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Ethnic identity, acculturation and the prevalence of lifetime psychiatric disorders among Black, Hispanic, and Asian adults in the U.S.

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ABSTRACT

Background: Past research has asserted that racial/ethnic minorities are more likely to develop psychiatric disorders due to their increased exposure to stressors; however most large epidemiologic studies have found that individuals who are Black or Hispanic are less likely to have most psychiatric disorders than those who are White. This study examines the associations between ethnic identity, acculturation, and major psychiatric disorders among Black, Hispanic, and Asian adults in the U.S.
Methods: The sample included Wave 2 respondents to the National Epidemiologic Survey on Alcohol Related Conditions (NESARC), a large population-based survey, who self-identified as Black ($N = 6219$), Asian/Native Hawaiian/Other pacific islander ($N = 880$), and Hispanic ($N = 5963$). Multivariable regression analyses were conducted examining the relationships between ethnic identity, acculturation, and the prevalence of psychiatric disorders.
Results: Higher scores on the ethnic identity measure were associated with decreased odds of having any lifetime psychiatric diagnoses for those who were Black (AOR = 0.978; CI = 0.967–0.989), Hispanic (AOR = 0.974; CI = 0.963–0.985), or Asian (AOR = 0.96; CI = 0.936–0.984). Higher levels of acculturation were associated with an increased odds of having any lifetime psychiatric diagnosis for those who were Black (AOR = 1.027; CI = 1.009–1.046), Hispanic (AOR = 1.033; CI = 1.024–1.042), and Asian (AOR = 1.029; CI = 1.011–1.048).
Conclusion: These findings suggest that a sense of pride, belonging, and attachment to one's racial/ethnic group and participating in ethnic behaviors may protect against psychopathology; alternatively, losing important aspects of one's ethnic background through fewer opportunities to use one's native language and socialize with people of their ethnic group other may be a risk factor for psychopathology.
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1. Introduction

The estimated 12-month prevalence of diagnosable psychiatric disorders is 26–30% in the U.S. general adult population (Kessler et al., 1994, 1999, 2005; Regier et al., 1993). Psychiatric disorders are associated with increased impairment in role functioning including work limitations, chronic illness, morbidity, mortality due to physical illness, and higher rates of suicide (Gwynn et al., 2008; Holahan et al., 2010; Miller et al., 2006; Penninx et al., 2001; Whooley et al., 2002; Young et al., 2008). Although it was previously thought that psychiatric disorders might be more prevalent among racial/ethnic minorities due to their increased exposure to stressors such as discrimination (Cannon and Locke, 1977; Fischer, 1969; Kleiner et al., 1960; Kramer et al., 1973; Mirowsky and Ross, 1980), most large epidemiologic studies have not supported this assertion (Breslau et al., 2006; Hasin et al., 2005; Kessler et al., 2003; Kessler et al., 2005; Kessler et al., 1994; Smith et al., 2006). In contrary, these studies have reported that most psychiatric disorders are less prevalent among individuals who are Black or Hispanic than those who are White (Breslau et al., 2006; Hasin et al., 2005; Kessler et al., 2005; Kessler et al., 1994; Smith et al., 2006). Beyond the basic examination of the association between race/ethnicity and the prevalence of psychiatric disorders, little research exists to describe how individual perceptions of race/ethnicity and associated cultural experiences influence the risk of developing psychiatric disorders among members of minority groups.

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Two constructs that might be especially important determinates of psychological adjustment among racial/ethnic minorities are ethnic identity and acculturation. Ethnic identity refers to one's sense of self in broad terms including culture, race, language, or kinship (Burlew, 2000) and applies across multiple racial and ethnic groups (Phinney, 1989, 1996). The key elements of ethnic identity include: self-identification as a group member; attitudes and evaluations relative to one's group; attitudes about oneself as a group member; extent of ethnic knowledge and commitment; and ethnic behaviors and practices (Phinney, 1991). Two opposing hypotheses exist related to the influence of ethnic identity on psychological adjustment. Namely, (1) a strong ethnic identity may be protective in that it promotes positive psychological adjustment by buffering against stressors to which ethnic minorities may have increased exposure or (2) a strong ethnic identity may intensify stressors by emphasizing one's difference from the majority culture and escalating the stress of minority status (Phinney, 1991). Past research has generally supported the former, i.e., the buffering hypothesis, finding that a strong ethnic identity is associated with positive aspects of well-being (Smith and Silva, 2010) and reduced depressive symptoms (Mossakowski, 2003). Weaker associations have been found between ethnic identity and measures of other mental health symptoms (Smith and Silva, 2010). One study reported the association between ethnic identity and psychological adjustment varied by the component of ethnic identity being examined; the ethnic affirmation component of ethnic identity buffered against the effects of stress on self-esteem and the ethnic identity achievement component of ethnic identity exacerbated the effect of stress on self-esteem (Greene et al., 2006). Another study found that the association between ethnic identity and psychological adjustment, as assessed by a 10-item inventory on the prevalence of negative feelings, varies by age (Yip et al., 2008). Nonetheless, there is some evidence supporting the latter hypothesis. Specifically, those with a stronger ethnic identity report lower situational well-being (i.e. lower positive affect) when under increased stress (Yoo and Lee, 2008). Taken together, these previous studies examining associations between ethnic identity and psychological adjustment have focused on well-being, self-esteem, and mental health symptoms; however, to our knowledge, no study has examined the relationship between ethnic identity and psychiatric and substance use disorders as assessed by the DSM-IV.

The construct of acculturation refers to the acquisition of the cultural elements of the dominant society (Lara et al., 2005). Research on acculturation in Latino and Asian samples has generally found that greater acculturation has a negative effect on health behaviors, including substance use, poor diet, low birth weight and medical morbidity (Lara et al., 2005; Salant and Lauderdale, 2003). However, research on the relationship between acculturation and mental health outcomes has been inconclusive (Lara et al., 2005; Salant and Lauderdale, 2003). Many acculturation studies have used single items assessing English proficiency and/or time since immigration as a proxy for acculturation, which likely oversimplifies the acculturation process. Additionally, previous studies of acculturation have been limited by their focus on Latino populations, and more recently among Asian immigrants, while little attention has been given to acculturation among Black individuals. Although the majority of Black individuals in the United States are not immigrants, and English is their primary language, Black individuals do have unique aspects to their culture that differ from that of the majority culture that warrant their inclusion when examining the association between acculturation and psychological adjustment. More research is needed to clarify the relationships between ethnic identity, acculturation, and psychiatric and substance use disorders.

While the existing literature suggests that a strong ethnic identity may have a positive effect on psychological adjustment, research on the relationship between acculturation and psychological adjustment is inconclusive. Past research is limited in that it has not examined the associations of ethnic identity and acculturation with multiple DSM-IV psychiatric and substance use disorders, studies have focused their examinations of these concepts on one racial/ethnic group, and they have used varying methodological approaches and measures. In this study we use data from Wave 2 the National Epidemiologic Survey on Alcohol Related Conditions (NESARC), a large population-based survey, to examine the association between ethnic identity and acculturation and major psychiatric disorders among "Black, non-Hispanic", "Hispanic, any race", and "Asian, non-Hispanic" adults in the U.S.

2. Methods

2.1. Design and study sample

NESARC is a nationally representative prospective longitudinal survey, conducted and sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), designed to study alcohol and drug problems and their associated psychiatric comorbidities. Lay interviewers from the U.S. Census Bureau administered the NESARC in English in face-to-face interviews using laptops with computer assisted personal interviewing (CAPI). All potential NESARC participants were informed in writing about the nature of the study, the statistical uses of the survey data, the voluntary aspect of their participation and the federal laws that provide for the confidentiality of identifiable survey information. The research protocol, including informed consent procedures, received full ethical review and approval from the U.S. Census Bureau and the U.S. Office of Management and Budget. The NESARC data were obtained without identifying information about the individual study participants.

NESARC respondents included non-institutionalized civilians, 18 years and older, living in the U.S., including the District of Columbia, Alaska, and Hawaii. Wave 1 of NESARC was conducted between 2001 and 2002, in which 43,093 individuals were interviewed with a response rate of 81.0%. Wave 2 of the NESARC was conducted between 2004 and 2005, and consisted of 34,653 individuals (a response rate of 86.7%). Black and Hispanic households were oversampled. In households where young adults resided (age 18–24 years), the young adults were sampled at a rate of 2.25 times that of other members of the household. The NESARC sample was weighted to adjust for the probabilities of selection and non-response. Once weighted, the data were representative of the U.S. population for region, age, sex, race, and ethnicity, based on the 2000 Decennial Census of Population and Housing. Additional details about survey methodology have been described elsewhere (B. F. Grant et al., 2006). The ethnic identity and acculturation items were only assessed at Wave 2, therefore only Wave 2 data is used in this study. The present analyses were based on individuals who self-identified as "Black, non-Hispanic", "Asian/Native Hawaiian/Other pacific islander, non-Hispanic", "Hispanic, any race" and had complete data on the ethnic identity and acculturation measures.

2.2. Measures

2.2.1. Psychiatric disorders

NESARC diagnoses were made according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994) by using The National Institute on Alcohol Abuse and Alcoholism Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version (AUDAIS-IV), a diagnostic interview designed for use by lay interviewers (B. F. Grant et al., 2003). The reliability of various modules of the AUDADIS-IV has

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