What We Know and Don't Know About the Mental Health of Ethnic Minority Groups

Stanley Sue, Ph.D.

University of California, Davis

In contrast to the conclusions reached by the U.S. Surgeon General's Supplement, there is evidence that the various ethnic minority groups may exhibit significant differences in the prevalence of mental disorder. These differences cannot be fully explained by disparities or inequities in mental health services.

African Americans

African Americans appear to have relatively low prevalence rates despite a history of prejudice, discrimination, and the resulting stress. Major surveys involving thousands of Americans have been conducted in the Epidemiological Catchment Area Study (ECA), National Comorbidity Study (NCS), and National Survey of American Life (NSAL) reveal that African Americans do not have a higher prevalence of mental disorders than nonHispanic Whites. The ECA found some racial differences in prevalence. However, the differences in mental illness prevalence between African Americans and non-Hispanic Whites were largely eliminated when differences in age, gender, marital status, and socioeconomic status were taken into account (U.S. Surgeon General, 2001). In contrast to the findings from the ECA, results from the NCS (Kessler et al., 1996) indicated that even without controlling for demographic and socioeconomic differences, African Americans had lower lifetime prevalence of mental illness for all of the disorders surveyed than did non-Hispanic whites. Finally, in the NSAL under the leadership of James Jackson, lower lifetime prevalence rates were found to be lower for

major depression, panic disorders, social phobia, agoraphobia, generalized anxiety disorder, and dysthymia. Thus significantly lower rates of mental disorders were found for African Americans (Carpenter 2002; Chernoff 2002).

The findings are puzzling because African Americans popularly believed to have high rates of mental disorders because of racism and overrepresentation in high risk conditions (e.g., poverty and homelessness). The results called attention to an interesting paradox concerning racial health and mental health disparities. In contrast to the mental health findings, African Americans on average remain worse off than the general population on almost every other important societal and health indicator—infant mortality, crude death rates (the average annual number of deaths during a year per 1,000 people at midyear), health care, wealth and income, housing, and poverty. There are at least three possible influences that are operating. First, mental health coping strategies along with structural inequalities may contribute to observed physical health disparities. For example, Jackson speculates that "comfort" habits such as smoking, poor diet, drinking alcohol, etc., may relieve mental health problems but increase physical health risks (Chernoff 2002). Second, cultural resources such as spirituality among African Americans may be effective in reducing mental stress. Third, racism may produce subclinical symptoms such as anger, alienation, inability to achieve or master the social and economic environment, etc. but not affect the prevalence of mental disorders. These possibilities must be examined.

Mexican Americans

An analysis of the ECA data for Mexican Americans revealed that Mexican Americans and non-Hispanic white Americans had very similar rates of psychiatric

disorders, except for drug abuse/dependence and major depressive episode, which were more prevalent among non-Hispanic whites (U.S. Surgeon General, 2001). However when the Mexican American group was separated into two subgroups, those born in Mexico and those born in the United States, results indicated that those born in the United States had higher rates of depression and phobias than those born in Mexico.

The NCS (Kessler et al. 1994) found that relative to non-Hispanic whites, Hispanics had a higher prevalence for current affective disorders and active comorbidity. There were no disorders in which the prevalence was lower for Hispanics than for non-Hispanic whites. In an analysis of the NCS data on Mexican Americans (i.e., examining only Mexican Americans and not other Hispanic groups, such as Puerto Ricans, Cubans, and South Americans), Ortega and his colleagues (2000) found that Mexican Americans were less likely than non-Hispanic whites to have any mental disorder. Similar to the Los Angeles site ECA findings, Mexican Americans born outside the United States were found to have lower prevalence rates of any lifetime disorders than Mexican Americans born in the United States. In fact, on various measures of acculturation (e.g., place of birth, parents' place of birth, and language used at home), prevalence was directly related to level of acculturation after controlling for the effects of sex, age and marital status.

The Mexican American Prevalence and Services Survey (MAPSS) examined rates of psychiatric disorders in among 3,012 Mexican Americans residing in Fresno County, California (Vega et al. 1998). This study found that the lifetime rates of mental disorders among Mexican Americans were generally lower than those found in the NCS national sample. It also found that rates among immigrants born in Mexico were remarkably lower than the rates of mental disorders among Mexican Americans born in

the United States. The convergent evidence from the ECA, the NCS and MAPSS suggest that Mexican-born immigrants have better mental health than do U.S.-born Mexican Americans and the national sample overall.

Why is acculturation negatively related to mental health for Mexican Americans? Some speculate that acculturation may lead to erosion of traditional family networks and the family structure, which provide family members with support, resources and protective/preventive benefits (Escobar et al. 2000). Vega and colleagues (1998) have also argued that these discrepancies in prevalence rates may be due to the different levels of expectations held by U.S.- and Mexican-born Mexican Americans. In their view, immigrants may have a lower set of expectations about educational and income attainments than do U.S.-born Mexican Americans, making them less likely to become demoralized when income and achievement do not reach certain targets (Escobar et al. 2000).

Asian Americans

Both the ECA and NCS surveyed relatively few Asian Americans, so prevalence rates are difficult to estimate. The Chinese American Psychiatric Epidemiological Study (CAPES) is one of the most rigorous and large scale investigation of any Asian group in the United States. This study examined rates of depression among more than 1,700 Chinese Americans in Los Angeles County (Sue et al. 1995; Takeuchi et al. 1998). CAPES results showed that Chinese Americans had low to moderate levels of depressive disorders. These rates were lower than those found for the general population in the NCS but similar to those for the Los Angeles site of the ECA. Interestingly, neurasthenia, a culture-bound syndrome defined by DSM-IV (American Psychiatric Association, 1994)

as involving somatic symptoms and fatigue, could be diagnosed in about 7% of the respondents (Zheng et al. 1997). The neurasthenic symptoms often occurred in the absence of symptoms of other disorders, and more than half of those with this syndrome did not have a concomitant Western psychiatric diagnosis. Therefore, neurasthenia does not appear to be another disorder (e.g., depression) in disguise. If culture-bound syndromes are included within the estimates of the prevalence of mental disorders, then it is especially difficult to argue that Chinese Americans in particular and Asian Americans and Pacific Islanders in general have significantly lower prevalence rates.

Sue and Zane (1985) found that recently immigrated Chinese students were less autonomous and extroverted and more anxious than Chinese students who had lived in the United States for a longer time. In another investigation, Abe and Zane (1990) found significant differences between non-Hispanic whites and foreign-born Asian American college students on a measure of psychological maladjustment. Results demonstrated that foreign-born Asian Americans reported greater levels of interpersonal distress than did non-Hispanic whites, even after controlling for other demographic differences as well as the influences of social desirability, self-consciousness, extraversion, and other-directedness (i.e., being attuned to the desires and needs of others).

On the MMPI, less acculturated Asian Americans have scored significantly higher than either acculturated Asian Americans or non-Hispanic White Americans scales of symptoms and disturbance (Sue et al., 1996; Tsai and Pike, 2000). Thus there is evidence from personality inventories that Asian Americans score as high as whites, and in some cases even higher, on measures of disturbance. In addition, acculturation appears to be inversely related to prevalence rates or symptom levels.

Native Americans

In the case of American Indian and Alaska Natives, the Surgeon General (2001) noted that no large-scale prevalence survey has been conducted. However, results are available from smaller studies. In general, these studies have found that American Indians have fairly high rates of mental disorders (Kinzie et al., 1992; (National Center for Post-Traumatic Stress Disorder and the National Center for American Indian and Alaska Native Mental Health Research, 1996), especially for alcohol and substance abuse.

Conclusions and Implications

Research findings support the hypothesis that ethnic minority groups vary in the prevalence of mental disorders. A number of important and interesting questions emerge from the findings.

1. Why are prevalence rates low among African Americans who experience the stress and racism, are overrepresented in high risk groups, and experience poorer physical health?
2. Why do acculturated Mexican Americans have higher rates of mental disorders than less acculturated Mexican Americans, while the opposite may be true for Asian Americans?
3. When estimating prevalence rates for groups, how should culture bound syndromes be treated?
4. What is the relationship between the presence of mental disorders and subclinical symptoms?

These questions are important to address and much more research is needed for each of the major ethnic minority groups.

References

Abe, J., & Zane, N. (1990). Psychological maladjustment among Asian and Caucasian American college students: Controlling for confounds. *Journal of Counseling Psychology, 37*, 437–444.

Carpenter, S. (2002) What can resolve the paradox of mental health disparities? *Monitor on Psychology, 102*, 46.

Chernoff, N.N. (2002) NIMH Study: Blacks mentally healthier. *American Psychological Society Observer,* 15, 21-36.

Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry, 8,* 64-72.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshelman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM–III–R disorders in the United States. *Archives of General Psychiatry, 51*, 8–19.

Kinzie, J.D., Leung, P.K., Boehnlein, J., Matsunaga, D., Johnson, R., Manson, S., Shore, J.H., Heinz, J., & Williams, M. (1992). Psychiatric epidemiology of an Indian village: a 19-year replication study. *Journal of Nervous and Mental Disorders, 180*, 33-39.

National Center for Post-Traumatic Stress Disorder and the National Center for American Indian and Alaska Native Mental Health Research. (1996). *Matsunaga Vietnam Veterans Project*. White River Junction, VT: Author.

Ortega, A.N., Rosenheck, R., Alegria, M., & Desai, R.A. (2000). Acculturation and lifetime risk of psychiatric and substance use disorders among Hispanics. *Journal of Nervous and Mental Disease, 188,* 728-735.

Sue, S., & Zane, N. (1985). Academic achievement and socioemotional adjustment among Chinese university students. *Journal of Counseling Psychology, 32,* 570–579.

Sue, S., Keefe, K., Enomoto, K., Durvasula, R., & Chao, R. (1996). Asian American and White college students' performance on the MMPI–2. In J. N. Butcher (Ed.), International adaptations of the MMPI: Research and clinical applications (pp. 206–220). Minneapolis: University of Minnesota Press.

Sue, S., Sue, D., Sue, L., & Takeuchi, D.T. (1995) Psychopathology among Asian Americans: A model minority? *Cultural Diversity and Mental Health, 1*, 39–54.

Takeuchi, D.T., Chung, R. C., Lin, K. M., Shen, H., Kurasaki, K., Chun, C., & Sue, S. (1998) Lifetime and twelve-month prevalence rates of major depressive episodes and dysthymia among Chinese Americans in Los Angeles. *American Journal of Psychiatry, 155,* 1407–1414.

Tsai, D. C., & Pike, P. L. (2000). Effects of acculturation on the MMPI-2 scores of Asian American students. *Journal of Personality Assessment, 74,* 216-230.

U. S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity. A Supplement*. Rockville, MD: U.S. Department of Health and Human Services.

Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderate, E., Catalano, R., & Carveo-

Anduaga, J. (1998) Lifetime prevalence of DSM–III–R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry, 55,* 771–778.

Zheng, Y. P, Lin, K. M., Takeuchi, D., Kurasaki, K. S., Wang, Y. X., & Cheung, F. (1997). An epidemiological study of neurasthenia in Chinese-Americans in Los Angeles. *Comprehensive Psychiatry, 38,* 249–259.

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