
A SNAPSHOT OF BEHAVIORAL HEALTH ISSUES FOR ASIAN AMERICAN/ NATIVE HAWAIIAN/PACIFIC ISLANDER BOYS AND MEN: JUMPSTARTING AN OVERDUE CONVERSATION

PURPOSE OF THE BRIEF

As part of the Substance Abuse and Mental Health Services Administration's (SAMHSA) efforts to promote behavioral health equity and to support President Obama's "My Brother's Keeper" Initiative to address opportunity gaps for boys and young men of color, SAMHSA and the American Psychological Association co-sponsored the "*Pathways to Behavioral Health Equity: Addressing Disparities Experienced by Men and Boys of Color*" conference in March 2015. The purpose of the conference was to address the knowledge gap on behavioral health and overall well-being for boys and young men of color. Issues discussed included (a) gender and identity, (b) social determinants of health and well-being, (c) mental health, substance use, and sexual health, (d) misdiagnosis, treatment bias, and the lack of culturally competent screening instruments and treatment strategies in behavioral health, (d) the impact of profiling and stereotypes on behavior, and (e) unique culturally based strategies and programs.

This brief highlights these issues specific to Asian American, Native Hawaiian, and Pacific Islander (AANHPI) boys and men. This is a diverse population that is often overlooked, underserved, and not well understood. The challenges specific to AANHPI males need to be elevated, and strategies to

address these issues need to be documented.

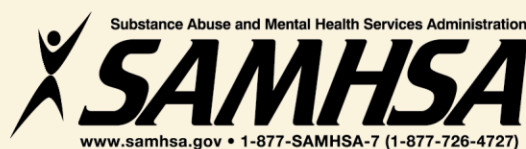
Recognizing that this brief is not a comprehensive, in-depth discussion of all the pertinent behavioral health issues for each AANHPI subgroup, this brief represents a start to a much overdue conversation and action strategy.

WHO IS THIS BRIEF FOR?

The primary audiences for this brief are policy-makers, clinicians and practitioners, researchers, national/regional and state leaders, community leaders and consumers, and men and boys of color and their families and communities.

WHO ARE ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS?

The AANHPI population consists of over 50 distinct ethnicities in the U.S. Historically, Asian Americans, Native Hawaiians, and Pacific Islanders have been lumped into an umbrella racial category. Since 2000, the U.S. Census made the Native Hawaiian and Pacific Islander (NHPI) a distinct racial category from the Asian American category.

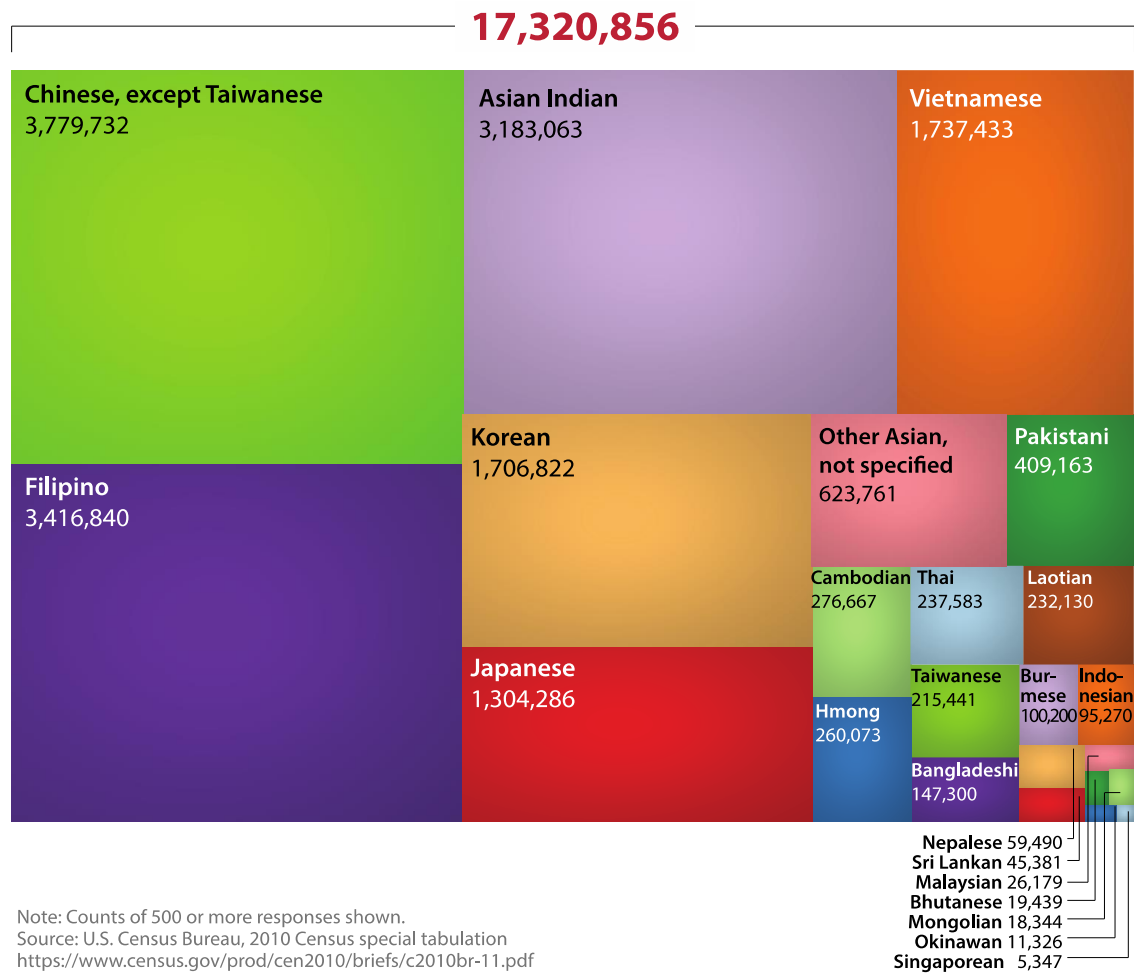


SOME HIGHLIGHTS ABOUT THE AANHPI POPULATION INCLUDE:

- Asian Americans are the fastest growing racial/ethnic minority group in the U.S. Currently, there are 17.3 million Asian Americans, comprising nearly 5% of the total U.S. population, with an additional 4 million identifying as multiracial Asian Americans.¹
- The largest racial groups include (in order): Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, Pakistani, Cambodian, Hmong, and Laotian.¹
- The population of Asian Americans (alone or in combination) is projected to increase to 48 million, or 11.7% of the U.S. population by 2060.²
- The total population of NHPs, including those of more than one race, was 1.4 million of the U.S. population.³
- There are approximately 518,000 Native Hawaiians, 174,000 Samoans, and 108,000 Guamanians or Chamorros in the U.S.³
- By 2060, there will be more than 2.9 million people of Native Hawaiian and Other Pacific Islander heritage in the U.S.²

The Asian Population in the United States

Counts of detailed responses: 2010

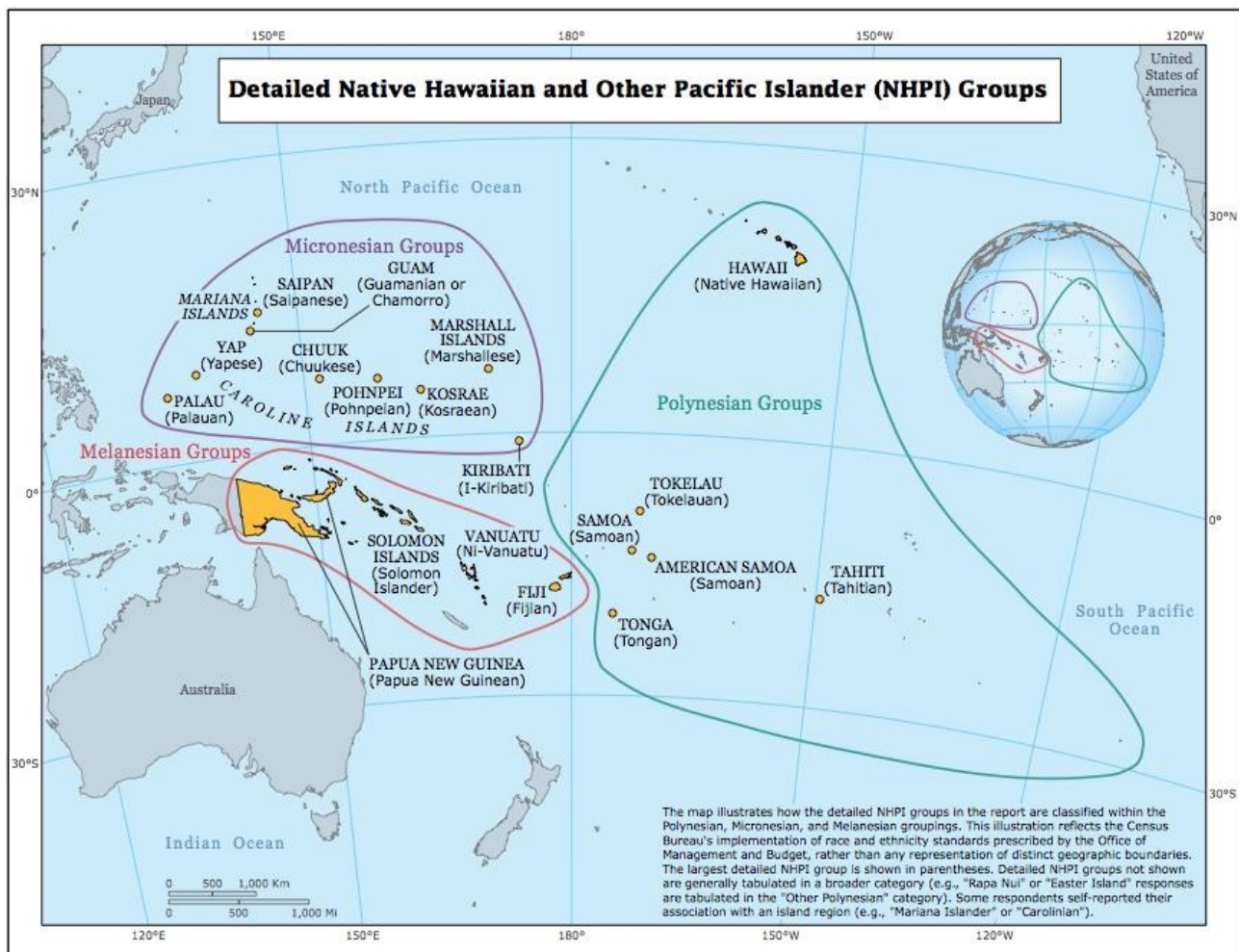


AANHPI HISTORICAL CONTEXT AND GENERATIONAL CONSIDERATIONS

Each Asian American community has a unique historical context and experience in the U.S.:

- The first Asian American arrivals in the U.S. were Filipinos (1587), Chinese (1840s), Japanese (1860s), Asian Indians (1880s), and Koreans (1940s). Most of these early immigrants were laborers who worked in very poor conditions on railroads and in canneries, farms, and mines,⁴ and some were students or sojourners who expected to return to their countries of origin.
- The Chinese Exclusion Act of 1882 and the 1924 Immigration Act limited the number of Asian immigrants into the U.S., essentially halting Asian immigration for several decades.⁴

- The Immigration and Nationality Act of 1965 abolished national quota systems, resulting in a resurgence of Asian immigration, consisting primarily of educated individuals in health and science careers (e.g., doctors, nurses, and engineers).⁴
- In 1975, Southeast Asian refugees (primarily from Vietnam, Cambodia, and Laos), fleeing wars, oppression, and other tragic conditions, began to resettle in the U.S. They usually came without formal education, money, or resources.⁴
- Today, Asians immigrate to the U.S. for a variety of reasons, many joining family members who have already settled in various parts of the U.S., especially California, New York, New Jersey, Hawaii, and Texas.⁴



ADAPTED FROM HIXSON, L., HEPLER, B.B., & KIM, M.O. (2012). THE NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER POPULATION: 2010. WASHINGTON DC: U.S. CENSUS BUREAU.

For Native Hawaiians and Pacific Islanders, historical context includes American colonization, resulting in unique experiences in both the mainland U.S. and their native Pacific Islands.

- The U.S. acquired Hawaii and Guam after the Spanish American War of 1898. Hawaii remained a U.S. territory until it became the 50th state in the U.S. in 1959, while Guam officially became a U.S. territory in 1950.⁵
- The U.S. acquired the islands of Tutuila in 1900 and the island of Manu‘a in 1904. In 1929, the U.S. declared the islands as American Samoa and it became a U.S. territory.⁵
- In the 1950s, Native Hawaiians, Chamorros, Samoans, and Other Pacific Islanders began migrating to the U.S. mainland in search of economic and educational opportunities. Today, most Pacific Islanders in the U.S. reside in Hawaii or California.⁵

EMPHASIZING THE DIVERSITY OF THE AANHPI POPULATION

When discussing AANHPIs, it is critical to recognize the heterogeneity of the group. AANHPIs are not all the same. Rather, this group consists of:

- Over 50 unique countries of origin, with distinct languages, cultural values, family customs and traditions, indigenous practices, and colonial histories.
- Over 20 major religions, including Hinduism, Buddhism, Sikhism, Catholicism, Taoism, Confucianism, Protestant Christianity, animism, and polytheism.
- A diversity of phenotypes and physical characteristics, including a spectrum of skin tones, eye shapes, hair textures, and other traits.
- A range of generations – from recent immigrants to 4th generation AANHPIs in the U.S.
- A spectrum of sociocultural experiences in the U.S., including racism, discrimination, and exclusion. While widespread among the AANHPI populations, discrimination and racism are often directly targeted at immigrants, refugees, and individuals who do not speak English well.⁶

- A range of educational experiences and opportunities, with some groups attaining the highest levels of education, while other groups receiving limited education and experiencing high rates of high school dropouts.⁷
- A range of socioeconomic status, with AANHPIs represented among the wealthiest and the most impoverished groups in the U.S.⁷ Challenges related to socioeconomic status include low incomes (especially among some Southeast Asians and NHPs), under-employment, relatively low salaries compared to education level and other qualifications, and barriers to upward mobility in employment, especially at the higher levels (in particular for Asian Americans).⁸
- Variations in the prevalence of physical chronic diseases for many AANHPI subgroups; for instance, Filipino Americans and NHPs report higher prevalence of cardiovascular disease, obesity, and diabetes than East Asian Americans.^{9,10}

A simplistic, stereotypical understanding of the AANHPIs does a disservice to the many cultures represented and their unique strengths, traditions, and values. It also obscures the disparities in economic and educational attainment and psychosocial well-being, often generating biases that limit opportunities and minimize health and behavioral health issues.

BEHAVIORAL HEALTH CONCERNS FOR AANHPI MEN AND BOYS

The National Latino and Asian American Study (NLAAS) was the first large national dataset that investigated the mental health statuses of Latinos and Asian Americans. While they did not examine experiences of NHPs, some findings on Asian Americans have been notable:

- 17.2% of Asian American men reported any lifetime presence of a psychiatric disorder, such as depression, anxiety, or a substance abuse disorder, which is similar to Asian American women (17.4%),⁶ but well below the U.S. national average of 46% for both American men and women of all racial groups.⁶

- Asian American men who spoke English well were less likely to report lifetime psychiatric disorders compared to men less fluent in English.⁶
- On the contrary, Asian American men who were born and raised in the U.S. were more likely to report some sort of psychiatric disorder, particularly substance use disorders, than Asian American immigrant men.⁶

Given this, it is important to understand how behavioral health manifests through different psychological symptoms, as well as for different AANHPI subgroups.

DEPRESSION

Several studies have focused on depression and the Asian American community, but few have focused on the NHPI community. Some studies that have examined experiences of Asian American men reveal:

- Asian American male college students were more likely to suffer from depression than their female counterparts.¹¹
- Asian American men who endorsed masculine gender role norms reported higher levels of depressive symptoms,¹² supporting the notion that pressure to conform to gender role norms can be detrimental to Asian American men's psychological health.

Disaggregating data is necessary to understand the different patterns of depression among the various AANHPI subgroups.

- South Asian men tended to experience more psychological distress when they had greater financial strain, higher family cultural conflict, and lower self-rated social position in the community.¹³
- Vietnamese, Cambodian, and Laotian refugee men reported a number of risk factors that influenced their depressive and anxiety symptoms, including having a large family in the U.S. (which led to more financial pressures), difficulty adjusting to American culture, and the experience of multiple traumatic events.¹⁴
- When Chinese American adolescent boys are stereotyped as perpetual foreigners, they are often

victimized (e.g., physically assaulted and verbally teased), which increases the risk for depressive symptoms.¹⁵

- Gay Asian American men who experience their racial group as being devalued were more likely to report depressive symptoms and were also more likely to engage in risky sexual behaviors than those who did not view their racial group as devalued.¹⁶
- While Native Hawaiians reported more depressive symptoms than Whites, there were no gender differences between Native Hawaiian men and women on depressive symptoms.¹⁷

SUICIDE

In general, AANHPI men have been found to have lower suicide rates than men from other racial groups. Despite this, there are unique factors that affect how suicide manifests for men and boys.

- The most at-risk Asian American male age group for suicide was Asian American men between ages 75 and 84 years (42.1 per 100,000), which is over 4 times the rate for Asian American men overall (8.8 per 100,000).¹⁸
- Reports indicate that men in Hawaii die by suicide more often than females (3:1 ratio),¹⁹ while males comprise 90% of suicides in Guam.²⁰
- In Western Samoa, the rate of suicide for every 100,000 people was similar (64 males and 70 females), but in Guam, almost 5 times more young men aged 15-24 years died by suicide than young women (49 males compared to 10 females per 100,000 people).²¹
- In Micronesia, there were 11 times more young men who died by suicide than young women (91 males versus 8 females), and in Chuuk State, Federated States of Micronesia, young men aged 15-24 years died by suicide 11 times more than females (182 males versus 12 females).²²

SCHIZOPHRENIA

While the national prevalence of schizophrenia among AANHPI populations is unknown, community studies reveal patterns among selected groups of AANHPIs.

- In Hawaii, Chinese, Japanese, Filipinos, and Native Hawaiians had significantly lower rates of schizophrenia than Whites. However, in disaggregating the data, it was found that:
 - ❖ Native Hawaiians had significantly higher hospitalization rates than the Asian American groups,
 - ❖ Filipino and Japanese Americans reported the highest severity of illness, and
 - ❖ Chinese, Japanese, and Filipino Americans have longer lengths of hospital stays, in comparison to Whites.²³
- In California, rates of schizophrenia for Filipinos (23.8%) were higher than the rate for African Americans (20%).²⁴
- In New York City, Asian Americans were three times more likely to be diagnosed with schizophrenia than Whites.²⁵
 - ❖ Higher percentages of Asian Americans were admitted through emergency rooms than all other racial groups.²⁶
 - ❖ When hospitalized, Asian Americans were about 70% less likely to utilize inpatient services but stayed considerably longer than all other racial groups.²⁶
- Asian Americans who experience acculturative stress²⁷ and discrimination²⁸ may be at risk for symptoms of schizophrenia (e.g., visual and auditory hallucinations).
- There is very little schizophrenia research that disaggregates data between Asian American men and women, with the exception of one finding that Asian American men with psychotic symptoms are more likely to use inpatient services than their female counterparts.²⁶
- U.S.-born Asian American men were significantly more likely to have a substance use disorder than foreign-born Asian American men.⁶
- Filipino American men were more at risk for substance abuse issues than Chinese American men.⁶
- Asian American men across various ethnic groups (Chinese, Filipinos, Vietnamese, and Koreans) reported similar levels of alcohol use problems.²⁹
- Chinese and Vietnamese males reported more alcohol problems than their female counterparts, whereas Korean females tended to have more alcohol use problems than Korean men.²⁹
- In California, Pacific Islander middle and high school males (ages 11-18 years) had the highest rate of lifetime smoking (18.7%), past-month cigarette smoking (39.3%), lifetime methamphetamine use (12.8%), and past-month methamphetamine use (11.7%), in comparison to all other racial groups.³⁰
- In California, Pacific Islander middle and high school males (ages 11-18 years) had the highest rates of marijuana use (22%) along with African Americans at the same rate and the highest binge alcohol use rate (22.3%) compared to all other racial/ethnic groups.³⁰
- Gay and bisexual AANHPIs who engaged in substance use were more likely to also engage in risky sexual behaviors than those who did not use substances.³¹

HELP SEEKING ATTITUDES AND BEHAVIORS

In general, the AANHPI populations are less likely to seek professional help for behavioral health issues than all other racial groups. This pattern is particularly evident for Asian American boys and men.

- Asian American women, in general, have more positive help-seeking attitudes than Asian American men.^{32,33}
- AANHPI men report many factors that may affect their help-seeking behaviors, including cultural issues, stigma, the lack of culturally

SUBSTANCE USE AND ABUSE

In comparison to the general population, alcohol use and illicit drug use have generally been found to be less prevalent among AANHPI populations. However, when disaggregating the data, specific trends for different subgroups of AANHPI men emerge:

competent services, gender role conflicts, and racism.³⁴

- Asian American families tend to teach men to be logical, counter-dependent, and less emotionally demonstrative, whereas emotional expression is taught as more acceptable for Asian American women,³⁵ resulting in reluctance for Asian American men to seek help for their mental health issues.

SOCIAL DETERMINANTS OF BEHAVIORAL HEALTH

Many factors may influence a person's ability to attain optimal mental health. For instance, a person's social, economic, and physical environment may either increase or decrease the amount of stress in her or his life. Those individuals who encounter more obstacles are likely to be at greater risk for behavioral health problems (e.g., depression, substance use) than those who have fewer problems and less psychological stress. This next section will focus on several factors that may influence the behavioral health of AANHPI boys and men.

EDUCATIONAL FACTORS

While many Asian American ethnic groups are found to attain college degrees at rates much higher than the general population and compared to other racial/ethnic minority groups, there are many educational disparities affecting Southeast Asians, Native Hawaiians, and Pacific Islanders.

- A high percentage of Southeast Asians have less than a high school education; for example, 59.6% of Hmong did not have a high school diploma, while about half of Cambodians and Laotians (53.3% and 49.6%, respectively) did not have a high school diploma.⁷
- Native Hawaiians and Pacific Islanders have the highest high school dropout rates among AANHPI subgroup at 7.6%, followed by Cambodians and Hmong at 6.7%. Both are slightly higher than Whites (5%), but lower than African Americans (12%) and Latinos (27%).³⁶

Some studies have found gender differences regarding AANHPI men and boys.

- In Washington State, Asian American female students outperform Asian American male students in every subject, particularly in writing, where 82% of Asian American girls meet the standard in writing, as opposed to 68% of boys.³⁷
- In Washington State, 9% of Asian American boys were enrolled in some special English Language Learner (ELL) or special education program, compared to only 5% of Asian American girls.³⁷
- In the Southeastern U.S., Asian American girls reported significantly higher educational goals, intrinsic academic motivation, and perceptions of school as useful for their future compared to boys.³⁸

Stereotypes may affect educational outcomes and general school experiences:

- Samoan, Native Hawaiian, and Filipino youth, particularly males, reported that teachers stereotyped them as gang members or lazy.³⁹
- Southeast Asian males report being stereotyped by teachers and counselors as troublemakers or unmotivated, resulting in lack of support in their academic performance.⁴⁰
- Hmong male students reported that their teachers and counselors stereotyped them as gangbangers, while Hmong female students were encouraged and cared for.⁴¹
- Filipino American male high school students in California believed their counselors and teachers viewed them as delinquents, failures, or gang members and therefore did not encourage them to go to college; while Chinese American males in the sample reported that their teachers were caring and encouraged them to attend college.⁴²

While bullying affects both AANHPI boys and girls, it is crucial to examine how bullying may affect behavioral health and academic performance for AANHPI boys.

- Of students who report being bullied, Asian American students report more than any other racial group that the bullying is because of race.⁴³
- 17% of Asian American youth reported being violently victimized (e.g., had a gun/knife pulled on him, stabbed, cut, or jumped at least once in the past year).⁴⁴

College attainment varies widely among the AANHPI community:

- While 27% of all Americans over age 25 years have attained a college diploma, 44% of the Asian American population attained a college degree.
- However, only 14% of Cambodian, 14% of Hmong, 12% of Laotians, 16% of Guamanians or Chamorros, 16% of Native Hawaiians, and 10% of Samoans have college degrees.⁴⁵
- While the majority of Asian American college students prior to 2000 were male, the number of Asian American females with undergraduate and graduate degrees has surpassed that of Asian American men.³⁶

INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM

There are disturbing trends regarding AANHPI individuals, particularly males, in the criminal justice system.

REGARDING ARRESTS:

- Samoan youth had the highest rates of arrests of any ethnic group in the San Francisco Bay Area (San Francisco County and Alameda County), followed by African Americans, Laotians, and Vietnamese.⁴⁶
- In the year 2006, Samoans were reported to have the highest arrest rate of any racial/ethnic group in San Francisco, at 140 arrests per 1,000 people. In fact, compared to White youth, Samoan youth were 11 times more likely to be arrested.⁴⁷
- Southeast Asians had the next highest arrest rates, including Cambodians (63 per 1,000), Laotians (52 per 1,000) and Vietnamese (28 per 1,000 people).⁴⁷

REGARDING INCARCERATION:

- On a national level, U.S.-born Laotian and Cambodian men, ages 18-39 years, are reported to have the highest incarceration rate of all AANHPIs, at 7.26% of their total population.⁴⁸
- The number of U.S.-born Vietnamese men, ages 18-39 years, who are incarcerated is 5.6% (in comparison to 0.46% of foreign-born).⁴⁸

- U.S.-born Indian American men who dropped out of high school, ages 18-35 years, had higher rates of incarceration (6.7%) than foreign-born Indian American male high school dropouts (0.3%).⁴⁸
- In Hawaii, Native Hawaiian boys represented over half of those in the juvenile justice system (53.1%), even though Native Hawaiians comprise only 30% of the total population in Hawaii.⁴⁹
- In California in 2010, most incarcerated adult Asian American males were incarcerated as first admissions (not incarcerated previously) rather than parole violators.⁵⁰
- Filipinos were the largest subgroup of Asian American incarcerated adult males ($N=386$), and about 25% were incarcerated for parole violation.⁵⁰
- Vietnamese were the second largest subgroup of Asian American incarcerated adult males ($N=307$), and about 26% were incarcerated for parole violation.⁵⁰

RACIAL MICROAGGRESSIONS

Racial microaggressions are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group. In recent years, microaggressions have been found to negatively impact various historically marginalized groups, including AANHPI boys and men, with people who experience microaggressions reporting more mental health issues, self-esteem issues, binge drinking, and other negative outcomes.⁵¹ While there are many types of microaggressions that affect the entire AANHPI population, examples of microaggressions that may specifically influence AANHPI men and boys include:

- **Desexualization/Emasculation:** experiences in which AANHPI men are perceived or treated as being less masculine and/or physically inferior than non-AANHPI men (e.g., making a generalized statement that AANHPI men are not physically attractive or are weak).
- **Assumptions of Stereotypes:** instances in which people assume that AANHPI men would behave or be a certain way (e.g., someone who assumes

that an Asian American man would be highly intellectual or physically weak, or that an NHPI man would be intellectually inferior or violent)

CONCLUSION AND NEXT STEPS

This brief provided a preliminary snapshot of selected behavioral health issues across the broad spectrum of AANHPI boys and men. Given the heterogeneity of the AANHPI population, it is important to recognize the various systemic barriers, community structures, cultural values, and other social determinants that might influence disparities within certain communities. For instance, many Southeast Asians migrated to the U.S. as refugees, thereby not having resources from previous generations that could protect against educational disparities. In contrast, Native Hawaiians and Pacific Islanders have been negatively influenced by colonialism and systemic racism, which may result in the lack of access to resources, which subsequently may influence one's ability to reach one's fullest potential. Thus, the historical and present contexts of these communities differentially affect various subgroups within the AANHPI population. Growing up in a densely Asian American populated urban area on the West Coast versus a refugee resettlement community in rural Minnesota or a newly arrived Bhutanese community in the Midwest may present different behavioral health challenges, resources, and supports.

Despite many of these challenges and risks, it is necessary to highlight the myriad strengths of AANHPI boys and men. Many of these men have overcome great adversity in their lives (e.g., immigration/migration, educational obstacles, socioeconomic challenges, political persecution, etc.) and many have managed to thrive and be resilient. Many of these men face daily obstacles, ranging from overt racial discrimination to subtle microaggressions, but are still able to take care of their families, manage multiple roles and identities, maintain positive attitudes, and uphold a strong work ethic. For many young AANHPI boys, they develop in a world where they have few public role models in powerful leadership positions or in the influential media. They navigate communities and social institutions that range from hostile to supportive and embracing. They too demonstrate remarkable resilience, oftentimes with a modicum of support from the very institutions put in place to support their

development. Some of these boys thrive and flourish, others go off track.

Given the information presented in this brief, it is necessary to create strategies to support AANHPI boys and men and maximize their potential and well-being. From a public health and social justice approach, we need to better understand the risk and protective factors for this population and disaggregate by gender and ethnicity. The risk factors may deviate from the usual factors and include racism, microaggressions, trauma, devaluing of one's culture and ethnicity, or poverty and limited opportunity. On a systems level, we need to identify data, research, and workforce issues that are inquiring and responsive to this population. Programmatically, it would be important to have strategies for early identification and early intervention for AANHPI boys and men at risk of mental and substance use problems. Treatment and recovery supports similarly need to be tailored to the specific populations. Clinicians, educators, and other practitioners can create more programs, services, and resources specifically geared to AANHPI boys and men. These efforts build on the individual, family, community and cultural strengths and resiliency, and the community-based research which helps to underscore what works for these boys and men. Finally, building the social capital in communities where AANHPI men and boys live, work, learn and play is a critical public health investment.

These strategies will be the focus of future information briefs which will highlight successful behavioral health interventions, programs, services, and supports for AANHPI men and boys that have been documented by academic research and community evaluation efforts. As stated at the outset, this brief is just beginning the conversation. Our intent is to garner the data, the research, and the community voice to align with the White House's My Brother's Keeper Initiative and better meet the needs of this underserved population of AANHPI men and boys.

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END NOTES

- ¹Hoeffel, E. M., Rastogi, S., Kim, M. O., & Shahid, H. (2012). *The Asian Population: 2010*. Washington, DC: U.S. Census Bureau.
- ²Colby, S. L., & Ortman, J. M. (2015). Projections of the Size and Composition of the U.S. Population: 2014 to 2060. Washington, DC: U.S. Census Bureau.
- ³Hixson, L., Hepler, B. B., & Kim, M. O. (2012). *The Native Hawaiian and Other Pacific Islander Population: 2010*. Washington, DC: U.S. Census Bureau.
- ⁴Nadal, K. L., & Sue, D. W. (2009). Asian American Youth. In C. S. Clauss-Ehlers (Ed.), *Encyclopedia of Cross-Cultural School Psychology* (pp.116-122). New York: Springer.
- ⁵Fischer, S. R. (2013). *A History of the Pacific Islands, Second Edition*. New York: Palgrave Macmillan
- ⁶Takeuchi, D. T., Zane, N., Hong, S. E., Chae, D. H., Gong, F., Gee, G. C., Walton, E., Sue, S., & Alegria, M. (2007). Immigration-Related Factors and Mental Disorders Among Asian Americans. *American Journal of Public Health, 97*(1): 84-90.
- ⁷Reeves, T. J., & Bennett, C. E. (2004). We the People: Asians in the United States. Census 2000 Special Reports. Washington, DC: U.S. Census Bureau.
- ⁸de Castro, A. B., Rue, T., & Takeuchi, D. T. (2010). Associations of employment frustration with self-rated physical and mental health among Asian American immigrants in the U.S. labor force. *Public Health Nursing, 27*(6), 492-503.
- ⁹Panapasa, S., Jackson, J., Caldwell, C., Heeringa, S., McNally, J., & Williams, D. (2012). Pacific Islander Health Study Report. Ann Arbor: University of Michigan Institute for Social Research.
- ¹⁰Nadal, K. L. (2011). *Filipino American Psychology: A Handbook of Theory, Research, and Clinical Practice*. New York: Wiley & Sons.
- ¹¹Cress, C. M., & Ikeda, E. K. (2003). Distress under duress: The relationship between campus climate and depression in Asian college students. *NASPA Journal, 40* (2), 74-97.
- ¹²Iwamoto, D. K., Liao, L., & Liu, W. M. (2010). Masculine norms, avoidant coping, Asian values, and depression among Asian American men. *Psychology of Men & Masculinity, 11*(1), 15-24.
- ¹³Masood, N., Okazaki, S., & Takeuchi, D. T. (2009). Gender, family, and community correlates of mental health in South Asian Americans. *Cultural Diversity & Ethnic Minority Psychology, 15*, 265-274.
- ¹⁴Chung, R. C., & Bemak, F. (2002). Revisiting the California Southeast Asian Mental Health Needs Assessment data: An examination of refugee ethnic and gender differences. *Journal of Counseling & Development, 80*, 1, 111-119.
- ¹⁵Kim, S. Y., Wang, Y., Deng, S., Alvarez, R., & Li, J. (2011). Accent, perpetual foreigner stereotype, and perceived discrimination as indirect links between English proficiency and depressive symptoms in Chinese American adolescents. *Developmental Psychology, 47*(1), 289-301.
- ¹⁶Chae, D. H., & Yoshikawa, H. (2008). Perceived group devaluation, depression, and HIV-risk behavior among Asian gay men. *Health Psychology, 27*(2), 140-148.
- ¹⁷Kanazawa, A., White, P. M., & Hampson, S. E. (2007). Ethnic Variation in Depressive Symptoms in a Community Sample in Hawaii. *Cultural Diversity & Ethnic Minority Psychology, 13*, 1, 35-44.
- ¹⁸Shiang, J., Blinn, R., Bongar, B., et al. (1997). Suicide in San Francisco, CA: A comparison of Caucasian and Asian groups, 1987-1994. *Suicide and Life-Threatening Behavior, 27*(1), 80-91.
- ¹⁹State of Hawai'i Department of Health. (2004). *Fatal injuries in Hawai'i: 1996-2000*. Honolulu, HI: Injury and Prevention Control Program.
- ²⁰Guam Department of Public Health and Social Services (2007). *Suicide 2000-2007*. DPHSS Annual Suicide Statistics Reports. Mangilao, GU: Author.
- ²¹Booth, H. (1999). Pacific Island suicide in comparative perspective. *Journal of Biosocial Science, 31*(4):433-448.
- ²²Hezel, F. X. (2001). *The New Shape of Old Island Cultures: A Half Century of Social Change in Micronesia*. Manoa, HI: University of Hawaii Press.
- ²³Sentell, T., Unick, G. J. Ahn, H. J., Braun, K. L., Miyamura, J., Shumway, M. (2013). Illness severity and psychiatric hospitalization rates among Asian Americans and Pacific Islanders. *Psychiatric Services, 64*(11),1095-1102.
- ²⁴Barreto, R. M., & Segal, S. P. (2005). Use of mental health services by Asian Americans. *Psychiatric Services, 56*, 746-748.

- ²⁵Chow, J. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93*(5), 792–797.
- ²⁶Shin, J. K. (2009). Inpatient Stays of Asian Patients with Psychiatric Diagnoses in New York City. *Issues in Mental Health Nursing, 30*(2), 112-121.
- ²⁷DeVylder, J. E., Oh, H. Y., Yang, L. H., Cabassa, L. J., Chen, F., & Lukens, E. P. (2013). Acculturative stress and psychotic-like experiences among Asian and Latino immigrants to the United States. *Schizophrenia Research, 150*(1), 223-228.
- ²⁸Hans, O., Yang, L. H., Anglin, D. M., & DeVylder, J. E. (2014). Perceived discrimination and psychotic experiences across multiple ethnic groups in the United States. *Schizophrenia Research, 157*(1), 259-265.
- ²⁹Kim, S. S., Lee, H., Kiang, P., Kalman, D., & Ziedonis, D. M. (2014). Factors associated with alcohol problems among Asian American college students: Gender, ethnicity, smoking and depressed mood. *Journal of Substance Use, 19*(1-2), 12-17.
- ³⁰Austin, G., & Skager, R. (2008). California Student Survey of Drug, Alcohol, and Tobacco Use. Sacramento, CA: California Attorney General Office, Crime and Violence Prevention Center.
- ³¹Operario, D., Choi, K. H., Chu, P. L., McFarland, W., Secura, G.M., Behel, S. et al. (2006). Prevalence and correlates of substance use among young Asian Pacific Islander men who have sex with men. *Prevention Science, 7*(1), 19-29.
- ³²Gloria, A. M., Castellanos, J., Yong, S. P., & Kim, D. (2008). *Journal of Counseling & Development, 86*(4), 419-428.
- ³³Shea, M., & Yeh, C. J. (2008). Asian American Students' Cultural Values, Stigma, and Relational Self-construal: Correlates of Attitudes Toward Professional Help Seeking. *Journal of Mental Health Counseling, 30*(2), 157-172.
- ³⁴Chang, T., & Subramaniam, P. R. (2008). Asian and Pacific Islander American men's help-seeking: Understanding the roles of cultural values and beliefs, gender roles, and racial stereotypes. *International Journal of Men's Health, 7*, 121-136.
- ³⁵Chang, T., Yeh, C. J., & Krumboltz, J. D. (2001). Process and outcome evaluation of an on-line support group for Asian American male college students. *Journal of Counseling Psychology, 48*, 319-329.
- ³⁶Aud, S., Fox, M., & KewalRamani, A. (2010). *Status and Trends in the Education of Racial and Ethnic Groups*. Washington, DC: National Center for Education Statistics.
- ³⁷Hune, S., & Takeuchi. D. T. (2008). Asian Americans in Washington State: Closing Their Hidden Achievements. Washington State Commission on Asian Pacific American Affairs. A report submitted to the Washington State Commission on Asian Pacific American Affairs. Seattle, WA: University of Washington.
- ³⁸Kiang, L., Supple, A. J., Stein, G. L. (2012). Gendered Academic Adjustment among Asian American Adolescents in an Emerging Immigrant Community. *Journal of Youth and Adolescence, 41*(3), 283-294.
- ³⁹Mayeda, D., Chesney-Lind, M., & Koo, J. (2001). Talking Story with Hawai'i's Youth: Confronting Violent and Sexualized Perceptions of Ethnicity and Gender. *Youth & Society, 32*, 99-128.
- ⁴⁰Ngo, B., & Lee, S. J. (2007). Complicating the Image of Model Minority Success: A Review of Southeast Asian American Education. *Review of Educational Research, 77* (4), 415-453.
- ⁴¹Lee, S. J., and Kumashiro, K. K. (2005). A Report on the Status of Asian Americans and Pacific Islanders in Education: Beyond the "Model Minority" Stereotype. Washington, DC: National Education Association of the United States.
- ⁴²Teranishi, R. T. (2002). Asian Pacific Americans and critical race theory: An examination of school racial climate. *Equity & Excellence in Education, (35)*2, 144-154.
- ⁴³Robers, S., Zhang, J., & Truman, J. (2010). *Indicators of School Crime and Safety: 2010*. National Center for Education Statistics. Washington, DC: U.S. Department of Education and U.S. Department of Justice.
- ⁴⁴Maffini, C. S., Wong, Y. J., & Shin, M. (2011). The potential impact of violent discrimination on somatic symptoms among Asian American adolescents: A national longitudinal study. *Asian American Journal of Psychology, 2*(3), 157-167.
- ⁴⁵Ogunwold, S. U., Drewery, M. P., Jr., & Rios-Vargas, M. (2012). *The Population With a Bachelor's Degree or Higher by Race and Hispanic Origin: 2006-2010*. American Community Survey Brief. Washington, DC: U.S. Census Bureau.
- ⁴⁶National Council on Crime and Delinquency (2001). *Asian/Pacific Islander Communities: An Agenda for Positive Action*. Oakland, CA: Author.

⁴⁷National Council on Crime and Delinquency (2007). *Under the Microscope: Asian and Pacific Islander Youth in Oakland Needs, Issues, Solutions*. Oakland, CA: Author.

⁴⁸Rumbaut, R. G., & Ewing, W. A. (2007). *The Myth of Immigrant Criminality and the Paradox of Assimilation: Incarceration Rates among Native and Foreign-Born Men*. Immigration Policy Center. Washington, DC: American Immigration Law Foundation.

⁴⁹Mayeda, D. (2010). Hawaii Youth Correctional Facility recidivism study. Honolulu, HI: Department of the Attorney General.

⁵⁰Tamayose, B., & Takahashi, L. (2012). Asian American, Native Hawaiian, and Other Pacific Islanders' Experience with the California State Justice System. University of California Asian American and Pacific Islander Policy Multicampus Research Program. Los Angeles, Author.

⁵¹Nadal, K. L., Wong, Y., Sriken, J., Griffin, K., & Fujii-Doe, W. (2015). Racial Microaggressions and Asian Americans: An Exploratory Study on Within-Group Differences and Mental Health. *Asian American Journal of Psychology*, 6(2), 136-144.

