

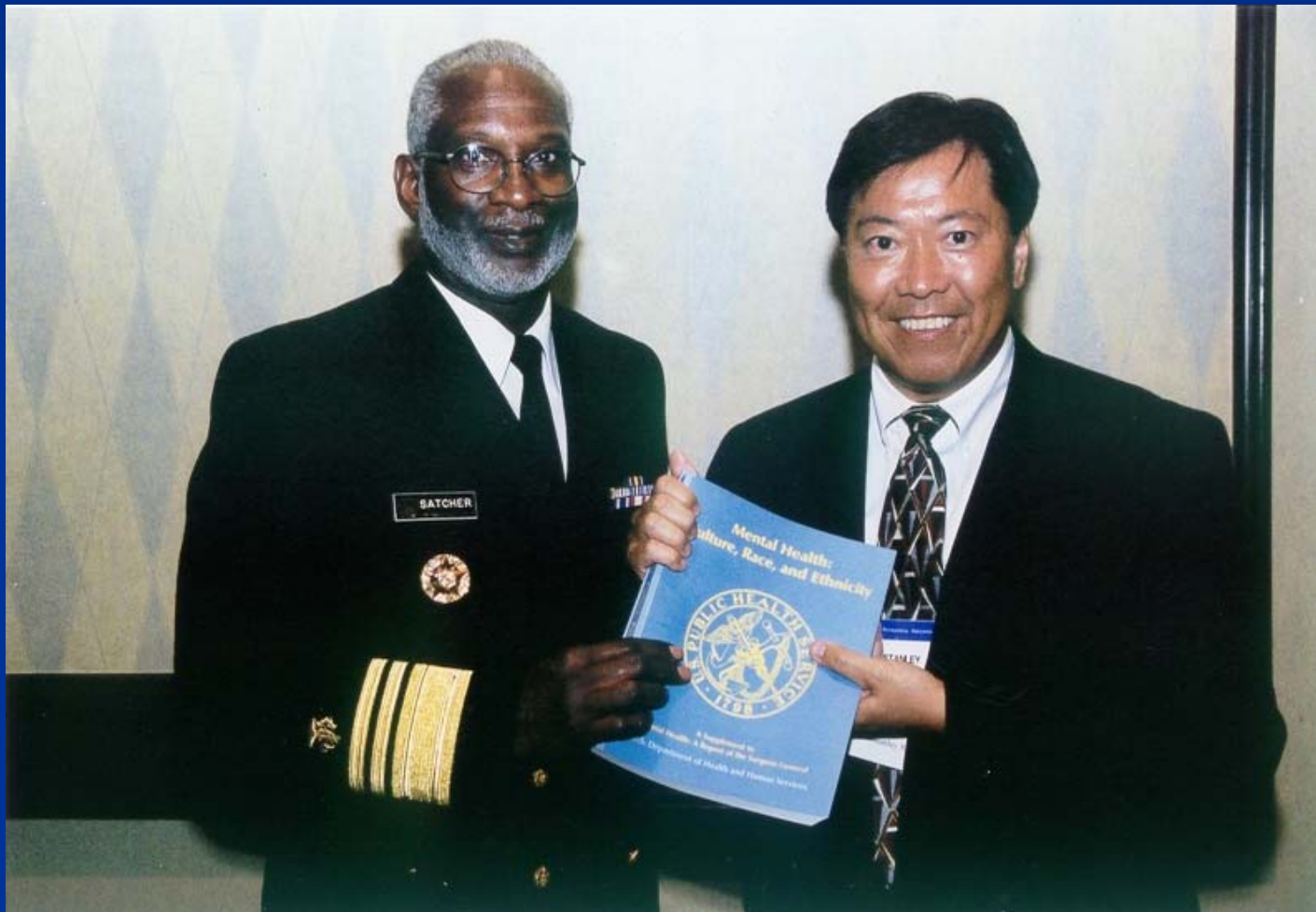
How Mentally Healthy Are Members of Ethnic Minority Populations?

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Overview

- How mentally healthy are members of ethnic minority groups, especially Asian Americans?: Prevalence issues
 - Theoretical Assumptions
 - Empirical Evidence
 - Controversies and Dilemmas

2001 U.S. Surgeon General David Satcher, MD



Surgeon General Themes

- Culture counts
- Minorities bear a greater burden from unmet mental health needs
- Disparities because of less access and lower quality of care (similar prevalence and poorer quality of care)
- Seek treatment

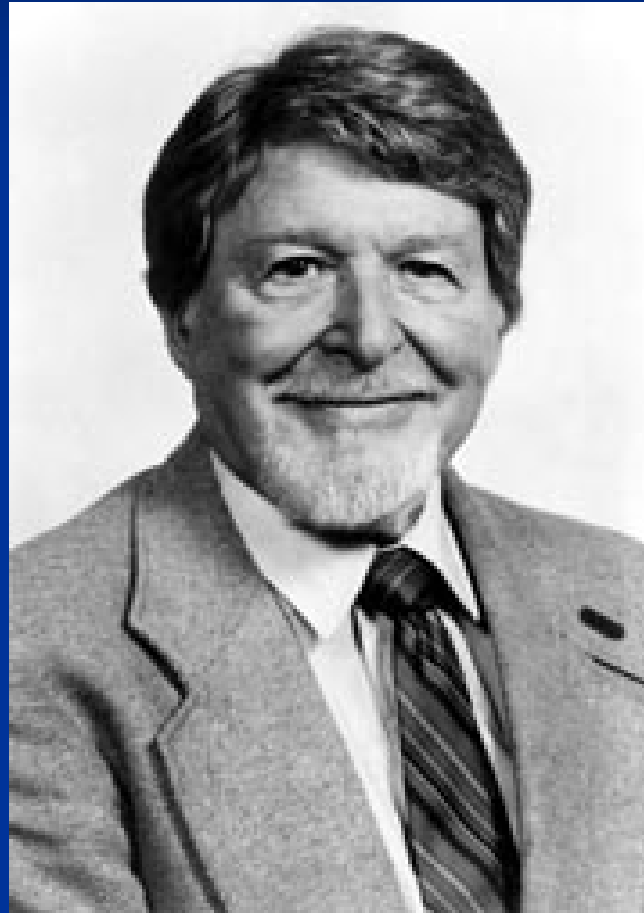
Controversies

- Are there really no ethnic/racial differences in prevalence rates?

Hypotheses for Asian Americans

- In view of relatively low rates of crime, delinquency, and divorce; and high socioeconomic standing and educational attainments, Asian Americans are relatively well adjusted
- Asian Americans have “immunity” against social stressor, because of cultural and family strengths
- With acculturation and assimilation, prevalence of mental disorders increase

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DeVos

Roles

■ JAPANESE

“Being oneself” is subordinate to acting in accordance with role expectations

Clearly defined family roles.

- Japanese father--head of the household, a role that is irreproachably legitimate and dominant, demanding unquestioned respect from the child.
- Mother--deferent and supportive of her husband. Sees to it that her children develop a proper attitude toward their father. Self control and avoidance of direct confrontation.
- Children--socialized to be obedient and role appropriate behaviors (oldest versus youngest; male versus female).

■ AMERICANS

- “Relate to each other in an intimate fashion without resorting to the laying of roles. “Be yourself,” “Be open and honest,” “Don't be phony,” and “Don't play roles or games”
- More egalitarian family relationships.

Sincerity

■ JAPANESE--the “sincere” individual acts in accordance with role expectations, not personal subjective feelings.

■ AMERICANS--the sincere person behaves on the basis of openness and feelings rather than role prescriptions.

Farewell to Manzanar

“There was no question in my mind that my mother loved my father; that is why she served him. This attitude, that to serve meant to love, became an integral part of my psychological makeup and a source of confusion when I later began to relate to me.

There was also no question in my mind that my father was absolute authority in their relationship and his relationship to his children. During and after the Second World War, when his dreams and economic situation had hit bottom, and he was too old to start over again as he had already done several times, he raged at his wife and family and drank. His frustration toward the society that rejected and humiliated him caused him to turn on his own and on himself. I never understood how she so patiently endured him during those times. But she never abandoned him, understanding, as I did not, the reasons for his anguish, for his sense of failure.

Even though respect for him diminished then, I always felt that he was very powerful and that he dominated her with this power. As they grew older and inevitable thought of their passing entered my mind, I worried that she would be lost if he died before her. When that sad day arrived, I learned what is meant by the Asian philosophical truism "Softness is strength." I had taken my gravely ill father, along with my mother, to see his doctor. The doctor informed me privately that we should take him to the hospital where he would be comfortable, as he could not live more than ten days.”

Farewell to Manzanar

“It was raining. I numbly drove the car toward the hospital, straining to see through the blurred windshield and my own tears. My mother was not crying. “Riku,” he said, weakly. He never called her Riku...always ‘Mama.’ ‘Don’t leave me. Stay with me at the hospital. They won’t know how to cook for me...or how to care for me.’ She patted his hand. ‘You’ve been a good wife. You’ve always been the strong one.’

Not wanting him to tire, I tried to quiet him. He sat up bolt-like and roared like a lion. ‘Shut up!’ I quaked at his forcefulness, but he felt some comfort in knowing he could still ‘save face’ and be the final authority to his children, even at death’s door. My mother’s quiet strength filled the car as she gently stroked his forehead. Without tears or panic she assured him she would stay with him until the end.

He died that afternoon a few hours after he entered the hospital. For the ten years afterward that my mother lived, she never once appeared lost or rudderless, as I feared she would be with him gone. Hadn’t he been the center of her life? Hadn’t the forms in their relationship, the rituals of their roles all affirmed his power over her? No. She had been the strong one. The structure had been created for him; but it was her essence that has sustained it.”

Mental Health Implications

1. Sincerity means to behave not according to feelings but to roles
2. Performance of family roles leads to predictability and avoids role and personal degradation
3. Prejudice and discrimination effects are not echoed in the family
3. Warmth in family may be sacrificed
4. Japanese Americans have a cultural means of reducing stress and its impact

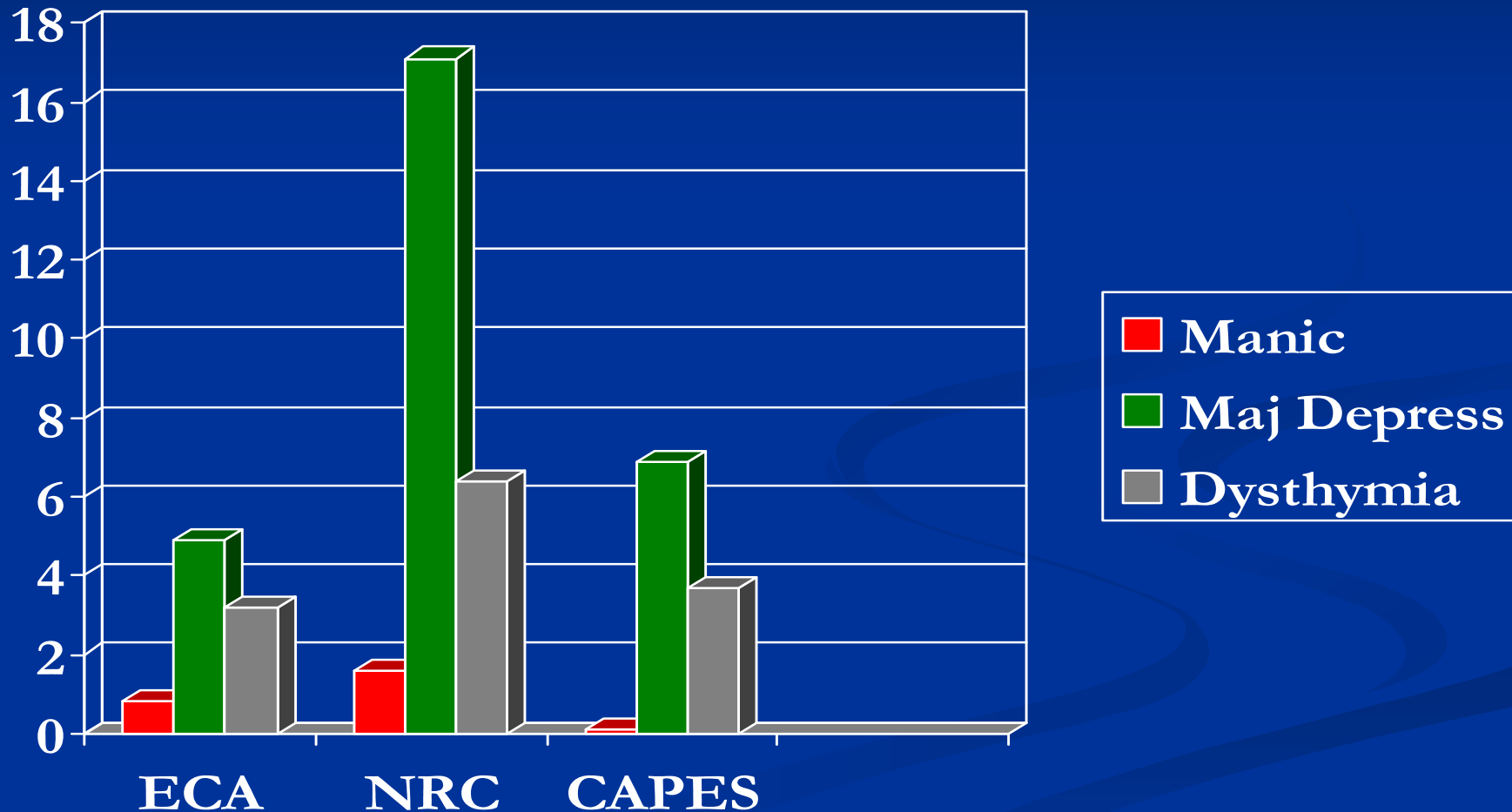
Francis Hsu: Assumptions

1. Act because of human need for intimacy which makes life meaningful
2. Act in accordance to roles
3. Some cultures satisfy need for intimacy better than others
4. Chinese (Asian) cultures able to satisfy intimacy better than individualistic (Western) cultures so Chinese better adjusted

Findings for Asian Americans

- Small scale studies with selected populations
- ECA
- Chinese American Psychiatric Epidemiological Study (CAPES)
- NLAAS

Lifetime Prevalence of Mood Disorders



NLAAS Prevalence for Any Depressive, Anxiety, and Substance Abuse Disorders

- Asian Americans 18 years or older
- Resided in any of the 50 states and Washington, DC.
- Chinese, Filipino, Vietnamese, and other Asian Americans
- 2095 Asian American individuals
- Weighted response rates were about 70%
- Interviews 2.4 mean hours in English or Ethnic languages

	Lifetime Prevalence	12-Month Prevalence
Gender		
Men	17.18	8.44
Women	17.43	9.87
Ethnic origins		
Chinese	18.00	10.00
Filipino	16.74	8.99
Vietnamese	13.95	6.69
Other Asians	18.29	9.55
Nativity status		
US-born	24.62	13.22
Foreign-born	15.16	8.00
English-language proficiency		
Excellent/good	17.24	8.82
Fair/poor	17.47	9.85

Neurasthenia

In China, a condition characterized by physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and various signs suggesting disturbance of the autonomic nervous system. In many cases, the symptoms would meet the criteria for a DSM-IV Mood or Anxiety Disorder. This diagnosis is included in the Chinese Classification of Mental Disorders, Second Edition (CCMD-2).

Prevalence of Neurasthenia (NT) in CAPES Project

- 112 out of 1,747 (6.4%) Chinese Americans met ICD criteria of NT
- Of these, 63 (56.3%) did not experience any current and lifetime DSM-III-R diagnoses, yielding a 12-month or lifetime prevalence rate of “pure” NT of 3.61%
- This rate was much higher than any of the other psychiatric disorders in this sample
- Compared with normal subjects, “pure” NT subjects had significantly higher SCL-90-R total and factor scores, experienced more psychosocial stress, and perceived less social support
- Compared with subjects with depression and anxiety disorders, “pure” NT cases reported significantly less SCL-90-R psychological symptoms, but had a strikingly similar elevation in the somatization subscale score. These data suggest that NT is a distinctive clinical condition overlapping only partially with the other better recognized diagnostic entities.

Marshall et al. 2005

- Little is known about the long-term mental health of trauma-exposed refu-gees years after permanent resettlement in host countries.
- Objective To assess the prevalence, comorbidity, and correlates of psychiatric dis-orders in the US Cambodian refugee community.
- Design: A cross-sectional, face-to-face interview con-ducted in Khmer language on a random sample of households from the Cambodian com-munity in Long Beach, Calif, the largest such community in the United States, between October 2003 and February 2005. A total of 586 adults aged 35 to 75 years who lived in Cambodia during the Khmer Rouge reign and immigrated to the United States prior to 1993 were selected. One eligible individual was randomly sampled from each house-hold, with an overall response rate (eligibility screening and interview) of 87% (n =490).

Main Outcome Measures

- Exposure to trauma and violence before and after im-migration (using the Harvard Trauma Questionnaire and Survey of Exposure to Com-munity Violence)
- Past-year prevalence rates of posttraumatic stress disorder (PTSD) and major depression (using the Composite International Diagnostic Interview version 2.1)
- Alcohol use disorder (by the Alcohol Use Disorders Identification Test).

Results

- All participants had been exposed to trauma before immigration. 99% experienced near-death due to starvation and 90% had a family member or friend murdered. Seventy percent reported exposure to violence after settlement in the United States.
- High rates of PTSD (62 %), major depression (51 %), and low rates of alcohol use disorder were found. PTSD and major depression were highly comorbid in this population and each showed a strong dose-response relationship with measures of traumatic exposure.
- Having poor English-speaking proficiency, unemployment, being retired or disabled, and living in poverty were also associated with higher rates of PTSD and major depression. Premigration trauma remained associated with PTSD and major depression; postmigration trauma with PTSD and major depression; and older age with PTSD and major depression.
- Conclusion: More than 2 decades have passed since the end of the Cambodian civil war and the subsequent resettlement of refugees in the United States; however, this population continues to have high rates of psychiatric disorders associated with trauma.

Asian American Mental Health

- Prevalence rates somewhat low
- Presence of “culture-bound” syndromes (neurasthenia)
- High symptom count
- Studies conflict on acculturation and disturbance (community studies v. college students)
- SEA mental health and high risk groups

Hypotheses for Ethnic Minority Groups

- Stress causes mental disorders (Diathesis-Stress Theory)
- Prejudice and discrimination are stressors
- Because of prejudice and discrimination, ethnic minority groups have higher prevalence of mental disorders

Racism and Mental Health

- “I can conceive of no Negro native to this country who has not, by the age of puberty, been irreparably scarred by the conditions of his life. The wonder is not that so many are ruined but that so many survive.” James Baldwin (1957, p. 71):
- “Racist practices undoubtedly are key factors—perhaps the most important ones—in producing mental disorders in Blacks and other underprivileged groups....” (Kramer, Rosen, & Willis, 1973, p. 353).
- Discrimination as a stressor

Findings for African Americans

- **Epidemiological Catchment Area Study (ECA)**
- **National CoMorbidity Study (NCS)**
- **National Survey of American Life (NSAL)**

Epidemiological Catchment Area Study (ECA)

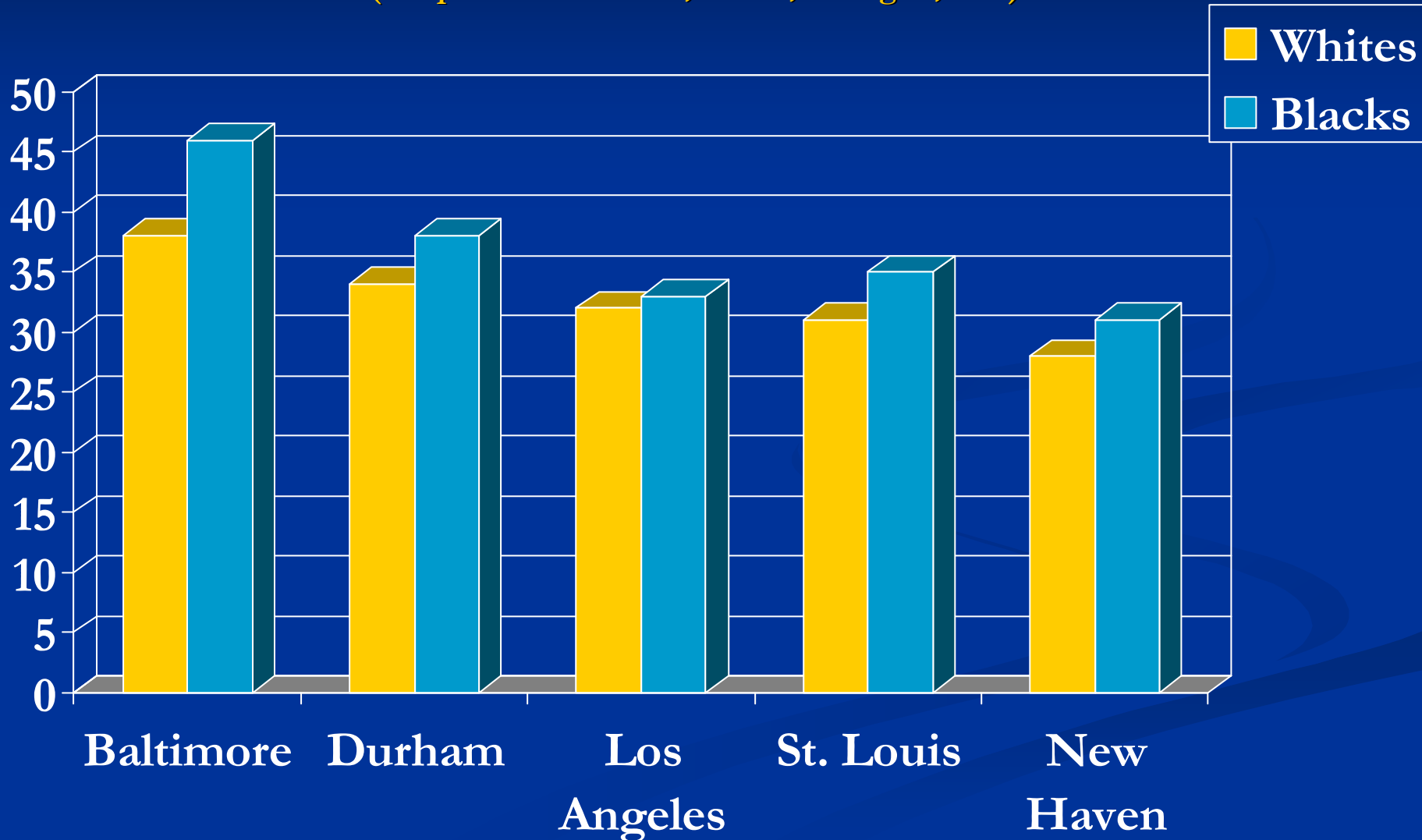
Lifetime Prevalence of Any Disorders

(Robins, Locke, & Regier, 1991)

	Total	Whites	Blacks
Baltimore	41	38	46
Durham	35	34	38
Los Angeles	33	32	33
St. Louis	31	31	35
New Haven	28	28	31

Epidemiological Catchment Area Study (ECA) Lifetime Prevalence of Any Disorders (%)

(Adapted from Robins, Locke, & Regier, 1991)

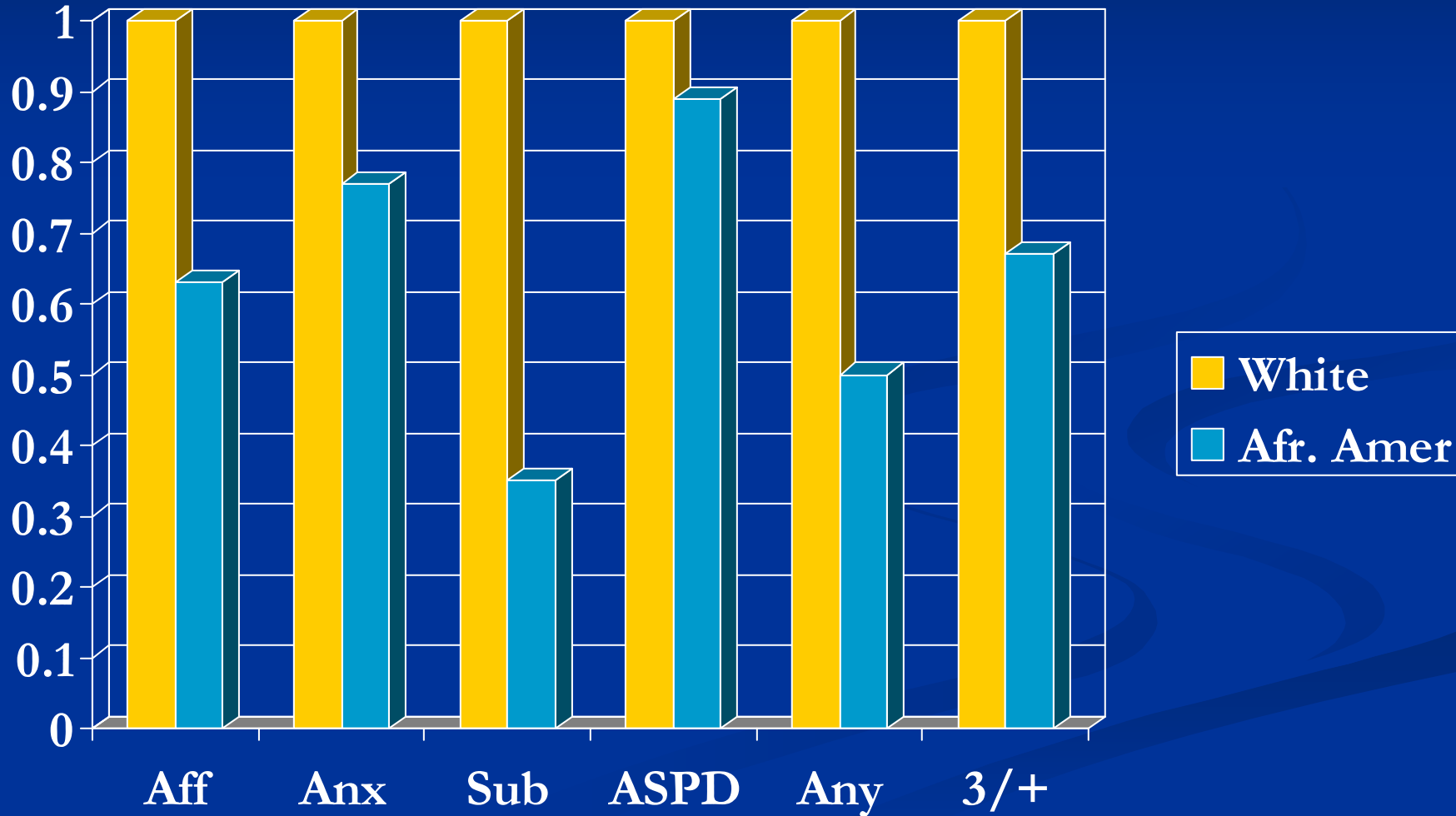


ECA

- Racial differences were few. They are largely attributable to demographic differences (social class) and, in the case of older individuals, to a higher prevalence of cognitive disorders among African Americans

National Comorbidity Study

(Odds ratios for lifetime prevalence by Kessler et al., 1994)



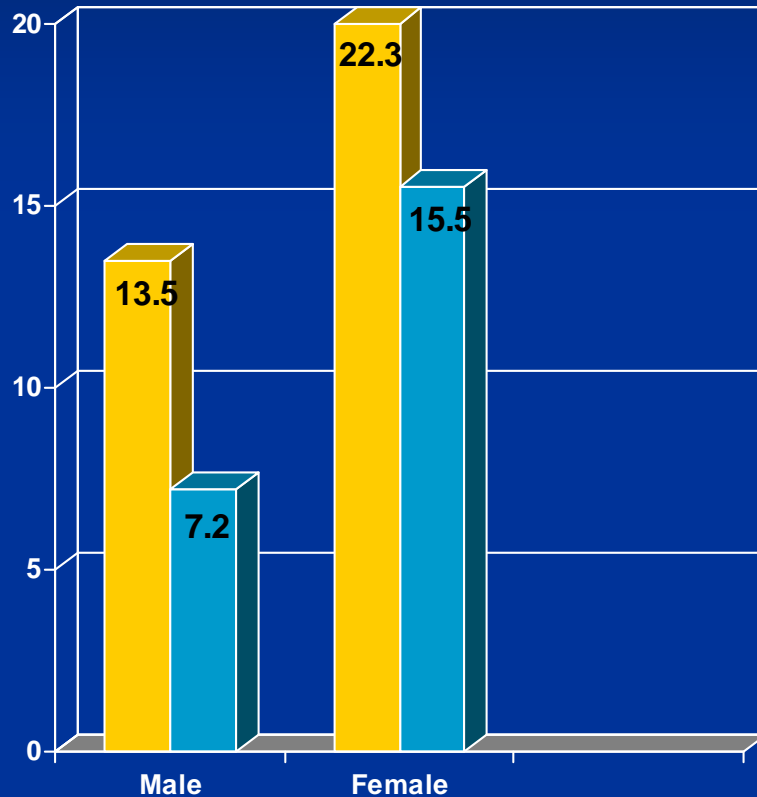
James S. Jackson
University of Michigan



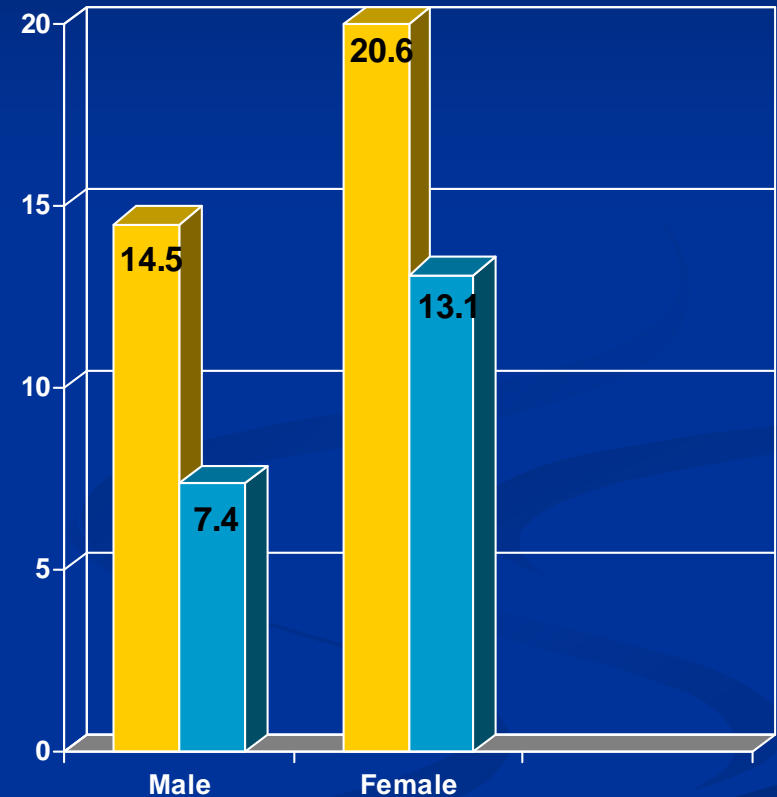
NCS and NSAL Lifetime Prevalence Rates for Major Depression by Race and Gender

(in percentages) (Jackson)

NCS



NSAL



■ African American
□
■ White

Source: NSAL, 2001, preliminary estimates; NCS, National Co-Morbidity Study, 1990-92.

African American Mental Health

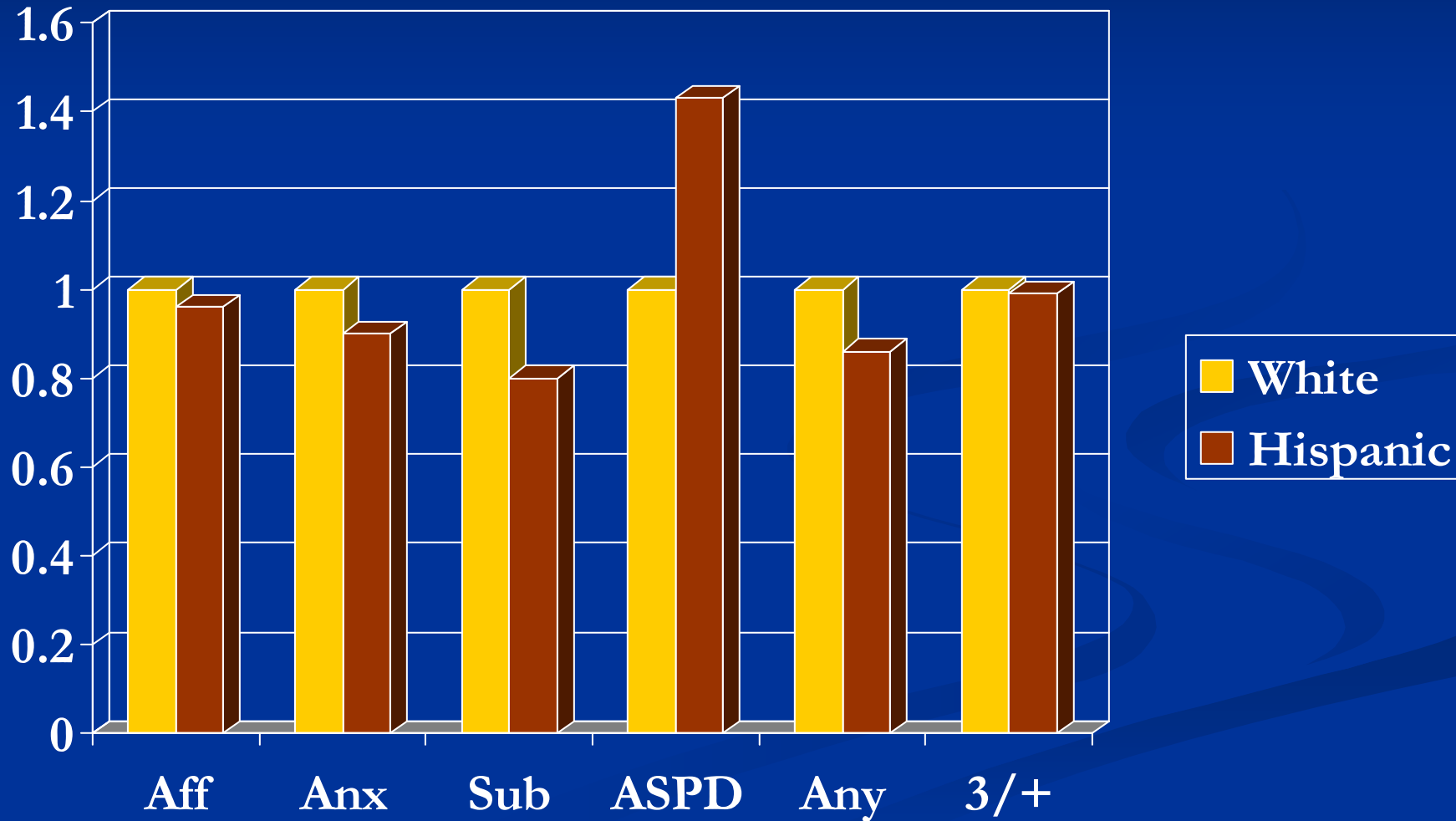
- Most evidence shows prevalence rates lower than nonHispanic Whites
- They are overrepresented in high risk groups
- General health risk
- High symptoms
- Greater persistence and severity
- Black Caribbean immigrants had lower rates of psychiatric disorders compared with US-born Caribbean Blacks; longer in U.S., higher prevalence

What About Mexican Americans?



National Comorbidity Study

(Odds ratios for lifetime prevalence by Kessler et al., 1994)



NLAAS

- Mexican (n=868), Puerto Rican (n=495), Cuban (n=577), and “other” (n=614)
- Lifetime Prevalence for Psychiatric Disorders
 - Men 28.14
 - Women 30.23
- One Year
 - Men 13.47
 - Women Life 17.40
- Immigrants lower prevalence than American born. However, longer residence in the United States to be associated with increased prevalence rates of lifetime and past-year psychiatric disorders, except when age was controlled, there was no significant difference in lifetime or past-year prevalence according to years of residence in the United States.

Mexican American Mental Health

- Mexican Americans prevalence rates for mental disorders same as (Robins, Locke, & Regier, 1991), or somewhat lower than, those of nonHispanic Whites
- Mexican Americans born in Mexico have much lower rates than those born in the U.S.; place of birth more important variable than age, gender, and social class
- Immigrant Mexican Americans have rates similar to Mexicans in Mexico
- U.S. born Mexican Americans have rates similar to nonHispanic Whites
- Differences among Hispanics (Cubans low, Puerto Ricans high)

Native American Mental Health

- No large scale studies available
- Small scale studies suggest prevalence high
- Alcohol abuse is a serious problem

Why Discrepancy?

- The recent findings from the National Survey of American Life were not yet available to the science editors who worked on the Supplement.
- Because of relatively small numbers of ethnic minority groups included in research and the methodological and conceptual differences in various prevalence studies, researchers may differ in their conclusions.
- The process for writing the Supplement gave primary responsibility for writing initial drafts of the ethnic chapters to the science editors. The chapters were then edited and coordinated by the senior science editor. Although all the editors were consulted about the entire Supplement, coordination of the chapters may have been hindered because of the initial division of labor or philosophical differences between editors.
- There may have been some reluctance to conclude in the Supplement that some ethnic minority groups were more disturbed than others. This conclusion might promote stereotypes involving a deficit model of functioning, or, conversely, a model minority group image for some groups and not others.
- It seems counterintuitive to conclude that African Americans have relatively low rates of mental disorders given their experiences of racism and their overrepresentation in high risk groups. Thus, some researchers may want to err on the side of caution and to demand more persuasive evidence.

2006 National Survey on Drug Use and Health

Among persons aged 18 or older, prevalence of past year MDE:

12.1% American Indians or Alaska Natives
7.8% Whites
6.3% African Americans
5.8% Native Hawaiians or Other Pacific Islanders
5.4% Hispanics
3.0% Asians

Among persons aged 12 or older, prevalence of past year substance dependence or abuse:

19.0% American Indians or Alaska Natives
12.0% Native Hawaiians or Other Pacific Islanders
10.0% Hispanics
9.2% Whites
9.0% African Americans
4.3% Asians

Among persons aged 12 or older, prevalence of past year SPD:

25.9% American Indians or Alaska Natives
11.4% Whites
10.8% Native Hawaiians or Other Pacific Islanders
10.8% Hispanics
10.5% African Americans
7.8% Asians

Irrespective of Prevalence Disparities in Treatment Exist

- Need/utilization
- Dropouts
- Guidelines for treatment