Mind the Gap: Disaggregating Data in an Effort Towards Mental Health Equity Within the AAPI Community

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In her autobiographical essay collection titled *Minor Feelings: An Asian American Reckoning*, acclaimed Korean American writer Cathy Park Hong states, "I decided to see a therapist to treat my depression. I wanted a Korean American therapist because I wouldn't have to explain myself as much. She'd look at me and just *know* where I was coming from" (p. 5). Hong's cogent assertion highlights the increasingly salient need for widely available culturally-responsive, trauma-informed mental health care as the demographic portrait of the United States grows progressively diverse: "[minority] population trends have created a 'demographic imperative' for the social institutions that serve youth to modify their traditional programs and services to serve these minority youth more effectively" (Gibbs & Huang, 1989, p. 2). Additionally, her specification of *Korean* American underscores a more implicit but equally pertinent gap within the mental health field—the hidden but vast within-group differences present in the Asian American and Pacific Islander (AAPI) community as a pan-ethnic body comprising over 50 subgroups speaking an estimated 100 different languages (National Alliance on Mental Illness [NAMI], n.d.). Hong did not demand an *Asian* therapist or even an *Asian American* therapist. She, a Korean American woman understanding the singular nuances of her Korean American identity, resolutely chose to search for a Korean American therapist. In other words, Hong demonstrates concomitantly the necessity for culturally competent models of care and community-driven data disaggregation among AAPIs within the mental health field.

Despite being a profoundly heterogeneous group, the AAPI community is often addressed as a monolith. This is most evident in the construction and dissemination of the "model minority" myth, an insidious racial stereotype that characterizes AAPIs as universally

and invariably successful, subservient, reserved, and industrious (Chow, 2017). The essentialized and presumed collective prosperity of the AAPI population neglects glaring and important within-group variances. For example, the median household income of AAPIs, $86,000, is the highest of all racial groups in the U.S. (Budiman & Ruiz, 2021b). This statistic has been and continues to be widely touted as indisputable proof of AAPIs' inherent propensity for quiet affluence and success (Chow, 2017). What the one-dimensionality of this number does not convey are the substantial wealth disparities found among AAPIs. Burmese Americans have an annual median household income of $44,000, and a quarter of Mongolian Americans live in poverty (Budiman & Ruiz, 2021b). In fact, according to the Pew Research Center, the AAPI community is the most economically fragmented and polarized racial group in the U.S. (Kochhar & Cilluffo, 2018).

The pitfalls and inaccuracies linked to regarding AAPIs as monolithic are clear and carry over into the mental health field. Current leading theories and treatments of trauma are conspicuously Eurocentric and fail to confront efficaciously the psychological legacies of structural, historic marginalization and disenfranchisement that minority populations—including AAPIs—in the U.S. face (Craps et al., 2015). Furthermore, mental health research conducted on the AAPI community is rarely done so in a disaggregated manner and, as a result, creates and disseminates sweeping generalizations about the mental health outcomes and barriers experienced by AAPIs (Park, 2020). The paper will examine the social and systemic salience of data disaggregation as an epistemological, reclamative tool to establish mental health equity within the AAPI community. It will achieve this by highlighting the distinctly heterogenous topography of the AAPI community in a contemporary American context, delineating the state of mental health and mental health access among AAPIs, defining the importance of data

disaggregation as a narrative reclamation tool, and envisioning what the future of the mental health field could hold in the aftermath of a paradigm shift towards data disaggregation. The paper will conclude with equity-centered recommendations for the mental health field informed by the results gleaned through its mixed-methods procedural approach.

With regard to the United States' racial composition, this past decade has represented a historic epoch; for the first time, the white population has experienced a sustained decline, meaning all population growth between 2010 and 2020 can be attributed to minority groups (Frey, 2020). Out of said groups, the AAPI community has exhibited the most explosive rate of growth, nearly doubling over the relatively brief span of nine years (Budiman & Ruiz, 2021a). However, the mental health field has not kept up with the nation's rapidly expanding diversity. In 2019, the American Psychological Association reported that 83% of active psychologists identified as white, 7% Hispanic, 4% Asian, 3% Black/African American, and 2% "Other." Contrastingly, the racial make-up of the U.S. that year was 60.1% white, 18.5% Latinx/Hispanic, 13.4% Black/African American, and 5.8% Asian (U.S. Census Bureau, n.d.). These disparities reiterate the glaring need for community-driven, culturally informed mental health care, as well as demonstrate the presence of potential barriers to entry for people of color looking to work in mental health, though the latter point falls outside the present scope of this paper.

AAPIs have markedly lower rates of mental health services utilization than the general population: 8.6% vs. 17.9% respectively (Abe-Kim et al., 2007). Furthermore, only 17% of AAPIs who struggle or likely struggle with mental illness seek out professional help (Abe-Kim et al., 2007). Said disparities in mental health care access have influenced the mental health outcomes of the AAPI community: suicide is the leading cause of death for AAPI youth between the ages of 15 and 24 (Centers for Disease Control and Prevention [CDC], 2018). Nevertheless,

this research, while informative and impactful, is limited in its capacity to be edifying due its neglect of the significant cross-sectional differences present in the AAPI population. For example, Abe-Kim et al. (2007) assessed the use of mental health-related services among U.S.-born and immigrant AAPI, but the ethnic origin designations of the participants were restricted to “Chinese,” “Filipino,” “Vietnamese,” and “Other Asian” (p. 94). The categorization of “Other Asian” erases the distinct lived experiences of the over 45 unnamed and consequently excluded AAPI ethnic subgroups. Mental health—or the lack thereof—does not manifest homogeneously across the numerous communities encapsulated by the term “AAPI.” On the contrary, ethnicity has been shown to shape children’s conceptualizations of mental health and illness, symptomatology, coping styles, help seeking behaviors, treatment utilization, and responsiveness to treatment (Gibbs & Huang, 1989, p. 9-10). In other words, one’s ethnic and cultural positionality informs the unique ways in which they understand and experience mental health.

Religion poses a compelling case study with respect to the relationship between one’s ethnicity and mental health. Religiosity has, in the past, universally been thought to have a considerable positive impact on the mental health of minority populations (Huang et al., 2012, p. 2). Ai et al. (2016) examined the role of religious attendance as a protective factor against poor mental health among AAPIs. The authors found that "the role of religious involvement, as well as that of social support, is not uniform among culturally heterogeneous [Asian Americans]” (p. 2122). The extent to which religiosity was mentally uplifting differed between the assessed AAPI ethnic subgroups. While religious coping was found to be positively correlated with self-rated mental health (SRMH) in the Chinese subgroup, religious involvement had no observed impact on SRMH within the Vietnamese subgroup (Ai et al., 2016, p. 2124-2125). Had

the study evaluated AAPIs as a single community, these culturally shaped nuances would have been lost. Therefore, ethnicity should inform substantially mental health researchers' and practitioners' best practices, if cultural competence in the field is to be institutionalized:

> "Cultural competence has been defined in various ways, but there is a general consensus in the field of mental health that this term refers to 'the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values. . . [it] underscores the recognition of patients' cultures, and then develops a set of skills, knowledge, and policies to deliver effective treatments" (Gibbs & Huang, 1989, p. 5).

In that vein, data disaggregation offers a recursive, community-driven approach for disentangling historically conflated—and thus invisibilized—narratives about the mental health of AAPIs to ultimately establish mental health equity within that community.

To gather qualitative, primary information on the reparative role of data disaggregation, I conducted unstructured interviews with three different Filipinx mental health and research experts: Hannah Rhea Divino, the Holistic Health Director at Little Manila Rising; Krystle Abalos, the Community Health Equity Specialist at Little Manila Rising; and Roy B. Taggueg Jr., Director of Research at the University of California, Davis' Carlos Bulosan Center. Concerning the epistemological significance of data disaggregation as a means to reclaim the long homogenized—and thereby unseen—narratives of AAPIs, Taggueg stated:

> "And we recognize as well that. . .there's a huge distrust with regards to these white colonial traditions around research—about how it's supposed to be done, how data is supposed to be collected. If we took the same types of perspectives that other researchers outside of the discipline use, i.e., going out there with questions that we want to know,

> asking community folks to fill out a survey or a questionnaire or do an interview about things that we want to know—and all of that stuff, right? We didn't want to do that, because we knew that if we went down that pathway, we would just be replicating the same systems of power that got us to where we are to begin with."

Taggueg is critiquing the established conventions of how to conduct research, which are Eurocentric and extractive in nature. These traditions are diametrically antithetical to data disaggregation, which prioritizes the rich stories and voices of community members—thus refusing to flatten them to one-dimensional, quantitative summaries. In his own research, Taggueg challenges Western notions of knowledge creation by centering group storytelling within the Flipinx population through talking circles known as *Kwentuhans*. Similarly, Divino shared:

> "In our organization, we have people who have lived experiences and people who are from the Community and who have gone through or are directly affected by sociohistorical institutional trauma; we intentionally lift up these stories and our own experiences to shape the future."

Underlying both Taggueg and Divino's perspectives on the power of data disaggregation in the context of AAPI mental health is a focus on communal storytelling as a channel for structural healing.

Equipped with their insight, I resolved to put my knowledge into practice and organized a Kwentuhan-style workshop on intergenerational trauma and decolonizing mental health for the Little Manila After School Program (LMASP). The session included a vocabulary check-in to demystify any inaccessible language or field-specific jargon, a short reading on defining trauma and decolonizing mental health through an AAPI-lens, and a group discussion about the key

concepts of the reading. It was conducted entirely via Zoom. All participants were AAPI high school students local to Stockton. Throughout the discussion, attendees were asked to post their thoughts on a Google Jamboard. The following are a few anonymous student responses:

- "I would define 'decolonizing mental health' as the next step in not only uniting BIPOC but fighting and doing what generations before us could not do."
- "To me, it seems as though society does not place enough focus on the mental health of different cultures. Simply maintaining a single form of reparations for mental health is not enough for different people. Hundreds of millions of people populate the United States alone so there will be an obvious group of those who apply to themselves to that form of treatment. Cultures aren't respected in the medical field as much as they should be."
- "I would define 'decolonizing mental health' as honoring our ancestors' way of healing."

The students' contributions—like Hong's essay—humanized the present shortcomings of the mental health field in adequately serving minority populations and reinforced the need for AAPI-specific data disaggregation in mental health care. They summed it up best: "Simply maintaining a single form of reparations for mental health is not enough for different people." Following the conversation, attendees were asked to communicate how they were feeling. "Appreciated," "affirmed," "survivor," and "heard" were among the words they shared.

Discussion

The current predominant paradigm of mental health care is not culturally competent and fails to grasp fully the nuanced and socio-historically produced barriers to mental health the AAPI community faces. Additionally, mental health research today addresses the AAPIs as a

monolith and obscures the complex heterogeneity of that community which is highly problematic, as narrative/data disaggregation and mental health equity are inextricably linked. The development of social scientific methods and implements that examine specifically the distinct psychological landscapes of different AAPI subcommunities represents a fecund area of future equity and social justice-oriented research. With regard to this, the colonial mentality scale (CMS) developed by researchers E. J. R. David and Sumie Okazaki in 2006 constitutes an exemplar (David & Okazaki, 2006). The CMS is a psychological measure that assesses the unique colonially-produced feelings of internalized racism and cultural inferiority that afflict the Filipinx American community:

> "In particular, the notion of colonial mentality (CM), a specific form of internalized oppression following colonialism, has been discussed extensively by scholars and Filipino American community members as a factor that can potentially explain the high rates of mental health problems among Filipino Americans" (David & Okazaki, 2006, p. 241).

Five factors are evaluated by the CMS: "internalized cultural/ethnic inferiority," "cultural shame and embarrassment," "colonial debt," "physical characteristics," and "within-group discrimination" (David & Okazaki, 2006, p. 245); the multi-dimensional framework of the scale directly corresponds to the multi-faceted nature of the Filipinx American experience. Constructing a toolkit for examining the individual narratives of individual AAPI subgroups is the first step in normalizing data disaggregation, which represents the first step towards establishing mental health equity for AAPIs. Moreover, mental health interventions and/or services that center storytelling as a disaggregation tool may offer a countermeasure to homogenization for practitioners that is both client-centered and culturally responsive. All in all,

data disaggregation is “the most effective way to form evidence-based policy around the distinct needs of these diverse communities” (Washington Center for Equitable Growth [WCEG], 2020).

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