

# **New Directions. Issues of Gender, Ethnicity, Discrimination and Acculturation**

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*Much of the theorizing on stress and its impact on psychological adjustment and health focuses primarily on individual differences in exposure and on the roles that a variety of psychosocial moderators and mediators play in accounting for differences in the outcomes of interest. Less attention is given to the analysis of macrolevel variables such as gender, ethnicity, and socioeconomic status that condition the exposure, experience, response, and impact of life stresses in stress-disease models. The three papers in this section expand current models of stress and disease by investigating several hypotheses about the roles that gender, ethnicity, discrimination, and acculturation play in accounting for group differences in psychological distress and dysfunction in subjective and objective indicators of health problems and depression, and in teen drug use.*

In the first chapter, Jackson, Williams, & Torres tackle the complex problem of accounting for racial/ethnic inequalities in health by investigating the relative contributions of two types of social stressors-- (1) exposure and experiences of discrimination, and (2) social and economic disadvantage-- on multiple indicators of functional health status as mediated and/or moderated by a number of theoretically meaningful psychosocial resources. Specifically, they conducted a series of theoretically driven analyses to determine whether exposure to or the characteristics of the experience of racial discrimination (i.e., number, chronicity and perceived stressfulness) would account for differences in overall stress (i.e., number of life events) and in functional health outcomes (i.e., depressive symptoms, depressive disorders, number of chronic illnesses, life satisfaction, subjective health status), *independent of social status variables*. They also investigate whether these contributions are mediated or moderated by perceived self-efficacy, emotional support, strength of religious beliefs, and disposition towards action in response to discrimination. Comparisons are made between nonwhites, whites vulnerable to discrimination, and non-vulnerable whites.

The results are complex and confirm several of the hypotheses. For example, the results confirm expectations that nonwhite ethnics make more reports of discrimination than either group of whites, that whites do experience discrimination, but that the links between ethnic group and negative health outcomes are direct and significant only for nonwhites. However, contrary to expectations, self-reported discrimination does not explain the ethnicity-health outcome independent of social status indicators. The one partial exception is depressive symptoms, but this exception is mediated by the frequency and stressfulness of the discrimination experiences. In addition, tentative support exists for the hypothesis that psychosocial resources, especially self-efficacy and social supports, exert a protective effect-- especially for whites-- while a disposition to action in response to discrimination is associated with an apparent exacerbation of life stresses. This apparent “stress-generation” effect was unexpected and merits further investigation. The evidence also suggests that self-efficacy can

buffer the stress proliferation effect among those coping with discrimination, but only in vulnerable whites.

This work expands the discussion of the role that racism-related stressors play in health status by placing their effects in the context of other health-status predictors, mediators and moderators. The study demonstrates that these effects are not restricted to nonwhites, but that the pattern of effects differs across groups. It is worth noting, however, that some of the effects for the vulnerable whites group are open to debate because of problems with the definition of this group: the authors include Hispanics and Asians, whom they identify as protected minorities, in the vulnerable white group. This is a debatable decision that potentially confounds the results. Hispanics and Asians are classified by public policy as ethnic minorities that suffer varying degrees of direct and institutional discrimination, and very likely are the ones that account for the majority of the experiences of discrimination in the vulnerable white group. As people of color, at least within the sociopolitical context of the United States, including them with other ethnic whites can barely be justified and misses the opportunity to test for differences among the various non-white groups.

Also, in light of the substantial epidemiological evidence on this issue and the arguments posed later by Rosenfield, the effects of discrimination are likely mediated not only by socioeconomic achievement but also by gender and age. This is especially true given the inclusion of depression symptoms and depressive disorder as outcomes, with the prevalence of both consistently linked to gender. Increasing evidence also points to differences in exposure to racism and discrimination and response to discrimination as a function of age. For example, older African Americans typically report experiencing fewer incidents of discrimination due to their race, they are more likely to attribute mistreatment to their age or gender or both than to race, and they are somewhat less likely to react aggressively to such incidents.

In addition, models testing the effects of discrimination and social status stressors on health need to account for the effects of other chronic and episodic stressors on functional health outcomes. One of the most interesting questions the field must address is whether exposure to racial/ethnic discrimination is a qualitatively different type of stressor that confers additional health risk above and beyond that already accounted for by other chronic life stresses. What makes ethnic minority status especially deleterious to health is the additional burden of stress attributable to this unique social status. These discriminatory experiences not only confer additional burden of risk, but also can exacerbate the health effects of other social status and nonracial stressors (e.g., economic deprivation, job stressors, family stressors). It is important to appreciate this complexity of effects, which likely accounts for the consistent racial health differentials noted in the epidemiological literature.

In the second paper, Vega, Zimmerman, Warheit & Gil investigate the role of acculturation and acculturative stresses in predicting Latino adolescent drug use by testing a theoretically sophisticated and complex conceptual model using sophisticated statistical modeling techniques. They note, correctly, that much of the work on the role of acculturation in health and functional adjustment is based on false assumptions and suffer from a variety of conceptual and methodological problems that limit the generalizability of the findings and the strength of the conclusions that can be drawn. Focusing their attention on teen drug use, they propose and test a model that includes level of acculturation and acculturative stresses as independent constructs, as well as most of the major risk and protective factors known to be implicated in licit and illicit substances.

Their results confirm the fact that immigration experiences and status, level of acculturation, and acculturative stresses are distinct but related constructs, and that risk for substance use in young Latino teens is influenced by a complex interaction of parental, family, and peer factors, only some of which are mediated through acculturative process pathways. *Particularly noteworthy are the findings of the effects of family socioeconomic status (SES), parental level of acculturation, and family support on risk for early initiation of licit substance use as mediated through teen level of acculturation and acculturative stresses. Especially noteworthy in those findings are the complex and somewhat counterintuitive and contradictory relationships between parental SES, parental and child level of acculturation, and teen risk for drug use.* For example, when higher family income is associated with higher parental acculturation and higher parental acculturative stresses, it is also associated with higher parental alcohol use and family drug problems, more acculturated teens, and lower family support; these in turn are associated with increased risk for early substance use initiation. However, higher SES, traditional two-parent families provide more social support and have lower acculturated teens, factors which appear to provide greater protection against substance use initiation. Thus, higher parental acculturation is associated with both positive (i.e., more parental substance use and more acculturative stresses) and negative (i.e., higher income and more social supports) contributors to *risk* for teen drug use contingent on other parental, family, child, and peer mediators.

*This study makes significant conceptual and methodological contributions to research on acculturation, stress and functional outcomes in Latinos. However, the model needs to be expanded to address a number of other important issues, including gender, age, national origin, and community of residence.* For example, the current study does not investigate possible gender differences in pathways of risk. Extant evidence places Latinos at substantially lower risk for substance use, probably because of parental and other family forces that afford more effective protection for girls than for boys.

Also, substantial evidence points to age related differences in risk-- including results from this study. Thus, additional research is needed to test for differences in the pathway of effects of acculturation and acculturative stresses at different developmental stages.

In their earlier work, Vega and colleagues reported important differences between Cubans and Nicaraguans in Dade County, which suggests that a different pattern of relationships between the factors in the model might be expected between Latino groups that differ in nationality and in their immigration experiences in the United States (e.g., Cubans, Nicaraguans, Puerto Ricans, Dominicans, Mexicans, Mexican-Americans, other Latin Americans). Investigating these within-group differences will be important in advancing the field and identifying general pathways from group-specific pathways of effects.

A third important factor in predicting risk for drug use initiation is the nature of the communities in which the groups are acculturating. Latino immigrant groups establish residence in a variety of different communities, which affect their acculturative experiences and their relative risk for drug exposure. For example, those immigrants who establish residence in relatively homogeneous and traditional Latino communities where drug use is fairly uncommon can be expected to acculturate at a much slower rate and to experience fewer acculturative pressures; Their children are at relatively low risk of exposure to illicit substances, except for alcohol. On the other hand, those who migrate to more ethnically heterogeneous and transitional communities where drugs are more readily available are likely to face greater pressures to acculturate (i.e. to speak English), greater intergenerational conflicts, and greater opportunities for drug experimentation. Thus, the children would be at greater risk for early drug use.

In the last chapter, Rosenfield offers a compelling argument that gender differences in mental health-- that is, greater prevalence of depression in women and greater prevalence of antisocial behaviors in men-- cannot be explained simply by differences in biological vulnerabilities or response tendencies, but also require consideration of social stratification mediated through socialization. She argues that women report more psychological distress and depression than men do because women are socialized to value compassion and caring for the well being of others and greater empathy. This socialization is reflected in their overrepresentation in care-taking jobs and in the assumption of primary responsibility for the care-taking of children and spouses. These roles involve lower social status and power, a greater burden of interpersonal stresses, lower self-esteem, lower perceived power, and thus greater risk for depression.

On the other hand, men are socialized for independence, the pursuit of personal goals, less focus on the needs and concerns of others, higher self-esteem, greater perceived personal power, and lower empathy. Such socialization, in turn, contributes to a greater likelihood of expressing distress through acting-out rather than acting-in disorders.

*These hypotheses are tested on several data sets, with strong support for the hypothesized greater vulnerability to depression in women due to their social orientation toward others rather than toward self, but weaker and less direct support for the hypotheses about antisocial behavior risk in men, at least in terms of self-orientation and low empathy as risk factors.* Compelling evidence indicates that greater depressive distress is experienced by women who carry greater burdens of care-taking responsibilities, who hold jobs with lower autonomy, and who evidence greater emotional responsiveness to the stresses experienced by significant others.

*It is important to note which factors are associated with greater depression in men. Specifically, Rosenfield reports evidence that links husbands' depression to wives' employment and relative contribution to the family's income. Men experience more depressive symptoms when wives contribute more money to the household, while wives report less depression. This evidence supports Rosenfield's contention that depression is linked, at least in part, to issues of power in close relationships. However, I would expand her analysis by suggesting that the results reflect not just changes in power but also changes in role expectations. Increased dysphoric mood in the husbands probably reflects feelings of emotional deprivation, loss of status and power, and confusion over how to cope with these changes. Relatively lower availability and utilization of social supports among men and the difficulties men often experience in dealing with softer feelings (e.g., sadness, pain, self-doubt) contribute to greater distress from such changes in the dynamics of their primary relationships than would be evident in women.*

These cross-sectional analyses reflect short-term, subclinical mood changes and cannot be interpreted as evidence of risk for stable, long-term depressed mood or for syndromal depression. Nevertheless, Rosenfield's paper makes a significant contribution to the ongoing debate about gender differences in risk for depressive distress and depression by advancing theories about the role macrosocial processes play in contributing to differential risk.

A few comments about Rosenfield's analysis of antisocial behavior are in order. *She extends the analysis of self-other social orientation to argue that men are at greater risk for antisocial behaviors in part because of their socialization toward greater self-orientation and the associated lower empathic ability. Rosenfield provides only indirect support for this hypothesis through data on gender differences among teens in comfort with pain and distress in significant others. This analysis of antisocial behavior is relatively weak because it fails to address the roles that anger, hostility, and socialization to greater action and risk-taking in men would play in this disorder.* Men may evidence less empathy than women do, not because of differences in the capacity to experience empathy, but because of greater discomfort expressing softer

emotions. Men are generally more comfortable with and more willing to express their anger overtly and to act on that anger. This behavioral propensity is socialized as part of the definition of masculinity, while the ability to be emotionally supportive and empathic is viewed as a more feminine trait, and thus a potential source of distress. Exceptions to this rule will be situations that can be framed positively, such as being empathic from a position of power and caretaking (e.g. being fatherly, being supportive of a subordinate).

*Another complication in this analysis is the fact that many of the risk-taking behaviors included in measures of antisocial behaviors (e.g., fighting, joy riding, petty theft, demonstrating courage by meeting challenges) are also considered rites of passage for men, especially in some communities and cultures. Engaging in these behaviors confers status and fosters strong ties with peers, while at the same time increasing risk for social penalties (e.g., problems with parents and more prosocial peers, suspension from school, arrests, incarceration) as the frequency and severity of the behavior increases. Thus, the socio-structural contributions to risk for antisocial behavior are mediated through a variety of complex mechanisms of male socialization, of which self-other orientation and empathy constitute one likely pathway. It would be interesting to determine in future, prospective studies how important these risk factors are compared with other more proximal factors suggested above.*

## **Summary and Implications for Future Research, Treatment, and Prevention**

The three chapters in this section make significant contributions to the growing body of evidence that macrosocial processes, related to gender, ethnicity and ethnic discrimination and to acculturation and acculturative stresses, are important contributors to the observed differentials in health and illness and in the risk and protective factors associated with these functional outcomes, depression and anti-social disorders. Differential exposure to ethnic/racial discrimination confers risk for distress and dysfunction both directly and conditioned by socioeconomic status, as well as mediated by psychosocial resources. Acculturative processes in non-U.S. born Latinos, and probably other immigrants as well, interact in complex ways with parental, familial and personal characteristics to confer risk for early substance use initiation. Finally, gender stratification confers differential risk through the mechanisms of gender role socialization, which in turn shapes social burdens and social orientations to account for differences in risk for depression and antisocial disorders.

To advance the field, future theoretical models of stress and health need to include consideration of gender and ethnicity as factors in both socio-structural and individual differences factors. These factors are likely to directly impact stress exposure and to shape patterns of responses and coping, the availability and utilization of resources for coping, and the interplay of these factors to predict health/disease outcomes. It is particularly important that future research investigate within-- as well as between-- ethnic group differences in risk and protective factors, and develop more sophisticated measures of socio-cultural experiences such as racism and discrimination, acculturation and acculturative stresses, as well as more sensitive measures of social status variables.

In the final analysis, the ultimate goal of this research is not just to explain group differences in relative health status and risks for dysfunctional health outcomes, but also to reduce, if not eradicate such differences. Jackson et al.'s analysis indicates that the experience of discrimination, especially in the context of socioeconomic deprivation, has demonstrably pathogenic effects, but that these effects can be moderated and mediated by psychosocial resources. This directs attention in future research to developing and testing intervention strategies that are effective in fostering greater self-efficacy, more effective resources for support, and better management of the negative consequences of action in the face of discrimination. To reduce the health risks that accompany action in the face of discrimination specifically requires preparation for coping with subsequent increases in negative life events. As suggested by Vega et al., efforts to prevent acculturation-related risks need to go beyond information dissemination targeting youth to include strengthening the family and fostering family cohesion and support in the face of the changes that come with increasing acculturation. Finally, Rosenfield's analysis points to changing gender role expectations and socialization as a target for interventions designed to prevent or reduce gender differences in risk for mood and antisocial disorders.