AANHPI Youth Mental Health: Hearing Their Voices and Understanding Their Perspectives

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I. Introduction

The mental wellness of our youth has been an increasing public health concern in the United States (US). The Morbidity and Mortality Weekly Report, released by the Centers for Disease Control and Prevention, reports roughly one in five youths between the ages of 12 and 17 have experienced a significant depressive episode (Bitsko et al., 2022). The statistics are considerably more concerning for high school students. The report revealed that in 2019, prior to the COVID pandemic, almost 37% of high school students experienced persistent feelings of sadness and hopelessness within the previous year, while 19% had thoughts of suicide (Bitsko et al., 2022). In addition, the National Vital Statistics Reports in 2021 recorded suicide as the number two leading cause of death amongst male and female youths aged 15 to 19; this is only behind unintentional injuries (Heron, 2021). The statistics are even more worrying for Asian Americans (AA), where suicide is the leading cause of death among both male and female youths aged 15 to 19 (Heron, 2021). Moreover, a recent study found the suicide rate of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) youth and young adults (5 to 24 years) is rapidly rising and has doubled from 3.6 to 7.1 per 100,000 from 1999 to 2021 (Reyes, Song, & Bhatt, 2024).

The burden of depression and suicide ideation among AANHPI youths is not homogeneous across sub-ethnic communities. The AANHPI communities are incredibly diverse, including young people with ancestry from more than forty countries. Each has its unique cultural heritage, acculturation experiences, socioeconomic backgrounds, and health behaviors that can impact mental health and suicide risk (Ai, Appel, Lee, & Fincham, 2022; Ramakrishnan, 2014; Wong, Uhm, & Li, 2012; Wyatt, Ung, Park, Kwon, & Trinh-Shevrin, 2015). Lowry et al. examined the US Youth Risk Behavior Surveillance System (YRBSS) data between 2001 and 2007 and found that 26.2% of NHPI youths seriously considered attempting suicide. During the same period, Asian (16.9%), White (16.8%), and Hispanic (17.7%) high school students had comparable rates of suicidal thoughts, with Black high school students having the lowest rate at 12.8% (Lowry, Eaton, Brener, & Kann, 2011). Using the same YRBSS data from 1991 to 2015, Subica and Wu found that NHPI adolescents in the US reported significantly higher suicide thoughts and attempts at 22 .9% and 14.9%, respectively, compared to Asian (19.6% and 8.5%), White (18.9% and 6.7%), Hispanic (19.1% & 10.8%) and Black (15.2% & 8.1%) adolescents (Subica & Wu, 2018).

The recent surge in anti-Asian sentiments has only increased the mental health burden on AANHPI youths. Multiple studies have found a correlation between the rise in anti-Asian sentiments following the COVID-19 pandemic and heightened psychological distress, including reported symptoms of depression and anxiety in AANHPI youths (Benner, Rojas, Kim, Hou, & Coulter, 2023; Liu et al., 2023; Teng, Hon, Wang, & Tsai, 2023; Zhou, Banawa, & Oh, 2023). A survey of 176 Asian American adolescents and young adults using the Young Asian American Health Survey conducted from May 2021 to March 2022 found that 76% of AA teenagers and young adults have expressed a diminished sense of safety during the pandemic. The majority of the respondents also reported a rise in symptoms of depression in comparison to their pre-pandemic state (Huynh et al., 2022). AANHPI youths are also less inclined than their non-AANHPI peers to seek help and support, further exacerbating struggles with mental health issues (Chen et al., 2022; Li & Seidman, 2010; Subica et al., 2019). These findings highlight the pressing and necessary task of uncovering distinct youth mental health challenges and needs across and within AANHPI communities.

Research, practice, and policy on youth mental health services are frequently overlooked in AANHPI youth populations. At the federal level, an anti-Asian bias has been found in the federal grant review process where less than 1% of the National Institute of Health's funding supports scientific research on AANHPI populations even though AANHPI represents 6% of the US population, consequently contributing to the invisibility of the

AANHPI community (Yip et al., 2024). In 2023, the California Department of Public Health (CDPH)'s Office of Suicide Prevention (OSP)'s request for applications for "Youth Suicide Prevention Media and Outreach" included all racial and ethnic populations except AANHPI populations from the call to address suicide prevention in youth (CDPH, 2023). These structural-level barriers perpetuate the image of the stereotype that AANHPI youth are immune from mental health problems.

The AANHPI community faces unique cultural, linguistic, environmental, and socio-economic barriers that can make accessing mental health services difficult. In this study, we aim to examine the prevalence of poor mental health in AANHPI youths, their perceptions of risk and protective factors for mental wellness, the facilitators and barriers to accessing mental health services, and identify service and policy gaps. The study also brings the voice of AANHPI youth to the forefront to learn about their unique experiences and the opportunities and challenges they face. With this understanding, we strive to uplift AANHPI youth and their mental health needs. Furthermore, we aim to disseminate findings to California policymakers, state agencies, and county behavioral health plans to make more informed and equitable recommendations for future mental health funding allocations that will promote mental wellness for AANHPI youth.

II. Methods

This study employed a mixed-method approach guided by the Social Ecological Model and Minority Stress frameworks (Bronfenbrenner, 1977; Chu, O'Neill, Ng, & Khoury, 2022; "Minority Health and Health Disparities Research Framework," 2017). We utilized quantitative data from the California Healthy Kids Survey (CHKS) and qualitative data from youth focus groups. The CHKS is a survey of 9th and 11th-grade students from high schools across California, providing valuable insight into the mental health status, behaviors, and school context of AANHPI youth. For this study, we disaggregated the CHKS data for the school year 2021/22 and examined outcomes of past-year suicide ideation and depressive symptoms to support an understanding of mental health prevalence in high school students for nine groups in California: Asian Indian, Chinese, Filipino, Japanese, Korean, Native Hawaiian and Pacific Islander, Southeast Asian (including Cambodian, Laotian, and Hmong), Vietnamese, and other Asian (unspecified). See Appendix 1 for CHKS survey questionnaire and methods.

In partnership with community-based organizations serving AANHPI youth in northern and southern California, we conducted nine youth focus groups (Asian Indian, Chinese & Taiwanese, Cambodian & Laotian, Filipino, Hmong, Japanese, Korean, Native Hawaiian and Pacific Islander, and Vietnamese), with seven conducted in-person and two conducted virtually with high school students between the ages of 14 to 17 (N=66) (Table 1). Each focus group was led by two non-AANHPI facilitators. Youth participants completed a demographic survey and engaged in a group discussion on ethnic identity, perspective on mental health experiences for AANHPI youth, protective and risk factors connected to mental health, and access and availability of mental health services. A mental health clinician was also in attendance to ensure the youth's well-being during the discussion. All youth participants received a $50 gift card for participation, and additional incentives were offered by some community-based organizations.

The audio recordings of the focus groups were transcribed via the Temi transcription service program and then uploaded into Dedoose software for data management and analysis. The codebook was developed based on study goals and prior literature with the following deductive codes: *AANHPI identity, mental health description and terms, risk and protective factors, AANHPI contextual nuances, services and interventions, and best quotes*. Using thematic analysis, our six-person team independently coded the same transcript to solidify these codes with further refinements and identify new codes from the data. Once the team was in agreement, two members of the study team were assigned to code each focus group transcript. Coders met to discuss any discrepancies in their coding, and there was a final team discussion to resolve discrepancies. After coding all nine focus groups, the team met to discuss excerpts from each code, synthesize key findings, and develop the overarching themes. Finally, themes were further presented, discussed, and validated with community and research partners.

Table 1. AANHPI Youth Focus Groups, October 2023-March 2024

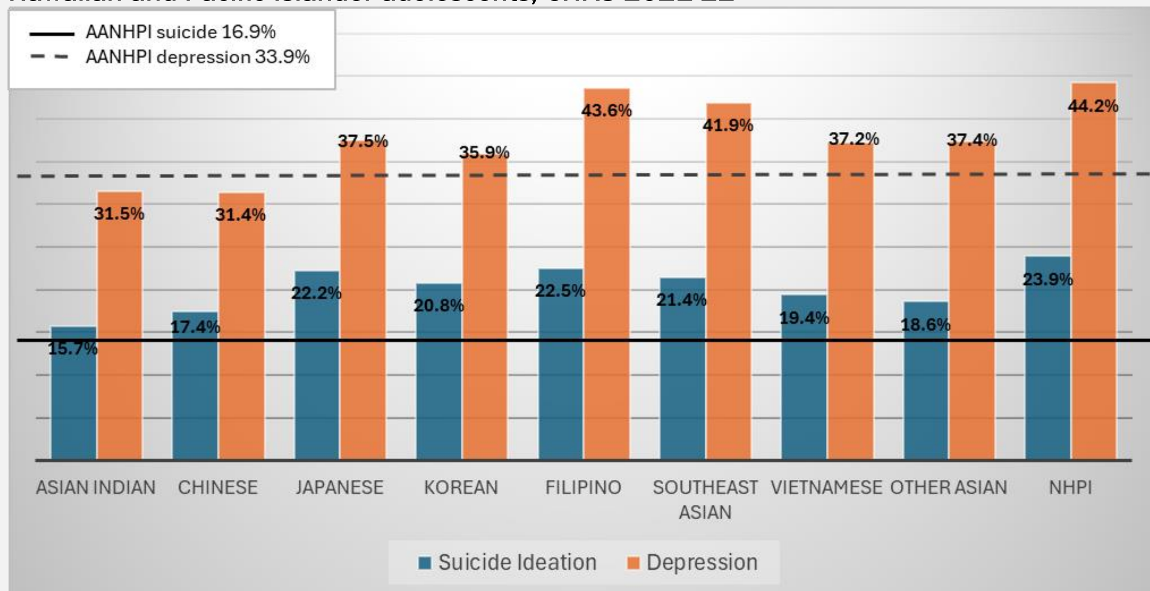
N = 66	Location	Count
AANHPI-Specific Focus Group		
Asian Indian*	Cerritos, CA	6
Cambodian & Laotian	Oakland, CA	8
Chinese & Taiwanese	Irvine, CA	6
Filipino	Carson, CA	7
Hmong	Sacramento, CA	9
Japanese*	Los Angeles, CA	7
Korean	Los Angeles, CA	7
Native Hawaiian and Pacific Islander	South San Francisco, CA	6
Vietnamese	Anaheim, CA	10

*Virtual focus groups, all others conducted in-person.

III. The prevalence of depression and suicide ideation

Using the CHKS 2021-22, we found as an aggregate, AANHPI high school students in California reported an alarmingly high prevalence for past year experiences of depressive symptoms (33.9%) and suicide ideation (16.9%). Disaggregating the data, we found that NHPI, Filipino, Southeast Asian (including Cambodian, Hmong, and Laotian), and Japanese youths reported the highest prevalence of depression and suicide ideation (See Figure 1). When we examined within-Asian and NHPI groups, we found a consistently higher prevalence of depression and suicide ideation for youth with multiple identities (Figures B.1 and B.2). Across all groups, multiethnic Asian (identifying as more than one Asian subgroup) and multiracial Asian+NHPI reported higher suicide prevalence compared to monoethnic Asian (Figure B.1). For depression, prevalences varied although most groups reported higher depression among youth with multiple identities (Asian Indian, Chinese, Japanese, Korean, Vietnamese, Other Asian, NHPI), except for Filipino students showed similar or even higher prevalence for monoethnic than multiethnic or multiracial identities (Figure B.2). In addition, girls consistently reported higher prevalences compared to boys (Figures B.3 and B.4). NHPI girls had the highest prevalence of depression and suicide (56.5% and 30.5%, respectively), compared to boys (31.2% and 16.9%, respectively). Similar patterns were seen for all other groups.

Figure 1. Past-year suicide ideation & depressive symptoms among Asian American, Native Hawaiian and Pacific Islander adolescents, CHKS 2021-22



Notes: Southeast Asians include Cambodian, Hmong, and Laotian. NHPI is Native Hawaiian and Pacific Islander. Specific other Asian groups were not identified.

IV. Understanding youths' perspectives

Four key themes emerged that were consistent across all nine AANHPI-specific focus groups: 1) Youth identities, 2) Mental health terminology and experiences, 3) Factors that contribute to poor mental health, and 4) Mental health support and services. We summarize the youths' insights and highlight their perspectives to illuminate their specific needs.

Table 2. AANHPI Youth Focus Groups, Participant Characteristics, October 2023-March 2024

N = 66	Count	(%)
Race and ethnicity		
Monoracial AANHPI	58	(88)
Multiracial AANHPI	8	(12)
Monoethnic AANHPI	56	(85)
Multiethnic AANHPI	10	(15)
Gender		
Female	34	(52)
Male	29	(44)
Other	3	(4)
Age		
14-15	15	(23)
16-17	51	(77)
Generation status of youths		
Born outside of the USA	6	(9)
Born in the USA, at least 1 parent born outside	51	(77)
Born in the USA, both parents were born in the USA	9	(14)
Parent education		
High school degree or less	18	(27)
Some college	9	(14)
College degree	15	(23)
Graduate or professional degree	16	(24)
Don't know or did not respond to the question	8	(12)

Theme 1. Youth identities

The majority of youths voiced that the umbrella term "Asian American" is too broad (with the exception of the Chinese & Taiwanese focus group), and the terminology does not express their individual blend of heritage and cultural identity. Youths from the Native Hawaiian and Pacific Islander (NHPI), Hmong, and Cambodian & Laotian focus groups, which have smaller population sizes in California, pointed out that the term "Asian American" generally refers to East Asian heritage such as Chinese, Japanese, and Koreans, and creates a false narrative that masks the heterogeneity of AANHPI ethnic groups. They believe their ethnic identity and cultural practices differ considerably from that of East Asians, and therefore, the term does not accurately represent them. Youth from our focus groups discussed how each of their heritage is unique and expressed a preference for using terms specific to their group, such as "Hmong American" or "Japanese American."

In almost all cases, youths' identities were a rich interplay of at least two or more identities that spanned cultures, ethnicities, sexual and gender identities, and family immigration experiences. The youth described a diverse environment where unique AANHPI youth identities parallel, interconnect, and may even conflict across spaces—home, school, and community. This concept of individuals possessing multiple social and cultural identities concurrently is often referred to as biculturalism (Schwartz & Unger, 2010), and has been further expanded to the notion of intersectionality, described as the complex experiences of individuals based on their intersecting social positions and the structural systems in which they reside (Polanco-Roman et al., 2023; Viruell-Fuentes, Miranda, & Abdulrahim, 2012). In our focus groups, all youth participants described living in an environment where they were balancing generational status (immigrant vs. 2nd or 3rd generation experiences), cultural traditions, AANHPI-specific languages, religions, and social norms within and across homes, schools, and communities.

"Asians as a whole, I feel ***we're kind of put into a box where it's like you are all just Asian****. It's different from Southeast Asians or even Indians or Chinese, [but] you all get [to be] just Asian, but it's a different category."*
--Cambodian & Laotian focus group, 17-year-old male youth

"I hate the term Asian. I think it's very general. ***It's generalizing a huge group of people****, like South Asian, Southeast Asian, and the East Asian."*
--Korean focus group, 17-year-old female youth

"When people use the word Asian, they normally [are] talking about East Asians, probably 90% of the time. ***Asia's just such a big continent and it represents so many different cultures*** *and I feel like that can't be summed up in just one word."*
--Asian Indian focus group, 16-year-old female youth

*"****They don't really know what Hmong or Mien is****. They'll just assume we're one of the popular ones. Like, you know, Korean, Chinese."*
--Hmong focus group, 17-year-old female youth

*"****I really think of Polynesian as their own category****. [Because] the differences in the food, the culture, the way we do things."*
--Native Hawaiian and Pacific Islander focus group, 14-year-old male youth

*"****I try to balance being Hmong and being Americanized at the same time****. So, every week, I would go to school the whole week, and then on weekends, I would go do community service (to learn about my culture). It got to the point where I got tired of it and I couldn't find balance. There was no free time for me to have fun. And so it kind of created this drama between me and my father."*
--Hmong focus group, 17-year-old male youth

"With my friends, if they're a different race than me, I'm more American around them. [If] we are both Cambodian, sometimes we talk about Cambodian food. [In] my community we're not gonna say sometimes [like] we dance, we pray respect to Buddha."
--Cambodian & Laotian focus group, 17-year-old male youth

Theme 2. Mental health terminology and experiences

Mental health or mental well-being is an important part of overall health, but talking about it can be difficult. Post-COVID pandemic, mental health conversations are more normative in school spaces, which allowed for an easier transition to talking about mental health in all nine focus groups. For AANHPI youth coming from diverse social and cultural backgrounds and balancing their different identities at home, school, and community, talking about mental health is challenging as they need to overcome barriers like cultural and

language discordance, and negative stigma associated with mental health. The youth in our focus groups mostly reported that in their home and their respective AANHPI community, mental health is not discussed openly due to cultural stigma and lack of language to describe poor mental health. Suicide was also perceived to be very different from mental health, with suicide being viewed as more taboo with the act itself a violation of religious and certain cultural values, and not as readily accepted as an appropriate mental health topic for discussion. Even when mental wellness is talked about, the youths conveyed that their AANHPI languages frequently do not have the necessary vocabulary or terminology to express mental health problems with constructive framing. In addition, translations from English to AANHPI-specific languages do not often have a direct or equivalent term in the AANHPI-specific language. Instead, the youth pointed out that when mental health is brought up at home with parents and families, it is often represented as concern or "described" with negative and dismissive language. Phrases of concern that the youths shared include "are you ok," "person going through a hard situation," and feeling "sad," or "hurt." Examples of dismissive phrases about mental health include "overreacting," "not mentally ok," "making a big deal." Youths also acknowledged negative phrasing, such as "crazy," "laziness," and "something is wrong with the person," is used to describe someone with a mental health struggle. In all nine focus groups, youths expressed barriers when it came to discussing their mental health and well-being with parents/caregivers due to prevailing social norms, cultural stigma, language discordance, sexual and gender identities, and intergenerational experiences between immigrant families and youth being raised in the US. In addition, there is an added layer to uphold a certain image that everything is okay within the larger AANHPI community.

"I consider myself pretty fluent in Vietnamese, ***there are no words to describe mental health****. It's really hard. So even if [you are] fluent in Vietnamese, you can't really articulate your thoughts in regard to mental health."*
--Vietnamese focus group, 15-year-old female youth

*"****There's a lot of words in English that aren't translated in Khmer****."*
--Cambodian & Laotian focus group, 17-year-old male youth

"In terms of ***talking about suicide with family, that's like a taboo topic****."*
--Chinese & Taiwanese focus group, 17-year-old male youth

*"****In Japanese culture, you don't really tell people about your mental state****."*
--Japanese focus group, 16-year-old female youth

*"****My family, they just trying to hide it****, especially with all the boys, every time your uncle or your elder, they see [you are] trying to be emotional. Like, stop being, like, stop being a…"*
-- Native Hawaiian and Pacific Islander focus group, 14-year-old male youth

"I feel like with my parents, I don't really talk about it that much. Especially with ***Indian parents, I feel there's more a conservative feel on mental health****."*
--Asian Indian focus group, 16-year-old female youth

*"****They [family] don't want to talk about it****. Because they don't like showing any emotions, emotions [are] like open wounds."*
---Filipino focus group, 16-year-old male youth

Theme 3. Factors that contribute to poor mental health

3a. Navigating pressure, expectations, and forming connections in a complex environment

From the youth focus groups, we found that the pressure to succeed (in academics or sports), social conformity, intergenerational differences, and socioeconomic status were some of the most frequent stressors that weighed heavily on the youths. These stressors are not unique to youths at this stage of life,

but what makes it more formidable for the youth in our study is that they must navigate these challenges within the context of biculturalism and intersectionality. Biculturalism creates an environment where multiple sets of cultural norms, acculturation stages, life experiences, and languages are concurrently present, sometimes in disagreement (Schwartz & Unger, 2010). Through an intersectionality lens, youth are navigating expectations placed on their social identities by schools and other systems in parallel to overcome their challenges at home and within their AANHPI community (Viruell-Fuentes et al., 2012). Within this context, youth shared a heightened sense of pressure and expectation to succeed, stemming from their parents' background of adversity and their aspirations for their children to achieve success or from pressure to conform to culturally high standards for achievement. Furthermore, this setting also constructs circumstances where children of immigrants carry with them the additional burden of helping their families to navigate or adapt and integrate into American culture. Youths in our study focus groups expressed feelings of an increased sense of responsibility to assist their parents in integrating into their new surroundings. We found this environment further intensifies the pressure and expectations on young people and creates barriers to forming meaningful connections at home and school.

"I go to a really predominantly white school. ***My friends are very different from me****. I only have two Indian friends. We don't really talk about our cultures.* ***I'm less authentic in that sense with my culture****. I'm more like, you know, fitting in and stuff."*
--Asian Indian focus group, 16-year-old female youth

"The idea of living up to what your parents want you to be. My parents, they came here with nothing, just to give me a good life. ***So doing my best and being successful is not a choice****. I have to be successful to make their sacrifice worth it. You can't come back with a bad score. You can't say you have a bad day. You can't do any of those things."*
--Filipino focus group, 16-year-old male youth

"Polynesian households, they're a lot about your academics, making sure that your grades are good. And then they're also a lot about sports. Most families always have to have at least one or two kids playing a sport. ***It's a lot of pressure to keep up****."*
-- Native Hawaiian and Pacific Islander focus group, 14-year-old female youth

*"Koreans have those labels, they're afraid to break out of that because reputation matters a lot. So if you think about performing arts or something like a creative field. Ajumma (aunt) is going [to tell you] you're not gonna make any money from that. Or that's not good enough****. So there's already this fear of not living up to their standards****."*
--Korean focus group, 17-year-old female youth

"A lot of immigrant children are forced to grow up as translators for their parents. I remember having to fill out my own school paperwork as early as six. Having that kind of responsibility on me, that early did not do wonders for my mental health. ***A lot of immigrant children [have] too much responsibility and family stress too early on****."*
--Vietnamese focus group, 17-year-old genderfluid youth

3b. Intergenerational conflict

Additionally, the youths conveyed a higher barrier to establishing open communication, building understanding, acceptance, and ultimately, support and growth with their parents. In short, youths expressed that differences in life experience and language discordance make it more difficult to connect within the context of home life. The youth in our focus groups frequently talked about parents growing up in their heritage country in hardship, in a cultural environment where understanding of mental health is limited, or where feelings and affections are not normally talked about or displayed. Youths shared that their parents' experiences make it harder for them to understand youth experiences and lead to downplaying or dismissing their struggles. Moreover, almost all AANHPI focus groups reported complexity in communication with their

parents due to language discordance (Table 3). Youths expressed frustration with the inability to communicate effectively in English with their parents. During the discussion, many youths shared that they feel more comfortable and can communicate more successfully with their parents when they are able to use a combination of English and their heritage language. Unfortunately, in many cases, language proficiency is discordant on both sides, making effective communication difficult at home. As a result, it can be challenging for the youth to convey their needs and concerns effectively and find mutual understanding. This can lead to additional stress and challenges for young individuals as they try to navigate their personal goals and needs while meeting their family's and cultural heritage expectations.

*"They [parents] grew up in poverty and **when they think about problems that we have, oh we're too young to have like real problems.**"*
--Vietnamese focus group, 15-year-old female youth

*"Sometimes it feels like there is a barrier between me and my elders. Sometimes it feels better to talk about mental health with my friends or even my siblings. **I feel it's more about relatability. We grew up in different situations and different environments.**"*
-- Native Hawaiian and Pacific Islander focus group, 14-year-old male youth

*"My parents grew up without talking about mental health. It's a very difficult subject to talk about, 'cause **I feel they don't know how to reassure me.**"*
--Hmong focus group, 17-year-old female youth

*"**Parents aren't really aware of mental health.** I know personally my parents aren't too educated about it nor do they really believe in that stuff."*
--Vietnamese focus group, 15-year-old female youth

*"**That's something that kind of confuses them.** These topics like mental health, gender, those types of stuff, they were never introduced [or] being affectionate."*
--Chinese & Taiwanese focus group, 17-year-old male youth

*"**When you have to explain everything in detail to someone that isn't fluent in English, it's so horrible that it just makes you more mad.**"*
--Filipino focus group, 16-year-old male youth

*"You kind of pick and choose what language you use. Like when I talk to them I definitely use I **a mix of both languages.** Some words will be in English and some will be in Gujarati. I find **that's the easiest way to get my point across is by using both languages.**"*
--Asian Indian focus group, 16-year-old male youth

Table 3. AANHPI Youth Focus Groups, Language Discordancy at Home, October 2023-March 2024

	Youth language proficiency (speak & read)		
N = 66	Both equally	More English than AANHPI	Only English
Language spoken at home		Count (%)	
Only English	0 (0)	3 (5)	4 (6)
English + 1 other language	9 (14)	26 (39)	13 (20)
English + 2 or more other languages	0 (0)	4 (6)	0 (0)
Only AANHPI language	4 (6)	2 (3)	1 (1)

3c. Experiences of discrimination

Youth from our focus groups shared distinctive pressures and expectations. Across all AA focus groups, youth expressed the added pressure to live up to the Asian stereotype of being smart or good in math. These stereotypes may persist among their peers, teachers, and school staff who will make the assumption that AANHPI youth are doing well. AANHPI youths from the focus groups also pointed out experiences of discrimination they encountered at school. This includes the perception of being a perpetual foreigner or experiencing ridicule and being unfairly blamed for the spread of COVID-19. When young people experience discrimination and bullying in school, it can lead to feelings of alienation and cause youth to lose their sense of connection and belonging. Consequently, many youths from the study shared that they do not present their authentic self at school and consciously hide some parts of their ethnic identity. Instead, youths revealed shifting language and social behaviors to meet the expectations of their social environment. We learned from the focus groups that expressing multiple identities for the youths depends on context, with a strong preference to display AANHPI identity at home and projecting their American identity at school and with peers. Youth may not always feel their race and ethnicity are accepted and want to show the side that will help them forge connections, feel a sense of belonging, and reduce the likelihood of discrimination. While the code-switching as a result of expressing (or not expressing) their ethnic identity in different contexts is very common for youth in our focus groups, we observed that youths who attend schools where Asians constitute the majority tend to be more comfortable sharing both their AANHPI and American identities concurrently.

*"**At school there's like stereotypes, Asians do better**. So I feel there's some more pressure."*
--Chinese & Taiwanese focus group, 14-year-old male youth

*"Where are you from? And I'm like, I was born in US. And they're like, **where are you really from**?"*
--Japanese focus group, 16-year-old female youth

*"**I feel a lot of discrimination and kind of hate [at school]**. I don't look the part. **I just kind of get treated differently.**"*
--Cambodian & Laotian focus group, 17-year-old male youth

"During Covid, people were saying that Covid started from Chinese people eating bats and stuff like that."
--Japanese focus group, 16-year-old female youth

*"[With family], you speak a lot more Khmer. At school, **act more white to fit in with friends and in the community.**"*
--Cambodian & Laotian focus group, 15-year-old female youth

"When I'm with my family, I identify as Filipino. But when I'm outside, I identify as American."
--Filipino focus group, 16-year-old female youth

*"I identify myself as mixed Asian [with] my family. And then **with my friends, if they're like a different race than me, I'm more American around them**."*
--Cambodian & Laotian focus group, 17-year-old-male youth

*"**I don't like outwardly display my heritage at schoo**l [because] it's not super Indian."*
--Asian Indian focus group, 16-year-old youth

*"**Most of my friend groups [are] Asian. So we have a closer bond**, I feel. We're all Asian, and there's no difference between us."*
--Chinese & Taiwanese focus American group, 14-year-old male youth

*"**I go to a school that's predominantly Asian. So at school, being Vietnamese, it's pretty normalized.**"*
--Vietnamese focus group, 15-year-old female youth

*"**I feel like I belong because most of them [my friends] are mixed**."*
--Japanese focus group, 16-year-old female youth

Theme 4. Mental health support and services

4a. Trust is a necessary component in youths' decision to seek support

Mental health is a critical aspect of overall well-being, and young people experiencing persistent feelings of sadness and being overwhelmed need a safe space to reach out and receive help and support (Table 4). Our focus group findings suggest that youth prefer to seek help from someone they can trust. For the youth, trust means feeling understood and supported without being judged. It also means that their struggles are acknowledged and validated, they receive help without feeling ashamed or embarrassed, and their privacy is protected. This perception of trust can be influenced by many factors, including internalized cultural stigma, understanding of mental health services, past experiences seeking mental health support, shared lived experiences between the provider and the youth seeking support, language proficiency, generational rapport, acculturation, and existing knowledge or relationship with the provider or organization.

Trust is a necessary component when building meaningful relationships with youth, but it is often difficult to attain. Many young people expressed hesitation to seek help because of a lack of confidentiality, internalized cultural stigma, reporting requirements, and past poor experiences. In all 9 AANHPI focus groups, to some degree, youth expressed an underlying sense of cultural stigma, embarrassment, and judgment associated with seeking out support for mental health. Many youths also conveyed hesitation to seek services, fearing the information would reach their parents or be reported to formal institutions (i.e., schools, mental health agencies). For some youths who have sought out support previously from parents or counselors, negative experiences in the interaction often turn them off from seeking additional help in the future. For youth who reached out to their parents, generational and acculturation differences can leave youth feeling misunderstood, with some expressing a feeling of being dismissed for their struggles. When youth sought out school resources, such as school counselors, most youths expressed a lack of timely availability, confidentiality, established rapport, and trust. The youth shared that when their vulnerability is not met with empathy, understanding, and confidentiality, they are unlikely to trust or seek out support.

*"Kids don't really want to talk to adults about their issues because there's a generation gap and also having it be confidential. Because **anyone in your surroundings can judge you**."*
--Korean focus group, 17-year-old female youth

*"If you talk about mental health, **they'll think you're crazy**."*
--Hmong focus group, 17-year-old male youth

*"**If you say that you have a mental illness, you're like broken, you're not mentally sane**. So people don't respect you as much. And in Korean culture, it's like reputation, it's super important for them to maintain this image. So that's why they don't talk about it."*
--Korean focus group, 17-year-old female youth

*"My mom tells me, if I go to a therapist and I tell them stuff, then **they'll probably send me to the mental asylum or something**."*
--Hmong focus group, 17-year-old female youth

"When they think their kid is talking to someone at school. They go against the idea because ***they feel a social worker gonna take them away****."*
Filipino focus group, 16-year-old male youth

"In my family, when I look sad, they're like what's wrong? And I'm like, just tell them about what actually happened and they were like, ***suck it up****."*
--Chinese & Taiwanese focus group, 16-year-old male youth

"If I say something wrong or concerning in her point of view, then it turns into a lecture. So ***I can't really say anything****."*
--Japanese focus group, 16-year-old female youth

*"****I fear that they'll say that it's like my fault****."*
--Korean focus group, 16-year-old female youth

*"****Everyone at school has been saying it's not trustworthy*** *because the counselor has been going around telling the teacher."*
--Native Hawaiian and Pacific Islander focus group, 14-year-old female youth

*"****We go to our friends more than a trusted adult or professional because we can't trust [them]****."*
--Filipino focus group, 16-year-old male youth

"You have to book appointments. If you need help, ***you have to wait three days to talk to someone****."*
--Vietnamese focus group, 15-year-old youth

4b. Finding support from peers and family

Although the youths expressed some reluctance to seek help, they also shared a wealth of information on the resources they use and the attributes that they find supportive and trusting. The majority of the youths in our focus groups said they would talk to their peers if they needed support. Peer support can mean between friends or in group settings. In both cases, the youths report feeling understood and accepted because their peers often have the same cultural and generational experiences as they do. Overwhelmingly, most young people in our focus groups prefer to seek out help from someone they have existing relationships with, such as parents, siblings, cousins, grandparents, or other close relatives. This preference is likely due to the fact that family members and other adults in their lives are often the people with whom young people have the closest, most significant, and trusting relationships. In almost all cases, youths expressed a strong desire for their parents' help and support. The youth also conveyed their awareness of their parents' love and concern for them. However, whether the support is successfully provided is often determined by the underlying parent-child relationship, language proficiency on both sides, and parents' previous experiences with mental health. Strengthening the parent-child relationship is one avenue as youth need to know their parents will listen, acknowledge, and support them despite cultural and generational differences. Effective communication is also an essential part of any trusting relationship, and it is especially important in the adult-youth relationship whether with parents/caregivers, teachers/school staff, or other adults. Furthermore, communication is often impeded if parents and youth do not have proficiency in the same language. This is a common problem expressed in the focus groups by many youths. Despite this language barrier, youths are optimistic that with the availability of more in-language mental health resources and mental health providers who speak AANHPI languages and offer education to parents/families, dialogue and recognition of mental health problems can improve for AANHPI youth. Finally, some youths shared that their parents are very sensitive and understanding of their mental health needs. In further discussion, we learned that families who have been touched by mental health struggles or are otherwise knowledgeable through work are often more aware, educated, and open to talking and seeking support and help for mental health issues.

*“**If my parents were able to speak English the way I was able to communicate with my friends, I would be able to use more descriptive words to explain how I am feeling**. [I am] not fluent in Vietnamese [and not] able to express myself in the [same] way I can with English.”*
--Vietnamese focus group, 15-year-old female youth

*“**Because of the endorsement of a health professional that she [mom] trusted, she was able to tackle the concept better. She is more open to discussing and learning more about mental health**. I've seen her pull up YouTube videos on mental health professionals who describe the concept in Vietnamese. And she's learned more from those.”*
--Vietnamese focus group, 17-year-old genderfluid youth

*“**After whatever my sister went through, they were more aware and more open to how important it was**. So I sort of got it easy.”*
--Chinese & Taiwanese focus group, 15-year-old female youth

*“**She [mom] is more well-informed [through work] about this kind of mental health stuff**. So I feel like if I were to talk to her about it, what I'm saying wouldn't be foreign to her. I **think she comes from a place where she understands it more.**”*
--Asian Indian focus group, 16-year-old male youth

4c. Cultural considerations for professional and school-based mental health services

In addition to seeking help from peers and family members, some youths expressed a desire to seek professional help from therapists or school-based wellness counselors. However, many mentioned the importance of finding someone who understands their cultural background and values, has shared lived experiences, is non-judgmental, and can help bridge the cross-cultural boundaries between them and their parents. Lastly, we found that internalized stigma and cultural norms teach youths to maintain a certain image, stay silent about their struggles, and project a sense of strength even in difficult times. These expectations can make it challenging for them to seek mental health services. These youth may feel that reaching out for support is a sign of weakness, fear judgment, or may struggle to find the courage to do so. Therefore, it is important to recognize the impact of internalized stigma and cultural norms and provide resources that are sensitive to their needs and create non-stigmatizing ways to seek services.

*“It’s much easier to talk to another Asian Indian woman. **I wouldn’t be comfortable talking to an Indian man or a White woman. [Because] they wouldn’t really understand my experiences.**”*
--Asian Indian focus group, 16-year-old female youth

*“The counselor I was talking to was Korean and a female. So I think **I felt more open because I felt like if I talked to her it would've somehow felt more relatable**. If I talk with people who are more similar to me, they would be more understanding, more confidential about it.”*
--Korean focus group, 16-year-old female youth

*“**I just wish we had more therapists that spoke more foreign languages. To better explain to our parents.**”*
--Hmong focus group, 17-year-old male youth

*“**I kind of wanna keep that image, like it's good, like I am living a good life.**”*
--Korean focus group, 16-year-old female youth

*"**[It is] frowned upon to talk about your mental health**, to talk about what's really going on in your mind. **We're culturally supposed to [have] high expectations at all times.**"*
--Cambodian & Laotian focus group, 17-year-old male youth

*"**There is this pressure to keep up appearances, like effortlessness.**"*
-Korean focus group, 16-year-old female youth

Table 4. AANHPI Youth Focus Groups, How Comfortable Are You Talking About Mental Health with…, October 2023-March 2024

	Scale 1 (not comfortable) to 10 (very comfortable)		
N = 66	Low (1 – 3)	Moderate (4 – 7)	High (8 – 10)
How Comfortable Are You Talking About Mental Health with:		Count (%)	
Friends	4 (6)	16 (24)	45 (68)
Teachers	20 (30)	37 (56)	8 (12)
Parents or caregivers	17 (26)	22 (33)	26 (39)
Older family member	20 (30)	30 (45)	15 (23)
Staff at the community organization	7 (11)	35 (53)	23 (35)

Notes: Row% does not add up to 100% because 1 participant did not respond to the questions.

V. Recommendations

1. **Increase the visibility of AANHPI identities and their mental health experiences**
   a. Increase availability and access to disaggregated AANHPI youth mental health data.
      - Mental health data should recognize multiple identities by disaggregating data based on racial and ethnic identities (including multiethnic and multiracial), sexual and gender identities, languages spoken in the household, and generational experiences.

   b. Acknowledge and validate AANHPI experiences of poor mental health and the burdens they carry in different spaces to express these experiences with parents/family, schools, and communities through:
      - Educational outreach and media campaigns by and for AANHPI youth and their families to reduce mental health stigma and increase communication about mental health and wellness.
      - Improving mental health literacy that is youth-centered and translated to specific Asian and NHPI languages.
      - Incorporating training for schools and mental health providers about AANHPI youth mental health experiences and needs.

2. **Reframe mental health services for AANHPI youth that focus on building connections and trust, and allow for non-stigmatizing entry into culturally-specific and youth-centered mental health services from prevention to early intervention, crisis intervention, and treatment**
   a. Create one-on-one and group spaces for AANHPI youth in schools and community settings through prevention programs and early intervention services that do not require having a mental health diagnosis, which reduces the stigma associated with mental health.
   b. Build in time for mental health service providers to build rapport and trust with youth that is billable under MHSA/BHSA or local funding for early intervention and treatment services.

c. Increase the mental health workforce by training AANHPI youth to serve as mental health peer ambassadors/educators/navigators and training adults with shared lived experiences to serve as mental health community health workers, paraprofessionals, and licensed mental health professionals.
d. Establish a state-wide AANHPI youth mental health network with diverse participation from AANHPI youth, mental health providers, youth-serving community-based organizations, schools, researchers, and policy stakeholders to share learnings/expertise, develop an anti-racist framework for AANPHI youth mental health services, and advocate for AANHPI youth mental health needs.
e. Incorporate anti-racist strategies for youth mental health services in schools and the mental health services system that eliminate preconceived notions of AANHPI youth mental health, reduce their barriers to seeking services, build a mental health workforce who has shared lived experiences, and adapt culturally-specific strategies and youth-centered approaches for mental health services.

VI. Conclusion and call to action

After the COVID-19 pandemic, youth mental health and wellness were spotlighted as a high-priority public health concern. Yet AANHPI youth remained invisible within this mental health crisis. Our findings showcased how issues of mental health and suicide among AANHPI youth remained hidden. First, there is a lack of disaggregated data to showcase how the prevalence of mental health and suicide vary among the heterogeneous AANHPI groups. When disaggregating data by ethnic identity (and even further by monoethnic, multiethnic, and multiracial), key groups have higher suicide ideation and depressive symptoms, such as NHPI, Filipino, and Southeast Asian youth. Second, AANHPI youth themselves remained silent on these issues due to the lack of language/terminology around mental health, especially in AANHPI languages, difficulties in communication with parents/caregivers and families, and the negative stigma associated with mental health. This silence perpetuates in AANHPI communities as the youth aim to uphold a positive image.

These findings point to an urgent need to not only elevate the visibility of AANHPI youth mental health needs but also to acknowledge and validate their experiences. Efforts from youth and their families, community organizations and school stakeholders, mental health service providers, policymakers, and funders at the local and state levels are needed. We envision a future youth mental health services system that:

- empowers AANHPI youth and their families to share their experiences and stories,
- embraces continual collection of disaggregated AANHPI data and community-based participatory research to inform mental health needs and appropriate service delivery,
- strengthens and funds stronger collaborations between community organizations serving AANHPI youth and schools to reduce barriers for AANHPI youth to access and utilize mental health prevention, early intervention, crisis intervention, and treatment services,
- finances mental health service providers to have the time to build trust and connections through an anti-racist lens and culturally-specific strategies when working with youth,
- grows the youth mental health workforce pipeline by training AANHPI youth to serve as peer mental health educators/navigators and training adults with shared lived experiences to serve as mental health community health workers, paraprofessionals, and licensed mental health professionals, and
- prioritizes specific funding streams for services to AANHPI youth and their families.

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References

Ai, A.L., Appel, H.B., Lee, J., & Fincham, F. (2022). Family Factors Related to Three Major Mental Health Issues Among Asian-Americans Nationwide. *J Behav Health Serv Res, 49*(1), 4-21. doi: 10.1007/s11414-021-09760-6

Benner, A.D., Rojas, F.A., Kim, S.Y., Hou, Y., & Coulter, K.M. (2023). COVID-19 Anti-Chinese Discrimination, Current Pandemic Stress, And Adolescents' Mental Health. *J Racial Ethn Health Disparities*. doi: 10.1007/s40615-023-01663-w

Bitsko, R.H., Claussen, A.H., Lichstein, J., Black, L.I., Jones, S.E., Danielson, M.L., . . . Ghandour, R.M. (2022). Mental Health Surveillance Among Children - United States, 2013-2019. *MMWR Suppl, 71*(2), 1-42. doi: 10.15585/mmwr.su7102a1

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist. , 32*(7), 513.

CDPH. (2023). *CDPH Announces $16.3 Million in Awards for Youth Suicide Prevention*. Retrieved from https://www.cdph.ca.gov/Programs/OPA/Pages/NR23-028.aspx.

Chen, B., Lui, J., Benson, L., YJ., L., Ponce, N., & Lau, A. (2022). Closing the care gap. *UCLA Asian American & Pacific Islander Policy Initiative, Research Brief*.

Chu, J., O'Neill, S.E., Ng, J.F., & Khoury, O. (2022). The cultural theory and model of suicide for youth. In Youth suicide prevention and intervention: best practices and policy implications. *Springer International Publishing.* , 99-106.

Heron, M. (2021). Deaths: Leading Causes for 2018. *Natl Vital Stat Rep, 70*(4), 1-115.

Huynh, J., Chien, J., Nguyen, A.T., Honda, D., Cho, E.E., Xiong, M., . . . Ngo, T.D. (2022). The mental health of Asian American adolescents and young adults amid the rise of anti-Asian racism. *Front Public Health, 10*, 958517. doi: 10.3389/fpubh.2022.958517

Li, H., & Seidman, L. (2010). Engaging Asian American youth and their families in quality mental health services. *Asian J Psychiatr, 3*(4), 169-172. doi: 10.1016/j.ajp.2010.08.008

Liu, S.R., Davis, E.P., Palma, A.M., Stern, H.S., Sandman, C.A., & Glynn, L.M. (2023). Experiences of COVID-19-Related Racism and Impact on Depression Trajectories Among Racially/Ethnically Minoritized Adolescents. *J Adolesc Health, 72*(6), 885-891. doi: 10.1016/j.jadohealth.2022.12.020

Lowry, R., Eaton, D., Brener, N., & Kann, L. (2011). Prevalence of Health-Risk Behaviors Among Asian American and Pacific Islander High Shool Students in the U.S., 2001-2007. *Public Health Reports, 126*, 39-49.

Minority Health and Health Disparities Research Framework. (2017). *National Institute on Minority Health and Health Disparities*.

Polanco-Roman, L., Ebrahimi, C.T., Mafnas, K.S.W., Hausmann-Stabile, C., Meca, A., Mazzula, S.L., . . . Lewis-Fernández, R. (2023). Acculturation and suicide-related risk in ethnoracially minoritized youth in the US: a scoping review and content analysis of the empirical evidence. *Soc Psychiatry Psychiatr Epidemiol, 58*(8), 1121-1137. doi: 10.1007/s00127-023-02494-0

Ramakrishnan, K. (2014). State of Asian Americans and Pacific Islanders Series: A Multifaceted Portrait of a Growing Population: Center for American Progress.

Reyes, M.P., Song, I., & Bhatt, A. (2024). Breaking the Silence: An Epidemiological Report on Asian American and Pacific Islander Youth Mental Health and Suicide (1999–2021). *Child Adolesc Ment Health*.

Schwartz, S.J., & Unger, J.B. (2010). Biculturalism and Context: What Is Biculturalism, and When Is It Adaptive?: Commentary on Mistry and Wu. *Hum Dev, 53*(1), 26-32. doi: 10.1159/000268137

Subica, A.M., Aitaoto, N., Sullivan, J.G., Henwood, B.F., Yamada, A.M., & Link, B.G. (2019). Mental illness stigma among Pacific Islanders. *Psychiatry Res, 273*, 578-585. doi: 10.1016/j.psychres.2019.01.077

Subica, A.M., & Wu, L.T. (2018). Substance Use and Suicide in Pacific Islander, American Indian, and Multiracial Youth. *Am J Prev Med, 54*(6), 795-805. doi: 10.1016/j.amepre.2018.02.003

Teng, C.C., Hon, S., Wang, A., & Tsai, W. (2023). Impact of COVID-19 discrimination fear on psychological distress among East Asian college students: The moderating role of emotion regulation. *Am J Orthopsychiatry, 93*(1), 86-96. doi: 10.1037/ort0000659

Viruell-Fuentes, E.A., Miranda, P.Y., & Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Soc Sci Med, 75*(12), 2099-2106. doi: 10.1016/j.socscimed.2011.12.037

Wong, J.Y., Uhm, S.Y., & Li, P. (2012). Asian Americans' family cohesion and suicide ideation: moderating and mediating effects. *Am J Orthopsychiatry, 82*(3), 309-318. doi: 10.1111/j.1939-0025.2012.01170.x

Wyatt, L.C., Ung, T., Park, R., Kwon, S.C., & Trinh-Shevrin, C. (2015). Risk Factors of Suicide and Depression among Asian American, Native Hawaiian, and Pacific Islander Youth: A Systematic Literature Review. *J Health Care Poor Underserved, 26*(2 Suppl), 191-237. doi: 10.1353/hpu.2015.0059

Yip, T., Lorenzo, K., Bae, J., Hall, G.N., Cheah, C.S.L., Kiang, L., . . . Tseng, V. (2024). Anti-Asian biases in federal grant reviews: Commentary on Yip et al. (2021). *Am Psychol*. doi: 10.1037/amp0001337

Zhou, S., Banawa, R., & Oh, H. (2023). Stop Asian hate: The mental health impact of racial discrimination among Asian Pacific Islander young and emerging adults during COVID-19. *J Affect Disord, 325*, 346-353. doi: 10.1016/j.jad.2022.12.132

Appendix A. Study Methodology and Limitations

California Healthy Kids Survey Data and Analysis

Data were from the California Healthy Kids Survey (CHKS), a school-based survey of 9th and 11th graders attending California schools 2021-22. CHKS included two self-reported race and ethnicity questions: (Q6) major ethnoracial groups with a "mark-all-that-apply" option, and (Q7) eleven Asian and NHPI categories with a "mark-all-that-apply" (See Figure A.1). From Q6, we create racialized groups of American Indian/Alaskan Native (AI/AN), Black, Hispanic/Latinx, White, and multiracial. For Asian and NHPI groups, adolescents who selected both Asian Q6 and Asian ethnicities Q7 were categorized into Asian Indian, Chinese, Filipino, Japanese, Korean, Southeast Asian (SEA; specifically, Cambodian, Hmong, Laotian), Vietnamese, and other Asian group (unspecified). Those who selected NHPI in Q6 or NHPI ethnicity in Q7 (including Native Hawaiian, Guamanian, Samoan, Tahitian, or other Pacific Islander) were categorized into the NHPI group. With Q7's "mark-all-that apply" option, we further distinguished participants who selected a single Asian or NHPI identification and those who selected multiple Asian or NHPI identifications. Categories for each Asian subgroup included: monoethnic/monoracial Asian (selected 1 single group in Q7), multiethnic Asian (selected more than 1 Asian group in Q7, but not NHPI), and multiracial Asian (selected Asian in Q6 or Asian subgroup in A7, and selected at least one additional group in Q6: AI/AN, Black, Hispanic/Latino, White, or unspecified multiracial, but not NHPI). For NHPI adolescents, categories included monoracial NHPI (selected only one single group-NHPI in Q6 or in Q7), multiracial NHPI and Asian (selected Asian and NHPI in Q6 or in Q7, but did not select any other racial group in Q6), and multiracial NHPI (selected NHPI in Q6 or in Q7, and selected at least one additional group in Q6: AI/AN, Black, Hispanic/Latino, White, or unspecified multiracial, but not Asian). See Figure A.2 for sample sizes and distribution of monoethnic, multiethnic and multiracial identities for each Asian and NHPI groups.

The primary outcome was suicide ideation (SI) captured by: "During the past 12 months, did you ever seriously consider attempting suicide?" and depressive symptom: "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more that you stopped doing some usual activities?"

Study limitations

CHKS is a survey conducted by schools who self-select to participate, often with districts collecting CHKS every other school year. Student participation within schools is high with past studies showing >85% student response rates. However, our study findings are not generalizable to the whole AANHPI youth population in California. While the sample sizes are large for AANHPI youth, data for Cambodian, Hmong and Laotian were combined into "Southeast Asian" group due to smaller sample sizes. Students were not asked to specify which NHPI group or other Asian group if they selected these options in Q7. Qualitative voices are coming from select youth who participate in a youth program offered by our community partners. The focus group findings are also not generalizable to the whole AANHPI youth population, and present a snapshot of their voices and perspectives. Future research is needed to gather more quantitative and qualitative data from AANHPI youth.

Figure A.1. Race and ethnicity questions in California Healthy Kids Survey, 2021/22, and classification of Asian and Native Hawaiian and Pacific Islander groups

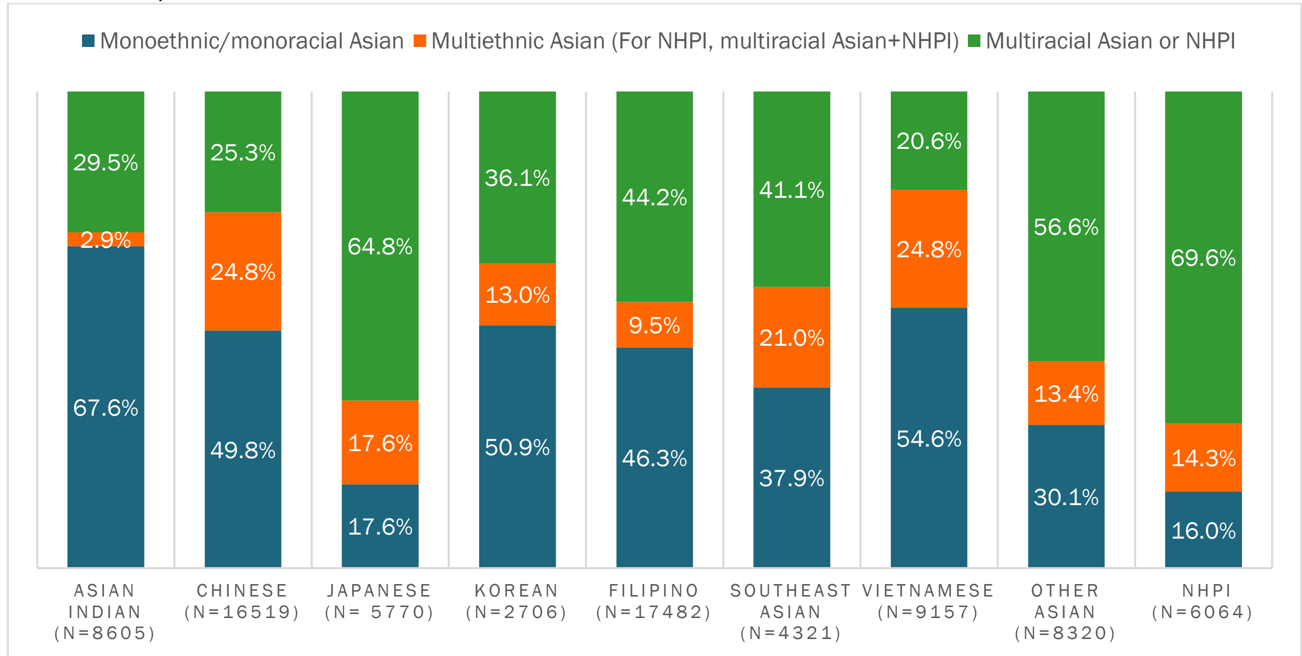
6. What is your race or ethnicity? ***(Mark All That Apply).***

A) American Indian or Alaska Native
B) Asian or Asian American
C) Black or African American
D) Hispanic or Latinx
E) Native Hawaiian or Pacific Islander
F) White
G) Something Else

7. If you are Asian or Pacific Islander, which groups best describe you? ***(Mark All That Apply).***
If you are **not** of Asian or Pacific Islander background, mark "A) Does not apply."

A) Does not apply; I am not Asian or Pacific Islander
B) Asian Indian
C) Cambodian
D) Chinese
E) Filipino
F) Hmong
G) Japanese
H) Korean
I) Laotian
J) Vietnamese
K) Native Hawaiian, Guamanian, Samoan, Tahitian, or other Pacific Islander
G) Other Asian

Figure A.2. Sample sizes and proportion of monoethnic, multiethnic and multiracial Asian and NHPI adolescents, CHKS 2021-22 data



Notes: Southeast Asian includes Cambodian, Laotian, and Hmong. NHPI is Native Hawaiian and Pacific Islander. Specific other Asian groups were not identified.

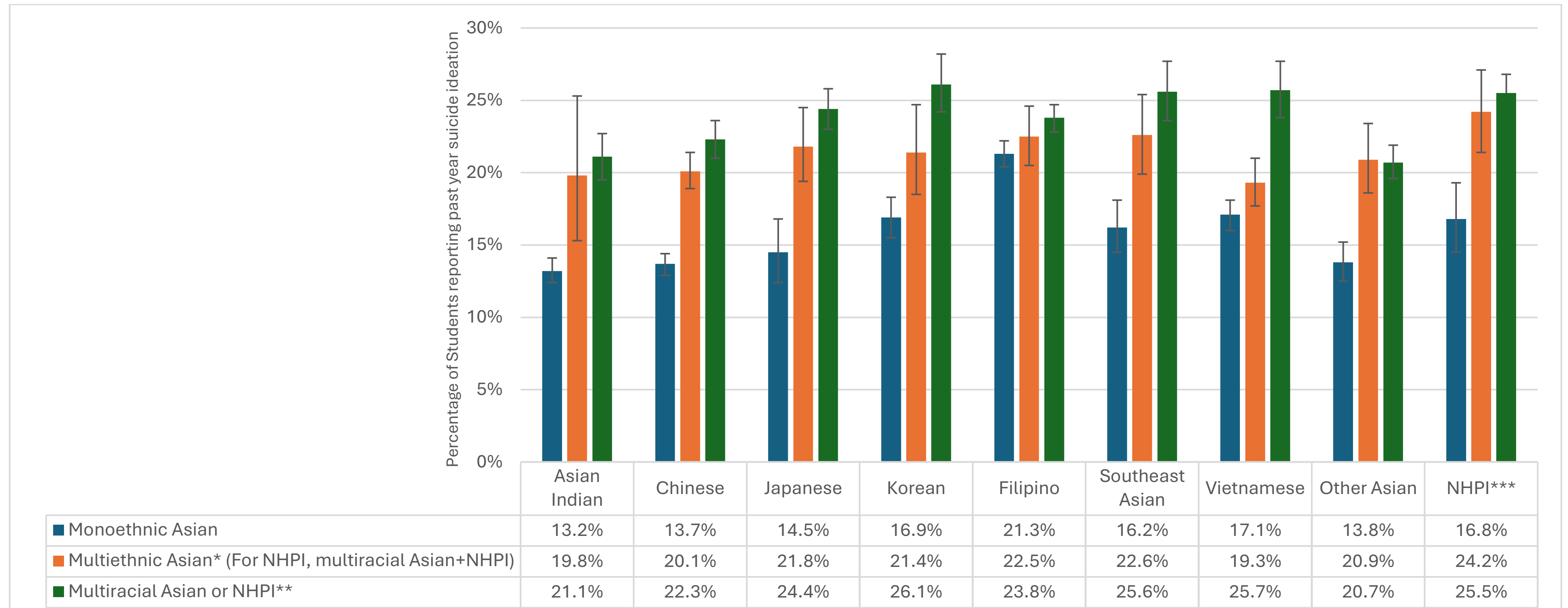
*Multiethnic Asian refers to identification with more than one Asian ethnic subgroup. This category is not mutually exclusive; thus, a Chinese and Southeast Asian adolescent would be included twice in the orange bars under Chinese and Southeast Asian. See additional notes under NHPI.

**Multiracial Asian or NHPI refers to identification as Asian or NHPI (but not both) and another racial/ethnic group of American Indian/Alaskan Native, Black, Hispanic/Latinx, White or unspecific multiracial/mixed.

***NHPI categories are as follow: Monoracial NHPI represents NHPI only (Blue bar). Multiracial Asian+NHPI for NHPI includes those who identified as both Asian and NHPI (Orange bar). Multiracial Asian or NHPI for NHPI represents those who identified as both NHPI and another racial/ethnic group of American Indian/Alaskan Native, Black, Hispanic/Latinx, White or unspecific multiracial/mixed (Green bar).

Appendix B. California Healthy Kids Survey Tables—Disaggregation of Asian and NHPI youth

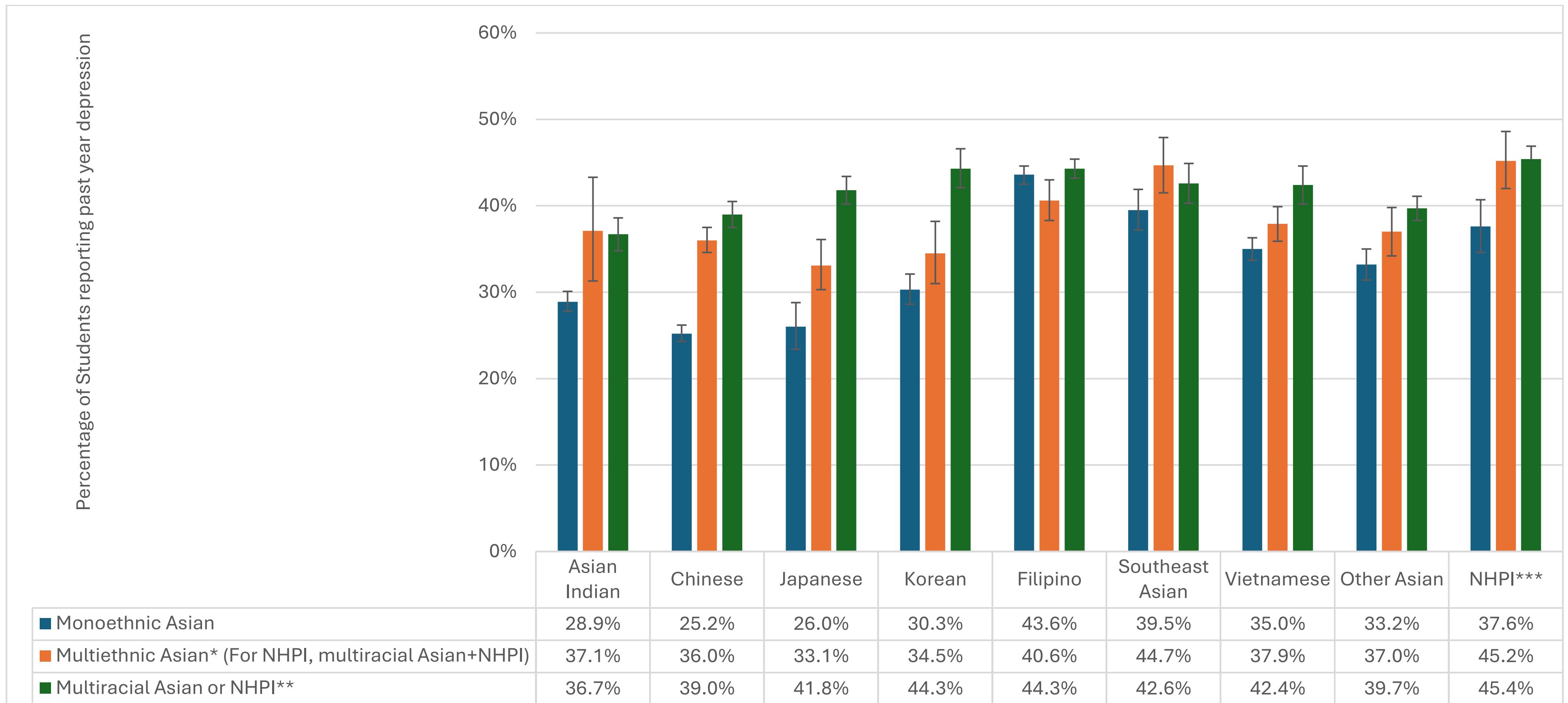
Table B.1 Suicide Ideation by monoethnic, multiethnic, and multiracial identities among Asian and NHPI youth, CHKS 2021-22



	Asian Indian	Chinese	Japanese	Korean	Filipino	Southeast Asian	Vietnamese	Other Asian	NHPI***
Monoethnic Asian	13.2%	13.7%	14.5%	16.9%	21.3%	16.2%	17.1%	13.8%	16.8%
Multiethnic Asian* (For NHPI, multiracial Asian+NHPI)	19.8%	20.1%	21.8%	21.4%	22.5%	22.6%	19.3%	20.9%	24.2%
Multiracial Asian or NHPI**	21.1%	22.3%	24.4%	26.1%	23.8%	25.6%	25.7%	20.7%	25.5%

*Multiethnic Asian refers to identification with more than one Asian ethnic subgroup. This category is not mutually exclusive; thus, a Chinese and Southeast Asian adolescent would be included twice in the orange bars under Chinese and Southeast Asian. See additional notes under NHPI.
**Multiracial Asian or NHPI refers to identification as Asian or NHPI (but not both) and another racial/ethnic group of American Indian/Alaskan Native, Black, Hispanic/Latinx, White or unspecific multiracial/mixed.
***NHPI categories are as follow: Monoracial NHPI represents NHPI only (Blue bar). Multiracial Asian+NHPI for NHPI includes those who identified as both Asian and NHPI (Orange bar). Multiracial Asian or NHPI for NHPI represents those who identified as both NHPI and another racial/ethnic group of American Indian/Alaskan Native, Black, Hispanic/Latinx, White or unspecific multiracial/mixed (Green bar).

Table B.2 Depressive symptom by monoethnic, multiethnic, and multiracial identities among Asian and NHPI youth, CHKS 2021-22



	Asian Indian	Chinese	Japanese	Korean	Filipino	Southeast Asian	Vietnamese	Other Asian	NHPI***
Monoethnic Asian	28.9%	25.2%	26.0%	30.3%	43.6%	39.5%	35.0%	33.2%	37.6%
Multiethnic Asian* (For NHPI, multiracial Asian+NHPI)	37.1%	36.0%	33.1%	34.5%	40.6%	44.7%	37.9%	37.0%	45.2%
Multiracial Asian or NHPI**	36.7%	39.0%	41.8%	44.3%	44.3%	42.6%	42.4%	39.7%	45.4%

*Multiethnic Asian refers to identification with more than one Asian ethnic subgroup. This category is not mutually exclusive; thus, a Chinese and Southeast Asian adolescent would be included twice in the orange bars under Chinese and Southeast Asian. See additional notes under NHPI.

**Multiracial Asian or NHPI refers to identification as Asian or NHPI (but not both) and another racial/ethnic group of American Indian/Alaskan Native, Black, Hispanic/Latinx, White or unspecific multiracial/mixed.

***NHPI categories are as follow: Monoracial NHPI represents NHPI only (Blue bar). Multiracial Asian+NHPI for NHPI includes those who identified as both Asian and NHPI (Orange bar). Multiracial Asian or NHPI for NHPI represents those who identified as both NHPI and another racial/ethnic group of American Indian/Alaskan Native, Black, Hispanic/Latinx, White or unspecific multiracial/mixed (Green bar).

Figure B.3 Suicide Ideation by female and male Asian and NHPI youth, CHKS 2021-22

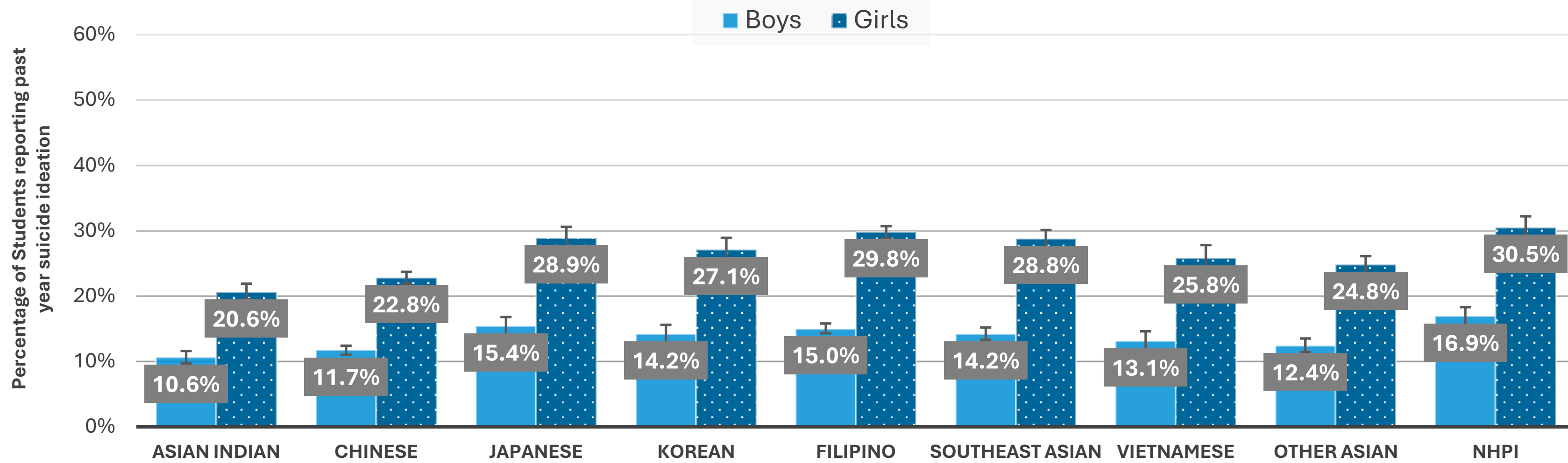
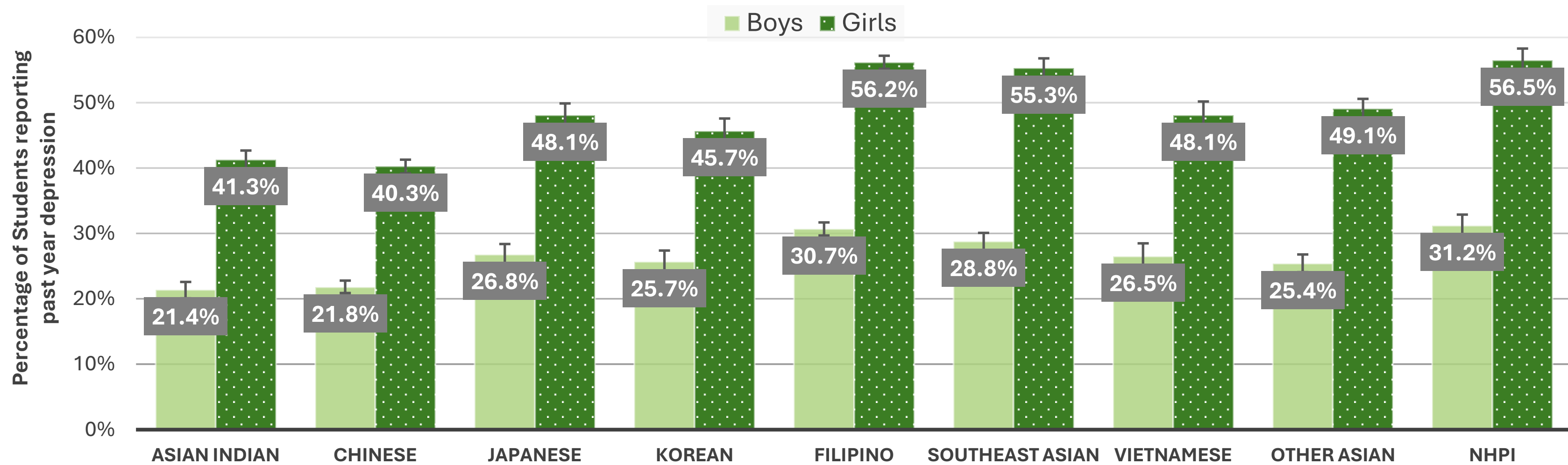


Figure B.4 Depressive symptoms by female and male Asian and NHPI youth, CHKS 2021-22



Notes: Southeast Asian includes Cambodian, Laotian, and Hmong. NHPI is Native Hawaiian and Pacific Islander. Specific other Asian groups were not identified.