attribution style, sometimes referred to as

self-enhancement, enables individuals to maintain a positive sense of self. On the other

hand, in Eastern culture where collectivism is heavily embedded, self-effacement is

more crucial than self-enhancement (Mezulis et al., 2004). Consequently, parents from

Asian culture make more negative attributions compared to their Western counterparts

(Choi et al., 1999).

Given such Asian cultural values, it is likely that EAA parents practice negative

modeling and consequently, negative attributional inferences. EAA youth observing and

modeling their parents' negative inferences may adopt maladaptive cognitions and

develop mental health problems.

Although the parenting styles embedded in East Asian culture may pose potential

risks for EAA youth, some studies suggested that East Asian parents' authoritarian

parenting may not necessarily lead to negative outcomes among EAA youth (Chao &

Aque, 2009; Choi et al., 2013; Jose et al., 2000). For example, Jose and colleagues

(2000) distinguished Western notions of authoritarian parental control from Asian

applications of parental control, which is rather directive and warm. Therefore,

authoritarian parenting, although associated with poorer functioning among youth, may

have less detrimental effects on Asian youth as compared to their European American

counterparts (Chao & Aque, 2009). In a similar vein, Kim and Cain (2008) found that

EAA youth perceived their parents' authoritarian parenting practices as not so aversive,

but as necessary to discipline them and to well care for them (Kim & Cain, 2008). These

findings illustrate that parenting styles are subject to cultural influences, and thus, the

influence of parenting styles developed in Western contexts on EAA youth's mental health outcomes need to be interpreted with caution.

Interplay between Familial Factors in EAA Families

Previous studies reported family processes that interplay and explain EAA youth's mental health problems in contrast to their European American counterparts. For example, Kim and Ge (2000)'s study on Chinese American families found that Chinese immigrant parents' stress and depressive symptoms (i.e., parent-level factor) were related to disrupted parenting practices (i.e., dyad-level factor). These practices, in turn, were significantly related to negative attributions and depressive symptoms among youth (Kim & Ge, 2000). Other studies compared parents' parenting styles between Western and non-Western cultures and found that lower authoritarian parenting does not always guarantee positive outcomes among EAA youth (Liu, 2018; Steinberg et al., 1994). Specifically, youth's perceptions of low authoritarian parenting were not significantly associated with positive parent–youth relationship or social adjustment outcomes (Liu, 2018; Steinberg et al., 1994; Warikoo et al., 2020). On the other hand, authoritative parenting had a less positive impact on EAA youth compared to their European American counterparts (Steinberg et al., 1994). Taken together, it appears that although familial-level factors interplay in different ways and determine youth mental health outcomes, these effects are not universal across cultural groups.

Clinical Implications in Social Work

The present study offers suggestions on potential foci to address in prevention and intervention programs to support EAA youth and families. For example, our integrative framework suggests providing psychoeducational programs early to help facilitate

successful cultural adjustment, parent–youth communication, and conflict resolution skills as a necessary approach to reduce EAA youth's risk of mental health problems. Emphasis on these family factors as critical points of intervention can help reduce the intergenerational acculturation gap and strengthen parent–youth relationships, leading to healthy family functioning. Although previous family-based educational programs have involved only parents (Leidy et al., 2010), future programs should include parents and youth. Moreover, given the role of youth processes in connecting family-related factors and youth health outcomes, psychoeducational activities that reduce their negative bias and attribution may protect youth from risk of mental health problems.

It is also important for social work practitioners to be culturally responsive and client centered when serving EAA youth and families. Not only should they understand intergenerational dynamics and consider the impact of immigration and acculturation, they also need to have nonjudgmental attitudes toward parenting styles and family relationships that are culturally appropriate to EAA families (Chao, 1994). For example, given that authoritarian parenting is linked to adverse outcomes among EAA youth, program developers and clinicians can learn how to employ its positive aspects and blend them with different parenting strategies (Choi et al., 2013; Kho et al., 2019). Through these efforts, they can engage in culturally sensitive practice with these families in a way that respects their culture and traditions.

Relevance to Social Work

According to the International Covenant of Economic, Social and Cultural Rights, every individual has a right to the highest attainable standard of mental health (Earle, 2006). The social work grand challenges, such as "ensure healthy development for all

youth" and "close the health gap" (Gehlert et al., 2020), speak to EAA youth's mental health issues. More attention should be given to the social justice implications of mental health among EAA youth, and a critical analysis and cultural lens on existing theories and specific interventions to directly support this population is critical.

As immigrants and racial minorities, EAA youth have experienced and continue to face stressors and barriers to maintaining positive mental health, which warrant more careful attention in the field of social work. The model-minority myth is reinforced by inadequate data on Asian Americans, which in turn, negatively influences resource allocation and implementation of culturally appropriate care to support EAA communities (Park et al., 2019). Furthermore, by pitting EAAs against other racial minority groups, this White-constructed stereotype may divert attention from addressing structural inequality and racism and impede those who require or would benefit from social justice (Zhou, 2003).

In the context of structural racism, COVID-19 has exacerbated negative influences and amplified multiple threats, including anti-Asian hate crimes, discrimination, and violence (Gover et al., 2020). In addition to the model minority, recently emerged pejorative labels like "China virus" and "kung flu" created by stigmatized media are pervasive in society, increasing stigmatization and othering of EAA youth and families (Crowder, 2020). Failure to address these multiple health challenges, as inextricably linked to anti-Asian hate crimes and reinforced by structural racism through practice, will result in racial health disparity and social work injustice.

Conclusion

The proposed conceptual framework attempts to redress the shortcomings in the previous literature on EAA families by reinterpreting family constructs and elements of the Western-based TMFP theory in the East Asian cultural context. Reoperationalizing the constructs defined in the theory using a cultural lens approach could aid the development of culturally responsive measures, thereby improving the quality of empirical research with EAA families.

Current multicultural mental health services and intervention programs tend to commit the mistake of applying inappropriate Western and Eurocentric theories to interpret the attitudes, behaviors, and values of non-White minority groups (Delatolla et al., 2021; Spencer & Dornbusch, 1990). Consequential evaluations of these programs or clinical assessment may not successfully reflect or understand the needs of EAA families. With the increasing number of EAA families and other Asian groups in the United States, our proposed integrative framework can provide a greater understanding of youth mental health in the East Asian cultural context. Although this framework focuses on only EAA families, examples of acculturation and family processes and recommendations addressed to reduce mental health risks among EAA youth may also serve as a point of advocating for families from other racial and ethnic minority groups.

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Figure 1

Summary of Triadic Model of Family Process
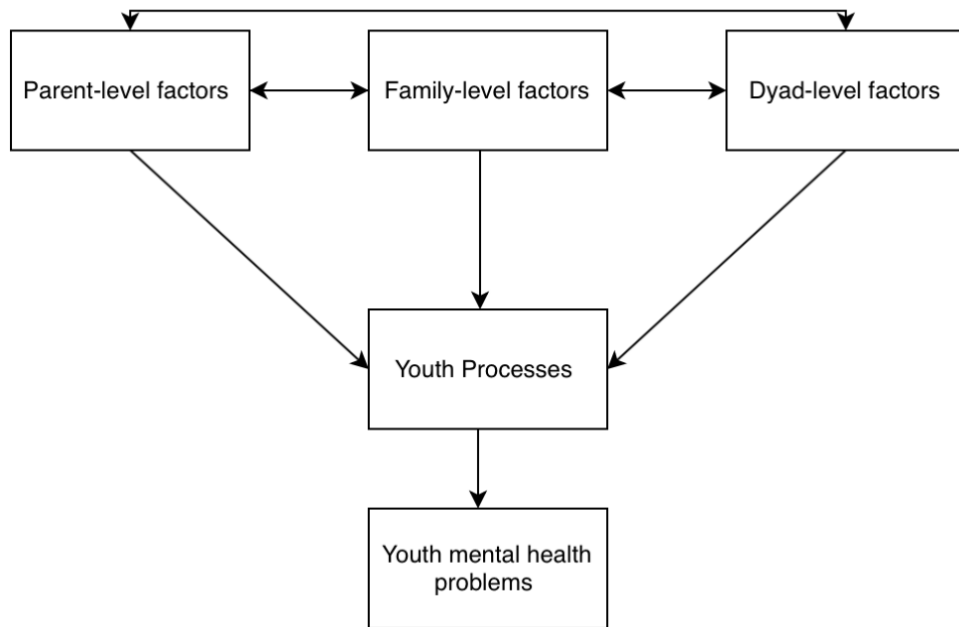
Figure 2

An Integrative Framework of TMFP and AGDT
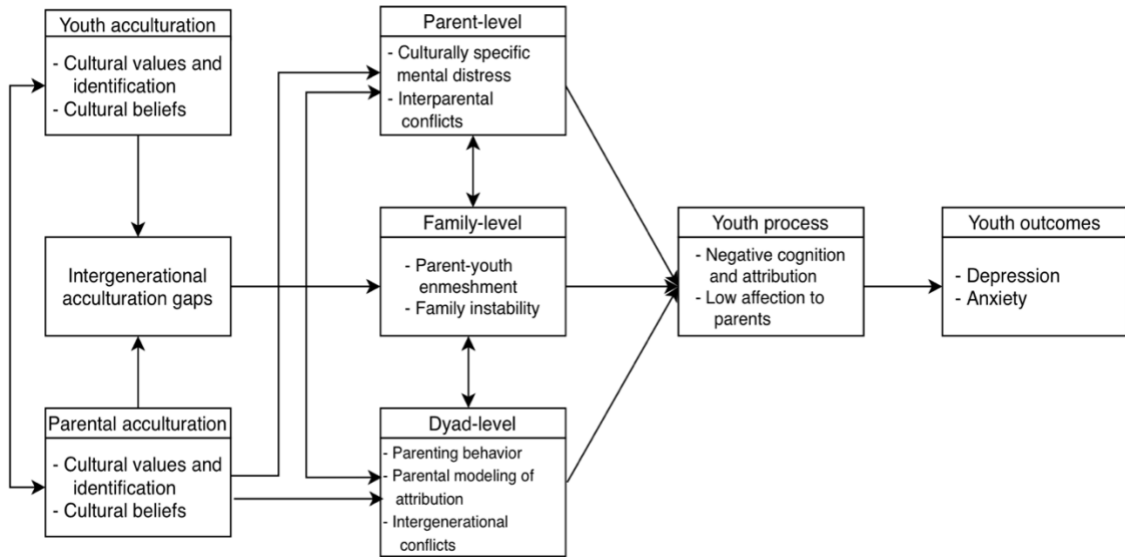
Chapter Three: Manuscript Two

The Relationship between Familial Factors and Youth Mental Health Outcomes

in Korean American Families:

The Mediation Effects of Youth's Negative Emotionality

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Introduction

Adolescence marks a vulnerable period for the emergence and progression of

depression (Lu et al., 2018). Between 2005 and 2017, the percentage of youth who

experienced depression markedly increased across most age groups, with the largest

increases (from 8.7% to 11.3%) reported among youth aged 12 to 17 (National Institute of

Mental Health, 2015; Twenge et al., 2019). Extensive research has identified the negative

effects of youth depression on the risk of additional short- and long-term adverse

psychosocial outcomes, including bipolar disorder (Fergusson et al., 2005), suicidal

ideation and attempts (Mullen, 2018; Sust et al., 2018), and substance-related disorders (Humenksy et al., 2010). Further, these problems can impose a heavy financial burden both on families and society by increasing family health care costs (Guo et al., 2019). Thus, youth depression is no longer an individual youth's issue but one that families and societies need to address.

Moreover, the prolonged COVID-19 pandemic and public health crisis have amplified much more serious mental health problems of youth in general, but particularly more so for Asian American (AA) youth. During the COVID-19 pandemic, AA youth have been blamed for spreading the "Chinese virus" and became the direct targets of racism. This could increase AA youth's internalization of negative attitudes from the dominant group and increase their mental health problems (Cheah et al., 2020; Gee et al., 2020). According to a national report, the number of AA youth with depression increased sevenfold during the COVID-19 outbreak as compared to 2019 (National Center for Health Statistics, 2020). Moreover, in a systematic review of youth depression, about 35% of AA youth reported mild to severe depressive symptoms, higher compared to their European American (26.9%), African American, and Latinx (24.5%) peers (Kim et al., 2015).

Korean American (KA) youth have the highest risk of depression of any subgroup of EAA youth, (e.g., Mongolian, Chinese, and Japanese) counterparts, with rates as high as 33% (Huang et al., 2012; Yasui et al., 2018). Moreover, the report of higher depression rates among KA youth compared to those among youth living in Korea indicates that immigration experiences specific to KA families, such as acculturative stress and intergenerational conflict (IC) among family members, might be additional stressors (Chung et al., 2003).

Previous studies have found correlates of familial factors from multiple levels and relationships (e.g., child-related, parent-related, and family-functioning factors) associated with AA youth's negative mental health outcomes. However, very little is known about the underlying mechanisms through which familial factors may affect youth depression over time, particularly among those from KA families. Given that adolescence is a high-risk period for dramatic changes in emotional states and developing negative emotion (Lee et al., 2014; Schleider & Weisz, 2017), it is critical to further explore the link between familial factors and youth depression. One important potential mechanism to explore is youth's emotional function. To address this gap, this study employed a longitudinal design to investigate the effects of familial factors from different levels on youth depression and the mediating role of negative emotionality.

Explanatory Factors: Triadic Model of Family Process

Empirical research has identified family processes at the core of youth development and mental health outcomes (Choe, 2020; Gau et al., 2010; Schleider & Weisz, 2017). The current study used the triadic model of family process (TMFP) model as a theoretical framework. TMFP, developed by Schleider and Weisz (2017), expands family system theory to include the influences of familial factors from three levels (i.e., parent, family, and dyad) on development of youth depression via youth's negative emotional processes. Parent-level factors refer to aspects of the family process localized in a parent or between parents. Family-level factors involve overall family functioning and stability. Dyad-level factors include components related to interactions between parent and child.

Parent-Level Factors: Parents' Psychological Distress

Parents' psychological distress can influence youth's mental health problems (Burstein & Ginsburg, 2010). Parents continuously exposed to stressors in day-to-day life are more likely to experience negative feelings and psychiatric disorders (Choe, 2020; Silverstein et al., 2009). Youth who observe their parents' distress may also internalize their attitudes and behaviors, thereby thinking more negatively and being more sensitive to stressors (Schleider & Weisz, 2017). Previous studies have linked parents' psychiatric symptoms to depression among youth (Choe, 2020; Goodman, 2007; Hammen, 2009) by showing that children of parents with distress have elevated risk of internalizing problems across both childhood and adolescence (Choi, 2020; Goodman, 2007). A recent study also found that parental depressive symptoms predicted youth symptom trajectories and poorer treatment of child depression (Eckshtain et al., 2019).

Foreign-born parents undergo psychological distress because of additional sociocultural stressors, such as discrimination, language barriers, and difficulty integrating into mainstream culture (Choe, 2020; Gau et al., 2010). These stressors might be more frequent for Korean parents, who often remain largely monolingual with limited English and socialize primarily in groups of the same ethnicity even after years of settlement (Min, 2012). As such, cultural isolation and the cultural adaptation process can increase the likelihood of heightened psychological distress.

The expression of psychological distress is demonstrated in a cultural syndrome specific to KAs known as *hwa-byung*. Hwa-byung differs from other clinical disorders because it is heavily influenced by the Korean culture embedded in Confucianism (Lee

et al., 2014). Confucianism values several societal norms including suppression of emotion, submissive female gender roles, and the stigma of mental illness (Min et al., 2009). These norms make Koreans more likely to express their psychological distress via physical symptoms manifested in hwa-byung rather than direct words. Somatization, fatigue, and generalized aches and pains are typical symptoms of hwa-byung, and they are more frequently observed among women compared to men (Lee et al., 2014). Although studies have examined psychological distress and its effects on youth from racially and ethnically diverse families, few studies have examined culturally specific interrelations of distress and youth mental health outcomes. To better understand Korean parents' distress and its impacts on KA youth depression in the Korean cultural context, this study used hwa-byung to assess mothers' culturally specific symptoms of mental distress.

Family-Level Factors: Family Enmeshment

One family-level factor that can be related to youth depression but has less received attention is family enmeshment. Enmeshment is a type of dysfunctional family dynamic that is evidenced by a lack of family boundaries or extreme closeness between family members (Schleider & Weisz, 2017). Family enmeshment can be detrimental to youth development due to the increased diffusion of family roles (Davies & Sturge-Apple, 2014; Minuchin, 1985). Youth with an enmeshed family climate are excessively involved in family work and take on parental roles to meet family needs (Segrin et al., 2013). Such parentification of children is linked to feelings of burden and stress, potentially leading to negative mental health outcomes (Kerig, 2005; Kivisto et al., 2015).

Family enmeshment holds cultural values and thus, may function uniquely in KA families. Boundaries in families of Korean heritage are steeped in an Indigenous cultural concept called *Jung* (Choi, 2011). Jung emphasizes emotional bond and group harmony, and consequently, self-sacrifice in the service of group members and families is regarded as a high virtue in Korean society (Jin & Roopnarine, 2022). New immigrant parents may endorse these shared values of group and individual sacrifice for the family. Parents who lack English language fluency and knowledge of American culture may heavily rely on their child, expecting them to take charge of family duties, such as translating medical documents and bills (Xia et al., 2013). Taking on this role for family needs can bring additional burden and increase the risk of mental distress among KA youth who, perhaps unlike their parents, have adapted to American culture and value personal freedom and choice (Segrin et al., 2013).

Findings regarding the association between family enmeshment and youth negative outcomes are inconsistent. Studies on non-Asian families found that an enmeshed family climate was associated with low psychological flexibility and self-compassion (Berryhill et al., 2018) and increased internalizing behaviors among youth (Coe et al., 2018; Kivisto et al., 2015). On the other hand, Jin and Roopnarine (2002), with a sample of KA youth in late childhood and early adolescence (aged 9–14 years), reported that extreme family closeness was positively associated with youth socioemotional functioning, suggesting that family enmeshment may not always place youth at psychological risk. Although these mixed findings can be attributed to differences in race and ethnicity, they necessitate further investigation of how family enmeshment could affect youth at various stages of development. For example, it is possible that older youth have spent more time in the

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United States and thus, are more accustomed to U.S. culture compared to their younger counterparts, and such differences in age might lead to a difference in the relationship between family enmeshment and youth outcomes. Exploration of this relationship with older KA youth samples can contribute to our understanding of family enmeshment by youth age and development of more tailored interventions for individual youth.

Dyad-Level Factors: Intergenerational Conflict

Intergenerational conflict (IC) is a critical dyad-level factor associated with youth processes and mental health outcomes. IC involves family conflict due to sociocultural, psychological, behavioral, or cognitive disharmony between a member of an older generation and a member of a younger generation (e.g., parents and children; grandparents and grandchildren; Kimonis et al., 2014). Although its frequency and intensity vary by different factors, such as family status, personality, health condition, and other life events, IC may be more frequent and intense between middle-aged parents and youth in mid-adolescence (i.e., ages 14–16; Steinberg & Morris, 2001). A large body of literature has documented IC as a major stressor that can lead to negative developmental outcomes among youth, such as low self-esteem (Tucker et al., 2003), depression (Alaie et al., 2020), social anxiety (Kimonis et al., 2014), and substance use (Rothenberg et al., 2017).

For Asian immigrant families, it is important to consider the influence of culture when studying intercultural conflict. Intergenerational cultural conflict (ICC), a cultural component of IC, refers to disagreements over cultural values between parents and children (Lui, 2015). Specifically, immigrant parents tend to have a strong connection to their culture of origin and relatively weak ties to American society, whereas their children tend to endorse dominant American values and norms (Buki et al., 2003). This cultural

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discrepancy seems to be more common among families from non-Western cultures, such as Asian families (Choi et al., 2008).

Previous scholars have suggested connections between ICC and negative mental health outcomes of AA youth (Juang et al., 2012; Roley et al., 2014; Wei et al., 2020). For example, one study found that whereas IC (e.g., arguing over schoolwork and household chores) directly predicted youth depression, ICC was associated with youth depression indirectly through family dysfunction, and this association was stronger for immigrant youth (Juang et al., 2012). Based on these findings, although IC and ICC share a similar construct as family conflict, they may work differently to explain youth mental health outcomes. To better understand dyad-level factors in AA families and explore how each conflict is related to KA youth processes and mental health outcomes, this study used both constructs.

Youth Process: Negative Emotionality

According to TMFP, not only do familial factors directly influence youth mental health, but they also determine youth outcomes indirectly via youth processes. Youth processes include various cognitive and socioemotional domains that link familial factors and mental health outcomes. Negative emotionality, a less adaptive cognitive style, refers to a tendency to experience and express negative emotion (Belsky & Pluess, 2009). This temperament often results from a youth's lack of emotional regulation, maladaptive coding, and negative interpretation of events (Crick & Dodge, 1994; LaMontagne et al., 2022). Specifically, individuals high in negative emotionality are affectively sensitive to negative cues and interpret adverse events as due to internal factors (e.g., "It will always be my fault") rather than external factors (e.g., "It is not my fault"; Fiske & Taylor, 2013).

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Individual differences in negative emotionality are known risk factors for externalizing and internalizing behavior problems (Singh & Waldman, 2010).

Negative emotionality during adolescence is determined by the complex ways in which environmental factors interplay (Lipscomb et al., 2012). According to TMFP, youth processes explain the mechanism through which familial factors contribute to youth internalizing problem behaviors. For example, parental psychological stress, certain parenting styles (e.g., psychological control, rejection), and interparental conflicts can lead to negative problem behavior via the level of negative emotionality aroused in youth (Mackler et al., 2015). By observing and modeling these negative emotions, attitudes, and behaviors of their parents, youth become more vulnerable to subjective distress and negative emotionality (Cummings et al., 2002; Wang & Dix, 2017). Accordingly, youth with high negative emotionality tend to make negatively biased interpretation of family events and circumstances and thus, exhibit more internalizing problem behaviors (Fiske & Taylor, 2013).

A few scholars have investigated the relationships among familial factors, negative emotionality, and youth negative health problems (McCoy et al., 2009; Xuan et al., 2018; Yeh, 2011). For example, Yeh (2011) examined the role of negative emotionality in the relationship between parent–youth conflict and different problem behaviors among youth. The author found that negative emotionality mediated the effect of conflict on psychosomatic symptoms, social withdrawal, and deviant behavior. Another study revealed positive associations among maternal depressive symptoms, child's negative emotionality and externalizing problem behaviors (Dix et al., 2014). In this study, depressed mothers were negatively reactive to expression of negative emotion, and this

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reactivity explained the child's externalizing problem behaviors through the child's negative emotionality such as anger (Dix & Yan, 2014). Although these studies contributed novel knowledge on the role of negative emotionality in explaining youth mental health, none has empirically tested its mediating role in explaining the link between familial factors and youth depression outcomes.

The Current Study

Parental psychological distress, family enmeshment, IC, and ICC as negative familial factors have been linked to negative youth mental health outcomes (Branje, 2018; Jin & Roopnarine, 2022; Yasui et al., 2018). However, few studies examined this relationship using a sample of KA families, which have culturally unique individual characteristics and family values and relationships. Multiple familial factors may explain youth depression either directly or indirectly by youth's negative emotionality—that is, increasing youth's susceptibility to negative emotions and weakening their capability to control emotions. A more specific understanding of the role of negative emotionality can contribute to developing more effective family-based interventions to prevent mental problems among KA youth.

Thus, the current study aimed to examine how familial factors from three levels affect youth depression over time via youth negative emotionality. Specifically, this study examined how maternal culture-specific mental distress symptoms (hwa-byung), family enmeshment, IC, and ICC can explain youth depression by investigating the mediating effect of youth's negative emotionality (Figure 1). Overall, we expected that all three familial factors would be positively and longitudinally associated with youth depression and that negative emotionality would mediate this relationship. The

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associations between key variables were examined using both mother and youth reports on conventional and culturally nuanced dimensions of the family.

Methods

Primary Study Participants and Procedure

Data for this study were derived from the Midwest Longitudinal Study of Asian American Families project, a longitudinal survey (four-wave panel data from 2014 to 2020) of Filipino American (FA) and Korean American (KA) youth and their mothers living in a Midwest metropolitan area. Data for the first wave (W1) were collected in 2014 and included 365 FA and 407 KA mother–youth dyads ($N = 1,574$; 379 FA youth and 377 FA mothers; 410 KA youth and 414 KA mothers). The families were recruited from multiple sources, including phonebooks, public and private schools, ethnic churches, and temples. A proactive recruitment campaign continued until the project reached its target of 350 families. At W1, most participants (84%) were surveyed in person by trained bilingual interviewers. For the self-administered survey, the instruments were available in English, Tagalog, and Korean. The data at the second wave (W2) were collected 1.5 years after W1 in 2016 with a retention rate of approximately 78% ($N = 1,212$, 302 FA and 351 KA families). The third wave (W3) surveys were collected only from youth in 2018, with 309 FA and 341 KA youth ($n = 650$, 82% retention rate relative to W2). The data for both W2 and W3 were collected using self-administered questionnaires, either online or on paper in the same three languages. The selection criteria were maternal self-identification as Filipina or Korean with an adolescent child in middle or high school at W1.

Measures

Unless noted otherwise, the items of each scale were averaged and response options for all measures were ordinal Likert scales, ranging from 1 (*rarely or not at all*) to 5 (*very often or strongly*). Given the previous literature that addressed the importance of including both mothers' and youth's perceptions of family conflict (Lee et al., 2005) and the availability of measures, both maternal and youth reports of IC and ICC were used in this study. All items measured at W1 were used except for youth-reported depression as an outcome (W3) and youth-reported negative emotionality (W2).

Youth-reported depression was assessed by the Short Mood and Feelings Questionnaire (Angold et al., 1995) and the Seattle Personality Questionnaire for Children (Greenberg et al., 1989). The adapted measure consisted of 14 items that measured depressive symptomology in youth experienced in the past 2 weeks (e.g., "I didn't enjoy anything at all"). The measure was moderately highly correlated with a standardized measure (e.g., Child Depression Inventory; Kovacs, 1992) and has been used with racially and ethnically diverse youth including AA youth (Fung et al., 2019), supporting convergent validity. For the outcome variable in this study, we used this scale at W3. Cronbach's alpha for this study sample was .94.

Mother-reported culture-specific symptoms were measured using four items from the Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision), a screening tool used to assess clinical depression (Diwan et al, 2004; Gupta et al., 2006). Items asked mothers about the degree of core symptoms of hwa-byung, including anger and somatic symptoms in the past week (e.g., "Because I am upset, I had oppressive and heavy feelings in my chest."). Cronbach's alpha was .87 for this sample.

Youth-reported family enmeshment was measured using four items that assessed youth's perceptions of family enmeshment (Manzi et al., 2006). A sample item is "It is difficult for my family members to take time away from the family." In the current study, Cronbach's alpha was .84.

The measure of mother- and youth-reported ICC assessed the degree to which parents and youth have family disagreements or arguments with each other because of cultural differences or gaps (Lee et al., 2000). For this study, the mother and youth measures included 10 items each. Sample items are "[My child] is too direct about [his or her] thoughts, feelings, and opinions" for mothers and "[Your parents] tell you what to do with your life, but you want to make your own decisions" for youth. Cronbach's alphas were .75 for mothers and .85 for youth.

The mother- and youth-reported IC measure was adopted from Prinz's (1979) Conflict Behavior Questionnaire scale, which asks how often parents and youth get angry at each other or the parent does not listen to child's side of the story, or vice versa. The parent measure included five items and the youth measure included four items. Example items are "[My child] and I get angry at each other" for mothers and "[My mom] nags me a lot" for youth. Cronbach's alphas were .86 for mothers and .79 for youth for this study.

Youth-reported negative emotionality was assessed with a 4-item measure adopted from the Child and Adolescent Dispositions Scale to assess youth's emotional response to threat, frustration, and loss in the past 12 months (Lahey et al., 2010). The authors who developed this scale noted that negative emotionality among children and youth is influenced by not only genetic but also different environmental factors (Lahey & Waldman, 2003). Cronbach's alpha for this study sample was .85.

Based on findings from previous literature, several youth-reported demographic variables, and mental health-related variables were included as covariates. Youth gender (0 = *male*, 1 = *female*), age, nativity (0 = *foreign-born*, 1 = *U.S.-born*), and perceived family socioeconomic status (1 = *lower class* to 5 = *upper class*) were included as covariates. Additionally, given previous studies that found high correlations between depression at baseline and subsequent waves (e.g., Hasegawa et al., 2022), youth-reported depression at W1 was controlled in the model. The measure showed strong internal consistency for this study sample ($\alpha = .93$).

Analytic Strategy

Before testing the conceptual model, several univariate and bivariate descriptive analyses were conducted, including means and standard deviations of individual items and item-total correlations. To test the conceptual model, path analysis was tested in a structural equation modeling method using Mplus 7.0. A nonsignificant chi-square value, comparative fit index (CFI) greater than or equal to .95, and root mean square error approximation (RMSEA) and square root mean residual (SRMR) less than or equal to .08 were considered to indicate acceptable model fit (Hu & Bentler, 1999). Missing data were handled using full information maximum likelihood, which includes all available data points for model estimation (Enders & Bandalos, 2001). At each step of the modeling procedures, paths with *p*-values greater than .05 were removed for the sake of parsimony. The model fit was evaluated using the final model.

Once the path model was finalized, potential indirect effects of familial factors on youth depression via negative emotionality were tested. Maximum likelihood estimation and bootstrapped standard errors (5,000 draws) were used for model estimation. To test

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the significance of indirect effects, bias-corrected bootstrapped confidence intervals were

utilized (MacKinnon et al., 2004).

Results

Sample Characteristics

The current study used all three waves and only KA families' data for the analyses.

At W1, the average age of the youth was 14.76 years ($SD = 1.9$), with a larger

proportion of high school students (75.3%) than middle school students. Gender

distribution among youth was about equal, with 47.3% of youth indicating female

gender. About 58.1% of youth were U.S.-born, and the average years in the United

States among foreign-born youth was 11.76 years ($SD = 4.39$). The average scores of

perceived family socioeconomic status and depression at W1 were 3.03 ($SD = 0.70$)

and 1.81 ($SD = 0.73$), respectively.

The average age of Korean mothers was 45.3 years ($SD = 3.76$), and about 98.6%

of mothers were foreign-born. The average years of living in the United States among

mothers was 16.04 years ($SD = 8.53$). Most of them were highly educated (83.1%),

having at least some college education in either Korea or the United States. These

demographic characteristics indicate that our study sample was composed of highly

educated middle-income families, which is consistent with KA families in census or

national-level data (e.g., National Longitudinal Study of Adolescent to Adult Health).

Descriptive and Correlation Analysis

Table 2 presents means, standard deviations, and zero-order correlations for the

nine key study variables. As hypothesized, depression at W3 was positively associated

with most key familial variables, including maternal cultural symptoms ($r = .55$),

youth-reported IC ($r = .23$), mother-reported IC ($r = .02$), and youth-reported ICC ($r =$ .23). Based on the respective criteria of 2 and 7 for skewness and kurtosis (West et al., 1995), no variable had non-normal univariate distribution issues (range of absolute values in skewness = 0.00–0.29; range of absolute values in kurtosis = 0.00–1.00).

We examined the bivariate correlations of the key variables to assess multicollinearity. All variables had correlation coefficients in the range of .00 to .59, less than the cutoff value of ±.80 (Gujarati & Porter, 2009). In addition, the values of the variance inflation factor showed no evidence of multicollinearity for either mother-reported maternal cultural symptoms (1.07) or youth-reported variables (range = 1.07– 1.77).

Inferential Statistics

Before finalizing the model, the significance of the paths from demographic and mental health-related variables to the mediator variable (i.e., negative emotionality) and outcome variable (i.e., depression) were tested. The results showed that the paths from youth age, nativity, and perceived family socioeconomic status to both variables were not statistically significant ($p > .05$), whereas youth gender and depression at W1 were significant ($p < .01$ and $p < .001$, respectively). As a result, youth age, nativity, and perceived family socioeconomic status were removed from the model. The trimmed model demonstrated adequate model fit: $\chi^2(13) = 27.22$, $p < .05$, CFI = .92, TLI = .83, RMSEA = .052.

The results of pathways in the model are presented in Table 3. Among the key familial independent variables, family enmeshment ($\beta = .10$, $p < .05$) and youth-reported IC ($\beta = .14$, $p < .01$) were significantly associated with negative emotionality.

Mother-reported culture-specific psychological distress, mother-reported IC, youth-reported ICC, and mother-reported ICC were not significantly associated with negative emotionality. Negative emotionality ($\beta = .27$, $p < .001$), depression at W1 ($\beta = .17$, $p < .01$), and gender ($\beta = .13$, $p < .001$) were positively associated with depression at W3.

Mediation Analysis

A mediation analysis was conducted to examine how familial factors were associated with youth depression via youth negative emotionality (Table 3). The total effect of family enmeshment ($\beta = .03$, $p < .01$, 95% CI [0.01, 0.04]) on depression at W3 was statistically significant. While the direct effect of family enmeshment on depression at W3 was not statistically significant ($\beta = .00$, $p = 0.92$, 95% CI [-0.10, 0.11]), the indirect effect of family enmeshment ($\beta = .03$, $p < .01$, 95% CI [0.01, 0.04]) on depression at W3 via negative emotionality was statistically significant. This suggests that negative emotionality worked as a full mediator in the relationship between family enmeshment and depression.

The total effect of youth-reported IC on depression was not statistically significant ($\beta = .04$, $p = 0.49$, 95% CI [-0.02, 0.18]). Youth-reported IC was not directly associated with depression at W3 $\beta = .00$, $p = 0.96$, 95% CI [-0.01, 0.10]). The indirect effect of youth-reported IC ($\beta = .04$, $p < .01$, 95% CI [0.02, 0.06]) on depression at W3 via negative emotionality was significant, indicating that the effects of youth-reported IC on depression were fully mediated by negative emotionality.

Among the covariates, gender was directly associated with depression at W3 ($\beta = .13$, $p < .001$, 95% CI [0.17, 0.24]). The indirect effect of gender on depression at W3 via negative emotionality was also statistically significant ($\beta = .06$, $p < .001$, 95% CI

[0.05, 0.08]), indicating that negative emotionality partially mediated the relationship between gender and depression at W3.

Similarly, depression at W1 directly was associated with depression at W3 (β = .32, p < .001, 95% CI [0.28, 0.68]). The indirect effect of depression at W1 on depression at W3 via negative emotionality was also statistically significant (β = .08, p < .001, 95% CI [0.09, 0.13]). This means that the effect of depression at W1 on depression at W3 was partially mediated by negative emotionality.

Discussion

Guided by TMFP, this study longitudinally examined whether familial factors—maternal culture-specific symptoms of mental distress (i.e., hwa-byung), family enmeshment, IC, and ICC—were associated with youth negative emotionality and whether such processes led directly to depression among youth. We found that family enmeshment and youth-reported IC was significantly associated with youth depression via youth negative emotionality. However, mothers' culture-specific symptoms of mental distress, mother-reported IC, and ICC were not associated with negative emotionality and depression.

Parent-Level Factors

Mothers' culture-specific symptoms of mental distress were not associated with youth negative emotionality and depression. This finding is unexpected given most available literature has directly linked maternal psychopathology and youth negative emotions or depression (Choe, 2020; Goodman, 2007). One possible explanation for this lack of association is that hwa-byung has been generally recognized as a daily emotional expression rather than an indication of psychological illness in the United States (Lee et

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al., 2014; Rhi, 2004). If KA youth have adapted to American culture and think of their

mothers' symptoms as culturally normative rather than problematic, mothers' hwa-byung

might have less of an impact on youth outcomes. Although the use of this measure was

appropriate to our study aims and population, future studies might consider utilizing

measures that reflect different Korean culturally bound symptoms (Lee et al., 2014).

Another reason for the lack of an association in the current sample may be attributed to

informant variance. This study used different reporters (i.e., mother-reported maternal

symptoms of mental distress and youth-reported negative emotionality), and the result may

have been different if a youth-reported measure of maternal symptoms was used. Indeed,

other research has found that child reports regarding parental attitudes or behavior

measures are more reliable than parent reports in explaining a child's self-reported

behavior (Barry et al., 2008; Scott et al., 2011). Future studies should use both youth and

parent reports of parental symptoms to explore how they operate and explain youth

negative emotionality and depression.

Family-Level Factors

The finding of family enmeshment's effect on youth depression via negative

emotionality is in line with previous studies (Barber & Buehler, 1996; Berryhill et al.,

2018; Davies & Sturge-Apple, 2014; Kivisto et al., 2015). That is, extreme family

closeness inhibits youth's individualization process and emotional autonomy, which in

turn, transmits negative emotions and increases the risk of depression. Interestingly, our

findings contrast prior research showing family enmeshment as a buffer for KA younger

adolescents (Jin & Roopnarine, 2022). This may indicate that an enmeshed family may

work negatively for older adolescents, who become more sensitive to their family

environment. Indeed, a previous study supported this assertion by reporting differences in perceptions of family climate by age, in that older age was associated with higher levels of caregiver strain and pressure (Haber et al., 2012). A closer look at the function of enmeshed family climate and its impacts on youth outcomes by age is needed to replicate and more fully explain this study's finding.

Dyad-Level Factor

Our finding on the relationship between youth-reported IC and depression replicated previous studies that have found a significant association between mother–child conflicts and youth maladjustment and negative health outcomes (Shek & Ma, 2001; Yeh, 2011; Yeh et al., 2010). The present study went further to reveal that negative emotionality fully mediated the effects of conflict on youth depression. In our study, negative emotions aroused by the conflict with a mother were likely to induce depressive symptoms among KA.

In contrast to prior studies, ICC was not significantly associated with youth negative emotionality or depression. It may be the case that youth's negative emotionality is more directly explained by mother–youth conflicts on general topics rather than specific cultural elements. Another explanation is that the significance of ICC might have been lost by entering IC and other familial variables that have more statistical power. Indeed, in a separate analysis that only included ICC in the model, there was a significant relationship between youth-reported ICC and negative emotionality. Although both explanations are possible, further investigation is necessary to develop a more comprehensive understanding of the links from IC and ICC to depression.

Youth Negative Emotion as a Mediator

Negative emotionality mediated the relationships between family enmeshment and youth depression and between youth-reported IC and youth depression. These findings partially support the TMFP, which posits that familial factors not only directly but also indirectly lead to youth depression via youth processes (Schleider & Weisz, 2017). The indirect effect pathway via negative emotionality is particularly noteworthy, because this suggests that the link between familial factors and youth depression can be partially explained by negative emotion. Given that negative emotionality has long-term consequences for adjustment and mental health among youth (Yeh, 2011), the present findings call for greater attention to early intervention efforts in ameliorating the impact of negative emotions on youth depression.

Covariates

Regarding covariates, our finding related to youth sex is consistent with previous studies that have found that AA female youth have higher levels of negative emotions and internalizing problems compared to their AA male counterparts (Choi et al., 2020; Kim et al., 2016; Shrake & Rhee, 2004). Given these findings, investigation of youth sex as a potential moderator of the link among familial factors, negative emotionality, and depression would also be helpful. The findings can also provide possible directions to help KA female youth deal with emotion regulation in a constructive manner to promote their psychosocial growth.

Study Limitations and Future Research Directions

The current study has limitations, which also point to future research directions. Some theoretical concepts were not fully represented by constructs in our structural model. For example, youth negative emotionality is a more complex cognitive process

that involves youth's negative interpretation bias and attributional inferences (Bengtsson et al., 2022). More accurate and comprehensive measures of youth processes that align with the TMFP (e.g., attributional processes, emotional dysregulation) need to be included in future research. In a similar vein, some of family-level constructs and youth mental health outcomes that are critical to understand EAA family systems were excluded from this study. For example, anxiety, which is more common mental distress symptoms among EAA youth compared to depression (Brice et al., 2015; Mangubat, 2021), or culturally specific symptoms of mental distress (e.g., fear of interpersonal relations, feeling guilt) that are distinct among East Asians (Park & Park, 2020), were not examined in this study. For a more comprehensive understanding of the negative influences of familial risk factors on youth outcomes, future studies can examine these constructs through the primary data collection.

Additionally, this study relied on survey-based self-report data, which could potentially create social desirability bias and systematic measurement errors. Although youth's self-reported measures showed high validity and reliability (Ridgers et al., 2012), the issues of social desirability and cognitive complexity of recalling symptoms may remain (Chinapaw et al., 2010). Future studies should assess youth measures using more varied methods and multiple informants. Another limitation is our reliance on mothers' reports of psychiatric distress and IC, with no data on fathers' reports. Current literature has underlined the critical role of Korean fathers in childrearing and building family relationships (Choe, 2020; Kim & Rohner, 2002). Thus, caution is advised in interpreting the study findings, and future studies should include fathers in their parent samples. Finally, study findings may not be generalizable to all AA youth and families

because the study sample consisted of primarily middle-class KA families in one region. Further studies should examine the associations between variables with a larger family population and more variety in demographics (e.g., those with low socioeconomic status) and cultural backgrounds.

Implications for Research and Practice

Despite these limitations, our study has important theoretical and practical implications. The study findings provide some empirical support for the value of incorporating Asian cultural components in the TMFP. Although the TMFP lacks application to racially and ethnically diverse families, it can be culturally adapted and more usefully applied to AA families to gain a better understanding of KA youth depression. Also, to our knowledge, this study was the first to elucidate the longitudinal consequences of different familial factors on AA youth depression with attention to underlying mechanisms. Moreover, we used familial factors from different levels using both mother- and youth-reported measures, which enabled us to examine comparative impacts of familial factors by level and reporter.

The findings also can inform efforts to design interventions aimed at reducing youth's negative emotionality and alleviating the negative influences of familial risk factors on youth mental health. For example, facilitating emotion regulation skills among youth and teaching emotion-coaching techniques to mothers could be effective, and such interventions can be particularly useful for KA youth facing numerous challenges during the current pandemic.

In addition, information from this study could be helpful in guiding clinicians to make cultural adaptations to existing evidence-based family interventions and family education

programs. Specifically, in terms of family enmeshment and healthy family boundaries, culturally adapted interventions could focus on helping mothers adjust to a new culture in an early stage of immigration and better understand their children's experiences. This would not only encourage their responsibility and self-reliance, but also reduce youth's burden and risk of mental distress. Programs also may focus on strengthening immigrant family relationships and improving mother–youth mutual understanding. For example, treatment programs could address various content, including promoting cultural awareness and challenges, as well as cognitive knowledge and understanding of differences between Asian and American cultures. This could improve the quality of mother–youth relationships and facilitate youth's positive emotions, thus potentially improving their overall well-being.

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Figure 1

Conceptual Framework for Understanding Parent-, Family-, and Dyad-Level Factors, Negative Emotionality, and Depression in KA Families
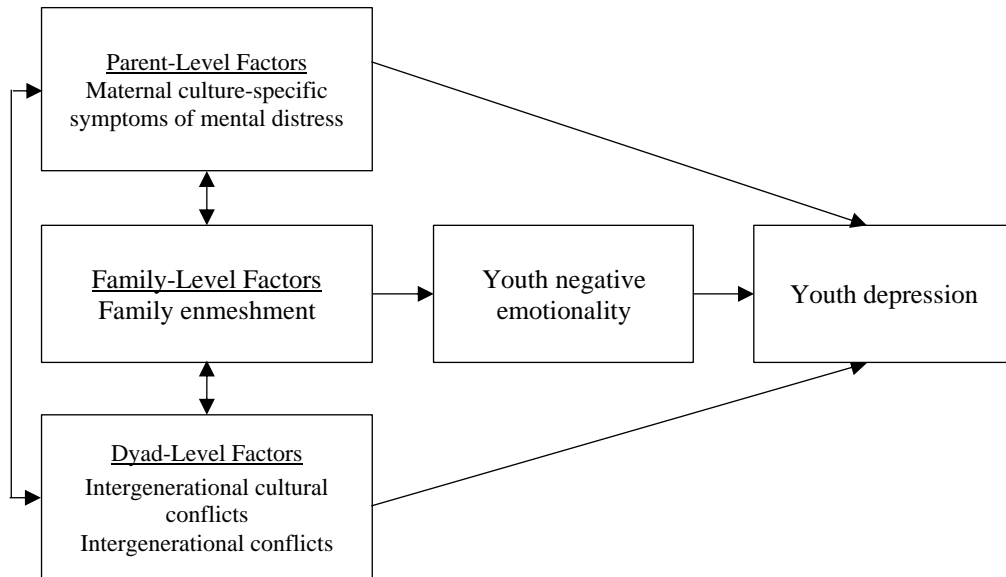
Figure 2.
Finalized Path Model
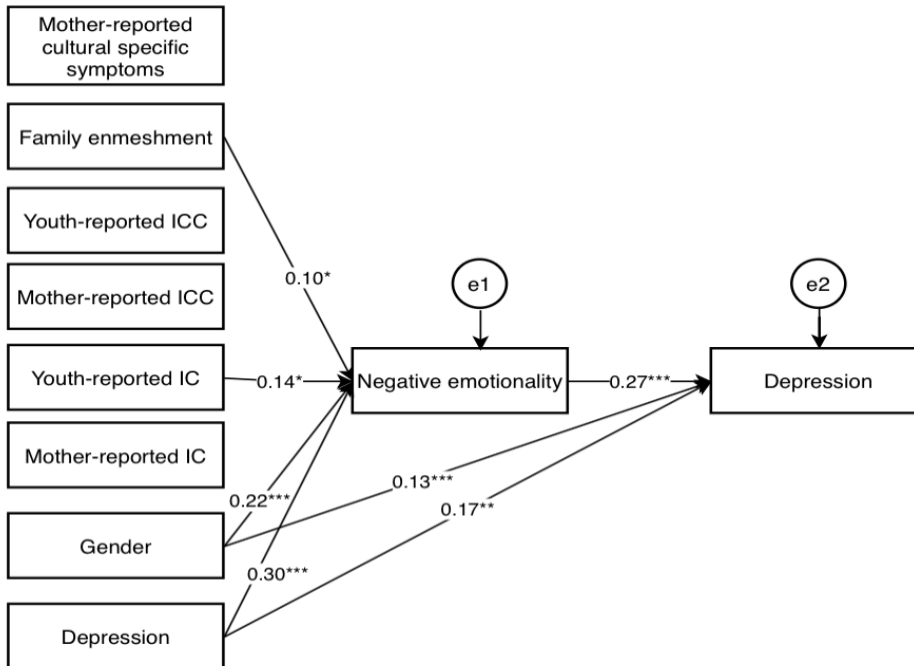
Note. Standardized path coefficients are presented. Solid lines indicate relationships that were significant at $p < .05$ (two-tailed). Parameter estimates for pathways that were not statistically significant at $p > .05$ were omitted from this figure.
*p < .05. **p < .01. ***p < .001.

Table 1

Descriptive Statistics of Mothers and Youth (n = 407) at W1

	Youth	Mothers
Variables	*n* (%) or *M* (*SD*)	*n* (%) or *M* (*SD*)
Gender (W1)		
Female	193 (47.3)	
Male	215 (52.7)	
Nativity status (W1)		
Foreign-born	171 (41.9)	408 (98.6)
U.S.-born	237 (58.1)	1 (0.5)
Educational attainment (W1)		
Less than high school		4 (0.97)
High school graduate or GED		50 (12.08)
Some college		99 (23.91)
College graduate		187 (45.17)
Graduate degree		58 (14.01)
Age (W1)	14.8 (1.91)	45.3 (3.76)
Years of residence in United States (W1)	11.8 (4.39)	16.0 (8.53)
Perceived family socioeconomic status (W1)	3.03 (0.70)	
Depressive symptoms (W1)	1.81 (0.73)	

Note. Mean (*SD*) for continuous variables or sample number (percentage) for categorical variables.

Table 2

Correlations and Descriptive Statistics of the Study Variables

	M	SD	1	2	3	4	5	6	7	8	9
1. Depression (Y, W3)	2.17	0.84	1								
2. Maternal cultural symptoms (M, W1)	1.66	0.83	.55**	1							
3. ICC (Y, W1)	2.37	0.78	.23**	-.35**	1						
4. ICC (M, W1)	2.67	0.59	.04	.12**	-.06*	1					
5. IC (Y, W1)	2.21	0.79	.23*	.07*	.53*	.26*	1				
6. IC (M, W1)	1.97	0.66	.02*	.20*	.21*	.56*	.29*	1			
7. Family enmeshment (Y,W1)	2.59	0.73	.06	-.07	.17*	.03	.02	.02	1		
8. Negative emotionality (Y,W2)	2.89	0.85	.40*	.08	.17*	.02	.24*	.04	.08	1	
9. Depression (Y, W1)	1.80	0.72	.43*	-.00	.31*	.02	.38*	.00	.07	.34*	1

Note. IC = intergenerational conflict; ICC = intergenerational cultural conflict; M = mother-reported; Y = youth-reported; W1 = Wave 1; W2 = Wave 2; W3 = Wave 3.
*$p < .05$. **$p < .01$.

Table 3

Direct and Indirect Effect and 95% Confidence Intervals for the Model

Pathways	β	SE	95% CI
Direct effect			
Family enmeshment → Negative emotionality	.10*	.06	0.02, 0.15
Youth-reported IC → Negative emotionality	.14*	.06	0.07, 0.19
Gender → Negative emotionality	.22***	.09	0.18, 0.38
Depression (W1) → Negative emotionality	.30***	.09	0.34, 0.37
Depression (W1) → Depression (W3)	.17**	.08	0.28, 0.68
Indirect effect			
Family enmeshment → Negative emotionality → Depression (W3)	.03*	.01	0.01, 0.06
Youth-reported IC → Negative emotionality → Depression (W3)	.04*	.02	0.01, 0.08
Gender → Negative emotionality → Depression (W3)	.06***	.02	0.18, 0.43
Depression (W1) → Negative emotionality → Depression (W3)	.08***	.02	0.06, 0.17
Gender → Negative emotionality → Depression (W3)	.08**	.03	0.04, 0.24
Depression (W1) → Negative emotionality → Depression (W3)	.16***	.03	0.13, 0.31

Note. β = standardized regression coefficient; CI = confidence interval; SE = standard error. The reference group for gender was female.

*p < .05. **p < .01. ***p < .001.

Chapter Four: Manuscript Three

Solution-Focused Brief Therapy for Adolescent Mental Health in Schools:

A Comparative Systematic and Meta-Analysis Review

between U.S. and East Asian studies

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Introduction

East Asian Americans (EAA), one of the largest Asian American sub-groups, represents 6 country-of-origin groups (e.g., Chinese, Korean, Japanese, Taiwanese, Mongolian, and HongKongers) that vary by cultural values and norms, socioeconomic status, and immigration backgrounds (Kim et al., 2001). Despite the heterogeneity within this group, most EAA has been treated as an aggregated group and generally perceived as well-adjusted and academically successful (Zhou, 2003). Because of U.S.

stereotype of EAA as the "model minority", many EAA, particularly children and youth,

face pressure for academic success and are likely to be targeted by bullies at schools

(Byun & Park, 2011; McMurtry et al., 2019). These experiences can also lead to

negative developmental and adverse mental health outcomes in later adulthood (Bulut &

Gayman, 2016).

Despite the need to support EAA youth in the face of such risks, this population has

not received much attention in intervention studies. Since most forms of conventional

psychotherapy have originated from Western societies that reflect dominant cultural

groups (Benish et al., 2011), these interventions may be culturally incongruent with the

values of EAA youth (Kim et al., 2016). For example, traditional therapy-based

interventions that utilize pathological or deficit-oriented approaches can lead to EAA

youth labeling themselves as problematic and increase their experience of stigma related

to health problems (Zhao et al., 2019). Thus, there is need for research that

systematically examines exiting interventions and tests their fit with cultural patterns,

meanings, and worldviews of EAA youth (Cheung & Jahn, 2017).

One popular evidence-supported intervention that aligns well with East Asian

cultural values and has been often used in East Asian countries is Solution Focused Brief

Therapy (SFBT). The current study was designed to examine the potential utility of

SFBT for EAA youth by synthesizing the English and East Asian literature on SFBT and

comparing the effectiveness of SFBT by country.

Solution-Focused Brief Therapy

SFBT is a strengths-based intervention developed by Steve de Shazer, Insoo Kim

Berg, and their colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin

in the early 1980s (Berg & Dolan, 2001). Over the previous decades, SFBT has continued to gain in popularity and has been widely implemented by individual counselors and family therapists in various settings, such as family therapy, school, and community (Hsu & Wang, 2011). Accordingly, SFBT has grown to become one of the major counseling approaches in the U.S. and other countries in the world (Hsu, 2009).

SFBT is a social constructivist theory and a postmodern approach. Unlike conventional Western approaches that assume that reality is a single and static form, social constructivism holds that realities exist in multiple forms and are re-constructed through active social interactions within multiple contexts (Dolan & De Shazer, 2012). Following this approach, SFBT emphasizes the interaction between the therapist and client to "co-construct" the client's new realities and desirable goals (Hsu & Wang, 2011).

Adopting this philosophical frame, SFBT made a major paradigm shift in dominant therapeutic approaches from a deficit to a strengths-based therapeutic approach (Kim, 2006). While traditional Western approaches focus on identifying underlying causes of clients' problems, SFBT addresses clients' strengths, hopes, and positive emotions as core components (Jordan & Bavelas, 2013). Thus, in SFBT, clients are often viewed as experts who are inherently resilient and capable to make positive changes (Kim, 2006). Since SFBT guides clients to lead the sessions as main agents of change with a focus on future solutions instead of their past experiences, it typically involves fewer sessions than other therapeutic approaches (Corcoran & Pillai, 2007). During the sessions, SFBT therapists use different techniques to elicit clients' skills and potential for changes, such as miracle questions, coping questions, and scaling questions (Corcoran & Pillai, 2007).

SFBT's approach to clients' strengths has been a progressive influence on psychotherapeutic interventions and widely used as an alternative to traditional Western therapy models (Franklin et al., 2012; Thompson, 2011).

SFBT in School Settings

School has been recognized as an optimal setting through which to intervene with children and youth. Youth spend most of their time in school, which provides opportunities for early identification and diagnosis of youth problems (Allison et al., 2014; Pulimeno et al., 2020). A growing body of evidence indicates that providing health-related supports and services directly within the school setting is effective (Hogan, 2003; Stephan et al., 2015). Moreover, schools can provide a setting through which materials and training can be also delivered to help school staff and parents collaborate with interventionists to promote youth's well-being (Pulimeno et al., 2020).

SFBT specifically has been proven to be an effective school-based intervention for children and youth. Studies have shown SFBT to be effective in school counseling for elementary school children (Sobhy & Cavallaro, 2010), middle-school age (Froeschle et al., 2007), and high school age students (Franklin et al., 2007). Bond and colleagues (2013) conducted a systematic review of the SFBT literature from 1990 to 2010 and found that SFBT was particularly effective as an early intervention when youth's health problems are at a mild-to-moderate level. Another meta-analysis conducted by Trepper et al. (2006) revealed that SFBT has positive treatment effects equivalent to other major counseling approaches, but could often achieve similar outcomes with fewer sessions, averaging about five sessions. All these findings provide promising evidence for the use of SFBT as an optimal school-based early intervention for at-risk youth.

Cultural Alignment of SFBT with EAA Youth and Families

SFBT can be particularly efficacious for clients of Asian heritage including EAA youth since its techniques are culturally aligned with East Asian cultural values (Cheung & Jahn, 2017). For example, SFBT's aim to foster a solution-oriented conversation with clients aligns well with Asian value of pragmatism (Cheung & Jahn, 2017). Clinicians using an SFBT approach focus on goal setting with tangible indicators of small steps toward progress that are feasible and observable, which can help clients' self-motivation and confidence (Lee & Mjelde-Mossey, 2004). SFBT techniques related to this approach, such as outcome questions (e.g., "What would be different if the problem were solved?") and miracle questions ("Assume your problem is gone. What does this mean to you?"), have been found to bring out clients' positive changes in short term and positive attitudes toward future (Astuti & Lestari, 2018; Hopson & Kim, 2004).

Moreover, SFBT's focus on interpersonal relationships are in line with the East Asian values of collectivism and group harmony (Hsu & Wang, 2011). SFBT originates from family systems theory and family therapy which emphasize interactional patterns among individuals (Miller, 2021). This therapeutic approach works by providing strategies by which individuals and families shift the way they perceive their problems, emphasize what their desired goals are, and explore ways that they have been successful in achieving their goals (Gingerich & Wabeke, 2001). One of the SFBT techniques that reflects these strategies is relationship questions (M. Y. Lee & Mjelde-Mossey, 2004). For example, relationship questions, such as "What would your friend or family say that will help you to make this change?" capture clients' interpersonal connections with their families while respecting their different cultural worldviews. These questions not only

help clients pay attention to outside resources that are useful for their goal setting, but also solution-finding, particularly when significant others are included in their preferred futures (Hsu & Wang, 2011). These reviews collectively suggest that SFBT is a culturally appropriate intervention approach for East Asians and EAA populations.

Review of SFBT Studies in East Asian countries

Many studies have shown promising results for the overall effectiveness of SFBT on behavioral and psychological outcomes of youth in East Asian countries (Gong & Hsu, 2017; Hung & Sung, 2007; Hsu et al., 2021; Kim & Kim, 2020; Li & Liu, 2021; Zhang et al., 2021). For example, Li and Liu (2021) examined the effects of a video health education model based on SFBT on Chinese youth's mental health during COVID-19 and found a greater reduction in rates of negative affect and anxiety scores in the SFBT group as compared to a control group. Another study examined the effectiveness of counseling programs on self-control, self-esteem, and depression among smartphone-addicted youth in Korea (Kim & Kim, 2020). The results showed that SFBT was effective for reducing depression and stress and enhancing self-control and self-esteem among these youth. Additionally, in Kim and colleagues (2015)'s meta-analysis with Chinese young adults, SFBT was effective in reducing their mental and behavioral health issues (e.g., depression, anxiety, and self-esteem), with medium to very large treatment effects.

Despite many promising findings, findings from the previous literature on youth behavioral problems are inconsistent, suggesting a need for further investigation. For example, a recent systematic review collected published and grey literature describing outcome studies of SFBT conducted with youth in the U.S. This study found that SFBT

had positive effects on externalizing problem behaviors, but not internalizing behaviors (Hsu et al., 2021).

On the contrary, SFBT has shown initial evidence of effectiveness for internalizing youth behavior problems in other studies (Bond et al., 2013; Kim & Franklin, 2009), with a larger effect size for internalizing problems as compared to externalizing problems (Franklin et al., 2009).

These varied results across studies might be explained by examining moderator effects in the context of meta-analysis (Conn, 2012). Moderator analyses in meta-analysis can be used to examine the relationship between various study characteristics (e.g. location, and sample characteristics) and effect sizes. Examining moderation effects allows clinicians to design and select interventions that are more efficacious for specific subsets of individuals (Gong & Hsu, 2017). While few studies on SFBT in school settings have performed moderation analyses (Franklin et al., 2020; Gong & Hsu, 2017), one study compared the effectiveness of SFBT between English and Chinese studies and examined the moderating role of location by country (Franklin et al., 2020). The authors found that while both English and Chinese studies reported significant treatment effects for SFBT, stronger treatment effects were observed in Chinese studies as compared to English studies (Franklin et al., 2020). Based on this finding, the authors suggest that future studies should involve more East Asian studies to understand the cultural effectiveness and adaptation of SFBT with EAA youth (Franklin et al., 2020).

To date, there has been a lack of studies that have systematically examined the effectiveness of SFBT across East Asian countries. Given the heterogeneity in cultural norms and characteristics among East Asian groups, including under-examined studies

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from other East Asian countries, such as Korea and Japan, this study seeks to address the gap in previous literature and contribute to understanding how SFBT works for East Asian heritage populations including EAA youth.

Study Aims

Building on a previous meta-analysis study (Franklin et al., 2020) that examined Chinese and U.S. studies on SFBT in school settings, this systematic review and meta-analysis aims to synthesize the studies on SFBT conducted in U.S. and East Asian countries. For this review, we included Chinese, Korean, and Japanese studies since SFBT has been developed and implemented in these countries and there is enough literature available for systematic review and meta-analysis (Kim & Kim, 2020). The findings will expand on the findings of previous literature on SFBT since it offers a comparative analysis across different East Asian countries. This study will also address the gap in SFBT literature on its effectiveness with EAA youth populations with specific health-related and developmental risks.

Overall, this study has three research aims:

Aim 1: To examine the treatment effects of SFBT across subgroups of study characteristics, including country of studies, youth outcomes, publication, study design, control group, Tier, and integrity;

Aim 2: To compare the treatment effects of SFBT on youth outcomes between the U.S. and East Asian studies;

Aim 3: To determine the moderating effects of country on SFBT treatment effects.

Methods

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Search Procedures

A literature review was performed using several electronic databases that are the major subject databases for clinical psychology, education, and medical research. To specify, for English studies, databases including PsycINFO, MEDLINE, PUBMED, and Educational Source were utilized. For Chinese studies, we used China National Knowledge Infrastructure (CHKI) as search platform and used four electronic databases to search studies (e.g., China Academic Journals Full-text Database, Chinese Insight). Three electronic databases were utilized to search Korean and Japanese studies, respectively (e.g., RISS, DBpia, KRpia for Korean studies and; ICHUSHI Web, J-STAGE, and CiNII for Japanese studies). For each electronic database, we used the keywords and logic terms as follow: (school* or college* or university* AND (SFBT or solution* or solution focused or solution-focused) AND (effect* or effic*). The search covered both peer-reviewed non-peer-reviewed sources, such as dissertations, to reduce potential publication biases. All English U.S. and East Asian studies published from 1995 to 2022 were searched.

Inclusion and Exclusion Criteria

The following criteria were used in the meta-analysis for inclusion and exclusion of studies. First, included studies had to report only quantitative results of the effectiveness of SFBT. Qualitative studies, review articles, and commentaries were excluded. Second, only studies that were originally published either in English, Chinese, Korean, or Japanese were included. Third, studies had to report at least one out of eight broad outcome categories related to psychosocial and academic adjustment outcomes for school-aged individuals, from primary school to college students. These 8 outcome

categories were selected given the increasing number of studies on practice of SFBT in mental health counseling and education fields that focused on these outcomes as primary interests (Franklin et al., 2020). Fourth, studies had to use quantitative data (e.g., appropriate sample size) to calculate and report significant or insignificant effect sizes. Fifth, eligible studies needed to be either a randomized controlled trial (RCT) or quasi-experimental, meaning that the studies had to include a comparison group for inclusion. Multiple studies that used the same dataset were counted once for each outcome variable.

Data Extraction and Management

After screening and selecting studies, data were extracted using an *Excel* spreadsheet. The information included country (English, Chinese, and Korean), the first author's name, type of article (published article or graduate thesis/dissertation), demographic information of the sample (i.e., age, race/ethnicity, gender), study design (RCT or Quasi-experimental), intervention characteristics (i.e., full SFBT versus SFBT in conjunction with other intervention), and Tier of intervention (i.e., Tier 1: school-wide and universal interventions; Tier 2: selective and specified interventions for small groups, and Tier 3: individualized and intensified). Also, youth outcomes were extracted based on eight categories: internalizing behavior problem (e.g., depression), externalizing behavior problems (e.g., aggression), academic attitudes (e.g., school burnout), academic behaviors (e.g., learning behavior efficiency), academic performances (e.g., GPA), social relationship (e.g., relationship with peers), psychological wellness (e.g., self-esteem, self-confidence), and overall well-being (e.g., quality of life, overall happiness).

Study Quality Rating

The methodological rigor of the included studies was assessed based on criteria developed by the American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures (1995) (Gingerich & Eisengart, 2000; Whaley & Davis, 2007). The six criteria used to assess a quality of the studies include: (1) randomization of the sample, (2) comparison with other treatments, standard services, or waitlist control, (3) definition of a specific problem or population, (4) use of validated and/or standardized outcome measures, (5) reported use of treatment manuals or curriculums, and (6) use of large sample size in each group ($n > 25$). Each criterion was scored as 0 if study did not meet criterion and 1 if study met criterion. Based on the number of criteria met, each study was scored 0 to 6 and ranked into one of three categories: high (when five or six criteria were met), moderate (when four criteria were met), and low (when three or fewer criteria were met) (Bolier et al., 2013)

Data Analysis

The researchers followed five steps for data analysis: (1) conducting descriptive statistics of study characteristics, (2) assessing publication bias, (3) calculating effect sizes in subgroup analyses, (4) identifying and quantifying heterogeneity, and 5) explaining heterogeneity with moderator analysis. The effect size estimates of outcome variables were calculated using the Hedges's *g* statistic, which represents the standardized difference between means of different groups (Cooper et al., 2019). Effect sizes of *g* = 0.2, 0.5, and 0.8 represent small, medium, and large effects, respectively (Cohen, 1988). The standardized effect sizes were adjusted using Hedges' small sample bias correction and noted as *d* in this review (Hedges et al., 2010; Ugille et al., 2014).

Subgroup and moderator analyses were conducted using meta-regression with robust

variance estimation (RVE), which allows computing multiple treatment effect sizes from

the same study without compromising the validity of statistical inference (Zhang et al.,

2021). Heterogeneity between studies was estimated using the I^2 statistic reported in

percentages. A higher I^2 represents higher heterogeneity, with a value of 0% indicating

no heterogeneity to 75% indicating high heterogeneity (Higgins et al., 2003). All

analyses were carried out using R 3.6.3 or STATA 14.0.

To investigate the potential source of heterogeneity, a series of subgroup analyses

were performed. Subgroup analyses were conducted to examine how the treatment

effects of SFBT varied across different subgroups of trials. Included studies were split

into subgroups, according to study characteristics including country, youth outcomes,

publication, study design, control group, Tier, and integrity (Aim 1). Next, a separate

subgroup analysis was performed to compare the effects of SFBT on youth outcomes

between English studies and East Asian studies. For this analysis, Chinese studies and

Korean studies were combined to represent East Asian studies (Aim 2). Study country

was also tested as a moderator in the analysis (Aim 3).

Publication Bias

Publication bias was assessed using a funnel plot and Egger's test. A funnel plot is

created by plotting effect size estimates to visually assess bias. Symmetrical distribution

of effect sizes indicates that there is a minimal publication bias. We additionally

conducted Egger's linear regression model to quantify the bias captured by the funnel

plot and to test whether it was significant (Egger et al., 1997).

Results

Data Collection Results For this review, the researchers separately present diagrams for English, Chinese, and Korean studies (Figure 1). The initial pool consisted of 114,583 English, 932 Chinese, 573 Korean, and 118 Japanese studies after removing duplications. We excluded 43,996 English studies, 576 Chinese studies, 443 Korean studies, and 75 Japanese studies based on title and abstract screening. A full-text screening of 1,168 English studies, 78 Chinese studies, 86 Korean studies, and three Japanese studies resulted in 32 English studies, 34 Chinese studies, 44 Korean studies, and 0 Japanese studies for final analysis ($N = 110$).

Included Study Characteristics

Table S1 presents the study characteristics of the included studies. The 110 studies included 5,641 participants. The average age of participants in English, Chinese, and Korean studies was 14.8 ($SD = 4.53$), 17.6 ($SD = 3.32$), and 12.5 ($SD = 3.03$) years old, respectively. Regarding the proportions of race/ethnicity in English studies, about 66.7% ($SD = 17.93$) were White, 13.0% ($SD = 20.10$) were African American, 17.3% ($SD = 17.51$) were Hispanic/Latinx, and less than 3% were others (e.g., including Asian Americans). English, Chinese, and Korean studies reported an average of 65.3%, 58.3%, and 55.2% female participants, respectively.

Most English studies included were peer-reviewed journal articles ($n = 29$, 90.6%) whereas the majority of Chinese studies and Korean studies were graduate theses or dissertations ($n = 27$, 79.4% for Chinese studies; $n = 40$, 90.9% for Korean studies). About half of the English ($n = 16$, 50.0%) and Korean studies ($n = 16$, 54.6%) were RCTs and about 82% of the Chinese studies were RCTs ($n = 28$, 82.4%). While about 45% of the

English ($n = 14$, 43.8%) and 54% of the Chinese studies ($n = 18$, 54.6%) used waitlist as comparison, more than 70% of the Korean studies used treatment as usual (TAU) as the comparison ($n = 32$, 72.7%). Tier 2 intervention was the most commonly delivered school interventions in English ($n = 21$, 67.7%) and Chinese (n = 34; 100%) studies whereas Tier 3 intervention was the most commonly delivered in Korean studies (n = 27, 61.3%). Full school-based SFBT was the most commonly used intervention approach in English ($n = 29$, 90.6%), Chinese ($n = 28$, 82.4%), and Korean studies ($n = 32$, 72.7%).

More than half of the English studies ($n = 18$, 56.3%) provided training to SFBT providers whereas most Chinese studies ($n = 16$, 55.2%) and Korean studies ($n = 5$, 35.7%) did not provide training to SFBT providers or did not provide this information. Interventions in English studies lasted from one week to 7 months ($M = 1.96$, $SD = 1.52$) averaged at 0.97 hours per session ($SD = 0.40$), with an average of 6.81 sessions in total. In the case of Chinese studies, interventions lasted from 1 to 3 months ($M = 1.82$, $SD = 0.41$), averaged 1.80 hours per session ($SD = 0.72$), with an average of 7.16 sessions in total. Similarly, interventions in Korean studies ranged from two weeks to 4.5 months ($M = 1.45$, $SD = 0.70$), with an average of 1.16 hours per session ($SD = 0.42$), with an average of 8.48 sessions in total.

Quality of the Included Studies

The description of the quality of the included studies is provided in Table S1. About 41.8% ($n = 46$) of the studies met five or six criteria, indicating high methodological rigor. Studies in the moderate category ($n = 45$, 40.9%) were lacking two of the six methodological rigor criteria, with adequate sample size and randomization being most commonly absent. The remaining studies ($n = 19$, 17.3%) met two or three criteria,

indicating low methodological rigor. In summary, more than 80% of the included studies satisfied adequate levels of methodological rigor.

Publication Bias

The result for the funnel plot by plotting effect size estimates is presented in Figure 2. Overall, the plot showed a reasonable level of symmetry. Additionally, the results of Egger's test were not significant ($p = 0.32$). These results indicate that there is no significant publication bias in this meta-analysis study.

Overall Treatment Effect and Subgroup Analyses

Table 1 describes overall treatment effect and subgroup analyses calculated using an intercept-only meta-regression model with RVE. Combining all English, Chinese, and Korean studies, the overall treatment effect size was $d = 0.74$, $p < 0.001$. Subgroup analyses showed that there is a significant treatment effect of SFBT for all studies, with treatment point estimate that ranged from moderate to high ($d = 0.57$, $p < 0.001$ in English studies, $d = 0.75$, $p < 0.001$ in Chinese studies, and $d = 0.88$, $p < 0.001$ in Korean studies).

Treatment effect size estimates were also significant across all youth outcomes, including internalizing problems ($d = 0.53$, $p < 0.001$), externalizing problems ($d = 0.49$, $p < 0.001$), academic attitude ($d = 0.79$, $p < 0.001$), academic behavior ($d = 0.36$, $p < 0.01$), academic performance ($d = 0.35$, $p < 0.01$), social relationship ($d = 0.72$, $p < 0.001$), psychological wellness of self ($d = 0.68$, $p < 0.01$), and overall well-being ($d = 0.67$, $p < 0.001$).

The treatment effect of SFBT was significant for both peer-reviewed journal articles ($d = 0.57$, $p < 0.001$) and graduate theses or dissertations ($d = 0.84$, $p < 0.001$), for both RCT ($d = 0.75$, $p < 0.001$) and quasi-experimental studies ($d = 0.74$, $p < 0.001$), and for full

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school-based SFBT ($d = 0.74$, $p < 0.001$) and SFBT in conjunction with other intervention ($d = 0.76$, $p < 0.001$). The treatment effects of SFBT for student outcomes were statistically significant in TAU ($d = 0.77$, $p < 0.001$) and waitlist control ($d = 0.76$, $p < 0.001$), but not in alternative interventions ($d = 0.23$, $p = 0.19$). Studies of all three Tiers of SFBT interventions reported statistically significant overall treatment effect, with $d = 0.56$, $p < 0.001$ in Tier 1, $d = 0.78$, $p < 0.001$ in Tier 2, and $d = 0.67$, $p < 0.001$ in Tier 3, respectively. The effects of SFBT were significant for studies that provided training ($d = 0.53$, $p < 0.001$) or no training ($d = 0.88$, $p < 0.001$).

Subgroup Analyses Result for Youth Outcomes

The results of the subgroup analysis for youth outcomes between English studies and East Asian studies are presented (Table 2). The treatment effect size estimate of SFBT for youth outcomes in English studies ranged from small to large, with majority of them yielding a small effect size. Small point estimates were found in internalizing problems ($d = 0.35$, $p < 0.01$), externalizing problems ($d = 0.42$, $p < 0.05$), academic performances ($d = 0.36$, $p < 0.05$), and psychological well-being of self ($d = 0.49$, $p < 0.01$). General well-being outcomes showed a large effect size ($d = 0.85$, $p < 0.01$). East Asian studies showed stronger treatment effects in youth outcomes compared to English studies. Significant moderate to large treatment effect size estimates were observed in internalizing problems ($d = 0.78$, $p < 0.001$), academic attitudes ($d = 0.83$, $p < 0.001$), academic behaviors ($d = 0.66$, $p < 0.01$), social relationships ($d = 0.86$, $p < 0.001$), psychological well-being of self ($d = 0.73$, $p < 0.001$), and general well-being ($d = 0.57$, $p < 0.01$).

Moderator Analysis

The effect sizes within the distribution of studies indicated study variability by showing $I^2 = 76.08\%$. This means 76% of the total variability was due to between-study heterogeneity, so exploration of moderating variables was warranted. The researchers tested the moderation role of a country of studies, with English studies defined as a reference group (Table 3). Comparison of the treatment effect size across three studies revealed a statistical difference between English studies and Korean studies, with $b_1 = 0.34$, $t(68) = 2.85$, $p < 0.001$. There were no differences between English studies and Chinese studies, $b_1 = 0.18$, $p = 0.20$.

Discussion

This systematic review and meta-analysis study examined the effectiveness of SFBT on youth outcomes in school settings through the review of English, Chinese, and Korean studies. Results showed that the treatment effects of SFBT were statistically significant regardless of country, youth outcomes, publication type, study design, Tier, and integrity. The results also indicated a difference in the treatment effects of SFBT on youth outcomes between English studies and East Asian studies. Additionally, study country significantly moderated the treatment effects, yielding a significant larger treatment effect in Korean studies compared to English studies.

An important finding from this study is SFBT is effective as compared to waitlist control or services as usual regardless of study characteristics. These findings suggest that SFBT can be successfully delivered and is relatively amenable for use at different intervention levels, across country, and in multiple forms. For example, based on the findings on school-based intervention Tiers, SFBT can be delivered to all students at a

universal level as well as students who are identified as having developmental or health issues and need additional support given the larger effect size for Tier 2. More investigation on how SFBT components can be applied to different Tiers will contribute to more tailored services for youth.

Moreover, the findings suggest that SFBT can be used within a broad range of therapeutic practices in combination with other approaches, such as art therapy. Recently, a new therapeutic intervention called SF-AT that combines SFBT perspectives with art activities as means of communication has been applied to various populations and found to be effective for youth with psychological issues (Liu et al., 2017; Nims, 2007). This integrated form of SFBT might particularly benefit East Asian immigrant youth who struggle with verbal communication of their health concerns with counselors because of the cultural stigma on mental illness (Kim et al., 2022).

The subgroup analysis examining youth outcomes comparison English studies and East Asian studies indicates that the SFBT is more efficacious for East Asian youth with mental health, academic, and interpersonal relationship challenges confronted in school compared to European American counterparts. Specifically, a large effect size observed for the internalizing problems and psychological wellness outcomes in East Asian studies suggests that SFBT can be conducive to reducing EAA youth mental health distress and acculturative stress (Schmit et al., 2016). Moreover, given the effectiveness of SFBT on academic attitudes and behavioral outcomes, SFBT could be a helpful approach to reducing anxiety and academic stress of EAA youth (Cheung & Jahn, 2017). Additionally, the results favoring SFBT for improving social relational outcomes in East Asian studies may indicate that SFBT techniques (e.g., relational questions) may work well with East

Asian cultural values of group harmony and collectivism. Given its flexibility and impact across many outcomes, SFBT may be a particularly desirable approach to use for addressing most social relational difficulties in school and community settings for EAA youth (Shen, 2005).

The moderator effects of the country revealed a larger treatment effect size in Korean studies as compared to English studies. While these findings may illustrate the positive effects of SFBT treatment for Korean youth, they also need to be interpreted with caution. Many of the Korean studies were graduate thesis or dissertations with small sample sizes (i.e., $n < 30$), which could result in overestimated treatment effects (Schmucker et al., 2017). Registered trials led by established research teams targeting larger sample sizes are needed to confirm these findings.

Interestingly, the treatment effects of SFBT were not statistically different from those of alternative interventions, indicating that SFBT did produce superior outcomes compared to alternative interventions (e.g., short-term cognitive behavioral therapy, problem-focused approach, and Adlerian therapy). One possible explanation for this null finding could be researcher allegiance, which refers to the tendency for researchers to prefer one therapy to another (Gaffan et al., 1995). For example, it is possible that studies that used alternative interventions as control groups were more likely to be carried out by the research teams whose allegiance lies with the non-SFBT treatment (Neipp & Beyebach, 2022). Studies have found the evidence that such bias of researchers has a considerable influence on treatment outcomes (Paley & Shapiro, 2002; Neipp & Beyebach, 2022). Similarly, researchers' preferences for alternative interventions can also lead to an overestimation of the effects and confounded the results (Miller et al., 2007). Future meta-analysis studies

can quantify the allegiance for treatment and assess if the association between allegiance and effect size varies by treatment group.

Limitations and Opportunities for Future Research

There are several limitations to this review and meta-analysis. Although the included English studies consisted of participants with various racial and ethnic backgrounds (e.g., Hispanics/Latinx, African Americans), this study failed to explore these sample characteristics. Future work should include more studies to explore how SFBT treatment varies by race and ethnicity of the samples. Additionally, subgroup analysis results should be interpreted with caution because of small sample sizes (i.e., < 30) in more than half of the studies, which may have decreased the probability of detecting the true effect size (Hunter & Schmidt, 2004). Also, the researchers could not conduct further subgroup analyses for study characteristics (e.g., study design, Tier, control group) because of the limited sample sizes in multiple subgroups. Another limitation of this study involves the exclusion of Japanese studies. Most Japanese studies were excluded for the analysis during the screening process because they were either review articles or commentaries, and even a few of them that used quantitative methods did not include comparison groups. More East Asian studies are needed with larger sample sizes to establish the efficacy of SFBT on youth outcomes. Further, there is an issue related to the measurement consistency of the field (Becker et al., 2011). It is possible that the measures for each youth outcome category may not represent the same construct (Pace & Brannick, 2010). Future studies need to closely examine the exact content of the measures in each study and ensure that the measures have appropriate levels of convergent validities and reliabilities.

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Research and Practice Implications

Despite these limitations, the findings from this study provide useful research and practical implications. While many studies have found SFBT as an effective intervention for different racial and ethnic youth groups, they have not focused on EAA youth as a target of interventions. A few studies have included EAA population as a part of ethnic minority groups; however, there are remaining issues which could lead to biased results on EAA populations, such as small sample sizes and aggregation of Asian American subgroups (Islam et al., 2010). Our findings suggest a need to test the effectiveness of SFBT and its application to the EAA context by including EAA youth as main targets. More research exploring the cultural meaning of SFBT and its use among East Asian populations would contribute to understanding SFBT as a culturally appropriate approach for EAA youth.

Regarding clinical significance, our findings suggest that SFBT can be an efficacious school-based intervention approach for EAA youth. Given the same culture of origin shared between East Asian youth and EAA youth, many of the components of SFBT that align with the East Asian culture could be applied to support EAA youth. Scholars and service providers should be cautious about simply implementing intervention without tailoring its components for specific groups because it may not result in positive results (Bellamy & Parish, 2020). Indeed, there are significant differences between East Asian youth and EAA youth groups, such as nativity, language preference, and immigration backgrounds (Lee et al., 2011). These components need to be considered when culturally adapting SFBT so that it is compatible with the EAA context.

Moreover, these findings provide evidence that support the utility of the SFBT for youth in school settings. School counselors and social workers can aid youth in making changes more efficiently by using SFBT approach. Providing other therapy approaches and managed health care in schools have been a challenging task for those school staff because of high health costs and enormous caseloads that limit their time when working with students. For those who need an effective, brief counseling approach to support youth, SFBT can be an effective short-term approach to use in school settings and can be combined with other interventions. Especially for EAA youth who face various challenges, such as racism, acculturation stress, academic burden, and difficulty in maintaining peer relationship, SFBT could be beneficial tool. By adopting SFBT approach that focuses on youth's strengths and successes, EAA youth can enhance their belief in their abilities and positive emotions to cope with stressors.

It is also recommended that school counselors and staff collaborate with youth and co-create their own counseling through SFBT interventions. By doing so, school counselors and clinicians can better ensure that they understand youth in the context of their environments and promote cultural responsiveness (Shute et al., 2011). This approach will also help them develop SFBT as a more culturally adaptive approach to the benefit everyone involved.

Conclusion

SFBT is an approach that was developed primarily based on Western culture, beliefs, and ideals. However, findings from previous studies and ours suggest the promising result that SFBT is a culturally appropriate and practical guide that can apply to youth with different racial and ethnic backgrounds in school settings. With

this culturally flexible approach, there is an opportunity to respect for individual

youth's worldviews derived from cultural values and beliefs.

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Figure 1.
PRISMA Flow Diagram of Literature Search

English Studies (1995 ~ 2022 March)　　　　Chinese Studies (1995 ~ 2022 March)　　　　Korean Studies (1995 ~ 2022 March)

Records identified through database search
(n = 114,583)

Additional records identified through other resources
(n = 76)

Records identified through database search (n =932)

Additional records identified through other resources
(n = 19)

Records identified through database search (n = 1,544)

Additional records identified through other resources
(n = 12)

Records after duplicates removed
(n = 49,195)

Records after duplicates removed
(n = 692)

Records after duplicates removed
(n = 573)

Records screened
(n = 45,195)

Records excluded after title/abstract review (n = 43,996)

Records screened
(n = 692)

Records excluded after title/abstract review (n = 576)

Records screened
(n = 573)

Records excluded after title/abstract review (n = 443)

Full-text articles assessed for eligibility (n =1,119)

Full-text articles excluded based on criteria (n =1,168)

Full-text articles assessed for eligibility (n = 116)

Full-text articles excluded based on criteria (n = 78)

Full-text articles assessed for eligibility (n =130)

Full-text articles excluded based on criteria (n = 86)

Studies included for coding and reporting (n =32)

Studies included for coding and reporting (n = 34)

Studies included for coding and reporting (n = 44)

Final number of studies for meta-analysis (110)

140

Figure 2.
Funnel Plot for Publication Bias
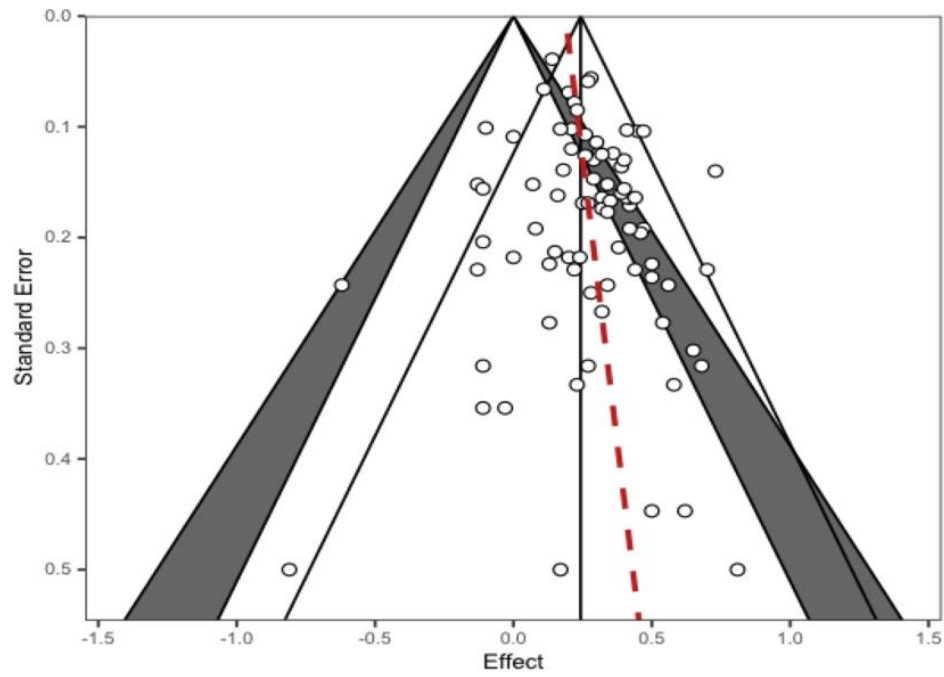
Table 1.

Overall Treatment Effect and Subgroup Analysis

	Parameter	Estimate / SE	t (df)	95% CI	*n / k*	*p* value
	Over Treatment Effect	0.74 / 0.06	14.0 (103)	0.64 – 0.85	110 /458	*< 001*
Country	English studies	0.57 / 0.10	5.56 (29.6)	0.36 – 0.78	32 / 150	*<.001*
	Chinese studies	0.75 / 0.10	7.48 (31.2)	0.54 – 0.95	34 / 164	*<.001*
	Korean studies	0.88 / 0.07	13.3 (39.1)	0.74 – 1.01	44 / 144	*<.001*
Outcome	Internalizing problems	0.53 / 0.13	4.17 (31.5)	0.27 – 0.79	35 / 79	*<.001*
	Externalizing problems	0.49 / 0.17	2.95 (15.9)	0.14 – 0.84	18 / 45	*<.001*
	Academic attitudes	0.79 / 0.10	8.08 (33.1)	0.59 – 0.99	36 / 58	*< .001*
	Academic behaviors	0.36 / 0.16	2.22 (18.0)	0.02 – 0.70	20 / 53	*< .01*
	Academic performances	0.35 / 0.11	3.25 (5.38)	0.08 – 0.62	7 / 12	*< .01*
	Social relationship	0.36 / 0.16	2.22 (18.0)	0.02 – 0.70	20 / 53	*<.01*
	Psychological wellbeing of self	0.35 / 0.11	3.25 (5.38)	0.08 – 0.62	7 / 12	*<.01*
	General wellbeing	0.72 / 0.11	6.73 (25.8)	0.50 – 0.94	29 / 50	*<.001*
Publication	Journal articles	0.57 / 0.10	5.88 (38)	0.37 – 0.76	40 / 192	*<.001*
	Thesis and/or dissertation	0.84 / 0.06	14.7 (60.6)	0.72 – 0.95	70 / 266	*<.001*
Study design	Randomized controlled trial	0.75 / 0.07	10.2 (63.3)	0.60 – 0.89	68 / 265	*<.001*
	Non-randomized controlled trial	0.73 / 0.08	9.81(39.4)	0.58 – 0.89	42 / 193	*<.001*
Control group	Treatment as usual	0.77 / 0.07	10.5 (53.7)	0.62 – 0.92	58 / 174	*<.001*
	Alternative intervention	0.23 / 0.16	1.50 (5.69)	-0.15 – 0.62	7 / 40	*p* = 0.19
	Waitlist control	0.76 / 0.08	9.77 (42.0)	0.61 – 0.92	45 / 230	*<.001*
Tier	Tier 1 intervention	0.56 / 0.11	5.02 (15.5)	0.33 – 0.80	17 / 56	*<.001*
	Tier 2 intervention	0.78 / 0.08	10.2 (56.1)	0.63 – 0.93	61 / 289	*<.001*
	Tier 3 intervention	0.67 / 0.10	6.88 (18.2)	0.46 – 0.87	20 / 85	*<.001*
Integrity	Full-SFBT	0.74 / 0.06	13.0 (89.9)	0.63 – 0.85	95 / 388	*<.001*
	SFBT in conjunction with other intervention	0.76 / 0.14	5.26 (12.6)	0.44 – 1.08	15 / 70	*<.001*

Note. SE: Standard Error; CI: Confidence Interval; *k*: numbers of independent effect size, *n*: sample size

Table 2.

Subgroup Analysis for Youth Outcomes between English and East Asian studies

		English studies			Asian studies[a]		
	Youth outcomes	Estimate / SE	95% CI	*n / k*	Estimate / SE	95% CI	*n / k*
Outcome	Internalizing outcomes	0.35** / 0.14	0.06 - 0.07	19 / 36	0.78*** / 0.23	0.30 – 1.27	16 / 43
	Externalizing outcomes	0.42* / 0.19	0.01 – 0.85	9 / 32	0.55 / 0.33	- 0.21 – 1.31	9 / 13
	Academic attitudes	0.57 / 0.37	- 0.46 – 1.60	5 / 9	0.83*** / 0.10	0.64 – 1.01	31 / 49
	Academic behaviors	0.05 / 0.21	- 0.44 – 0.54	8 / 14	0.66** / 0.22	0.16 – 1.15	12 / 39
	Academic performances	0.36* / 0.14	0.03 – 0.76	5 / 9	0.32 / 0.07	- 0.60 – 1.25	2 / 3
	Social relational outcomes	0.35* / 0.17	0.08 – 0.78	7 / 12	0.86*** / 0.12	0.62 – 1.10	22 / 38
	Psychological wellbeing of self	0.50** / 0.16	0.15 – 0.85	11 / 26	0.73*** / 0.08	0.58 – 0.89	47 / 103
	General wellbeing	0.85** / 0.20	0.30 – 1.39	5 / 12	0.57** / 0.57	0.09 – 1.05	12 / 19

Note.[a] Combined Chinese and Korean studies

SE: Standard Error; CI: Confidence Interval; *k*: numbers of independent effect size, *n*: sample size

Table 3.

Moderator Analysis by Country of Studies

	Estimate / SE	t (df)	95% CI	*N / K*	*p* value
Country of Studies (English[a])	0.56 / 0.10	5.52 (29.4)	0.35 – 0.77	110 / 458	*p* < .001
Chinese studies	0.18 / 0.14	1.30 (60.4)	- 0.10 – 0.47	110 / 458	*p* = 0.20
Korean studies	0.34 / 0.12	2.85 (68.4)	0.10 – 0.58	110 / 458	*p* < .001

Note. [a]Reference group
SE: Standard Error; CI: Confidence Interval; K: numbers of independent effect size, *N:* Overall sample size.

Appendix 1. Search Strategies for English, Chinese, Korean, and Japanese Studies

English Studies.

Electronic Databases: Child Development & Adolescent Studies, CINAHL Complete, Education Abstracts, Family Studies Database, PsycINFO, Social Sciences Abstract, the Cochrane Library, and Medline.

Chinese Studies.

Electronic Databases: we used the large infrastructure of the China Knowledge Resource Integrated Database. The specific databases we used include: China Academic Journals Full-Text Database, China Doctoral Dissertation Full-Text Database, China Masters' Thesis Full-Text Database, China Reference Works Online, and China Proceedings of Conference Full-Text Database.

Korean Studies.

Electronic Databases: RISS- Korean Education and Research Information Service, DBpia, KISS, and National Digital Science Library.

Japanese Studies

Electronic Databases: ICHUSHI Web, J-STAGE, and CiNii

Appendix 2. *Study Description (N = 110)*

Authors	Country	Publication	Sample	Demographic	Design	Control	Integrity	Tier	Example of Outcome
Ates (2016)	English	Journal articles	T = 15 C = 15	15.8 years old; Race N/R; 46% female	RCT	TAU	Full-SFBT	1	school burnout
Franklin et al. (2008)	English	Journal articles	T = 30 C = 29	10.9 years old; 73.3% White; 50% female	Quasi-experimental	WC	Full-SFBT	1	externalizing behavior
Franklin et al. (2007)	English	Journal articles	T = 46 C = 39	17.3 years old; 54.3% White, 63.0% female	Quasi-experimental	TAU	Full-SFBT	1	credit earned
Green et al. (2007)	English	Journal articles	T = 19 C = 19	16.1 years old; Race N/R; 100% female	RCT	WC	Conjunction	1	hope
Indriūnienė (2017)	English	Journal articles	T = 92 C = 100	17.1 years old; Race N/R; 55.4% female	RCT	WC	Full-SFBT	1	physical activity
Joker & Ghaderi (2015)	English	Journal articles	T = 15 C = 15	17.5 years old; Race N/R; 57% female	Quasi-experimental	WC	Full-SFBT	1	self-esteem
Littrell et al (1995)	English	Journal articles	T = 22 C = 10	15.6 years old; 89% White; 47.5% female	Quasi-experimental	AI	Full-SFBT	1	student concern
Marinaccio (2001)	English	Thesis and/or dissertation	T = 24 C = 24	Age N/R; Race N/R; Gender N/R	Quasi-experimental	TAU	Full-SFBT	1	adaptability
Boyer et al. (2014)	English	Journal articles	T = 76 C = 83	14.4 years old; Race N/R; 26.5% female	RCT	AI	Conjunction	1	ADHD symptom
Cook (1998)	English	Thesis and/or dissertation	T = 34 C = 34	10.5 years old; Race N/R; Gender N/R	Quasi-experimental	AI	Full-SFBT	1	self-concept
Kvarme et al. (2010)	English	Journal articles	T = 91 C = 65	12.5 years old; Race N/R; 63% female	Quasi-experimental	TAU	Full-SFBT	2	general self-efficacy
LaFountain & Garner (1996)	English	Journal articles	T = 176 C = 135	Age N/R; Race N/R; 57% female	RCT	WC	Full-SFBT	2	academic wellbeing
Altundağ & Bulut (2019)	English	Journal articles	T = 8 C = 8	17.0 years old; Race N/R; 60% female	RCT	WC	Full-SFBT	2	tension (social anxiety)
Corcoran (2006)	English	Journal articles	T = 56 C = 27	10 years old; 78% White, 37% female	Quasi-experimental	TAU	Full-SFBT	2	conduct
Froeschle et al.	English	Journal	T = 31	13 years old; 40%	RCT	WC	Full-SFBT	2	drug and

(2007)		articles	C = 30	White; 100% female					alcohol use
Newsome (2004)	English	Journal articles	T = 26 C = 26	12.5 years old; 71% White, 27% female	Quasi-experimental	TAU	Full-SFBT	2	GPA
Wallace (2009)	English	Journal articles	T = 204 C= 209	9.5 years old; 29% White; Gender N/R	Quasi-experimental	WC	Full-SFBT	2	internalizing behavior
Li & Liu (2021)	English	Journal articles	T = 60 C = 58	15.2 years old; Race N/R; 47.3% female	RCT	TAU	Full-SFBT	2	self-rating anxiety
Alguzo & Jaradat (2021)	English	Journal articles	T = 20 T = 20	15 years old; Race N/R; 100% female	RCT	AI	Full-SFBT	2	self-esteem
Novella et al. (2020)	English	Journal articles	T = 14 C = 21	19.3 years old; 73.1% White; 86.5% female	RCT	TAU	Full-SFBT	2	anxiety
Beauchemin et al (2021)	English	Journal articles	T = 63 C = 80	20 years old; Race N/R; Gender N/R	Quasi-experimental	WC	Full-SFBT	2	attitudes toward Wellness Promotion
Wallace et al. (2020)	English	Journal articles	T = 204 C = 209	9 years old; Race N/R; Gender N/R	RCT	WC	Full-SFBT	2	internalizing
Jaradat & Ababneh (2021)	English	Journal articles	T = 15 C = 15	17.0 years old; Race N/R; 100% female	RCT	WC	Full-SFBT	2	internal stimulation
Abdulla & Woods (2021)	English	Journal articles	T = 31 C = 33	17.2 years old; Race N/R; 100% female	RCT	AI	Full-SFBT	2	goal attainment expectancy
Öztürk Çopur & Kubilay (2022)	English	Journal articles	T = 34 C = 34	13.5 years old; 44.1% White; 17.6% female	Quasi-experimental	WC	Full-SFBT	2	verbal bullying
Aslan (2020)	English	Journal articles	T = 28 C = 30	12.5 years old; Race N/R; 56.7% female	Quasi-experimental	WC	Full-SFBT	2	social support
Martenstyn et al. (2022)	English	Journal articles	T = 57 C = 56	20.6 years old; Race N/R; 71.4% female	RCT	AI	Full-SFBT	2	perceived goal progression
Napier (2021)	English	Journal articles	T = 14 C= 12	18.6 years old; 65.3% White; 76.9% female	Quasi-experimental	AI	Full-SFBT	2	Resilience
Sağar (2021)	English	Journal articles	T = 15 C = 15	20 years old; Race N/R; 53.3% female	Quasi-experimental	WC	Full-SFBT	2	social anxiety

Beauchemin (2018)	English	Journal articles	T = 25 C = 22	18 years old; 84.7% White, 55.9% female	RCT	TAU	Full-SFBT	2	wellness
Javadian & Sabet Eqlidi (2022)	English	Journal articles	T = 15 C = 15	15 years old; Race N/R; 100% female	Quasi-experimental	WC	Full-SFBT	2	anxiety
Liu (2017)	English	Thesis and/or dissertation	T = 20 C = 20	10.years old; 2.5% White; 26.8% female	RCT	TAU	Conjunction	2	depression
Lin (2007)	Chinese	Thesis and/or dissertation	T = 7 C = 7	9.5 years old; 100% Chinese; Gender N/R	RCT	WC	Full-SFBT	2	social relational scale
Ho (2008)	Chinese	Thesis and/or dissertation	T = 5 C = 5	20 years old; 100% Chinese; Gender N/R	Quasi-experimental	WC	Full-SFBT	2	career belief scale
Hsieh (2007)	Chinese	Thesis and/or dissertation	T = 22 C = 22	19 years old; 100% Chinese; Gender N/R	RCT	WC	Full-SFBT	2	creativity assessment packet
Hung (2010)	Chinese	Thesis and/or dissertation	T = 12 C = 12	17 years old; 100% Chinese; 45.8% female	RCT	WC	Full-SFBT	2	happiness scale
Lo et al. (2004)	Chinese	Journal articles	T = 4 C = 8	16.5 years old; 100% Chinese; 87.5% female	RCT	WC	Full-SFBT	2	behavioral wellbeing
Li (2012)	Chinese	Thesis and/or dissertation	T = 10 C = 9	13 years old; 100% Chinese; 26.4% female	RCT	WC	Full-SFBT	3	internet addiction
Liu (2015)	Chinese	Thesis and/or dissertation	T = 8 C = 8	17.5 years old; 100% Chinese; 43.8% female	RCT	WC	Full-SFBT	3	self-perception bioimage
Huang (2007)	Chinese	Thesis and/or dissertation	T = 9 C = 8	10.5 years old; 100% Chinese; 75% female	RCT	WC	Full-SFBT	3	shyness
Chou (2003)	Chinese	Thesis and/or dissertation	T = 8 C = 8	10.5 years old; 100% Chinese; 75% female	RCT	WC	Full-SFBT	3	depression
Liu (2015)	Chinese	Thesis and/or dissertation	T = 8 C = 8	21 years old; Race N/R; 100% female	RCT	WC	Full-SFBT	3	social interaction

Study	Language	Publication type	N	Demographics	Design	Comparison	Condition	Time	Outcome
Zhu (2015)	Chinese	Thesis and/or dissertation	T = 29 C = 31	16.5 years old; Race N/R; 55.2% female	RCT	WC	Full-SFBT	2	relationship quality
Zhang (2012)	Chinese	Thesis and/or dissertation	T = 30 C = 30	16.5 years old; Race N/R; 43.3% female	RCT	WC	Full-SFBT	2	negative emotion
Song (2016)	Chinese	Thesis and/or dissertation	T = 36 C = 35	16 years old; Race N/R; 54.8% female	RCT	WC	Full-SFBT	2	social relationship
Sun (2013)	Chinese	Thesis and/or dissertation	T = 35 C = 34	19 years old; Race N/R; Gender N/R	RCT	WC	Full-SFBT	2	self-efficacy
Gui (2016)	Chinese	Thesis and/or dissertation	T = 14 C = 14	17.5 years old; Race N/R; 39.3% female	RCT	WC	Full-SFBT	2	negative emotion
Li (2014)	Chinese	Thesis and/or dissertation	T = 24 C = 24	19 years old; Race N/R; Gender N/R	RCT	WC	Full-SFBT	2	problem solving behavior
Wang (2010)	Chinese	Journal articles	T = 10 C = 10	20 years old; Race N/R; Gender N/R	RCT	WC	Full-SFBT	2	relationship stress
Huang et al. (2014)	Chinese	Thesis and/or dissertation	T = 10 C = 10	21 years old; Race N/R; Gender N/R	RCT	TAU	Full-SFBT	2	confidence
Zhang (2011)	Chinese	Thesis and/or dissertation	T = 16 C = 15	21 years old; Race N/R; 77.4% female	RCT	TAU	Full-SFBT	2	self-efficacy
Han (2012)	Chinese	Journal articles	T = 10 C = 10	21 years old; Race N/R; Gender N/R	RCT	TAU	Full-SFBT	2	self-acceptance
Wu et al. (2015)	Chinese	Journal articles	T = 10 C = 10	21 years old; Race N/R; Gender N/R	RCT	TAU	Full-SFBT	2	academic procrastination
Chueng (2006)	Chinese	Thesis and/or dissertation	T = 8 C = 8	21 years old; Race N/R; Gender N/R	Quasi-experimental	TAU	Full-SFBT	2	relationship stress
Sun (2011)	Chinese	Thesis and/or dissertation	T = 24 C = 24	21 years old; Race N/R; Gender N/R	RCT	TAU	Full-SFBT	2	self-esteem
Lien (2007)	Chinese	Thesis and/or dissertation	T = 10 C = 10	17 years old; Race N/R; Gender N/R	Quasi-experimental	TAU	Full-SFBT	2	self-acceptance
Wang (2014)	Chinese	Thesis and/or dissertation	T = 149 C = 146	16.5 years old; Race N/R; Gender N/R	Quasi-experimental	TAU	Full-SFBT	2	anxiety
Ye (2015)	Chinese	Journal articles	T = 10 C = 10	16.5 years old; Race N/R; Gender N/R	RCT	TAU	Full-SFBT	2	depression

Study	Language	Source	N	Participants	Design	Control	Treatment		Outcome
Zhou (2016)	Chinese	Thesis and/or dissertation	T = 12 C = 12	16.5 years old; Race N/R; Gender N/R	RCT	TAU	Full-SFBT	2	positive coping behavior
Zhou (2011)	Chinese	Thesis and/or dissertation	T = 32 C = 32	21 years old; Race N/R; 57.1% female	RCT	TAU	Full-SFBT	2	learning efficiency
Huang (2003)	Chinese	Thesis and/or dissertation	T = 7 C = 8	21 years old; Race N/R; 79.2% female	RCT	TAU	Full-SFBT	2	career seeking behavior
Tsai (2005)	Chinese	Thesis and/or dissertation	T = 8 C = 8	years old; Race N/R; 62.5% female	RCT	WC	Full-SFBT	2	emotional wellbeing
Su (2003)	Chinese	Thesis and/or dissertation	T = 8 C = 8	years old; Race N/R; 100% male	RCT	TAU	Full-SFBT	2	anger
Wu (2008)	Chinese	Thesis and/or dissertation	T = 15 C = 22	years old; Race N/R; 51.4% female	Quasi-experimental	TAU	Full-SFBT	2	learning behavior
Zhi & Zhang (2021)	Chinese	Journal articles	T = 21 C = 21	14.5 years old; Race N/R; Gender N/R	RCT	TAU	Full-SFBT	2	self-Esteem
Liu (2018)	Chinese	Journal articles	T = 65 C = 62	16.6 years old; Race N/R; 100% female	Quasi-experimental	TAU	Full-SFBT	2	peer relationship satisfaction
Oh (2019)	Korean	Journal articles	T = 8 C = 8	20 years old; 100% Korean; Gender N/R	RCT	WC	Conjunction	2	Goal selection
Shin (2019)	Korean	Journal articles	T = 8 C =10	20 years old; 100% Korean; Gender N/R	Quasi-experimental	WC	Conjunction	2	self-esteem
Hwang (2019)	Korean	Thesis and/or dissertation	T = 8 C = 8	19.5 years old; 100% Korean; 68.2% female	RCT	WC	Conjunction	2	career decision self-efficacy
Ju et al. (2020)	Korean	Thesis and/or dissertation	T = 20 C = 20	11 years old; 100% Korean; 55% female	Quasi-experimental	TAU	Full-SFBT	2	self-esteem
Lee et al. (2022)	Korean	Thesis and/or dissertation	T = 23 C = 18	17 years old; 100% Korean; 31.7% female	Quasi-experimental	WC	Conjunction	3	self-efficacy
An (2020)	Korean	Thesis and/or dissertation	T = 28 C = 27	11 years old; 100% Korean; 50.9% female	Quasi-experimental	WC	Conjunction	3	class atmosphere
Kim & Choi (2019)	Korean	Journal articles	T = 18 C = 18	16.0 years old; 100% Korean; Gender N/R	Quasi-experimental	WC	Conjunction	3	self-esteem

Kim (2019)	Korean	Thesis and/or dissertation	T = 10 C = 10	11.5 years old; 100% Korean; Gender N/R	RCT	WC	Conjunction	3	career maturity
Baek (2019)	Korean	Thesis and/or dissertation	T = 12 C = 12	11.5 years old; 100% Korean; 50% female	Quasi-experimental	WC	Full-SFBT	3	preference in assignment
Kang (2008)	Korean	Thesis and/or dissertation	T = 8 C = 8	10.5 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	2	interpersonal anxiety
Ko (2010)	Korean	Thesis and/or dissertation	T = 12 C = 12	11.5 years old; 100% Korean; Gender N/R	RCT	WC	Full-SFBT	3	Aggression
Ko (2008)	Korean	Thesis and/or dissertation	T = 8 C = 8	10 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	3	self-esteem
Kim (2009)	Korean	Thesis and/or dissertation	T = 5 C = 5	10 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	2	school adaptability
Kim S.Y. (2009)	Korean	Thesis and/or dissertation	T = 12 C = 12	16 years old; 100% Korean; Gender N/R	Quasi-experimental	TAU	Full-SFBT	3	self-concept
Kim Y.S. (2010)	Korean	Thesis and/or dissertation	T = 13 C = 17	12.7 years old; 100% Korean; 36.7% female	Quasi-experimental	TAU	Conjunction	2	social support
Kim (2008)	Korean	Thesis and/or dissertation	T = 30 C = 30	11 years old; 100% Korean; 53.3% female	Quasi-experimental	TAU	Full-SFBT	1	stress perception
Kim (2009)	Korean	Thesis and/or dissertation	T = 10 C = 10	10 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	3	self-control
Ryu (2006)	Korean	Thesis and/or dissertation	T = 10 C = 10	15 years old; 100% Korean; 15% female	RCT	TAU	Full-SFBT	1	self-control
Yang (2015)	Korean	Thesis and/or dissertation	T = 10 C = 10	13.1 years old; 100% Korean; 90% female	RCT	WC	Conjunction	3	school life adjustment
Lee (2009)	Korean	Thesis and/or dissertation	T = 10 C = 10	14 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	3	self-esteem
Lee (2007)	Korean	Thesis and/or dissertation	T = 10 C = 10	10 years old; 100% Korean; 40% female	RCT	TAU	Full-SFBT	3	School adaptability
Lee (2014)	Korean	Thesis and/or dissertation	T = 18 C = 19	11 years old; 100% Korean; 48.7% female	Quasi-experimental	TAU	Full-SFBT	3	School adjustment
Jeon (2004)	Korean	Thesis and/or dissertation	T = 8 C = 8	10 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	3	school adjustment (learning

									attitude)
Jung (2012)	Korean	Thesis and/or dissertation	T = 11 C = 11	12 years old; 100% Korean; 77% female	Quasi-experimental	TAU	Full-SFBT	2	test anxiety (worry)
Choi (2016)	Korean	Thesis and/or dissertation	T = 20 C = 20	16.5 years old; 100% Korean; Gender N/R	RCT	WC	Conjunction	3	school resilience
Choi (2012)	Korean	Thesis and/or dissertation	T = 12 C = 12	13.5 years old; 100% Korean; 75% female	RCT	TAU	Conjunction	3	self-concept
Choi (2011)	Korean	Thesis and/or dissertation	T = 10 C = 10	15 years old; 100% Korean; 100% female	RCT	TAU	Full-SFBT	3	self-esteem
Ha (2014)	Korean	Thesis and/or dissertation	T = 10 C = 10	10 years old; 100% Korean; 30% female	RCT	TAU	Full-SFBT	2	self-efficacy
Kim (2011)	Korean	Thesis and/or dissertation	T = 8 C = 8	11 years old; 100% Korean; 50% female	RCT	TAU	Full-SFBT	2	anxiety
Kim (2012)	Korean	Thesis and/or dissertation	T = 17 C = 17	13 years old; 100% Korean; Gender N/R	Quasi-experimental	TAU	Full-SFBT	3	self-efficacy
Kim. J.-U. & Lee, J.-H. (2016)	Korean	Journal articles	T = 12 C = 12	13 years old; 100% Korean; 29% female	RCT	WC	Full-SFBT	2, 3	emotional adjustment
Son (2002)	Korean	Thesis and/or dissertation	T = 12 C = 12	15.5 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	3	social isolation
Cho (2004)	Korean	Thesis and/or dissertation	T = 12 C = 12	11 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	3	school related attitudes
Kim (2005)	Korean	Thesis and/or dissertation	T = 12 C = 12	10 years old; 100% Korean; 67% female	Quasi-experimental	TAU	Full-SFBT	3	peer relationship
Kim (2014)	Korean	Thesis and/or dissertation	T = 18 C = 18	15 years old; 100% Korean; Gender N/R	Quasi-experimental	TAU	Conjunction	3	self-esteem
Jeong (2005)	Korean	Thesis and/or dissertation	T = 8 C = 8	9 years old; 100% Korean; Gender N/R	Quasi-experimental	TAU	Full-SFBT	3	self-esteem
Kang (2005)	Korean	Thesis and/or dissertation	T = 12 C = 12	11 years old; 100% Korean; Gender N/R	RCT	TAU	Full-SFBT	1	self-efficacy
Lee (2011)	Korean	Thesis and/or dissertation	T = 10 C = 10	11 years old; 100% Korean; 50% female	RCT	TAU	Full-SFBT	3	self-concept

Kim. N.J. (2008)	Korean	Thesis and/or dissertation	T = 5 C = 5	9 years old; 100% Korean; Gender N/R	Quasi-experimental	TAU	Full-SFBT	2	self-control
Ko (2016)	Korean	Thesis and/or dissertation	T = 28 C = 27	11 years old; 100% Korean; Gender N/R	Quasi-experimental	TAU	Full-SFBT	1	ego-resilience
Lim (2012)	Korean	Thesis and/or dissertation	T = 15 C = 15	10 years old; 100% Korean; 53.3% female	Quasi-experimental	TAU	Full-SFBT	1	motivation for learning
Moon (2016)	Korean	Thesis and/or dissertation	T = 7 C = 7	10 years old; 100% Korean; 43.0% female	RCT	TAU	Full-SFBT	1	self-esteem
Lee (2005)	Korean	Thesis and/or dissertation	T = 13 C = 13	7 years old; 100% Korean; Gender N/R	Quasi-experimental	TAU	Full-SFBT	3	self-control
Jung (2003)	Korean	Thesis and/or dissertation	T = 14 C = 14	14 years old; 100% Korean; 100% female	Quasi-experimental	TAU	Full-SFBT	3	school attitude

Note. T = number of participants in the treatment group; C = number of participants in the control group; N/R = Not reported; RCT = Randomized controlled trial; TAU = Treatment as usual; AI = Alternative intervention; WC = Waitlist control group; Full-SFBT = Full-SFBT intervention; Conjunction = SFBT in conjunction with other interventions.

Chapter Five: Summary of Dissertation Findings

The purpose of this dissertation, presented in three manuscripts, was to identify familial factors associated with East Asian American (EAA) youth mental health problems in their cultural context and assess the effectiveness of solution-focused brief therapy (SFBT) as a culturally adaptive school-based intervention. Although the lack of empirical evidence on EAA family processes and SFBT as risk and protective factors of EAA youth mental health outcomes persists, the three manuscripts reaffirmed previous research in demonstrating the roles of these factors in explaining EAA youth's mental health and developmental outcomes. This section briefly summarizes the findings and explains how they contribute to research and practice.

The integrative model of family processes proposed in the first manuscript contributes to identifying culture-specific familial factors in EAA families and delineating how these factors interplay to explain EAA youth mental health problems. Although most constructs from the original theories (i.e., Triadic model of family process and Acculturation gap-distress theory) remain in this framework, it outlines several important constructs (e.g., authoritarian parenting practices) that should be modified to fit the East Asian cultural context. This integrated framework can direct researchers and practitioners to include these constructs and apply them to the design of family-based interventions to reduce mental health risks among EAA youth. The second paper examined the longitudinal relationships among familial factors at three levels, negative emotionality, and depression using a sample of Korean American

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youth and their mothers. The results demonstrated that family enmeshment and intergenerational conflict are risk factors that can explain variation in EAA youth's processes and negative mental health outcomes. These findings contribute to guiding clinicians to make cultural adaptations to existing family-based interventions and education programs aimed at creating a healthy relational boundary and family relationship between parents and youth. The third paper examined SFBT for adolescent mental health using a comparative systematic and meta-analysis review between U.S. and East Asian studies. The results of subgroup and moderator analyses indicate that SFBT can be culturally adapted and effective across multiple contexts and countries for problems related to academic, interpersonal, and psychological issues among youth with Asian heritage, including EAA youth.

Overall, the findings of the three manuscripts contribute to research and practice by highlighting the importance of incorporating culture in developing theories and designing and implementing interventions. Specifically, the results demonstrated how familial constructs could be applied across cultural contexts and are linked to youth mental health problems within East Asian cultural context, thereby contributing to a better understanding of the EAA family dynamics and youth outcomes. Moreover, the findings of the third manuscript highlight the cultural adaptation of intervention as a critical component to better support at-risk EAA youth and understand their needs. More research exploring the cultural meaning and adaptation of existent theories and SFBT and their potential use in specific cultural contexts would benefit ethnic minority youth and their families. The following sections describe limitations, future research, and implications based on the three studies.

Limitations of Dissertation

Several limitations to this dissertation warrant caution regarding interpretation of the findings. One limitation relates to the lack of measures to assess the constructs that were identified in the theoretical framework. Specifically, while the integrative framework proposed in the first manuscript revealed important family and youth process-related constructs, the second manuscript did not test their relationships because it conducted secondary analyses of existing data. For example, there was a need to examine the role of attributional style, which is one of the important youth processes culturally specific to EAA youth (Tamis-LeMonda & McFadden, 2010). However, there were no measures to assess this construct in the dataset used in the second manuscript. Similarly, some family-related variables that were theoretically linked to youth process and mental health outcomes, such as parenting practices and family stability, were not available for the analysis. As such, absence of youth's process- and family-related measures has led to the lack of evidence for the hypothesized relationships between all variables proposed in the theoretical framework. More empirical studies that use primary data and various measures are necessary to validate the theoretical framework and better understand the relationships between key constructs.

Moreover, some immigration-specific characteristics that have been found to determine EAA youth outcomes (e.g., level of acculturation and age of arrival in the United States; Bulut & Gayman, 2016) were not included in the third manuscript because of the lack of empirical studies on Asian American youth. The vast majority of the included English studies did not report participants' racial and ethnic backgrounds or only focused on Caucasians and Latino youth as main participants. Since none of the English studies focused on Asian American youth, the findings that SFBT can be an effective treatment for all EAA youth need

to be interpreted with some caution. It is possible that studies that included Asian American

youth were missed because they did not meet the inclusion criteria. Thus, future empirical

studies of SFBT that use more rigorous methods and target Asian American youth will be

necessary to develop SFBT more culturally adaptive and receptive to EAA youth.

Another limitation of the three studies relates to the generalizability of the results. The

first manuscript critiqued and reconstructed assumptions of Western-based theories (e.g.,

TMFP) in East Asian cultural contexts, but the findings may not be generalizable to all EAA

youth and families. Scholars noted that mental health symptoms among youth can be

determined by various factors including the concentration of racial and ethnic minorities in a

neighborhood, generational status, and age of immigration (Lee et al., 2020; Tseng et al.,

2021). However, such neighborhood racial composition and immigration-related factors were

not considered in the first and second manuscripts. Also, in the third manuscript, the

significant treatment effects of SFBT may not apply to all EAA youth due to including

studies from only three (China, Korea, and Japan) of six East Asian countries. Future studies

with larger EAA family samples with different characteristics and East Asian countries are

needed to ensure the generalizability of the findings.

Future Research

Based on the findings, this dissertation provides direction for future research. First, future

studies could explore familial factors identified in the integrative framework, but which have

shown inconsistent findings in previous studies. For example, the question of in which

circumstances authoritarian parenting may positively or negatively affect EAA youth mental

health problems can be further studied. If research indicates that authoritarian parenting yields

any benefits for EAA youth mental health, this information could enhance our understanding

of specific family processes across cultures and inform parenting-focused intervention programs for East Asian parents.

Second, future studies could include qualitative or mixed methods approaches to explore the lived experiences of EAA youth and understand their family dynamics in more depth. Scholars have noted that correlational and quantitative research designs remain predominant in studies on Asian American youth, with a lack of qualitative studies involving this population, especially on the topics of family dynamics (Lui, 2015). The scarcity of such literature can impede our understanding of individual youth, whose perspectives might typically be difficult to capture in quantitative studies (Khankeh et al., 2015). Employing qualitative methods focused on the familial constructs and dynamics can contribute to more adequately documenting specific family concerns of EAA youth and better comprehending youth's cognitive processes linked to their mental health outcomes.

Implications for Social Work Practice

The findings from the three manuscripts have important implications for practice and clinical work with EAA youth and families. Practitioners and clinicians must develop an awareness of and sensitivity to EAA youth's unique experiences, cultural values, and practices. Further, it is recommended that future interventions for EAA youth be further tailored or refined based on the emerging theoretical framework. Individually and culturally tailored interventions were found more effective than nontailored interventions across mental health domains, as demonstrated by meta-analyses and empirical studies (Noar et al., 2007; Willems et al., 2017). The authors of these studies also suggested that the efficacy of interventions increased when individual and cultural tailoring was theory-based and when more theoretical constructs were added. Given these findings, the efficacy of SFBT regarding

youth outcomes can be further enhanced by tailoring based on the theoretical constructs of the integrative framework proposed in the first manuscript. For example, some SFBT techniques, such as relationship questions, can be utilized to address issues of family enmeshment and parent–youth relationships. In addition, given the role of EAA youth's negative emotionality in explaining their mental health problems, SFBT techniques for eliciting positive emotions (Kim et al., 2022) can be particularly beneficial for EAA youth and further utilized to prevent EAA youth's mental health problems. This can contribute to a better understanding of how and under what family conditions SFBT works for EAA families and thus enhancing its positive effectiveness of SFBT in family therapy setting by involving family members as an integral part of the treatment.

Closing

As the population of EAA grows and becomes more diverse, the demand for appropriate services and care will continue to grow. EAA youth mental health problems can be ameliorated with support from all people involved with these youth, including families, school counselors, community workers, and mental and physical professionals. Efforts to raise awareness of mental health problems among EAA youth should be continued through advocacy, education, research, and practice.

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