REPORT

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Piecing the Puzzle of AANHPI Mental Health:

A Community Analysis of Mental Health Experiences of Asian Americans, Native Hawaiians, and Pacific Islanders in California

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AA AND NHPI MENTAL HEALTH: PIECES OF THE PUZZLE

Report Overview

A persistent dichotomy has long been evident between self-reported data on mental health and the lived experience of community members in Asian American (AA), and Native Hawaiian and Pacific Islander (NHPI) communities. Self-reports portray a rosier picture than real life. *Piecing the Puzzle of AANHPI Mental Health: A Community Analysis of Mental Health Experiences of Asian Americans, Native Hawaiians, and Pacific Islanders in California* is a report series that aims to spur a more nuanced conversation about mental health among AA and NHPI populations by connecting survey data with community experiences as influenced by cultural nuances, U.S. foreign policy, and intergenerational trauma.[1] It is the product of a deep analysis of recent data from the UCLA California Health Interview Survey (CHIS), an exploration of past AA and NHPI experiences in the United States, and engagement with AA and NHPI community leaders in California.

This report builds upon two prior reports by AAPI Data and UCLA CHIS that describe the state of health and mental health of AA and NHPI populations in California.[2,3] Using results from the UCLA CHIS, this report offers insight on the following questions:

- What are the cultural and historical factors that shape how AAs and NHPIs access mental health care?
- What are the mental health experiences among AA and NHPI communities in California?

Piecing the Puzzle of AANHPI Mental Health: A Community Analysis of Mental Health Experiences of Asian Americans, Native Hawaiians, and Pacific Islanders in California is a multi-part series that includes (a) a report of cross-community themes for the AA and NHPI umbrella, and (b) seven community-specific briefs—organized by the eight detailed categories available for CHIS. The seven communities are: Native Hawaiian and Pacific Islander, Southeast Asian (including Vietnamese and Other Southeast Asian), South Asian, Filipino, Korean, Japanese, and Chinese. The report presents findings from the CHIS data, discusses barriers to mental health service utilization and access, and offers recommendations to better respond to the mental health needs of AA & NHPI communities.

Methodology

This report aims to place AA and NHPI mental health data in context with lived experience and the journey of each community in connection with American history. In collaboration with an intentional sample of community leaders, this exploratory report seeks to spur a more nuanced discourse on AA and NHPI mental health that connects present-day mental health needs with the systemic barriers and multi-generational trauma that were often byproducts of U.S. foreign policy. While the report highlights historical and sociopolitical points to frame the findings within context, it is not a comprehensive historical review of the AA and NHPI experience in the United States.

Dataset

The UCLA CHIS is an annual statewide population-representative health survey of Californians. This report uses a select set of core CHIS variables related to mental health needs, gun violence, and suicide ideation from the pooled 2020, 2021, and 2022 survey data. In addition, AAPI Data and the UCLA Center for Health Policy Research initiated a project, called the California AANHPI Community Needs Survey, that expands data collected for AA and NHPI populations in the form of a 15-minute follow-on survey for 2021 and 2022 CHIS AA and NHPI respondents. This report also includes a select set of AA and NHPI follow-on variables related to discrimination experiences, hate crime victimization, and difficulties with mental health service access from the 2021 and 2022 pooled survey data.[4] The report displays results that are available for adult and adolescent (ages 12–17) respondents.[5] Survey results are organized by the CHIS Asian and NHPI race alone categories, and by specific Asian subpopulations: Vietnamese, Other Southeast Asian (excluding Vietnamese), Filipino, South Asian, Korean, Japanese, and Chinese.[6] The report presents California total statewide estimates, as available, representing all respondents, as a benchmark or reference point. The community briefs also include population estimates from the Race and Ethnicity in the United States: 2010 Census and 2020 Census data visualization, 2020 Census Detailed Demographic and Housing Characteristics File A, and other sociodemographic information from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.

Analytical notes

AAPI Data and the UCLA Center for Health Policy Research acknowledge the past harms of data suppression on AA and NHPI communities, rendering their experiences and struggles invisible to policymakers and the general public. This report displays as much detailed data as possible, with clear notation on the statistical stability of each estimate. Results are considered statistically stable if the coefficient of variation is less than 30%.[7] Results that fail to meet this standard are labeled as statistically unstable and should be interpreted with caution. Where possible, the report highlights significant differences between racial groups (e.g., Asian and NHPI) and the California total population at 95% confidence levels.[8] As sample size permits, the research team conducted logistic regressions to understand the relationship between mental health outcomes and sociodemographic factors (i.e., age, gender, poverty level, educational level, citizenship status, nativity status, and English proficiency).[9]

AA and NHPI Mental Health Context

Recent experiences

The COVID-19 pandemic laid bare the longstanding health inequities faced by many communities of color, including AA and NHPI populations. The pandemic affected

AA and NHPI populations in distinct ways—from soaring death rates among NHPI and Filipino communities to rising anti-Asian hate sentiment and racialized violence toward Asian Americans. AA and NHPI communities bore the burden of blame for the global health crisis, and this scapegoating reignited a long history of AA and NHPI xenophobia. The pandemic highlighted the deep need for mental health support within AA and NHPI communities.[10,11] Many AA and NHPI-serving nonprofit organizations expanded their offerings to include mental health services and support groups during the pandemic.[12]

The COVID-19 pandemic highlighted that mental health care is deeply needed for AA and NHPI communities given the stressors from stay-at-home orders, social isolation, anti-Asian hate incidents and bullying, and gun violence. Yet research has shown that AA and NHPI populations were less likely to seek help or use mental health resources compared to other racial groups.[13,14] Results from a national AAPI Data/Momentive 2023 Poll revealed that only 20% of AA and 18% of NHPI adults sought support from mental health professionals compared to 28% of White adults.[15] AAs and NHPIs typically relied on family and friends as sources of support. The psychological toll from the pandemic and anti-Asian rhetoric had profound impacts across generations of AA and NHPI communities. The rise in discrimination and hate crimes deeply affected the safety and well-being of Asian American elders. They reported more harassment and physical assaults, leading to an increase in fear, stress, anxiety, and perception that the U.S. had become more dangerous to Asian Americans.[16] The stay-at-home orders worsened intimate partner violence against AA and NHPI women.[17,18] The vulnerability of people in dangerous situations was further compounded by lack of language access and limited resources to seek help. The pandemic also escalated bullying and harassment toward AA and NHPI youth, leading to negative psychological and academic consequences.[19,20] NHPIs were dying from COVID-19 at higher rates than any other racial or ethnic group,[21] and the pandemic had significant implications for NHPI mental health with reports of increased depression, anxiety, substance use, and psychological distress.[22]

Although the need for mental health care is high, research suggests that AAs and NHPIs have some of the lowest rates of mental health service utilization compared to other racial groups.[23,24] When they do seek help, AA and NHPI communities face significant barriers to accessing mental health support.[25,26] This includes language access barriers, lack of culturally aligned care, and cultural stigma toward mental health. In addition, the model minority stereotype enables the inaccurate assumption that AA and NHPI populations do not experience health disparities, or that only a small subset struggle.

AAs and NHPIs: Threads in the fabric of America

AAs and NHPIs have significantly contributed to U.S. society with Wong Kim Ark paving the way for birthright citizenship, Dalip Singh Saund serving as the first Asian American in Congress, Patsy Mink championing Title IX in education, Larry Itliong advocating for farm

workers' rights, Edith Kanaka'ole preserving native Hawaiian culture and arts, Amanda Nguyen advancing the rights of sexual assault survivors, and many others. Although AA and NHPIs have built strong communities and remain resilient, they have endured a long history of colonization, resettlement trauma, discriminatory practices, and racist policies in the U.S. well before the COVID-19 pandemic. These cumulative experiences continually shape AA and NHPI identity and well-being, and significantly undermine their mental health.

NHPIs are indigenous peoples of the Pacific Islands and have built a rich cultural history. However, U.S. colonization impaired all facets of NHPI livelihoods, ranging from access to public benefits, work eligibility, and voting rates. This forced assimilation, displacement from homelands, and systemic discrimination have had long-lasting psychological implications for NHPI communities. The impact of colonialism also runs deep in the Filipino American community, manifesting as "colonial mentality" and devaluing native cultural heritage.[27] Colonial dominance and the residual trauma of war in the Philippines significantly compromise the mental health of present-day Filipino Americans.

The impetus for the early waves of migration among Chinese, Japanese, South Asian, and Korean immigrants to the United States was to work as laborers in agriculture, mining, and railroad construction. Despite their contributions to the U.S. economy and infrastructure, Asian immigrants were perceived as a threat, exposed to harsh working conditions, and experienced racialized violence. Stoking more anti-Asian sentiment, the U.S. enacted discriminatory policies such as the 1882 Chinese Exclusion Act and 1924 Immigration Act to limit immigration, and Alien Land Laws to bar land ownership among AAs and NHPIs. Discriminatory practices against Chinese immigrants were extended over time to exclude other Asians, including Japanese, Korean, South Asian, and Filipino immigrants. Acculturation stressors coupled with experiences with discrimination exacerbated AA and NHPI mental health needs.

While Vietnamese and other Southeast Asians have built prominent and close-knit communities in the U.S., the trauma of war and the subsequent refugee resettlement remains. Southeast Asians have endured genocide, famine, and displacement, and this war-induced trauma has taken an economic and mental toll on families for generations.

Systemic racism and anti-Asian rhetoric are still pervasive today, and remain detrimental to AA and NHPI communities. Understanding the historical and intergenerational transmission of trauma that AA and NHPI communities have endured informs the extent of AA and NHPI mental health needs and barriers to access.

Data on AA and NHPI Mental Health

Mental health and well-being have long endured social stigma across all cultures, dissuading many people from admitting their need for support. One silver lining to the COVID-19 pandemic was a broad-based recognition of the constant strain, fear, and vigilance on our mental health and well-being as a society—no one was immune. And yet,

important culturally specific nuances are of fundamental importance in understanding one's own mental health and, as a matter of public health, overcoming culturally specific barriers to seeking and attaining mental health support.

Though mental health needs may manifest differently among disparate AA and NHPI communities, they share common threads—a rich and resilient culture that survived trauma and oppression, a deep-rooted recognition of the sacrifice of those who came before

KEY TAKEAWAYS

- **1 in 4 NHPI and 1 in 6 AA adults report a need for mental health support despite significant mental health stressors.** Nearly 24% of NHPI adults and 16% of AA adults identified needing mental health support. The rates for AA adults were statistically lower than for the California population overall (24%).
- **Nearly half of NHPI and AA adults report everyday experiences with discrimination and 20% of AA adults also report experience as a victim of a hate incident or crime.** NHPI adults most frequently report being asked where they are from and receiving poorer service in restaurants and stores. AA adults most frequently report being asked where they are from, treated as if they don't speak English, and receiving poorer service in restaurants and stores.
- **Nearly half of NHPI and AA adults are worried about being a victim of gun violence.** The prospect of becoming a victim of gun violence worries 45% of NHPI adults and 46% of AA adults. These rates are statistically significantly higher than that of the California population overall (30%).
- **21% of NHPI and 12% of AA adults report suicide ideation.** The rate for AA adults is statistically significantly lower than that of the California population overall (17%).
- **When AA and NHPIs do seek support, they encounter access barriers.** Of those who identified mental health support needs, 42% of NHPI adults and 31% of AA adults report difficulty accessing services.

them, and a pride in the ability to toil through adversity. These strengths have enabled AA and NHPI communities to thrive in the U.S., and yet these same strengths have masked their struggles and served as a barrier to self-care. For decades, community leaders have asserted the dichotomy between low rates of self-reported mental health needs and the pervasive mental health struggles they see in their communities every day.

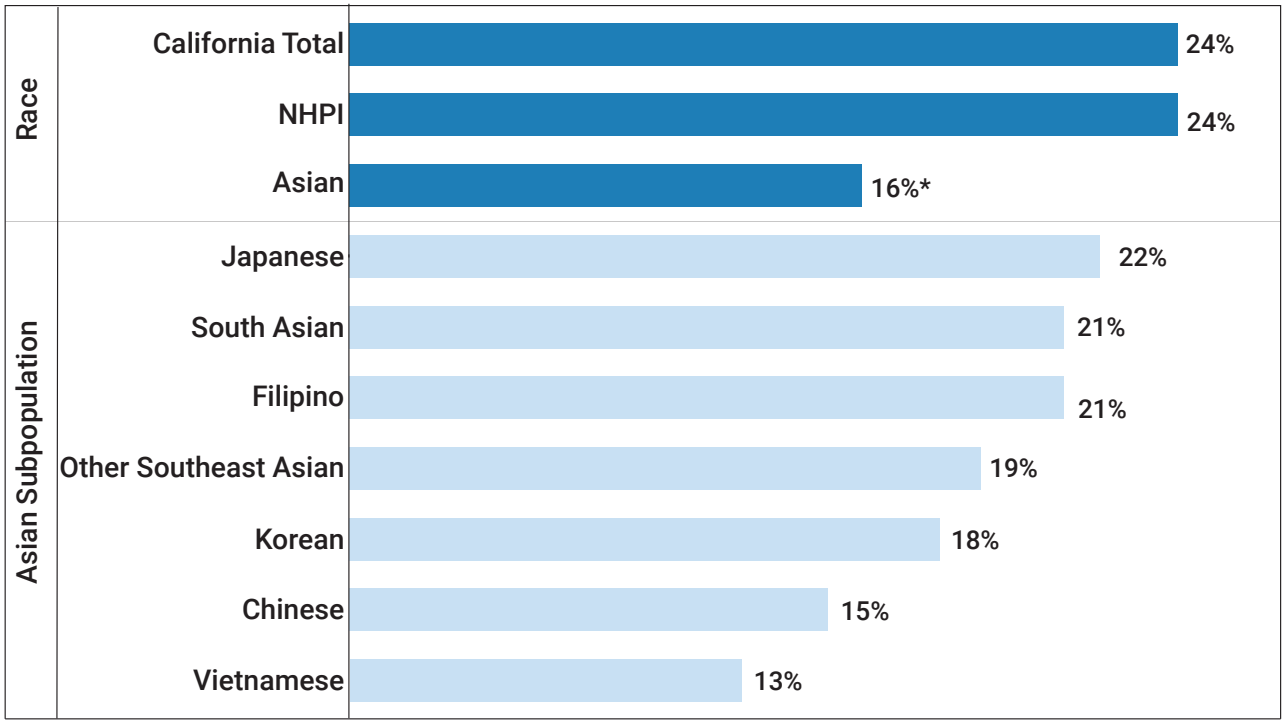
The goal of this report is to spur a more complex and nuanced discourse about mental health policies and services for AA and NHPI communities. We urge policymakers to triangulate across multiple data points and listen to community leaders on how to understand the many puzzle pieces of AA and NHPI mental health. Self-reported data on mental health needs will remain an important piece of the puzzle *and yet* the attentiveness of policymakers and health providers to contextual data, community voices, and common-sense analysis of the human experience is of critical importance.

Mental Health Needs

Despite low rates of reporting needs for mental health support, NHPI and AA adults face significant mental health stressors. Nearly a quarter of NHPI adults (24%) and one-sixth of AA adults (16%) self-identified as needing mental health support, which is on par or lower than that of California's overall population (24%), as Figure 1 indicates. The share was statistically lower for AAs than the overall California population. AA adults had lower rates of reporting mental health needs than White adults even after accounting for a host of sociodemographic characteristics (i.e., age, gender, poverty level, educational level, citizenship status, nativity status, and English proficiency), a finding consistent with other communities of color such as Hispanics and African Americans. Among AA adults, age, gender, nativity status, and English proficiency were associated with reporting mental health needs. AA respondents reporting the need for mental health support tended to be younger adults, female, born in the U.S., and English proficient. When examining the results by Asian subgroups, only 13% of Vietnamese and 15% of Chinese adults reported needing mental health support. Japanese, Filipino, and South Asian adults reported similar rates at around 21%. Almost a quarter of AA adolescents (24%), ages 12–17, reported needing mental health support, which was statistically lower than California's adolescent population statewide (34%), as Figure 2 illustrates. The estimates for NHPI adolescents were not statistically stable enough to draw any conclusions. Of the statistically stable estimates, 43% of South Asian adolescents and 31% of Vietnamese adolescents reported needing mental health support, followed by Korean and Chinese adolescents at 29% and 25%, respectively.

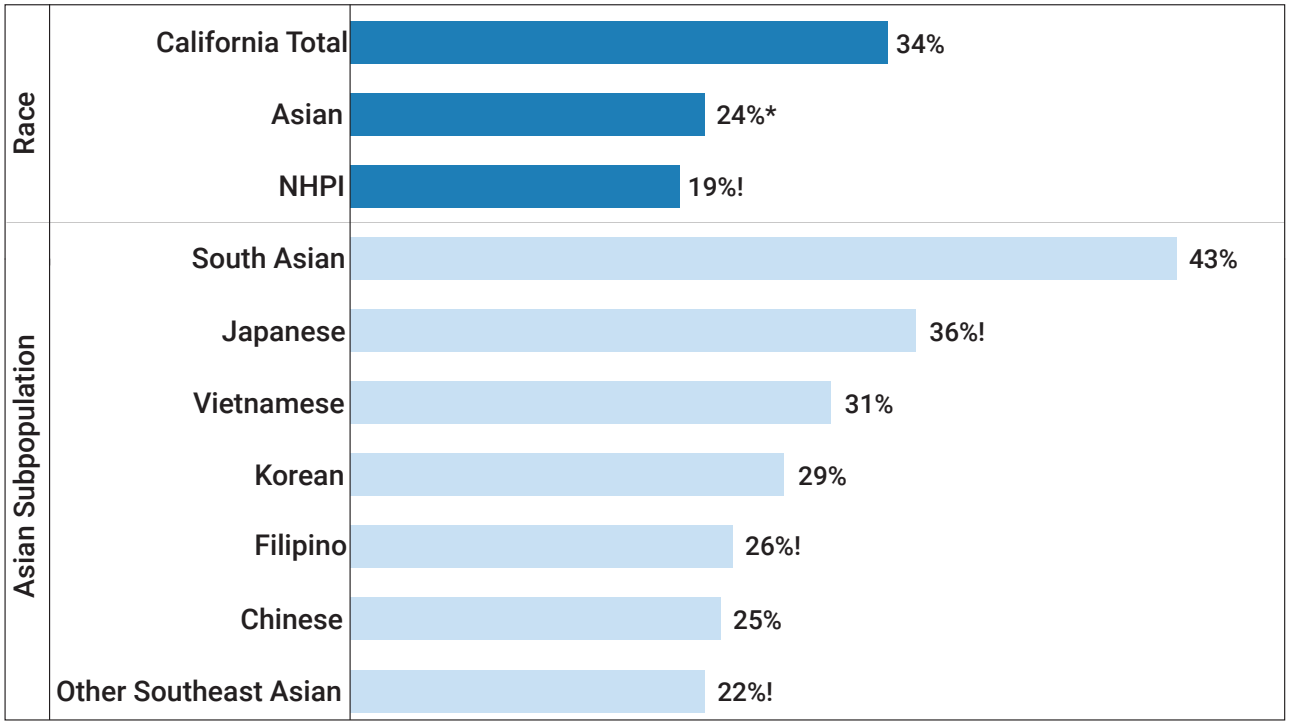
Because members of AA and NHPI communities may encounter systemic and cultural barriers to mental health care, self-identified mental health need may not provide a complete picture of the extent of mental health experiences for AA and NHPI communities. This is especially evident in the AAPI Data/AP-NORC November 2023 Survey that found that a majority of AAPI adults nationally rated

Figure 1. Adult respondents who reported need for mental health support



Source: 2020, 2021, and 2022 CHIS pooled data
An asterisk (*) indicates statistically significant difference with California total

Figure 2. Adolescent (ages 12-17) respondents who reported need for mental health support



Source: 2020, 2021, and 2022 CHIS pooled data
An asterisk (*) indicates statistically significant difference with California total
An exclamation mark (!) indicates statistically unstable estimates

their mental health as "very good or excellent," even though 12% of AAPI adults are at risk for an anxiety disorder. Nearly 7 in 10 experienced anxiety stressors of feeling irritable, worrying too much, or having trouble relaxing.[28]

Experiences with Discrimination and Hate

Everyday experiences with discrimination are common, with half being asked where they are from in an average month. CHIS findings revealed that in an average month almost half of both NHPIs (45%) and AAs (48%) frequently were asked where they were from with the assumption that they were not from the U.S., as Tables 1 and 2 shows.[29] For the responses with statistically stable estimates, 30% of NHPIs also reported experiencing poorer service at restaurants or stores. Among AA adults, 24% said that others frequently treated them as if they don't speak English, and 22% received poorer service than others at restaurants or stores.

The findings illuminate how Asian subgroups have varying experiences with discrimination in California, detailed further in Appendix Table H1. Over half of South Asians (62%), Other Southeast Asians (57%), and Koreans (54%) reported being questioned where they were from with the assumption that they were not from the U.S. South Asians (27%) and Vietnamese (14%) also frequently encountered having their name intentionally mispronounced while Other Southeast Asians also experienced being perceived as dishonest (39%), and being called names and insulted (38%).

The constant questioning of AA and NHPIs' place of origin continues the narrative of the "perpetual foreigner" stereotype, and that they

Table 1. Asian adult respondents' most frequent everyday experiences with discrimination in an average month

	Asian
People asked where you are from, assuming you're not from the U.S.	48%
People acted as if you don't speak English	24%
Received poorer service than other people at restaurants or stores	22%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note: A full list of the everyday experiences with discrimination can be found in the Appendix.

Table 2. NHPI adult respondents' most frequent everyday experiences with discrimination in an average month

	NHPI
People asked where you are from, assuming you're not from the U.S.	45%
Received poorer service than other people at restaurants or stores	30%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note: A full list of the everyday experiences with discrimination can be found in the Appendix.

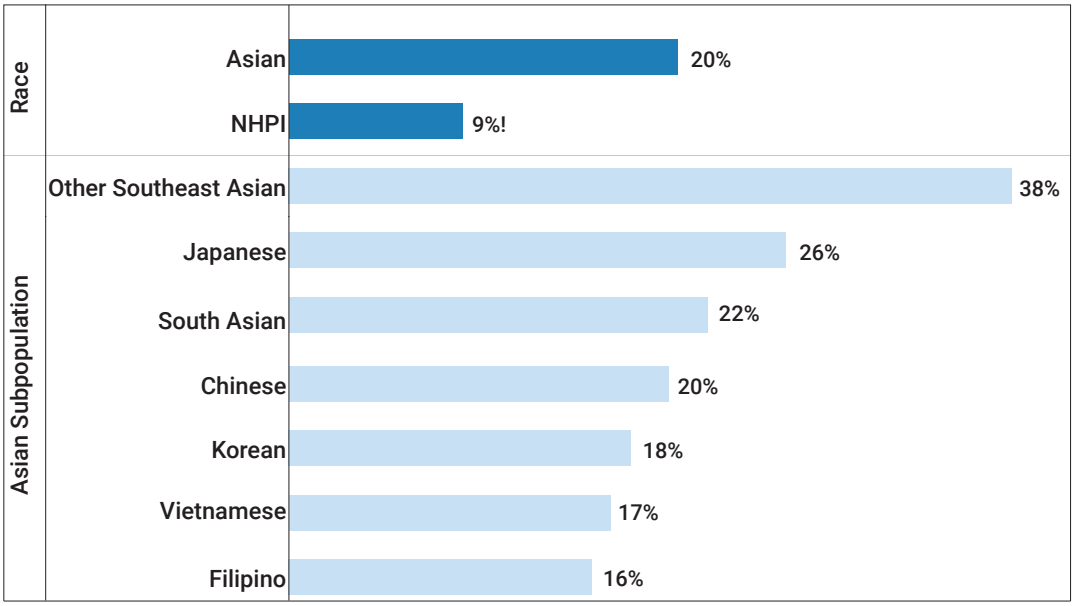
don't belong in the U.S. These present-day covert and overt acts of discrimination stem from a history of anti-Asian sentiment and racist immigration policies meant to limit the existence of AA and NHPI communities in the U.S. These ongoing discrimination experiences have detrimental and long-lasting implications on the identity development and psychological well-being of AA and NHPI communities.[30,31]

One in five AA adults have been a victim of a hate incident or crime. Recent findings from Stop AAPI Hate found that AA and NHPI community members have a broad understanding of hate experiences, and that these encounters are not just explicit acts of hate but can be coded or hidden.[32] Results from CHIS show that approximately 20% of AA adults indicated being a victim of a hate incident or crime at some point in their lives, as Figure 3 shows.[33] The estimates for NHPIs were not statistically stable enough to draw any conclusions.

Members of Asian subgroups in California expressed varying degrees of disclosure of hate incident or crime victimization. While up to 18% of Filipinos, Vietnamese, and Koreans reported being a victim of at least one hate incident or crime, over one-third of Other Southeast Asians (38%), and around a quarter of Japanese (26%) and South Asians (22%) reported victimization.

Hate incidents or crimes against AA and NHPI communities were especially exacerbated during the pandemic, corresponding to a rise in anti-Asian rhetoric and COVID-19 misinformation.[34,35] Complementary findings from the AAPI Data/Momentive 2022 Poll revealed that AAPIs nationally perceived an uptick in hate crimes from 2021 to 2022, and were worried about future attacks against their communities.[36] Racially motivated harassment and assaults are still pressing issues affecting AA and NHPI communities. The AAPI Data/AP-

Figure 3. Adult respondents who reported being a victim of a hate incident or crime



Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
An exclamation mark (!) indicates statistically unstable estimates

NORC November 2023 of AAPI adults across the United States found that over one-third (34%) of AAPI adults reported experiencing a hate incident, including verbal harassment and being called racial slurs. Another 16% have been a victim of a hate crime.[37] The U.S. has a long history of racialized violence against AA and NHPI communities, which has continued to the present day. These cumulative incidents have widespread implications for their safety and mental wellness.

Gun Violence

Nearly half of NHPI and AA adults worry about gun violence, at rates statistically higher than the California population overall. Findings from CHIS show that almost half of NHPI (45%) and AA (46%) adults stated that they were "very or somewhat worried" about being a victim of gun violence, in contrast to 30% of the general California population, as Figure 4 indicates. The shares for both NHPIs and AAs were statistically significantly higher than the California population at large. When compared to the White population, NHPIs and AAs had higher rates of worrying about gun violence even after accounting for a host of sociodemographic characteristics (i.e., age, gender, poverty level, educational level, citizenship status, nativity status, and English proficiency). This finding also was observed for other racial groups, such as Hispanics and African Americans. Among Asian subgroups, over half of Other Southeast Asians (52%) and nearly half of Chinese (45%), Korean (45%), Filipino (44%), and Vietnamese (44%) adults worried about gun violence.

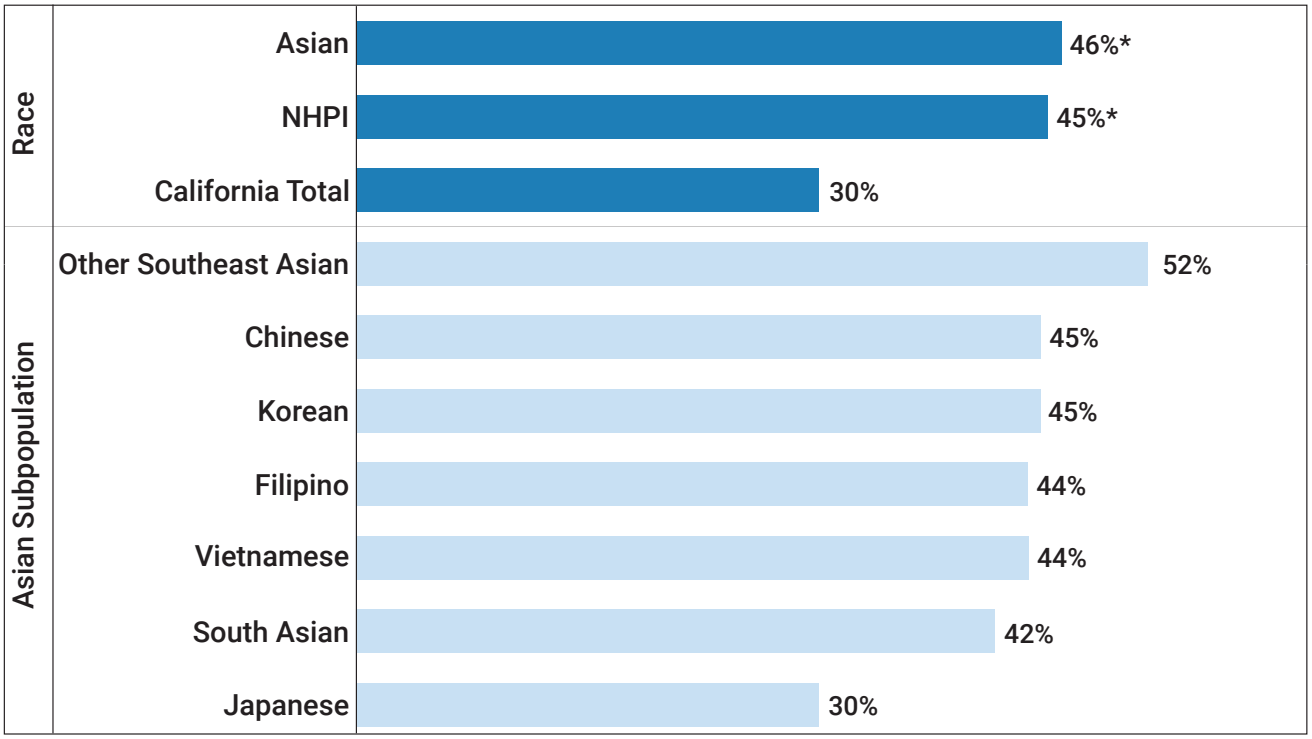
The impact of gun violence is felt across Asian communities by both adults and youth in California. Among AA adolescents (ages 12 to 17), 26% reported that they were worried about being shot by a firearm, matching the rates for the general California adolescent population, as Figure 5 shows. The estimates for NHPI adolescents were not statistically stable enough to draw any conclusions. Of the statistically stable estimates among Asian subgroups, a large share of Japanese adolescents (62%) worried about being shot by a firearm while the rates for Vietnamese, Chinese, and Filipino adolescents were between 31% and 38%.

Concerns about gun violence are not surprising given the uptick of mass shootings targeted at AA and NHPI communities since the pandemic. Findings from the AAPI Data/Momentive 2023 Poll revealed that Asian Americans at the national level were more likely than members of any other racial or ethnic groups to worry about being a victim of a mass shooting.[38] The tragic events that occurred at a spa in Atlanta, Georgia, a shopping mall in Allen, Texas, and a ballroom in Monterey Park, California, instill fear and anxiety among AA and NHPI communities, because they no longer know which public spaces are safe to congregate.

Suicidal Ideation and Suicidality

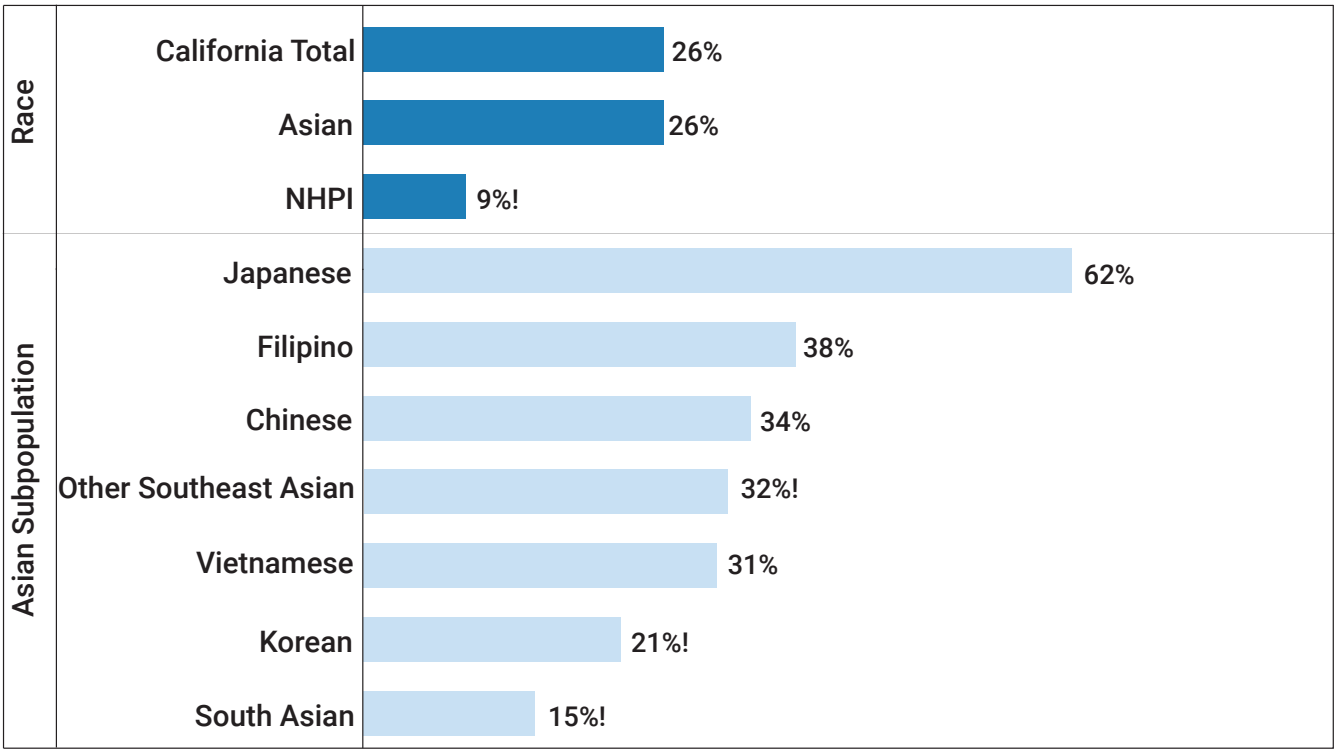
21% of NHPIs and 12% of AAs report suicide ideation. According to the Centers for Disease Control, suicide was one of the leading causes of death among AA and NHPI young adults between 2015 and 2020.[39] Risk factors associated with suicidal thoughts and behaviors include depression and anxiety, as well as experiences with discrimination.[40,41] Yet AAs are less likely to disclose suicide

Figure 4. Adult respondents who expressed worry about gun violence



Source: 2020, 2021, and 2022 CHIS pooled data
An asterisk (*) indicates statistically significant difference with California total

Figure 5. Adolescent (ages 12–17) respondents who expressed worry about being shot by a firearm



Source: 2020, 2021, and 2022 CHIS pooled data
An exclamation mark (!) indicates statistically unstable estimates

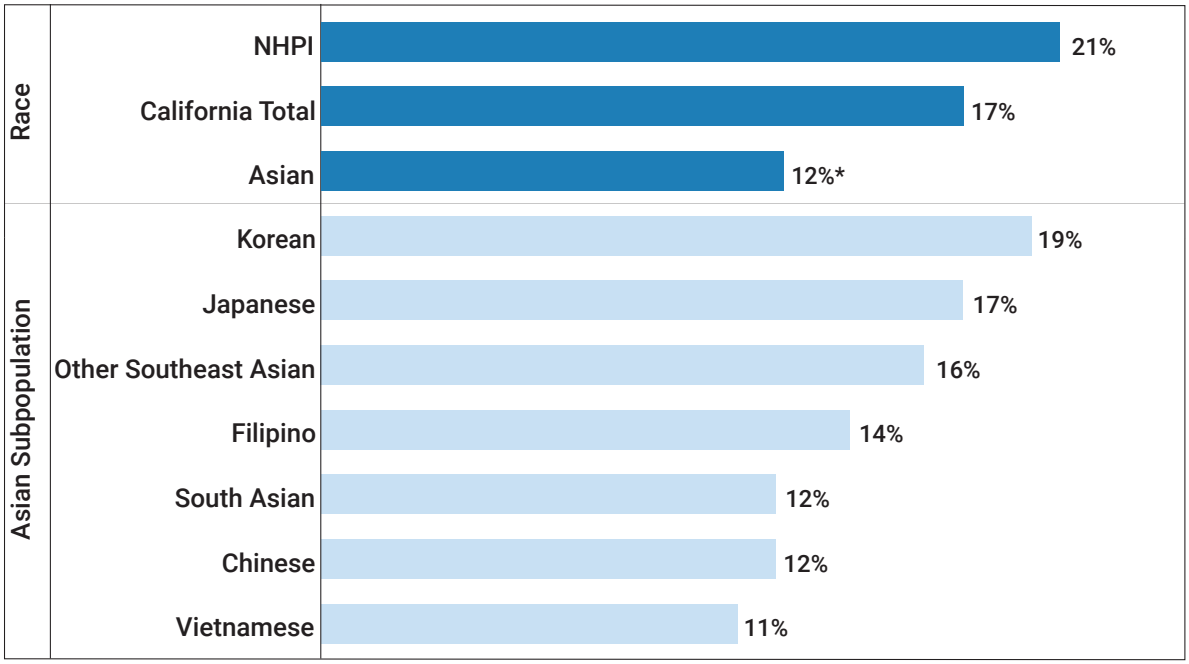
ideation compared to the White population,[42] suggesting that a critical analysis of the self-report data is necessary because the true prevalence likely is undercounted. The shame and stigma associated with mental illness mask the need among AA and NHPI communities, and the low utilization rates of mental health support services exacerbate the risk for suicidal behaviors.

Findings from CHIS reveal that one in five NHPI adults (21%), and one in eight AA adults (12%) disclosed ever having thoughts of attempting suicide, while the rate of suicide ideation for the general California population was 17%, as Figure 6 indicates. The share for AAs was statistically significantly lower than that of the California overall population. Among the Asian subgroups, 11% to 12% of Vietnamese, Chinese, and South Asians disclosed ever having thoughts of attempting suicide, while the rates of suicide ideation among Other Southeast Asians, Japanese, and Koreans ranged from 16% to 19%.

Barriers to Mental Health Access

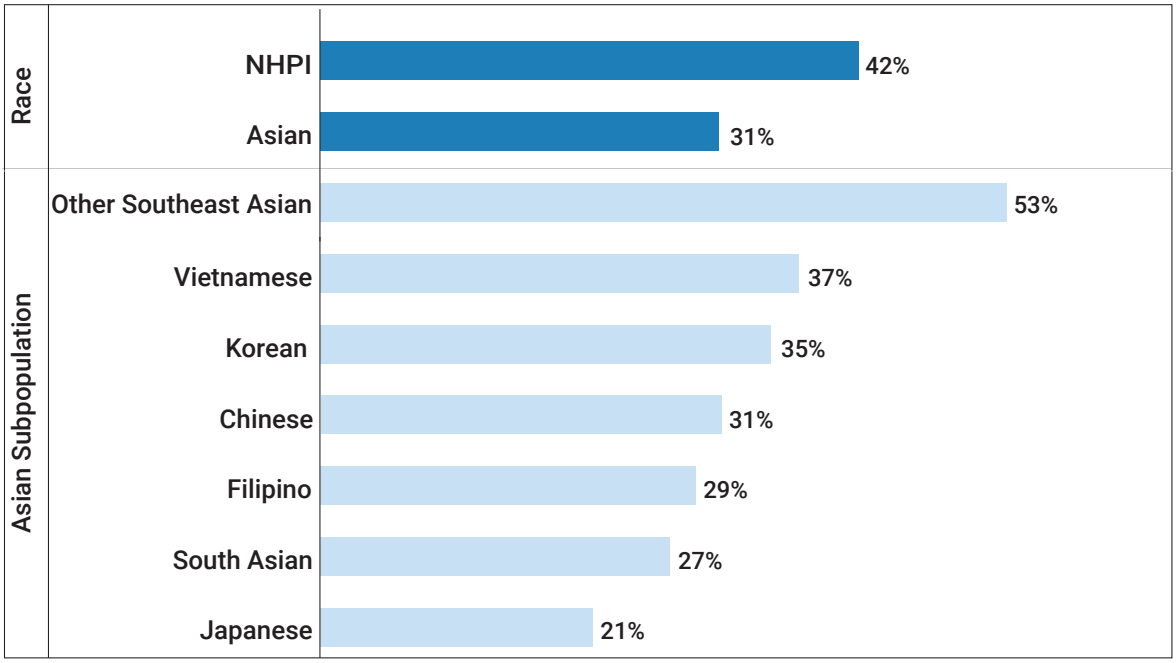
Of those who seek mental health support, 42% of NHPI and 31% of AA adults encounter barriers to access such as cost and awareness of options. Experiences with difficulty accessing mental health services resonate across AA and NHPI communities in California. Of those who seek mental health support, 42% of NHPI adults and 31% of AA adults had difficulty accessing services, as Figure 7 indicates. Age and poverty status were associated with having trouble accessing mental health support among AA adults, with younger adults and those who had fewer financial resources encountering more difficulty with access. Among the Asian subgroups, over half of Other Southeast Asians (53%), and over one-third of Vietnamese (37%) and Koreans (35%) had difficulty accessing care.

Figure 6. Adult respondents who ever had thoughts about attempting suicide



Source: 2020, 2021, and 2022 CHIS pooled data
An asterisk (*) indicates statistically significant difference with California total

Figure 7. Adult respondents who experienced difficulties with accessing mental health support



Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data

The extent of access barriers to mental health care among AA and NHPI communities may not be reflected in the survey data if older adults either do not recognize or are hesitant to report their needs and lack the support to seek help.

Cost, not knowing options, and lack of insurance were the most common barriers. For those seeking support, AA adults cited financial cost (13%), unfamiliarity with options (13%), and lack of insurance (8%) as the most common barriers to mental health care access. These barriers were also consistent across the Asian subgroups (see Appendix for more details). The estimates for NHPIs were not statistically stable enough to draw any conclusions. Cost, knowledge of options, and insurance are access barriers reported by those who do seek help, but a persistent gap in acknowledgment of the need for help impedes understanding of the full extent of barriers to both utilization and access to mental health support. The survey data may provide only partial insight into the breadth and depth of barriers that AA and NHPI communities face in acknowledging the need for, utilizing, and accessing mental health support. Older generations, immigrants, and those with less English proficiency may be especially vulnerable when they are less likely to report mental health needs in the first place.

AA and NHPI Cultural Contexts of Mental Health Barriers

In a 2021 study, the National Alliance on Mental Illness found that communities of color often face greater challenges in accessing support, and that 55% of AAs needed mental health support but did not receive it.[43] The study also revealed that when communities of color do seek care, they report fewer positive experiences with their health care provider compared to White patients. Based on the review of literature and feedback from community leaders, AA and NHPI communities face barriers in recognizing the need for and

accepting support, as well as connecting to those supports. There is a need to better understand mental health care barriers among AA and NHPI communities by considering each community's cultural context and history of health care experiences in the U.S.

Community resilience and perseverance in the face of adversity have helped members of AA and NHPI communities survive oppression and trauma, but made it difficult to recognize concerns and accept support. People in many AA and NHPI communities have a strong focus on resilience and perseverance that has enabled them to survive oppression and trauma, yet it deters help-seeking behaviors. For example, the result of war-induced trauma and colonization in the Philippines insist that Filipino Americans be resilient. This manifests as "survivor mentality"[44] that conflicts with help-seeking behaviors. In Japanese culture, references to *shikata ga nai* (meaning "it cannot be helped") and *gaman* (meaning "to endure and persevere") surface when discussing mental health. In the face of these notions, mental health problems often are perceived as something to simply accept, endure, and conceal. The societal pressures of the model minority stereotype only further exacerbate the inclination to simply accept and endure.

An inability to heal and reconcile past conflict and trauma has led to ripples of intergenerational trauma. Trauma runs deep within AA and NHPI communities and reverberates across generations, stemming from experiences of colonization, war, refugee resettlement, and racism and discrimination. Many AA families suppress traumatic history in silence, which inhibits healing and perpetuates the intergenerational transmission of trauma. Discussion of feelings between parents and children is not considered culturally normative in many AA families.[45] Disconnect and intergenerational conflicts arise within AA and NHPI families about the approach to mental health and help-seeking behaviors.

Strong stigma and shame are associated with mental health concerns—for both the individual and their family. Many AA and NHPI communities attribute mental health concerns to supernatural causes (e.g., spirits, demons), or a result of a weak mind or lack of willpower. Others also attribute mental health concerns to mistakes or bad behaviors committed by ancestors. Within AA and NHPI communities, individuals may not want to acknowledge their mental health issues, because doing so brings dishonor and shame to their family. People who openly discuss their mental health concerns risk their individual and family reputation and standing. Each culture's use of language is instructive of their perceptions of mental health problems. For Filipinos, *hiya* means "shame" in Tagalog, and is often used to describe mental health conditions. In Vietnamese, mental health disorders are labeled as *điên* meaning "madness" or "crazy."

Communities with limited English proficiency have few options. One-third of AAs in California have limited English proficiency, speaking English "less than very well." Moreover, 1 in 5 AAs in California live in a linguistically isolated household in which no one over the age of 14 speaks English exclusively or "very well."[46] Community organizations working closely with AA and NHPI populations observed that

language access is a significant barrier to accessing mental health care. Translated materials and resources on mental health are limited, and language barriers between health providers and some AA and NHPI population groups are acute. Acknowledging vulnerability about one's mental health problems requires courage, and it is exponentially more difficult for patients who need a translation specialist to communicate with their health provider.

The cultural competence of mental health care is fundamental (and beyond language access). Manifestations of mental disorders and descriptions of symptoms may look different across AA and NHPI communities—one's emotional response to any given situation is intertwined with one's system of beliefs and values. For example, South Asians often describe psychological distress in the form of physical symptoms, such as lack of sleep, body aches, and digestive problems. Koreans have a culturally specific mental health syndrome called *hwa-byung* (meaning "anger syndrome") that manifests as insomnia, fatigue, panic, and other physical symptoms. They use other nuanced words for various medical terms with different meanings and interpretations (e.g., panic, stress, worry, or nervousness). The treatment process also may be elusive for AA and NHPI communities. Native Hawaiians may have a strong mistrust of Western-based medicine and prefer traditional healing practices in health management—relying on a more integrative approach to health, encompassing physical, spiritual, emotional, and mental spheres. AA and NHPI communities may not understand the differences between the functions of various mental health providers (e.g., psychologists, psychiatrists, social workers, and counselors). Without community-specific knowledge of culture, traditions, and values, mental health professionals can misdiagnose or completely discount the signs of mental health concerns. Individual patients' system of beliefs and values also has a significant influence on their willingness to engage, to trust in the provider's recommendations, and to embark on the long journey of healing generations of trauma.

Taking Action: Progress and Recommendations

AA and NHPI mental health is a public health issue that cannot be solved solely by the individual experiencing mental health challenges. It is important to consider intergenerational trauma, mental health stigma, and cultural and linguistic care in addressing AA and NHPI mental health care. Understanding the detailed and nuanced needs of each of our AA and NHPI communities is critical to their health and well-being in the U.S. The following recommendations are driven by data as well as community narratives, and their goal is to spur action in improving AA and NHPI community and population outcomes. The throughline for each recommendation is that it must be pursued in partnership with community-based organizations, because they are the central hubs and trusted messengers within AA and NHPI communities.

Recommendation One: Create a mental health awareness and promotion campaign to change perceptions about mental health care.

- **Develop culturally centered anti-stigma interventions.** Among AA and NHPI communities, mental health stigma is

a major deterrent to acknowledging mental health needs and seeking mental health support. Creating a mental health awareness campaign can help frame mental health as a public health imperative rather than an individual health condition. State agencies, medical professionals, and community-based organizations must work collectively to promote mental health awareness and literacy, and encourage open discourse—encompassing information sharing, outreach, and culturally tailored messaging. This can include developing culturally centered anti-stigma interventions aimed at acknowledging AA and NHPI attitudes and beliefs, and encouraging help-seeking behaviors. It is also important to help communities understand that individuals and families are not to blame for mental health problems, and that psychological disorders have biological causes that can be treated just like any other health or medical condition.

- **Promote the availability of mental health services.** Another strategy to promote mental health awareness is to help AA and NHPI communities understand the availability of mental health services. Members of AA and NHPI communities often do not know what mental health resources are available or understand the differences between various mental health professionals. One way to mitigate this barrier is to curate mental health resources tailored to AA and NHPI communities, and disseminate this information through trusted community messengers. Important insights can be obtained through the existing efforts of community-based organizations, such as the Southern California Pacific Islander Community Response Collective (SoCal PICRT).[47] In response to COVID-19 misinformation and the resulting devastating impact of the pandemic on NHPI populations, SoCal PICRT created a coalition of NHPI-serving organizations to provide culturally aligned health information, services, and resources to the NHPI community. The AAPI Equity Alliance created resource guides available in nine languages to address mental health needs and healing for victims and community members affected by the Monterey Park shooting.[48] The Asian American Federation created the first Asian mental health directory serving communities in New York. This directory includes listings of mental health professionals with in-language services and an understanding of cultural needs.[49] Similarly, the Asian Mental Health Collective developed a national Asian American Therapist Directory, listing therapists who are ethnically and culturally aligned with Asian communities.[50] Acknowledging the needs of specific communities, SouthAsianTherapists.org provides one of the largest directories of therapists catering to the South Asian diaspora.[51] Leveraging the expertise of community-

based organizations is critical to AA and NHPI outreach about mental health care.

Recommendation Two: Expand training and supports on culturally and linguistically aligned care for existing mental health workforce.

- **Build cultural competency and better understand community-defined practices.** To best serve the needs of AA and NHPI communities, mental health providers must take a nuanced approach to care and better understand community-defined evidence practices to mental health care.[52] More training opportunities and investments are needed for existing mental health professionals to build cultural competency and improve language access in serving AA and NHPI communities. This can prepare mental health providers to look beyond mainstream practices, and tailor supports to the specific needs of the AA and NHPI community. For example, recognizing variations in the manifestation of mental health symptoms, being mindful of generational differences in mental health attitudes, and focusing on healing and trauma-informed care are crucially important, as is consideration of blended models of care (e.g., Western practices with culturally defined forms of care). Lessons and community-defined practices can be learned from the implementation of pilot programs serving the mental health needs of AA and NHPI communities in the California Reducing Disparities Project.[53] State agencies have the opportunity to support the expansion of mental health teams and to equitably fund providers and community-based organizations for bilingual and bicultural services. Expansion of mental health teams could include the use of paraprofessionals such as trained lay counselors, community mental health workers, and peer support specialists who are more likely to be culturally and linguistically congruent with AA and NHPI patients.[54] A promising example to learn from is the *promotoras de salud* model, in which community health workers serve as a cultural bridge with communities, community-based organizations, and health care agencies to eliminate health care access barriers among Latinx populations.[55]
- **Expand support for in-language services.** Because language barriers pose a significant challenge to accessing mental health care, additional investments and supports are needed to expand in-language services and bilingual mental health staff, especially therapists and clinicians. These services must ensure language competency and be mindful of regional dialects within AA and NHPI communities. Communication about behavioral and mental health phrases needs to be easily understood and accepted by community members. For

example, Asian Health Services created a Behavioral Health Glossary to help staff with specific words or phrases in Chinese, Korean, Vietnamese, and Khmer that can be used to talk about mental health.[56] Translation services and materials are vital to breaking down language barriers, and these resources should be well-tested with communities to ensure accuracy, and should be accessible to varying degrees of literacy levels.

Recommendation Three: Increase the number of AA and NHPI mental health providers.

- **Build a pipeline of culturally competent mental health providers and reflective of AA and NHPI communities.** California faces not only a mental health workforce shortage, but also a disproportionately composed body of mental health providers who collectively do not reflect the demographics of the state.[57] The COVID-19 pandemic further compounded the critical need for more mental health professionals.[58] To increase the diversity of the mental health workforce and build a future of providers serving AA and NHPI communities, investments must be made in developing an educational and workforce pipeline of diverse and culturally informed AA and NHPI mental health professionals. Recruitment efforts must begin early in the educational pipeline to build awareness in high schools about mental health careers, and create program pathways in postsecondary education. The California community college system, one of the largest providers of workforce training in the state, affords a prime opportunity to pilot and expand career education programs and stackable credential pathways focused on mental health care.[59,60] Considerations also need to be paid to the retention of AA and NHPI professionals in the mental health care pipeline by incentivizing their service to AA and NHPI communities in the form of scholarships, paid internships, and loan forgiveness. The legal and nursing workforce pipelines offer promising examples to inform the recruitment and retention of the AA and NHPI mental health workforce. These educational and workforce programs not only should include professional training, but also prepare future mental health professionals to understand the nuanced needs and histories of AA and NHPI communities, and how to leverage community assets.

STATE AND FEDERAL MOMENTUM

Mental health care is emerging as a top priority and need across AA and NHPI communities in California and nationally. The focus on health equity, particularly in responding to mental health disparities, is evident in California. For example:

- **California Assembly Bill (AB) 1726.** The passage of AB 1726 in 2016 underscored the urgency of eliciting more detailed data for AA and NHPI populations. Detailed data by ethnicity and country of origin would facilitate more targeted, culturally aligned outreach and services to AA and NHPI populations. Implementation of AB 1726 requirements is still underway.
- **Community-led approaches to develop an AA and NHPI Health Equity Policy Agenda.** In 2022, Asian Health Services formed a AA and NHPI Health Equity statewide collaborative with other lead organizations, including Asian Resources, Inc (ARI), Center for Asian Americans in Action, and Orange County Asian and Pacific Islander Community Alliance (OCAPICA), to create an actionable three-year statewide policy and research agenda for California focused on three key areas: data disaggregation, language access, and mental health, with participation from 50 community-based organizations, researchers, and advocates. Key to the formation of the Collaborative was the partnership with the California Commission on Asian and Pacific Islander American Affairs (CAPIAA). Recognizing the high need for mental health support among AA and NHPI communities amidst a severe workforce shortage, the Collaborative created a Mental Health Taskforce that is working on community-informed recommendations to eliminate mental health inequities and better serve the needs of the AA and NHPI communities.
- **California Reducing Disparities Project (CRDP) at the California Department of Public Health.** CRDP was founded to achieve mental health equity for five priority California populations including Asian and Pacific Islander populations. The California Pan-Ethnic Health Network (CPEHN) helped CRDP outline a strategic plan to reduce

mental health disparities. Some goals and recommendations center on creating community-defined evidence practices, increasing access to mental health services for underserved populations, improving disaggregated data collection standards, and supporting community engagement and involvement.

Recent discussions at the federal level have centered on advancing racial and ethnic health and mental health equity. Federal efforts include:

- **National Academies of Sciences, Engineering, and Medicine (NASEM) Report on Federal Policy and Health Equity.** NASEM took an "all-in government" approach to collaborate across federal agencies to review and offer recommendations to advance policies promoting racial and ethnic health equity. These include incorporating community input in policy development, and disaggregating racial and ethnic population data.
- **White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders (WHIAANHPI) Mental Health Summit**. WHIAANHPI hosted a summit in July 2023 on mental health care for AA and NHPI communities in recognition of the repercussions of the COVID-19 pandemic, the rise in anti-Asian hate, and increased gun violence. The Biden-Harris administration's mental health strategy to support AA and NHPI communities includes recognizing the need to improve language access, address culture and stigma, and strengthen health care providers' diversity and cultural competency.
- **U.S. Department of Health and Human Services (HHS) Language Access Plan**. HHS released an updated plan to increase access and services for people with limited English proficiency and those with disabilities. The plan calls for the assessment of current language access services and expansion of interpretation and language assistance efforts.

AA AND NHPI MENTAL HEALTH: COMMUNITY BRIEFS

The following Community Briefs provide deeper insights specific to seven AA & NHPI communities utilizing available CHIS data, which include: Native Hawaiian and Pacific Islander, Southeast Asian (including Vietnamese and Other Southeast Asian), South Asian, Filipino, Korean, Japanese, and Chinese. Each Community Brief highlights the unique mental health outcomes of the respective group while contextualizing this data within the broader context of their culture and history, illuminating tailored considerations and recommendations to address each community's mental health needs.

MENTAL HEALTH OF NATIVE HAWAIIAN AND PACIFIC ISLANDER COMMUNITIES

Native Hawaiians and Pacific Islanders (NHPIs) have their roots in several regions of the Pacific, including Melanesia, Micronesia, and Polynesia. They are the indigenous peoples of these islands for generations, and have built diverse and rich cultural legacies. Unfortunately, both European and U.S. colonization have resulted in the erasure of their customs, languages, and cultural practices, along with displacement from ancestral homelands. This cultural trauma leaves an enduring mark on NHPIs, and significantly diminishes their overall health and mental wellness.[61,62]

In particular, the U.S. colonization and subsequent militarization created a complicated web of immigration statuses governing the access of NHPIs to essential services and resources.[63] While many NHPIs are U.S. citizens, immigration status is nebulous and complex for many others. Depending on their country of origin, many Pacific Islanders may be U.S. nationals coming from United States territories, migrants from countries that entered a Compact of Free Association (COFA) agreement with the United States, or foreign nationals from countries with no association with the United States. U.S. nationals and COFA migrants are free to live and work in the United States, but may have limited access to public benefits.[64] As a result, some Pacific Islanders have less access to resources and opportunities, contributing to socioeconomic and health inequities.

Colonization and militarization have had lasting detrimental impacts on NHPI identities and quality of life through the decimation of sacred lands and the suppression of ancestral culture. The historical trauma of colonialism and the eradication of cultural identity have profound psychological implications. Forced assimilation and systemic discrimination are associated with dislocation, identity loss, and feelings of inadequacy, all of which exacerbate mental health problems among NHPI communities.[65] Though the mental health experiences of NHPI populations have been understudied, the research to date points to high rates of intergenerational trauma and depression.[66]

The disparities confronting NHPIs became conspicuously evident during the COVID-19 pandemic. Compared to all other racial and ethnic groups in California, NHPIs had the highest COVID-19 death rate (182 per 100,000).[67] COVID-19 wreaked havoc within NHPI communities as a result of limited access to health care, strained economic conditions, and multigenerational living arrangements. The pandemic exerted not only physical and economic impacts, but also a psychological toll within NHPI communities. The pandemic increased the rates of depression, anxiety, substance addiction, and distress among NHPI adults.[68] NHPI adolescents reported increased social isolation and deferred their academic goals, all of which impaired their mental health.[69]

Note. CHIS survey results for hate incident or crime victimization and reasons for difficulty accessing mental health services were not statically stable for NHPIs, so they are not presented in this chapter, but the full set of results can be found in the Appendix.

Mental Health Outcomes of NHPI Communities

A quarter of NHPI adults self-identified as needing mental health support. This is equal to the prevalence of adults self-identifying in California overall (24%). Estimates for adolescent NHPIs are not available due to statistical instability.

Everyday experiences with discrimination are common. The most frequent everyday experiences with discrimination that NHPIs encountered include being asked where they were from amid assumptions that they were not from the U.S. (45%), and receiving poorer service than others at restaurants or stores (30%) as Table A1 shows. NHPIs have experienced discrimination and racism throughout their history and continue to this day. NHPIs encountering assumptions that they are not from the U.S. are particularly unwarranted, since they are the native inhabitants of Hawaii and the Pacific Islands—territories that the U.S. has seized and claimed as its own.

Nearly half of NHPI adults are worried about gun violence. Almost half of NHPI adults (45%) indicated that they were "very or somewhat worried" about being a victim of gun violence, compared to 30% for California overall. These findings are consistent with national results from the AAPI Data/Momentive 2023 Poll, which found that 74% of NHPI respondents were highly concerned about being a victim of a mass shooting.[70] The estimates for NHPI adolescents were not statistically stable enough to draw any conclusions.

Over 1 in 5 NHPI adults (21%) have had thoughts of attempting suicide — with the overall California population at 17%. Research has shown that the leading cause of death in 2019 among young NHPIs between the ages of 15 and 24 was suicide.[71]

42% of NHPI adults had difficulty accessing care. For those seeking mental health support, 42% of NHPI adults had trouble accessing mental health services. Systemic and cultural barriers to mental health access such as lack of benefits, cost, stigma and shame, and unavailability of culturally aligned services make it difficult for NHPIs to get the support that they need.

Addressing NHPI Community Mental Health Needs

Given the profound impact of U.S. colonization and militarization on NHPI identity and

Table A1. NHPI adult respondents' most frequent everyday experiences with discrimination in an average month

	NHPI
People asked where you are from, assuming you're not from the U.S.	45%
Received poorer service than other people at restaurants or stores	30%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note. A full list of everyday experiences with discrimination can be found in the Appendix.

well-being, understanding of the unique impediments to mental health care is essential in order to best support the needs of the NHPI community. Some key considerations to better tailor support for the NHPI community include anti-stigma interventions aimed at informing attitudes and beliefs about mental health, and encouraging help-seeking behaviors as well as culturally aligned practices.

Cultural and linguistic accessibility of services. Stemming from historical trauma and cultural disruption, a misalignment or lack of trust often exists between patients and mainstream mental health providers who are unfamiliar with NHPI cultural backgrounds, values, and traditions.[72] For example, one study found that Native Hawaiians expressed a strong mistrust of Western-based medicine and prefer traditional healing practices in their health management.[73] The approach to health is integrative of physical, spiritual, emotional, and mental spheres among Native Hawaiian culture.[74] In Samoan culture, mental health is expressed as *soifua maloloina o le mafaufau* which is a holistic view of wellness encapsulating the need to address mental, physical, spiritual, and social health.[75] NHPI populations are diverse, and each community has different cultural approaches to health and well-being. Understanding the roles of family systems, collectivism, heritage and traditions, and spirituality is important in responding to NHPI mental health needs.[76] Tailoring support for NHPI communities should include understanding community-defined needs, goals, and practices, and training medical professionals on culturally aligned practices. Investing in a health care workforce pipeline to increase NHPI representation in the mental health profession is also vital in building trust and bridging the cultural mismatch.

Language access poses a significant barrier to mental health care. Expansion of in-language services and translated materials to include languages, such as Samoan, Chamorro, Tongan, and Fijian is critically important to opening up mental health care access for those with limited English proficiency.

Stigma and shame are barriers to help-seeking behaviors. In a 2019 study of NHPI attitudes toward depression and schizophrenia, researchers found evidence of the cultural stigma experienced in NHPI communities that can hinder help-seeking. NHPI study participants differed from the general U.S. public in three ways: (1) more frequently endorsing stigmatizing attributions to these conditions, (2) less frequently perceiving these conditions as serious, and (3) more commonly desiring to distance themselves from persons with depression.[77]

Mental health concerns can be viewed as a sign of a person's bad character or upbringing.[78] Combined with a fear of public shaming and ostracization, this perception can result in neglecting mental health needs and preventing help-seeking behaviors. Culturally tailored anti-stigma interventions that target NHPI mental health attitudes and beliefs may be an important part of responding to NHPI mental health needs. Community-based organizations have the expertise needed to foster peer support, culturally relevant outreach, navigation, prevention, and early intervention.

Native Hawaiian and Pacific Islander Population in California

Top Counties

Population Count (alone or in combination)

337,617

Top Languages Spoken (non-English)

Samoan
Chamorro
Fijian
Tongan

Poverty Status

Fijian: 9% (lowest)
Marshallese: 28% (highest)

Educational Attainment-Bachelor's Degree

Marshallese: 1% (lowest)
Chamorro: 19% (highest)

Top Subpopulations (alone or in combination)

Native Hawaiian 95,165
Samoan 68,747
Chamorro 40,015
Fijian 38,170
Tongan 26,899

Limited English Proficiency

Native Hawaiian: 5% (lowest)
Tongan: 21% (highest)

Foreign Born

Native Hawaiian: 4% (lowest)
Fijian: 69% (highest)

Source: The population estimates are from the Race and Ethnicity in the United States: 2010 Census and 2020 Census data visualization and the 2020 Census Detailed Demographic and Housing Characteristics File A, and other sociodemographic information is from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.

MENTAL HEALTH OF SOUTHEAST ASIAN COMMUNITIES

Southeast Asians form a highly diverse group that encompasses numerous cultures. Southeast Asians are not simply defined by geographic boundaries, but they share a political and historical experience of coming to the U.S. as refugees of war.[79] Almost 50 years ago, political unrest and war, such as the Vietnam War, the brutal Khmer Rouge regime, and the Secret War permanently changed the lives of numerous Southeast Asians. Many endured government-sponsored threats and intimidation once Communists gained control of Vietnam, Cambodia, and Laos.[80] Southeast Asians witnessed horrific genocide, and endured famine, and displacement. The repercussions of political turmoil and war continue to have significant and long-lasting impacts on Southeast Asian families for generations. These war-induced traumatic events have impacts on families for generations.

Starting with the evacuation of Saigon, Southeast Asians escaping war, genocide, political turmoil, and starvation in their home countries sought refuge in the United States.[81] Southeast Asians are the largest refugee community to ever resettle in the United States. Refugees are uniquely different from immigrants due to the traumatic circumstances forcing them to leave their homelands, the difficult journeys they undertake, and the obstacles they face after migration, such as unemployment, family separation, and racism.[82] All forms of trauma whether historical, generational, institutional, or present-day are key contributors of mental health problems in communities of color.[83] The intergenerational transmission of trauma is still very present among the Southeast Asian community.

The journey of resettlement for Southeast Asians is not only a physical shift but also a profound psychological transition encompassing grief, displacement, and the abrupt immersion into a new culture. These individuals must also grapple with financial instability, joblessness, language barriers, and outright discrimination. The complexities of adapting to new societal roles and navigating conflicts between generations add layers to their distress.[84] Moreover, the circumstances of their resettlement often placed many Southeast Asians in communities plagued by violence, racial tension, and under-resourced schools. These conditions further deteriorated their mental well-being.[85] The past traumas and resettlement strains manifest significantly in this community, leading to increased risks of post-traumatic stress disorder (PTSD) and depression.[86] As a consequence of their historical trauma, Southeast Asians are more susceptible than the broader population to severe mental health issues.

Note. Due to sample size limitations, only Vietnamese and an aggregated Other Southeast Asian category are available by CHIS. The CHIS category of Other Southeast Asian includes Laotian, Cambodian, Malaysian, Thai, Burmese, Hmong, and Indonesian populations.

Mental Health Outcomes of Southeast Asian Communities

13% of Vietnamese and 19% of Other Southeast Asian adults report needing mental health support — while 24% of adults in California overall express needing support. Nearly one-third of Vietnamese adolescents (31%) reported needing mental health support, with California adolescents overall at 34%. Estimates for Other Southeast Asian adolescents were not statistically stable enough to draw any conclusions. Southeast Asian adults and adolescents have low rates of self-identifying their need for mental health support despite their multi-generational history of trauma, suggesting that attention to community-specific complexities and nuances is necessary in order to understand the mental health needs of Southeast Asian communities.

Everyday experiences with discrimination are common. The most frequent everyday experiences with discrimination that Southeast Asian adults encountered include being asked where they were from, based on the assumption they were not from the U.S. (38% for Vietnamese, 57% for Other Southeast Asian) as Tables B1 and B2 indicate. Other Southeast Asian adults also frequently encountered being treated and perceived as dishonest (39%).

17% of Vietnamese and 38% of Other Southeast Asian adults have been victims of a hate incident or crime. Among Other Southeast Asian adults, gender and citizenship status were associated with reports of being a victim of a hate incident or crime, with those who were male and those without U.S. citizenship being most vulnerable to victimization.

Table B1. Vietnamese adult respondents' most frequent everyday experiences with discrimination in an average month

	Vietnamese
People asked where you are from, assuming you're not from the U.S.	38%
People acted as if you don't speak English	19%
People mocked or made offensive physical gestures towards you	14%
Being called names or insulted	14%
People intentionally mispronounced your name	14%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note. A full list of the everyday experiences with discrimination can be found in the Appendix.

Table B2. Other Southeast Asian adult respondents' most frequent everyday experiences with discrimination in an average month

	Other Southeast Asian
People asked where you are from, assuming you're not from the U.S.	57%
People acted as if they think you are dishonest	39%
Being called names or insulted	38%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note. A full list of the everyday experiences with discrimination can be found in the Appendix.

Southeast Asians are worried about being a victim of gun violence. 44% of Vietnamese adults and 52% of Other Southeast Asian adults are "very or somewhat worried," while 30% of the California adult population express concern about gun violence. Poverty status and education level were associated with concerns about gun violence among Vietnamese adults, with those who had fewer financial resources and those with higher levels of education expressing greater concern. Nearly one-third of Vietnamese adolescents (31%) worry about being shot by a firearm, with California adolescents overall at 26%. Estimates for Other Southeast Asian adolescents were not statistically stable enough to draw conclusions.

11% of Vietnamese and 16% of Other Southeast Asian adults report thoughts of suicide, while 17% of the California adult population overall disclose suicide ideation. The intergenerational trauma of refugee experiences—exposure to the violence of war, duress of forced immigration, and financial instability—causes mental health distress and exacerbates suicidal thoughts and behaviors.

Many who seek mental health services have trouble accessing care — 37% of Vietnamese adults and 53% of Other Southeast Asian adults. For those seeking care, Vietnamese adults reported financial cost (12%), unfamiliarity with options (11%), and lack of insurance (7%) as common barriers to care. The estimates for reasons contributing to difficulty accessing mental health services among Other Southeast Asian adults were not statistically stable enough to draw conclusions. A recent study found that older Vietnamese adults constitute one of the most underserved groups in the United States, despite their high risk for stress and other negative experiences.[87] Barriers to mental health service utilization and access among Southeast Asians include language barriers, lack of transportation, distrust or unfamiliarity with health care services, traditional cultural beliefs, preferences for alternative treatments, and high costs or lack of health insurance.[88]

Addressing Southeast Asian Community Mental Health Needs

Given the impact of war-induced trauma and refugee resettlement of Southeast Asians in the U.S., understanding of the unique impediments to mental health care is important in order to best support the needs of the Southeast Asian community. Some key considerations to better tailor support for the Southeast Asian community include addressing language access, stigma and attitudes about mental health, and healing from intergenerational trauma.

Cultural and linguistic accessibility of services. For Southeast Asians, language barriers prevent access to mental health resources. Many, including long-term U.S. residents, cite language as a significant obstacle to health care.[89] Cultural misunderstandings compound these challenges; many refugees need interpreters, and many mental health care providers lack understanding of refugee populations.[90] As a result of this significant disconnection with mental health care providers, individuals encounter difficulty in communicating their symptoms or concerns, thus reducing likelihood of obtaining mental health treatment.

Investment in a pipeline of bilingual, bicultural mental health professionals is of critical importance for provision of culturally and linguistically aligned care. Expansion of in-language services and translated materials beyond Vietnamese to include languages, such as Hmong, Khmer, and Lao is also important to ensure that Southeast Asian populations receive the mental health care they need.

Stigma and shame are barriers to help-seeking behaviors. Many Southeast Asian people hold discussions about mental health concerns privately or avoid the subject entirely, and this silence can have detrimental effects on their overall well-being. Members of Southeast Asian communities are highly concerned about becoming a victim of gun violence, and many have been a victim of a hate incident or crime. Notably, Vietnamese Americans have the highest overall rate of gun deaths and the second-highest rate of firearm-related suicides.[91]

However, mental health problems are often associated with personal weakness, inability to exercise willpower, and shame.[92] Southeast Asian men are expected to be emotionally strong and independent, often coping through emotional suppression and control.[93] Due to unfavorable perceptions about and fears of discussing mental health, many Southeast Asians often conceal or deny mental health problems.[94]

For example, in Vietnamese culture, mental health disorders are seen as a consequence of past misdeeds or ancestral sins.[95] This perception can result in neglecting mental health needs and preventing assistance from medical professionals. Mental health concerns, which have a negative connotation and are labeled as *điên* (meaning "madness or crazy") and *bênh tâm thân* (meaning "mind illness"), can bring significant disgrace and shame to the family. Consequently, those who need support may not be likely to seek it.[96] Providers must be attuned to the cultural values and context of their patients in order to be effective.

Healing from the intergenerational transmission of trauma. Prior research indicates that over 60% of Southeast Asian respondents report that their mental health conditions are intertwined with personal experiences of trauma and the ripple effects of intergenerational trauma.[97] These experiences, particularly parental trauma, have been shown to degrade family dynamics and the mental well-being of children within Southeast Asian refugee families in the U.S. Moreover, Southeast Asians are reluctant to discuss these experiences and the unhealed psychological wounds are passed down through generations.

Researchers have found that the intergenerational reverberations of wartime trauma are still present in the Vietnamese community. Their history of political conflict and resettlement has created a culture in which self-sacrifice is valued and self-care is considered selfish.[98] This cultural perspective is a foundation of the Vietnamese community's resilience, and yet it can lead to the neglect and dismissal of personal mental health. Attention needs to be paid to healing-centered and trauma-informed care in serving the needs of the Southeast Asian community.

Southeast Asian Population in California

Top Counties

Population Count (alone or in combination)

1,254,998

Top Languages Spoken (non-English)

Vietnamese
Khmer
Hmong
Thai
Lao

Poverty Status

Indonesian: 9% (lowest)
Hmong: 23% (highest)

Educational Attainment-Bachelor's Degree

Laotian: 15% (lowest)
Malaysian: 40% (highest)

Top Subpopulations (alone or in combination)

Vietnamese 798,624
Cambodian 123,949
Hmong 107,458
Thai 83,172
Laotian 63,384

Limited English Proficiency

Malaysian: 23% (lowest)
Burmese: 52% (highest)

Foreign Born

Hmong: 31% (lowest)
Burmese: 82% (highest)

Source: The population estimates are from the 2020 Census Detailed Demographic and Housing Characteristics File A, and other sociodemographic information is from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.
Note: The Southeast Asian population count includes the Hmong population and excludes the Filipino population.

MENTAL HEALTH OF SOUTH ASIAN COMMUNITIES

At the turn of the 20th century, the first appreciable numbers of South Asians (including Indians, Bangladeshis, and Pakistanis) started to settle on the West Coast of the United States. Indian men labored in the expanding West, constructing railroads, clearing and cultivating California's fertile agricultural land. In many ways, their experiences with systemic discrimination in the United States mirrored that of other Asian Americans—they were prohibited from obtaining citizenship, bringing their spouses from India, owning land, and entering into any long-term leasing agreements.

A significant flashpoint in the South Asian experience was the attack on the U.S. on September 11, 2001. The event changed the definition of what it meant to be South Asian American and, in a way, gave rise to a new racial category—being "brown" or "Muslim-looking."[99] The Patriot Act of 2001 created a new set of discriminatory practices that include aggressive arrest, detention, and airport profiling of South Asians as if they were terrorist suspects. These ongoing and widespread experiences of discrimination and racial profiling in the South Asian community have taken a psychological toll, resulting in higher rates of depression, anxiety, and fear.

In addition to race-based attacks, South Asians have been targets of faith-based hate crimes particularly directed at Sikhs and Muslims. This was evident through the violent Dotbuster Hinduphobic campaign of the 1980s that targeted members of Dharmic communities, including Hindus, Sikhs, Buddhists, and Jains. Violence, threats, vandalism, and arson against Muslims, Sikhs, and the larger South Asian community continued with the surge of Islamophobia following 9/11.[100] Fueled by white supremacy, Islamophobia, and the conflation of Sikhs with Muslims resulted in one of the deadliest hate crimes in a place of worship in U.S. history with the 2012 Oak Creek Sikh Temple Shooting. These past traumas are retriggered by the current Israeli-Hamas conflict within the South Asian community, given a recent uptick in hate incidents against Muslims in the U.S.[101]

Mental Health Outcomes of South Asian Communities

21% of South Asian adults and 43% of South Asian adolescents report need for mental health support. One in five South Asian adults self-identified as needing mental health support, while 24% of adult Californians overall expressed needing assistance. Age, gender, nativity status, and English proficiency were associated with identifying mental health needs. Among South Asian adults, those reporting the need for mental health support tended to be younger, female, born in the U.S., and have higher English proficiency. Among adolescents, 43% of South Asians self-identified needing mental health support, with the California adolescent population at 34%.

Everyday experiences with discrimination are common. The most frequent everyday experiences with discrimination that South Asians encountered include being asked where

they were from with the assumption they were not from the U.S. (62%), having their name mispronounced (27%), assuming they don't speak English (26%), and receiving poorer service than others at restaurants or stores (24%) as Table C1 indicates.

Over 1 in 5 of South Asian adults (22%) have been a victim of a hate incident or crime. According to the FBI's Annual Hate Crime Incident Analysis for 2022, Sikhs are second to Jews as the most frequently targeted group in the U.S. for cases of religiously motivated hate crimes.[102] These traumatic events have profound and long-lasting impacts on South Asians.

42% of South Asian adults are "very or somewhat worried" about gun violence — with 30% of California adults overall expressing concern. The estimates for South Asian adolescents were not statistically stable enough to draw conclusions. The rise of anti-Asian hate and uptick in gun violence leave deep impacts on the South Asian community. Repeated exposure to gun violence and mass shootings is associated with an increased risk of major depressive disorder and post-traumatic stress disorder.[103]

12% of South Asian adults report suicide ideation, with the California adult population at 17%. The extent of mental health needs and suicidal ideation may not be apparent. Suicidal behaviors among South Asian communities are often hidden or unreported in order to protect the family dignity and reputation.[104]

27% of South Asian adults had difficulty accessing care. South Asians reported financial cost (15%) and unfamiliarity with options (14%) as the most common barriers to mental health care access. Prior research on Asian American communities has shown that financial barriers hindered access to health care,[105] and South Asians are no exception. Financial costs coupled with other systemic and cultural barriers make mental health support difficult for South Asians to seek and obtain.

Addressing South Asian Community Mental Health Needs

Given the history of discriminatory practices and racial profiling against South Asians in the U.S., supporting the needs of the South Asian community requires understanding of the unique impediments to their mental health care. Some key considerations to better tailor

Table C1. South Asian adult respondents' most frequent encounters with everyday experiences with discrimination in an average month

	South Asian
People asked where you are from, assuming you're not from the U.S.	62%
People intentionally mispronounced your name	27%
People acted as if you don't speak English	26%
Received poorer service than other people at restaurants or stores	24%

Source: 2021 and 2022 CHIS AA AND NHPI Follow-on Survey pooled data
Note. A full list of the everyday experiences with discrimination can be found in the Appendix.

support for the South Asian community include language access and anti-stigma interventions aimed at informing attitudes and beliefs about mental health and encouraging help-seeking behaviors.

Cultural and linguistic accessibility of services. South Asia is vast and diverse, comprising several countries, each representing a distinct culture. Mainstream health care providers do not have a strong understanding of the diversity of the South Asian diaspora, the interconnection of ethnicity and faith, and their beliefs and attitudes toward mental health. Because South Asians commonly experience psychological distress as physical symptoms, their mental health problems can remain undiagnosed or untreated by medical professionals.[106] In addition, South Asian immigrants commonly have low adherence to mental health treatment regimens, because they may deem them as unnecessary or out of alignment with traditional forms of care.[107] For example, Sikhs are encouraged to participate in spiritual activities at the temple and to use prayer or meditation to treat depression, anxiety, or other mental illnesses.[108] Hindus believe that physical or mental illnesses involve the balance of biological, psychological, and spiritual elements, and that treatments must encompass all three factors.[109] Tailoring mental health support for South Asian communities should include understanding of community-defined needs, goals, and practices, and training of medical professionals on culturally aligned practices.

More than 1,000 South Asian languages are spoken. Among South Asians, the groups with the greatest prevalence of limited English proficiency include Bhutanese, Nepalese, and Bangladeshi.[110] Linguistic limitations constitute a significant barrier to accessing mental health services and communication of needs to health care professionals among South Asians. Expansion of the number of bilingual mental health professionals, along with services and translated materials in other languages, including Hindi, Dzongkha, Nepali, and Bengali, is vitally important in order to improve and broaden mental health care access.

Stigma and shame are barriers to help-seeking behaviors. Attribution of the causes of mental illness varies widely within the South Asian population. The emphasis on karma in Hinduism may place blame on the individual and their families' past sins for the onset of mental illness, whereas other South Asian cultures attribute mental illness to supernatural causes such as the "evil eye."[111] As such, South Asians frequently report a higher stigma against mental illness compared to other populations.[112] Permeating Pakistani, Bangladeshi, and North Indian cultures is a strong emphasis in maintaining *izzat* (meaning "public honor"),[113] and admission of having a mental health problem reflects poorly on families and results in detrimental implications for their social standing in their communities.[114,115] The stigmatization of mental illness makes the collectivistic communities of South Asians reluctant to seek help from mental health professionals and to openly disclose mental health issues. Key considerations for supporting South Asian communities include building community networks and culturally centering mental health support, outreach, and anti-stigma interventions.

South Asian Population in California

Top Counties

Population Count (alone or in combination)

1,069,425

Top Languages Spoken (non-English)

Hindi
Punjabi
Telugu
Tamil
Urdu
Nepali
Sinhala

Poverty Status

Asian Indian: 5% (lowest)
Pakistani: 19% (highest)

Top Subpopulations (alone or in combination)

Asian Indian 902,621
Pakistani 85,907
Sikh 36,975
Nepalese 19,677
Sri Lankan 18,794

Limited English Proficiency

Asian Indian: 18% (lowest)
Bhutanese: 44% (highest)

Foreign Born

Pakistani: 62% (lowest)
Nepalese: 82% (highest)

Educational Attainment-Bachelor's Degree

Bhutanese: 6% (lowest)
Asian Indian: 32% (highest)

Source: The population estimates are from the 2020 Census Detailed Demographic and Housing Characteristics File A, and other sociodemographic information is from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.

MENTAL HEALTH OF THE FILIPINO COMMUNITY

The Philippines' history of colonization has important influences on its people and culture. Spanish colonization's enduring legacies are notably evident in the widespread adoption of Spanish surnames and the predominance of Catholicism.[116] Colonization has implications for Filipino American mental health, and the introduction of religion plays a significant role in shaping mental health perceptions.[117]

Subtle yet profound impacts lie in the "colonial mentality" embedded in the Filipino community—a term describing the internalized inferiority complex stemming from prolonged colonization and historical trauma.[118] Populations experiencing the colonial mentality implicitly undervalue their native cultural heritage while elevating the culture of the colonizer. Filipino Americans tend to elevate all things perceived as American.[119] Research suggests that this colonial mentality distorted ethnic identity formation, inhibited the propensity to seek mental health services, and deteriorated overall psychological health among Filipino Americans.[120,121] Intergenerational trauma, particularly relating to wartime atrocities that prior generations experienced, persistently affects the mental health of Filipino American youth today.[122] As a result, colonial dominance and residual trauma of war pose significant barriers to the mental health of present-day Filipino Americans.

Treatment of Filipino workers as commodities traces back to 1587 when Filipino slaves were brought aboard Spanish ships to Morro Bay, California.[123] Presently, such commodification of Filipino labor has intensified amidst the COVID-19 pandemic.[124] Despite representing only 4% of the nursing workforce in the U.S., Filipino Americans accounted for over 30% of nursing fatalities due to the virus, a stark indicator of racial inequities in health outcomes during the pandemic.[125] Labor policies historically have favored output over the safety and welfare of workers, a trend that has disproportionately burdened Filipino Americans. During the pandemic, these frontline workers, particularly in health care and service sectors, have faced significant risks to their physical health, economic stability, and overall well-being. Racially motivated and xenophobic violence toward Asian Americans surged during the pandemic era, exacerbating the obstacles confronting Filipino Americans.[126] Consequently, the pandemic has not only highlighted the critical role of these frontline workers in sustaining societal functions, but also underscored the enduring physical and psychological burdens borne by Filipino American health care professionals.[127]

Mental Health Outcomes of Filipino Communities

21% of Filipino adults report need for mental health support — while 24% of adults in California overall express needing support. The estimates for Filipino adolescents were not statistically stable enough to draw any conclusions.

Everyday experiences with discrimination are common. The most frequent everyday experiences with discrimination that Filipino adults encountered include being asked where they were from with the assumption

they were not from the United States (47%), receiving poorer service than others at restaurants or stores (25%), assuming they do not speak English (22%) and having their name intentionally mispronounced (22%) as Table D1 shows. Complementary to these CHIS findings, other research has shown that Filipino Americans report experiencing assumptions of inferior intellect or criminality, as well as exclusion from the broader Asian American community.[128] These everyday encounters have cumulative effects that impair mental health.

16% of Filipino adults have been a victim of a hate incident or crime. Gender, poverty status, and English proficiency were associated with reports of being a victim of a hate incident or crime among Filipino adults. Those disclosing victimization tended to be male, have fewer financial resources, and have higher English proficiency. With the rise of anti-Asian hate crimes, racism that centers on targeting Filipino American health care workers further underscores their racialization as "disease carriers," tied to a longer history of Asian Americans as "yellow peril".[129]

44% of Filipino adults and 38% of Filipino adolescents worry about gun violence. About 44% of Filipino adults indicated that they were "very or somewhat worried" about being a victim of gun violence, while 30% of the overall California adult population expressed concern about gun violence. Among adolescents, 38% of Filipinos worried about being shot by a firearm, while 26% of California's overall adolescent population expressed worry.

14% of Filipino adults report thoughts of suicide — while 17% of the California adult population overall disclose suicide ideation. Though the Filipino adolescent estimates of suicide ideation were not statistically stable, other research has shown that rates of suicidal ideation are higher among Filipino youth compared to other ethnic groups.[130]

29% of Filipino adults had difficulty accessing care. Age and poverty status were associated with having trouble accessing mental health support among Filipinos, with younger adults and those with fewer financial resources encountering more difficulty with access. Unfamiliarity with options (14%), financial cost (14%), and lack of insurance (8%) were the most common barriers reported by Filipino Americans. Difficulty accessing care for Filipino Americans may also be due to unfavorable attitudes about health-seeking behavior, or fear of shame and social stigma attached to mental disorders. Additional systemic barriers that discourage Filipino Americans from seeking

Table D1. Filipino adult respondents' most frequent encounters with everyday experiences with discrimination in an average month

	Filipino
People asked where you are from, assuming you're not from the U.S.	47%
Received poorer service than other people at restaurants or stores	25%
People acted as if you don't speak English	22%
People intentionally mispronounced your name	22%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note. A full list of the everyday experiences with discrimination can be found in the Appendix.

help include immigrant status, lack of health insurance, language barriers, discrimination, and differences in acculturation experiences.[131]

Addressing Filipino Community Mental Health Needs

Given the history of colonization and treatment of Filipino Americans as commodities in the U.S., understanding the unique impediments to their mental health care is essential in order to support their needs. Some key considerations to better tailor support for the Filipino community include anti-stigma interventions aimed at informing attitudes and beliefs about mental health, and encouraging help-seeking behaviors.

Cultural and linguistic accessibility of services. For Filipino Americans, seeking help conflicts with notions of resilience. Filipino Americans are taught to be self-sufficient, with a "survivor mentality."[132] The result of war trauma, colonization, and high poverty rates in the Philippines may translate to the "survivor mentality" that insists on the resilience of Filipino-Americans. This cultural demand poses difficulties for those seeking mental health care. More training and investments are needed to promote culturally aligned practices to support Filipino mental health.

Because over 100 languages and dialects are spoken in the Philippines, language barriers pose a significant obstacle, particularly in the absence of staff members and clinicians fluent in Tagalog and other Filipino languages. In-language services and translated materials in Tagalog are vital to opening up mental health care access.

Stigma and shame are barriers to help-seeking behaviors. Stigma and shame deter help-seeking, because mental health problems are often regarded as hardships to be endured rather than conditions requiring treatment. Social stigma (e.g., fears of negative community perception, damaged family reputation, and social exclusion) and self-stigma (e.g., shame, embarrassment and self-blame) prevents Filipinos from seeking mental health care.[133] Terms referencing mental health have negative connotations. For example, the word *hiya* (meaning "shame") is closely associated with describing mental health. Community-based organizations have the expertise needed to foster peer support, culturally relevant outreach, navigation, prevention, and early intervention of mental health awareness and care.

Healing from the intergenerational transmission of trauma. Colonial mentality today manifests as unfavorable health-seeking attitudes originated from generations of trauma, rooted from U.S. occupation and socialization experiences.[134] Colonial mentality better explained depression symptoms among Filipino Americans, and had a significant direct effect on the depression symptoms that Filipino Americans experienced.[135] The impact of colonial mentality extends to preventing Filipino Americans from seeking mental health services. Understanding the community's pre- and post-colonial history can foster culturally aligned practices that leverage Filipino Americans' resilience and familial support systems.

Filipino Population in California

Top Counties

Population Count (alone or in combination)

1,741,613

Top Language Spoken (non-English)

Tagalog

Poverty Status

6%

Foreign Born

62%

Educational Attainment-Bachelor's Degree

41%

Limited English Proficiency

21%

Source: The population estimates are from the 2020 Census Detailed Demographic and Housing Characteristics File A, and other sociodemographic information is from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.

The pursuit of independence arising from political unrest and colonial rule in Korea drove early waves of immigration to the United States. Korean immigrants made significant contributions to the agricultural industry. The first Koreatown was created by organizing efforts of Korean farmworkers in Riverside, California.[136] One of the largest influxes of Korean immigration was a result of the U.S. involvement in the Korean War.[137] The Korean War caused massive death tolls, destroyed the peninsula, divided families, and created numerous war orphans.[138] The repercussions of war coupled with acculturation stressors had a profound effect on the Korean community in the U.S. Korean immigrants typically were silent about their experiences with political turmoil and war in Korea—perpetuating the intergenerational transmission of trauma. Korean immigrants also faced acculturation stressors of adapting to the U.S. They had fewer resources and faced alienation and isolation living in a new environment. The trauma from war and migration stressors continues to have psychological impacts on Korean Americans today.

Though more recent Korean immigrants were highly educated and had white-collar jobs in Korea, the U.S. did not acknowledge or recognize their expertise. Due to their limited English proficiency, Korean immigrants typically worked in jobs not commensurate with their prior educational and professional experience. Many Koreans turned to entrepreneurialism and became small-business owners.[139] A significant turning point in the Korean American identity and experience was the 1992 Los Angeles Uprising ("Sa I Gu"). Los Angeles' Koreatown and its surrounding businesses became the epicenter of six days of civil unrest after White police officers were acquitted for the brutal beating of Black motorist Rodney King. The civil unrest highlighted systemic racism, economic inequities, and police brutality in the U.S. The public narrative pitted Black and Korean communities against each other. Up until the civil unrest, the Korean community was largely invisibilized. Korean businesses endured 40% of property damage, and many people were killed or injured protecting their businesses.[140] Not only did the Korean community suffer financial hardship, but it also endured physical and psychological harm. This experience continues to shape the Korean American community's sense of belonging and well-being in the U.S.[141]

Mental Health Outcomes of Korean Communities

18% of Korean adults and 29% of Korean adolescents report needing mental health support. Close to one in five Korean adults self-identified as needing mental health support, with California's overall adult population at 24%. Almost one-third of Korean adolescents self-identified needing mental health support, while 34% of California's adolescent population overall expressed needing assistance.

Everyday experiences with discrimination are common. The most frequent everyday experiences with discrimination that Korean adults encountered include being asked where they were from, with the assumption they were

not from the U.S. (54%), assuming they don't speak English (31%), and receiving poorer service than others at restaurants or stores (24%), as Table E1 shows.

18% of Korean adults have been a victim of a hate incident or crime. Due to the fear and anxiety of anti-Asian hate during COVID-19, Korean older adults and their caregivers changed their daily routines (e.g., avoiding walks alone or using public transportation), according to recent research. In turn, these routine changes were associated with declining mental health.[142] Direct and vicarious experiences with hate crimes and incidents have ripple effects across generations of the Korean community.

45% of Korean adults are "very or somewhat worried" about gun violence — while 30% of California's adult population overall express concern about gun violence. The estimates for Korean adolescents were not statistically stable enough to draw any conclusions. The effects of recent mass shootings targeting the Asian community, such as the Atlanta spa shooting, leave Korean Americans questioning their safety and security in the U.S.

19% of Korean adults had thoughts of attempting suicide, while 17% of California's adult population disclosed suicide ideation. Research has shown that suicide rates among Korean Americans have increased, and that Korean American elders are particularly at risk.[143] This is concerning given the history of trauma that older generations of Koreans have faced, and underscores the critical need for mental health support for the Korean American community.

35% of Korean adults had difficulty accessing care. Koreans reported that unfamiliarity with options (15%), financial cost (14%), and lack of insurance (9%) were the most common barriers to accessing mental health care support. Various systemic barriers that prevent Korean Americans from accessing the support that they need include limitations in options as well as a lack of culturally aligned care. Financial constraints and lack of insurance are major barriers to affordability of mental health services, especially for Korean small-business owners.

Table E1. Korean adult respondents' most frequent encounters with everyday experiences with discrimination in an average month

	Korean
People asked where you are from, assuming you're not from the U.S.	54%
People acted as if you don't speak English	31%
Received poorer service than other people at restaurants or stores	24%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note. A full list of the everyday experiences with discrimination can be found in the Appendix.

Addressing Korean Community Mental Health Needs

Given the impact of war-induced trauma, acculturation stressors, and civil unrest on Korean Americans in the U.S., understanding of the unique impediments to mental health care is essential in order to best support the needs of the Korean community. Some key considerations to better tailor support for the Korean community include addressing language access, and stigma and attitudes about mental health.

Cultural and linguistic accessibility of services. Mental health professionals do not understand the cultural nuances and conceptions of mental health within the Korean community. Psychological disorders may manifest as somatic symptoms. For example, *hwa-byung* (meaning "anger syndrome") is a culturally specific mental disorder with various symptoms that can include insomnia, fatigue, panic, anxiety, indigestion, and general aches and pains.[144] Mainstream medical providers may misdiagnose or not recognize mental distress in the Korean community. This cultural misalignment highlights the gaps in mental health services for Korean Americans, and the need to increase training and supports for culturally aligned practices.

Language is a distinct barrier for Korean communities. Almost half of the Korean population in California has limited English proficiency.[145] Bilingual mental health professionals, in-language services, and translated Korean materials are vital to opening up mental health care access.

Stigma and shame are barriers to help-seeking behaviors. In Korean culture, mental illness is sometimes attributed to poor parenting, or a sign of personal weakness[146] that brings shame and dishonor to the family. In addition, mental health is associated with severe forms of mental illness, such as *jung-shin byung* (meaning "psychosis").[147] This stigma prevents many Korean Americans from disclosing mental health needs, and deters them from seeking mental health services. Partnering with community organizations and religious institutions can promote mental health awareness, and build trust in seeking professional support and outreach for early interventions. Community engagement activities also can focus on demystifying stigma, and encouraging help-seeking behaviors and mental health utilization.

Korean Population in California

Top Counties

Population Count (alone or in combination)

564,015

Top Language Spoken (non-English)

Korean

Poverty Status

13%

Foreign Born

68%

Educational Attainment-Bachelor's Degree

40%

Limited English Proficiency

44%

Source: The population estimates are from the 2020 Census Detailed Demographic and Housing Characteristics File A, and other sociodemographic information is from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.

The prospects of financial stability served as the impetus for the influx of the *Issei* ("first") generation of Japanese immigrants to the U.S. in the mid-1800s. They primarily worked in Hawaii's sugar plantations and California's farmlands. Japanese immigrants played a significant role in establishing the West as the core of fruit growing in the United States. Almost 80% of strawberry farmers in Los Angeles County were Japanese, many of whom began owning land and homes as well as opening businesses.[148] However, fears that Japanese immigrant farmers would take away jobs from White laborers brewed anti-Japanese sentiment.[149] This set off a series of discriminatory policies aimed at limiting the existence of the Japanese community in the U.S., including the Gentlemen's Agreement restricting immigration and California's Alien Land Laws preventing their ownership of California land. Japanese farm workers faced eviction and racialized violence across California. The history of institutionalized racism and xenophobic views continues to affect the livelihoods and well-being of Japanese Americans today.

The federal policy authorizing the imprisonment of people of Japanese heritage (including citizens) during World War II became one of the most notable civil rights violations in U.S. history, and left an indelible mark on the Japanese experience in the United States. Japanese American families were uprooted from their way of life, and suffered harsh living conditions, family division, the loss of their homes and businesses, and the denial of fundamental civil rights.[150] After the end of the war and release from internment camps, the Japanese community was left reeling from the agony and loss of cultural identity, assets and wealth, and economic opportunities. Some felt a diminished sense of purpose and were driven to take their own lives.[151] Enduring the material, psychological, and physical traumas of incarceration, families remained silent and rarely discussed the stigma of "camp." The historical trauma experienced by those interned was passed down through generations, often manifesting as emotional and psychological scars of their family's experience. This historical trauma continues to pose significant barriers to mental health care for present-day Japanese Americans.

Mental Health Outcomes of Japanese Communities

22% of Japanese adults report needing mental health support — while 24% of adults in California overall express needing support. Age was associated with reporting the need for mental health support among Japanese adults, with younger adults disclosing more mental health needs. The estimates for Japanese adolescents were not statistically stable enough to draw conclusions.

Everyday experiences with discrimination are common. The most frequent everyday experiences with discrimination that Japanese adults encountered include being asked where they were from, with the assumption they were not from the U.S. (35%), receiving poorer service than others (19%), being called names or insulted (17%), and being mocked or

having offensive gestures made at them (17%) as Table F1 shows. These daily experiences reinforce the long history of discrimination confronting the Japanese community in the U.S. The cumulative effects of discrimination stressors certainly take a toll on Japanese American mental health.

26% of Japanese adults have been a victim of a hate incident or crime. Nativity status and English proficiency were associated with reports of being a victim of a hate incident or crime among Japanese adults. Those disclosing victimization tended to be foreign born and have higher English proficiency. Since the pandemic, Asian Americans have feared racially motivated threats or attacks.[152] Exposure to hate crimes or incidents inflicts tremendous harm, fear, and anxiety. This can trigger recollection of past traumas in the Japanese American community.

30% of Japanese adults and 62% of adolescents worry about gun violence. Almost one-third of Japanese adults indicated that they were "very or somewhat worried" about being a victim of gun violence, matching the California population overall. Age was associated with concerns about gun violence among Japanese adults, with younger adults expressing greater concern. Many Japanese adolescents (62%) worry about being shot by a firearm, while 26% of California adolescents overall express worry.

17% of Japanese adults had thoughts of attempting suicide, matching the rate for California's total population. Suicidal thoughts and behaviors are especially concerning among Japanese communities. Rather than having open discussions about mental health, Japanese elders may encourage perseverance through mental health struggles instead.[153] This suppression inhibits people from seeking help for mental health support.

21% of Japanese adults had difficulty accessing care. Age and citizenship status were associated with having trouble accessing mental health support among Japanese adults, with younger adults and those without U.S. citizenship encountering more difficulty with access. Japanese adults report financial cost (9%) as a common barrier to accessing mental health support. This is consistent with previous research in which the lack of resources and financial constraints are significant deterrents to overall health care access for Asian American communities,[154] and this barrier is no exception for the Japanese community.

Table F1. Japanese adult respondents most frequent encounters with everyday experiences with discrimination in an average month

	Japanese
People asked where you are from, assuming you're not from the U.S.	35%
Received poorer service than other people at restaurants or stores	19%
Been called names or insulted	17%
People mocked or made offensive physical gestures towards you	17%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note. A full list of the everyday experiences with discrimination can be found in the Appendix.

Addressing Japanese Community Mental Health Needs

Given the history of anti-Japanese policies and impact of internment camps on Japanese Americans in the U.S., understanding of the unique impediments to mental health care is essential in order to best support the needs of the Japanese community. Some key considerations to better tailor support for the Japanese community include improving language access, reducing stigma and acknowledging attitudes about mental health, and seeking ways to promote healing from intergenerational trauma.

Cultural and linguistic accessibility of services. Japanese elders may hold cultural values encouraging emotional restraint, a fatalistic view on life that discourages dwelling on the past—characterized by the phrase *shikata ga nai* (meaning "it cannot be helped"). There is also an emphasis on *gaman* (meaning "to endure and persevere"), which further deters discussion about mental health needs and mental health utilization.[155] Some key considerations to better tailor support for the Japanese American community include partnering with community organizations to provide culturally aligned care and to promote mental health awareness.

Limitations in language proficiency pose a significant obstacle in accessing mental health services and communicating about mental health needs for many members of the Japanese community. Bilingual mental health providers, in-language services, and translated materials in Japanese are vitally important in opening up mental health care access.

Stigma and shame are barriers to help-seeking behaviors. Japanese traditional beliefs attribute the cause of mental illness to evil spirits or a weak mind rather than a medical condition.[156] Consequently, many Japanese people may believe that mental health problems are out of their control, and thus may be less likely to seek help from medical professionals. Mental health is highly stigmatized within Japanese culture, because lack of mental self-control brings great shame to individuals and their families.[157] A review article about mental health stigma in Japan illuminated negative and prejudicial attitudes toward people with mental illness, and a desire to maintain social distance from those who have schizophrenia and depression.[158] In efforts to combat stigma and improve treatment related to schizophrenia in Japan, the Japanese Society of Psychiatry and Neurology changed the term for schizophrenia from *seishin bunrestsu byo* (meaning "mind-split disease") to *togo shitcho sho* (meaning "integration disorder").[159] Mental health professionals must recognize how mental health is perceived and discussed within the Japanese community. Engaging with community organizations to better understand cultural beliefs and attitudes about mental health can help demystify stigma, and encourage help-seeking behaviors and mental health utilization.

Healing from the intergenerational transmission of trauma. The large aging Japanese population requires mental health professionals to be informed of the historical trauma associated with internment camps.[160] The persistent silence on discussing the internment camp experiences perpetuates the intergenerational transmission of trauma among Japanese communities. In addition, intergenerational conflict arises from divergent perspectives about recognizing mental health needs and seeking support. Some key considerations include focusing on healing-centered care and supporting discourse about mental health.

Japanese Population in California

Top Counties

Population Count (alone or in combination)

469,915

Top Language Spoken (non-English)

Japanese

Poverty Status

7%

Foreign Born

38%

Educational Attainment-Bachelor's Degree

36%

Limited English Proficiency

21%

Source: The population estimates are from the 2020 Census Detailed Demographic and Housing Characteristics File A, and other sociodemographic information is from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.

In the 1800s, Chinese immigrants set foot in California seeking jobs and prosperity away from their homeland. Predominantly perceived as inexpensive and unskilled laborers, Chinese immigrants were employed in mining, farming, and notably, construction of the Transcontinental Railroad. Despite their contributions, they often endured the harshest working conditions, received the lowest wages, and worked longer hours than workers of other ethnicities.[161] They grappled with violent discrimination and threats that severely affected their quality of life and mental well-being. This discrimination was rooted in the narrative of the "yellow peril," which framed Asians as threats to Western society.[162] After more than a decade of anti-Chinese sentiments and with pressure from Western states, the U.S. Congress passed the Chinese Exclusion Act in 1882, banning immigration of Chinese laborers.[163] This legacy of racism and external perceptions of being a perpetual outsider continues to diminish the mental health of Chinese Americans today.

Chinese Americans also faced patterns of being unjustly blamed for public health crises. In the early 1900s, San Francisco's Chinatown was scapegoated during the smallpox epidemic and the bubonic plague. As a result, Chinatown faced severe repercussions: it was quarantined, residents were denied medical care in local hospitals, and the community was effectively shut down.[164] Fast forward to 2020 and the scapegoating emerged again during the COVID-19 pandemic. Damaging narratives emerged, labeling the disease as the "Chinese Virus" or "Kung Flu," which fueled the continuation of anti-Asian sentiments. The result was not just a community grappling with the physical toll of a global health crisis, but also a "twin pandemic" of hate and disease. This led to increased psychological distress among community members, who had to cope with the difficulties of the pandemic, racially charged discrimination, gun violence, and hate crimes.[165] The deep-rooted racism, combined with recent events, emphasizes the compounded adversities faced by the Chinese and broader Asian community.

Mental Health Outcomes of Chinese Communities

15% of Chinese adults and 25% of adolescents report needing mental health support. Almost one in seven Chinese adults self-identified as needing mental health support, while 24% of adults in California overall expressed needing support. Age, gender, nativity status, and English proficiency were associated with reporting the need for mental health support among Chinese adults. Those reporting the need for support tended to be younger, female, born in the U.S., and have higher English proficiency. A quarter of Chinese adolescents self-identified needing mental health support, with California adolescents overall at 34%.

Everyday experiences with discrimination are common. The most frequent everyday experiences with discrimination that Chinese adults encountered include being asked where they were from, with the assumption they were not from the U.S. (43%), assuming they

don't speak English (25%), and receiving poorer service than others (19%) as Table G1 shows. The COVID-19 pandemic has intensified both the frequency and severity of anti-Asian harassment.[166] Discrimination toward Chinese Americans, such as presumptions about their nationality or language proficiency, reinforces the enduring "perpetual foreigner" stereotype.

20% of Chinese adults have been a victim of a hate incident or crime. These experiences were particularly evident during the rise in racially motivated harassment and attacks against the Chinese community in Chinatowns throughout the U.S. during the pandemic. Recent studies show that one in four Asian Americans has faced incidents fueled by bias, including physical intimidation, assault, property vandalism, and racial slurs.[167]

45% of Chinese adults and 34% of adolescents worry about gun violence. Close to half of Chinese adults (45%) indicated they were "very or somewhat worried", while 30% of the California adult population expressed concern about gun violence. Over one-third (34%) of Chinese adolescents worried about being shot by a firearm, with California adolescents overall at 26%. The mass shootings targeting Asian communities, especially Chinese Americans, in places once deemed safe—like Atlanta, Half Moon Bay, and Monterey Park—have stirred deep alarm and anxiety. Such acts of gun violence against Asian Americans echo the discrimination that Chinese Americans faced both historically and in current times.

12% of Chinese adults had thoughts of attempting suicide, while 17% of the California adult population overall disclosed suicide ideation. Older Chinese Americans experiencing racial discrimination are twice as likely to consider suicide than those not facing such bias.[168] This underscores the urgent need to prioritize mental health within the Chinese American community.

31% of Chinese adults had difficulty accessing mental health services. Age and gender were associated with experiencing challenges with access to mental health support among Chinese adults, with younger adults and females encountering more difficulty with access. Chinese adults reported that unfamiliarity with options (12%), financial cost (11%), and limited English skills (9%) were common barriers to accessing care. Chinese Americans face various systemic and cultural barriers to mental health access, including a lack of resources, language access, and a complex health system.

Table G1. Chinese adult respondents' most frequent encounters with everyday experiences with discrimination in an average month

	Chinese
People asked where you are from, assuming you're not from the U.S.	43%
People acted as if you don't speak English	25%
Received poorer service than other people at restaurants or stores	19%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
Note. A full list of the everyday experiences with discrimination can be found in the Appendix.

Addressing Chinese Community Mental Health Needs

Given the history of anti-Chinese sentiment and policies and scapegoating of Chinese Americans in the U.S., understanding of the unique impediments to mental health care is essential in order to best support the needs of the Chinese community. Some key considerations to better tailor support for the Chinese community include addressing language access, and stigma and attitudes about mental health.

Cultural and linguistic accessibility of services. Chinese culture, influenced by Confucianism, emphasizes resiliency and self-control, valuing societal harmony and moral conduct. People affected by mental illness may be perceived as unable to meet societal and moral expectations.[169] As a result, there is a strong focus on solving one's own difficulties by confronting struggles rather than by seeking assistance.[170] That cultural pressure deters help-seeking behaviors and mental health utilization. Among the Chinese community, mental health issues may also tend to manifest somatically, complicating recognition of mental distress. For example, *shenjing shuairuo* (meaning "neurasthenia" or "nervous breakdown" in Mandarin) is a form of physical and emotional distress characterized by fatigue, sleep problems, weakness, and pain.[171] Mainstream diagnostic tools and conceptualizations of mental illness can miss and discount these somatic symptoms. This gap highlights the inadequacy of existing services for the Chinese community.[172] Tailoring mental health support for the Chinese community should include understanding community-defined needs, goals, and practices, and training medical professionals on culturally aligned practices.

Due to high numbers of the Chinese population being in linguistically isolated households and having limited English proficiency, language is a distinct barrier for Chinese communities.[173] Bilingual mental health professionals, along with in-language services and translated materials in both Cantonese and Mandarin are vital to opening up mental health care access.

Stigma and shame are barriers to help-seeking behaviors. Chinese traditional beliefs attribute mental illness to wrongdoing by one's ancestors. Additionally, Chinese communities perceive mental illness as a result of social, moral, or religious causes rather than biological health concerns.[174] Chinese Americans view mental illness as a source of shame and dishonor, and so they may conceal mental health issues to maintain their family reputation. The desire to "save face" may discourage them from acknowledging the need for help and seeking mental health treatment altogether.[175] Community-based organizations have the expertise needed to foster peer support, culturally relevant outreach, navigation, prevention, and early intervention.

Chinese Population in California

Top Counties

Population Count (except Taiwanese, alone or in combination)

1,789,648

Poverty Status

12%

Educational Attainment-Bachelor's Degree

31%

Limited English Proficiency

44%

Top Languages Spoken (non-English)

Mandarin
Cantonese

Foreign Born

67%

Source: The population estimates are from the 2020 Census Detailed Demographic and Housing Characteristics File A and other sociodemographic information are from AAPI Data's *2022 State of Asian Americans, Native Hawaiians, and Pacific Islanders in California* report using the American Community Survey 2016–2020 five-year estimates.

APPENDIX

Table H1. Adult respondents' most frequent everyday experiences with discrimination in an average month

	NHPI	Asian	Vietnamese	Other Southeast Asian	South Asian	Filipino	Korean	Japanese	Chinese
Received poorer service than other people at restaurants or stores	30%	22%	13%	33%	24%	25%	24%	19%	19%
People acted as if you don't speak English	19%!	24%	19%	36%	26%	22%	31%	15%	25%
People acted as if they are afraid of you	7%!	8%	7%!	26%!	2%!	11%	7%!	5%!	9%
People acted as if they think you are dishonest	30%!	12%	8%	39%	11%	17%	4%!	11%!	11%
Been called names or insulted	11%!	16%	14%	38%	13%	16%	17%	17%	17%
Been threatened of harassed	9%!	11%	8%	27%!	9%	11%	10%	13%	10%
People intentionally mispronounced your name	26%!	16%	14%	30%	27%	22%	17%	10%	9%
Been spit at or coughed on	5%!	3%	2%!	2%!	2%!	3%!	5%!	5%!	3%!
People asked where you are from, assuming you're not from the U.S.	45%	48%	38%	57%	62%	47%	54%	35%	43%
People mocked or made offensive physical gestures toward you	10%!	16%	14%	34%	10%	16%	23%	17%	16%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
An exclamation mark (!) Indicates statistically unstable estimates

Table H2. Adult respondents' reasons for difficulty accessing mental health services

	NHPI	Asian	Vietnamese	Other Southeast Asian	South Asian	Filipino	Korean	Japanese	Chinese
Race/ethnicity	3%!	3%	1%!	7%!	1%!	2%!	4%!	1%!	5%
Financial cost	12%!	13%	12%	32%!	15%	14%	14%	9%	11%
Lack of insurance	8%!	8%	7%	30%!	7%!	8%	9%	5%!	6%
Limited English skills	0%!	5%	5%!	13%!	0%!	0%!	9%!	1%!	9%
Immigration status	0%!	1%!	1%!	9%!	0%!	0%!	3%!	0%!	1%!
Not knowing options	18%!	13%	11%	26%!	14%	14%	15%	10%!	12%
Concerns about what others think	2%!	5%	3%	5%!	5%!	6%	2%!	2%!	5%
Limited options in neighborhood	3%!	4%	3%!	15%!	2%!	4%!	3%!	1%!	5%
Other	7%!	2%	3%!	0%!	1%!	3%!	1%!	1%!	1%

Source: 2021 and 2022 CHIS AA and NHPI Follow-on Survey pooled data
An exclamation mark (!) indicates statistically unstable estimates

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The California Health Interview Survey covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. It is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households. CHIS interviews were offered in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Korean, and Tagalog. CHIS is designed with complex survey methods requiring analysts to use complex survey weights in order to provide accurate variance estimates and statistical testing. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the California Department of Health Care Services, and the Public Health Institute. For funders and other information on CHIS, visit chis.ucla.edu.

AAPI Data is a national research and policy organization producing accurate data and supporting community narratives that drive action toward enduring solutions for Asian American, Native Hawaiian and Pacific Islander (AANHPI) communities.

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7 The coefficient of variation is calculated by the standard error of an estimate divided by the estimated value.

8 Differences are statistically significant when two compared estimates pass a Z-test at the 95% confidence level. The Z-statistic is defined as the absolute value of the difference between estimates divided by the square root of the sum of the squares of the standard error of each of the estimates. This Z-statistic must be greater than or equal to 1.96 to indicate statistical significance at the 95% confidence level.

9 First the overall fit of the model is examined to see if it is significant (p-value less than 0.05) and then the parameter estimates are checked to see if any of the predictors are significant (p-value less than 0.05) in interpreting the logistic regression results.

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