Commentary: When in Rome? Integration and the rates of mental illness in black and minority ethnic youth

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Rates of mental illness vary in different ethnic groups within a country. The risk of mental illness and the overall rate in a group are influenced by at least four dimensions: individual factors; ecological factors; interactions between individual and ecological factors; and time. Groups with different histories, reasons for migration, social realities, school performance, family supports, maturational trajectories, cultures and...
religions may have different balances of risk factors and different rates of mental health problems. The impact of particular risk factors may vary. The rates of illness reflect an interaction of multiple factors at multiple levels.1

There has been a particular interest in the rates of mental illness in black and ethnic minority youth. This is in part because at least 50% of mental illnesses start in childhood, but also because there is a cultural, some would say human, imperative to do the best that we can for our children.2

Bhui et al.’s3 article originates from the determinants of adolescent well being and health study in London which has been a trailblazer in trying to understand the social factors linked to mental illness in black and ethnic minority youth. It investigates whether integration—a hot topic—is good for youth mental health. It reports that certain black and ethnic minority groups have lower rates of problems than their white peers. And that integrated black and ethnic minority youth, that is, those that have friends from other ethnic groups as well as their own, have the lowest levels of mental health problems. In addition, mental health improved for black and minority ethnic youth between the ages 11–13 and 13–15 years.

Despite exposure to more social risk factors this and other studies have reported that black and minority ethnic youth generally have the same or lower rates of mental health problems when compared with white youth in the UK.3,4

There are two main methodological issues of concern.

The first is the possibility of measurement error. Measuring mental health problems in youth is difficult. Most youth with psychological symptoms do not have mental health problems. The Strengths and Difficulties Questionnaire, which was used in the current study and that was developed in London, has been used internationally and is well regarded.3,5 However, its website does not report a cross-cultural validation in the UK (http://www.sdqinfo.org/py/doc/c0.py). Because of this some will question whether the rates of problems in black and minority ethnic populations are an artefact of measurement. But measurement error is unlikely to explain why rates of illness decrease over the follow-up period when for white populations they generally increase through adolescence.

A further issue is the exact nature of the mental health advantage. There may be lower rates of common mental disorders in black and minority ethnic youth but higher rates of other more severe problems such as psychosis.4 And in the common mental disorders literature all but one of the peer-reviewed studies in the UK sample city populations. And that national study has small numbers of ethnic minority youth.6

In the UK, nearly all the black and minority ethnic groups live in cities. However, only three-quarters of the white population live in cities and there are significant differences between white urban and rural groups.7 The findings may be more accurately characterized as black and minority ethnic youth living in cities are less likely to report common mental disorders than white youth living in the same areas.

Put like that, the findings may seem less surprising. We know that economic migrants and refugees to high-income countries tend to be intelligent, resilient and resourceful. They move into poorer environments vacated by parts of the host population that have done well for themselves. Black and minority groups stay in these areas because of the support they offer and because upward mobility is more difficult. In a poor inner city area, black and minority ethnic populations may have more diverse backgrounds but the white population may be less diverse because of selective migration out by the more successful. The mental health advantage may reflect the impact these differences in population have on rates of mental illness. In addition, because economic mobility and residential mobility may be slower for black and minority ethnic groups than white populations, controlling for poverty and socio-economic status as is done in Bhui et al.’s3 study and many others may actually increase the chance of finding a health advantage for black and minority ethnic groups.

If these methodological issues are not an explanation, then we are left with trying to understand what common factors disparate black and ethnic minority youth populations have which may convey a mental health advantage.

Some of the things these groups tend to have in common such as the experience of racism and lower social class and material wealth seem unlikely candidates for conferring a mental health advantage. Others, such as a supportive family—though the shape of the family takes a number of different forms—the fact that they are more likely to be religious and they are generally less likely to have substance misuse problems may offer an advantage.

And these factors may interact. Pascoe and Richman’s review and meta-analysis demonstrates that identity and social support moderate the association between risk of illness and exposure to racism.8 Noh et al.9 have reported that the risk of common mental disorders linked to exposure to racism is lowest in youth that have pride in their cultural heritage as well as a mastery of the new culture. Adolescence is a time when identity is very important.

Individual level factors such as identity, family and mastery may further interact with ecological level variables. Evidence demonstrates that the rate of mental illness is lower for black and ethnic minority groups in areas where the density of the immigrant population is higher.10 Such density effects are less pronounced for the host population. It takes a community to bring up a child; part of this is through the availability of guidance and support in adolescence.
but the efficacy of community also seems to have an impact on children and this is related to ethnic density.\textsuperscript{11}

Social efficacy is a form of social capital and other forms of social capital have also been raised as a possible reason for integrated youth reporting better health.\textsuperscript{3} There are many definitions of social capital and many different forms.\textsuperscript{12} Bonding social capital, which reflects thick ties between people such as family bonds, has been reported to be less important in common mental disorders than bridging social capital—in which links are made between different groups. Bridging social capital may be between groups with the same access to resources—horizontal bridging social capital—or groups with different access to social resources—vertical social capital.\textsuperscript{12}

Inequities may be produced by differences in access to resources. If this is the case, then lower rates of mental illness in integrated youth may be a result of building vertical social capital. They may be increasing their access to resources and thus improve opportunities, life experience and so mental health. Accessing different social networks also offers youth from black and ethnic minority groups a chance to practise the skills they will need to survive going forward.

If social capital follows the rules of capital investment it may grow over time. A greater yield could be expected throughout adolescence. Youth with friends that span other ethnic groups would have better mental health in the future because of their earlier access to vertical resources. Their more integrated social networks pay benefits for them initially and over time.

But the truth is at the moment we have little hard evidence as to why black and minority ethnic groups generally seem to have lower levels of common mental health problems than expected. It is tempting to argue in a post-modernist world where youth have to build their own identities that the certainty of having clear cultural roots and a community helps children through what is a difficult period.

They say that when in Rome do as the Romans do. But it seems that for black and ethnic minority youth pride in your culture, having a supportive cultural group as well as doing what the British do seems to be the best bet.

What black and ethnic minority groups are doing with their children and adolescents seems to be effective in protecting their mental health. I, for one, would like to know more about this; how it works and whether we can bottle it?

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References