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## **Deconstructing the Model Minority Myth: Exploring Health Risk Behaviors of American Asian and Pacific Islander Young Adults**

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### **ABSTRACT**

The model minority stereotype describes Asian and Pacific Islanders (API) as the epitome of assimilation into U.S. culture using hard work, intelligence, high educational attainment, and economic success to overcome the challenges of discrimination and recent immigration. Adopted model minority pressures assume a life of their own, with origins in childhood that are amplified during adolescence and young adulthood. In response to evidence of increased vulnerability to HIV and other sexually transmitted infection exposure, the present study compared prevalence estimates of health risk behaviors of API and cross-ethnic college students ( $N = 1,880$ ). Self-reported alcohol use and abuse tendencies, legal and illicit drug use, abuse and misuse, as well as HIV- and other STI-related sexual risk were compared. Results of independent samples t-tests revealed that API displayed greater risk for alcohol use, abuse, dependence, and negative outcomes related to use. After controlling for differences in the 90-day prevalence of sexual activity, Cochran-Mantel-Haenszel and chi-square analyses indicated significantly greater behavioral risks for infection among API. API males were nearly twice as likely as their cross-ethnic peers to engage in insertive oral and anal sex without a condom to the point of ejaculation. While reporting fewer risks compared to their male counterparts, API females were significantly more likely than their cross-ethnic peers to engage in behaviors which may enhance exposure to infection. Such findings suggest a shrinking cultural divide with regard to risk behaviors on college campuses, as well as a lack of perceived HIV and other sexually transmitted infection risk among API students. As universities continue to foster cultures of diversity, the unique experiences and prevention-based needs of API students must be addressed.

**Keywords:** Asian and Pacific Islanders; College students; Sexual behavior; Risk reduction

### **INTRODUCTION**

The process of adolescent and young adult development is complex, involving rapid cognitive, emotional, physical, and behavioral changes that influence both health-related

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decisions and subsequent outcomes. Often initiated during adolescence, behaviors such as alcohol, tobacco and other drug use, as well as unprotected sex, may serve as predictors of morbidity and mortality in adulthood (Lee & Rotheram-Borus, 2009). As a precursor to targeted health promotion and disease prevention efforts, extensive research has examined adolescent and young adult risk behaviors, notably focusing on racial and ethnic health disparities (Department of Health and Human Services, 2013). Yet while significant focus has been placed on the unique challenges faced by African American and Hispanic/Latino adolescents and young adults, less is known about the specific health needs and challenges of Asian and Pacific Islanders (API), whose proportion of the United States population continues to grow (Centers for Disease Control and Prevention, 2013).

Asian and Pacific Islanders constitute the fastest growing population in the United States, having grown at a four-fold greater rate than the general population between 2000 and 2010. There are approximately 20.8 million API living in the United States, speaking more than 100 languages and dialects (Center for American Progress, 2014). Four of the five languages with the largest percentage increase of use since 1980 are Asian languages, reflecting the more than 50 diverse ethnicities and identities (United States Census Bureau, 2013). The API population is further estimated to increase by more than 2,400% by 2050, compelling the public health community to develop policies and interventions to most effectively meet their growing needs (Tseng, 2009).

Based upon their stereotype as overachievers and as models to other minority groups, API often have the distinction of being labeled a “model minority” (Sabato & Silverio, 2010). This prominent reflection on social perceptions, rather than evidence-based outcomes, amplifies the difficulty of primary and secondary prevention and risk reduction efforts, as fewer resources are directed toward the API community. Contrasting the model minority stereotype, data from the Centers for Disease Control and Prevention’s National Health Interview Survey indicate that prior to passage of the Affordable Care Act, Asian Americans were twice as likely as Non-Hispanic Whites and African Americans not to have seen a doctor in the past five years, despite having a greater likelihood of developing hepatitis, stomach and liver cancer, and other diseases (Asian American Center for Advancing Justice, 2011). Significant informational and process barriers in health insurance marketplaces similarly hindered API enrollment during the Affordable Care Act’s first Open Enrollment Period, further impacting access to quality care and resources (Asian and Pacific Islander American Health Forum, 2014).

Adopted model minority pressures assume a life of their own, with origins in childhood that are amplified during adolescence and young adulthood. Wrought with tension and anxiety for adolescents of all ethnicities, racialized expectations further add to the pressures faced by Asian and Pacific Islanders seeking higher education. Caught between competing expectations of American society and cultural heritage, API students often feel a restricted sense of identity and limited choice. The unprecedented challenge of educating students from diverse cultural, social, and economic backgrounds who may face language-associated adversities may further isolate students, compromising emotional and physical health. Asian and Pacific Islander students report some of the highest rates of stress, anxiety, and depression – each of which has been associated with risk behaviors such as alcohol, tobacco and other drug use, as well as unprotected sexual intercourse which may lead to unintended pregnancy and/or sexually transmitted infections (STI) (Lee & Rotheram-Borus, 2009; Asian and Pacific Islander American

Scholarship Fund, 2012). Young et al.'s study of undergraduate students found that, compared to Caucasians, Asian and Pacific Islanders exhibited significantly elevated levels of depression (2010). The impact of such behaviors is compounded by reluctant use of mental health and counseling services. Asian and Pacific Islander Americans exhibit the lowest rates of utilization of mental health services compared to the general population (Wang, 2010). Moreover, the proportion of Asian Americans who employed mental health services were approximately one third of what might be expected given their population proportion (Yang, Phelan, & Link, 2008).

Despite misconceptions, Asian and Pacific Islanders are particularly vulnerable to HIV. In contrast to other racial/ethnic groups, Asian and Pacific Islanders were the only group to show a significant increase in HIV diagnoses between 2001 and 2008 (Adih, Campsmith, Williams, Hardnett & Hughes, 2011). Certain sexual risk behaviors that contribute to HIV transmission risk are as prevalent among API as they are among other ethnic groups. Several factors suggest an even greater risk of transmission among adolescents and young adults. The prevalence of alcohol consumption or drug use prior to sexual intercourse is significantly higher among Asian American young adults, compared to White, African American, and Hispanic/Latino counterparts (Lowry et al. 2011). Rates of alcohol use disorders similarly remain close to that of non-Asian and Pacific Islander populations, even among those who experience the flushing syndrome thought to reduce rates of alcohol dependence (Fong & Tsuang, 2007). Cultural and social norms, which discourage open discussion of sex within the API culture, contribute to heightened HIV risk among youth (Lee & Rotheram-Borus, 2009). These concerns are compounded by findings that the API population is considerably younger than other ethnic groups. While 21% of Whites are under 18 years of age, over one-quarter (26%) of Asian Americans and more than one-third (35%) of Native Hawaiian and Pacific Islanders are (Asian American Center for Advancing Justice, 2011). Data suggests that Asian and Pacific Islander youth have significantly less knowledge of basic information regarding HIV transmission, risk, and prevention practices (Sen et al., 2017). Despite such lack of knowledge, So et al. (2005) reported a 37% lifetime prevalence of unprotected sex as well as lifetime drug use associated with 30-day and lifetime sexual risk indices. This disparity suggests a greater percentage of the API population may be at risk of HIV transmission (Lee & Rotheram-Borus, 2009).

As institutions of higher learning continue to embrace cultural diversity, it is likewise vital that policies and practices reflect the unique needs of the student community. In response to evidence of increased vulnerability to HIV and other sexually transmitted infection exposure among Asian and Pacific Islander young adults, the present research examined sexual and other behavioral risks of API students, compared to their cross-ethnic peers. The results of the present research may not only illuminate the fallacy of the perceived model minority stereotype, but similarly impact the development of culturally and behaviorally relevant interventions for API students.

## **METHODS**

### **Study Sample and Data Collection**

The sample consisted of men and women enrolled in introductory health courses across three separate university campuses in the mid-Atlantic region of the United States spanning two academic years. Upon receipt of Institutional Review Board approval, a brief announcement regarding the study, including research objectives as well as participant benefits and risks, was

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made in each course. Students choosing to participate were provided a research packet, containing a cover letter, consent form, and questionnaire packet. Potential respondents were given one week to complete the required paperwork and questionnaires. Completed questionnaires were separated from the informed consent piece, and returned to the Principal Investigator via a locked drop box. All information was kept confidential, with respondent names not directly attributable to specific questionnaires. Identification numbers were used to code questionnaires.

### Measures

In addition to demographic information (age, race/ethnicity, gender identity, and sexually transmitted infection testing history), a measure of counseling and mental health services examined possible disparities in help-seeking behaviors. Two scales were used to measure differences in alcohol use and abuse tendencies, legal and illicit drug use, abuse and misuse between self-identified Asian and Pacific Islander students and their cross-ethnic peers. The 10-item Brief Michigan Alcoholism Screening Test assessed behaviors and consequences associated with alcohol abuse and dependence (Pokorny, Miller, & Kaplan, 1972). Aggregated by summing weighted scores to each item, scores may range from 0 to 29, with higher scores indicating greater behavioral risks for alcoholism. The Drug Abuse Screening Test similarly examined the use and consequences of illegal and prescription drugs (Skinner, 1982). Containing 20 items, an aggregate score is generated by summing all items endorsed in the direction of increased drug use problems, with possible scores ranging from 0 to 20. Both the Brief Michigan Alcoholism Screening Test and Drug Abuse Screening Test have reported high levels of validity and reliability, with alpha levels ranging from .86 to .99 (Pokorny, Miller, & Kaplan, 1972; Skinner, 1982). Reliability coefficients in the present study were 0.84 and 0.82, respectively.

HIV- and other STI-related sexual risk behaviors were assessed using the University of California San Francisco Center for AIDS Prevention Studies Sexual Behaviors Questionnaire (Chesney, Folkman, & Chambers, 1996). In addition to reporting the number of persons with whom they had sexual activity during the prior three month period, the 20-item scale asked participants to respond dichotomously to engagement in condom usage, as well as insertive and receptive anal, oral, and vaginal intercourse. Aggregate scores were calculated based upon responses to all items involving unprotected oral, anal, and vaginal sex. Scores could range from 0 to 22, with higher scores indicating greater participation in HIV- and other STI-related sexual risk.

### Data Analyses

All data were entered into SPSS Statistics 21.0 for Windows to identify missing information and outliers. Frequency counts for each scale were generated to examine missing data. None of the scales had greater than 2% missing data.

Despite provisions in the Affordable Care Act which focus on standardizing, collecting, analyzing, and reporting data on health disparities among seven Asian subgroups and four Native Hawaiian and Pacific Islander subgroups, power analyses indicated that disaggregating data in the current study would not have allowed for ample sample sizes to effectively examine the research hypotheses. As such, based upon respondent self-identification, racial/ethnic categories were dichotomized into 'Asian and Pacific Islander' and 'Non-Asian and Pacific Islander,' allowing for direct comparison of behaviors and outcomes. Self-reported alcohol use and abuse

tendencies, legal and illicit drug use, abuse and misuse, as well as HIV- and other STI-related sexual risk were compared via a series of independent samples t-tests, with significance levels set at .05. Self-reported sexual risk behaviors were compared via Cochran-Mantel-Haenszel tests, to determine the significance of associations. When non-significant, a series of chi-square tests were conducted. With non-API students as a reference group, odds ratios of sexual risk behaviors were calculated, using 95% confidence intervals to determine significance.

## RESULTS

The sample consisted of 1,878 respondents ranging in age from 18 to 24, with a mean age of 19.6. The majority of respondents (70.3%) were female. Nearly one-third of respondents (30.3%) indicated a prior history of counseling. Collectively, more than two-thirds of respondents (69.2%) indicated engagement in sexual behaviors in the three months prior to the study. Despite such activities, the vast majority (82.7%) indicated no history of testing for sexually transmitted infections.

As mentioned previously, self-reported racial/ethnic identities were dichotomized into 'Asian and Pacific Islander' and 'Non-Asian and Pacific Islander,' to allow for direct comparison of behaviors and outcomes. Although comprising only 6.3% of the sample, analyses indicated a large enough sample of Asian and Pacific Islanders to provide an appropriate degree of statistical power. Presented in Table 1 in dichotomized fashion, demographic information suggests that Asian and Pacific Islander students were significantly less likely than their cross-ethnic peers to have a history of counseling (31.4% vs. 14.2%,  $p < .001$ ). Asian and Pacific Islander students were similarly less likely to have engaged in sexual activity in the prior ninety days (69.8% vs. 60.7%,  $p < .001$ ) or to have received testing and counseling for sexually transmitted infections (16.3% vs. 14.3%,  $p < .05$ ).

Results of independent samples t-tests revealed that, compared to their cross-ethnic peers, Asian and Pacific Islander respondents displayed greater risk for alcohol abuse, dependence, and negative outcomes related to use ( $p < .05$ , Table 2). Consistent with prior research suggesting a diminishing cultural impact on substance use and abuse patterns, independent samples t-tests revealed no significant difference in drug abuse patterns and behavioral outcomes between Asian and Pacific Islander students and their cross-ethnic peers.

Despite a significant difference in the 90-day prevalence of self-reported sexual behaviors of Asian and Pacific Islander students and their cross-ethnic peers, results of independent samples t-tests indicated no differences in risk for HIV and other sexually transmitted infections. After controlling for differences in the 90-day prevalence of sexual activity, Cochran-Mantel-Haenszel and chi-square analyses indicated significantly greater behavioral risks for infection among Asian and Pacific Islanders. Odds ratios, presented in Table 3, suggest that Asian and Pacific Islander males were nearly twice as likely as their cross-ethnic peers to engage in insertive oral and anal sex without a condom to the point of ejaculation (OR = 1.43 and 1.99,  $p < .001$  for each, respectively). Asian and Pacific Islander males were similarly at elevated risk for engaging in both behaviors without ejaculation (OR = 2.03 and 1.34,  $p < .001$  and  $p < .01$ , respectively). While reporting fewer risks compared to their male counterparts, Asian and Pacific Islander females were significantly more likely than their cross-ethnic peers to engage in behaviors that may enhance exposure to infection. They were nearly 30% more likely to engage in receptive oral and anal intercourse without a condom to the point of ejaculation ( $p <$



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.001 and .01, respectively), and between 30% and 76% more likely to report such behaviors without ejaculation ( $p < .01$  and  $.001$ , respectively). Such findings further suggest a shrinking cultural divide with regard to risk behaviors on college campuses, as well as a lack of perceived HIV and other sexually transmitted infection risk among Asian and Pacific Islander students.

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Table 1.

*Socio-demographic characteristics of student respondents (N=1,878)*

	<b>Total</b>		<b>Race/Ethnicity</b>			
	<i>n</i>	(%)	<b>Asian/Pacific Islander (n = 120)</b>		<b>Non-Asian/Pacific Islander (n = 1,758)</b>	
	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
<b>Gender</b>						
Male	552	(29.3)	50	(41.7)	502	(28.6)
Female	1,322	(70.3)	70	(58.3)	1,250	(71.1)
Transgender	4	(0.2)			4	(0.2)
Other	2	(0.1)			2	(0.1)
<b>History of Counseling*</b>						
Yes	568	(30.3)	17	(14.2)	551	(31.3)
No	1,308	(69.7)	103	(85.8)	1,205	(68.6)
<b>Sexually Active in Last 3 Months*</b>						
Yes	1,264	(69.2)	71	(60.7)	1,193	(69.8)
No	562	(30.8)	46	(39.3)	516	(30.2)
<b>History of STI Testing**</b>						
Yes	324	(17.3)	17	(14.3)	307	(17.5)
No	1,549	(82.7)	102	(85.7)	1,447	(82.5)

Note: Results of independent samples t-tests comparing socio-demographic characteristics of Asian/Pacific Islander and Non-Asian/Pacific Islander students

\*  $p < .001$ , \*\*  $p < .05$

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Table 2.

*HIV-related Risk Behaviors of Asian/Pacific Islander and Non-Asian/Pacific Islander Students*

	Race/Ethnicity		<i>t</i>	<i>df</i>
	Asian/Pacific Islander	Non-Asian/Pacific Islander		
Drug Abuse	1.2 (2.0)	1.4 (2.1)	.98	1,830
Alcohol Use/Abuse	3.1 (3.3)	2.4 (2.9)	-2.26*	1,857
Sexual Risk	1.8 (2.6)	2.0 (2.1)	.62	1,637

*Note.* \* =  $p < .05$ . Standard Deviations appear in parentheses below means.



Table 3. *Sexual Risk Behaviors of Undergraduate Students by Race/Ethnicity, Past 90 Days*

<b>Behavior</b>	<b>% Asian/Pacific Islander</b>	<b>% Non-Asian/ Islander</b>	<b>p</b>	<b>OR</b>
<b>Males</b>				
Insertive anal sex with a condom	3.6	2.6	<.01	1.34 (1.29, 1.38)
Insertive anal sex without a condom, without ejaculation	4.0	2.9	<.01	1.34 (1.31, 1.36)
Insertive anal sex without a condom, with ejaculation	3.9	1.9	<.001	1.99 (1.96, 2.03)
Insertive oral sex with a condom	4.0	1.6	<.001	2.51 (1.47, 1.56)
Insertive oral sex without a condom, without ejaculation	28.6	14.3	<.001	2.03 (1.99, 2.08)
Insertive oral sex without a condom, with ejaculation	18.4	12.2	<.001	1.43 (1.41, 1.45)
Oral sex with women with a barrier	8.6	8.1	.2116	1.04 (1.01, 1.07)
Oral sex with women without a barrier	7.2	6.8	.2633	1.02 (0.98, 1.05)
<b>Females</b>				
Receptive anal sex with a condom	5.0	2.2	<.001	2.23 (2.18, 2.27)
Receptive anal sex without a condom, without ejaculation	5.1	2.9	<.001	1.76 (1.74, 1.79)
Receptive anal sex without a condom, with ejaculation	3.0	2.4	<.01	1.26 (1.22, 1.27)
Receptive oral sex with a condom	2.0	1.8	.6390	1.10 (1.07, 1.14)
Receptive oral sex without a condom, without ejaculation	30.4	23.2	<.01	1.30 (1.26, 1.35)
Receptive oral sex without a condom, with ejaculation	23.6	18.2	<.001	1.30 (1.27, 1.33)
<b>Males and Females</b>				
Vaginal sex with a condom	35.4	39.4	.4198	0.98 (0.97, 1.00)
Vaginal sex without a condom, without ejaculation	27.8	32.9	<.01	0.83 (0.81, 0.87)
Vaginal sex without a condom, with ejaculation	22.7	20.8	<.05	1.09 (1.06, 1.14)

## DISCUSSION

The present study compared the sexual and other behavioral health risks of Asian and Pacific Islander students, compared to their cross-ethnic peers. It similarly examined the engagement in protective behaviors which minimize exposure to infection and other negative health outcomes. Contrasting the model minority stereotype, findings suggest that the prevalence of risk-related behaviors among API young adults is similar, if not greater, than their non-API counterparts. Equally alarming, API young adults were significantly less likely to access services and/or resources which may serve as protective factors for infection.

Prior research supports the finding that Asian and Pacific Islander students were significantly less likely than their cross-ethnic peers to report a history of counseling. Owing to a lack of culturally appropriate treatment approaches, as well as institutional barriers, it is estimated that only 17% of Asian and Pacific Islander Americans with a psychological problem seek professional help (Wang & Kim, 2010). Comparative studies of college students have similarly demonstrated that Asian students are less willing to access psychological services compared to Whites (Sullivan, Ramos-Sanchez, & McIver, 2007). Nearly one-third of Asian and Pacific Islanders utilizing mental health services do not return after their initial visit, suggesting that cultural factors may predispose them not to seek services, and that obstacles were likely encountered when services were sought (Wang & Kim, 2010).

Significantly lower levels of testing and counseling for sexually transmitted infections among Asian and Pacific Islander students are similarly supported by prior research. HIV- and other STI-related stigma is a primary barrier to testing and access to services in API communities, and similarly discourages API from speaking openly about sexual health. As a result, Asians and Pacific Islanders report the lowest rates of HIV antibody testing of all races and ethnicities, with nearly two-thirds never having been tested (Schiller, Lucas, Ward, & Peregoy, 2012). Despite being lower than their cross-ethnic peers, testing rates for API students in the present study parallel those found among 18-24 year old API's (14%) in the California Health Interview Survey (UCLA Center for Health Policy Research, 2007). The consistency of these rates across time is particularly alarming, in light of a rapid increase in cases of HIV and other STIs among Asian and Pacific Islander Americans over the past ten years. Despite increased awareness and prevention efforts, API report a higher prevalence of STIs, especially chlamydia and primary and secondary syphilis, compared to Caucasians (Lee, Florez, Traiman, McCarter, & Riesche, 2015). Such findings suggest a need for targeted prevention efforts, inclusive of testing and counseling, in response to risky behaviors in this population.

Although significantly fewer API students engaged in sexual intercourse compared to their cross-ethnic peers (69.8% vs 60.7%), Asian and Pacific Islander students were no less likely to engage in sexual risk behaviors. Such findings support prior research suggesting a relationship between acculturation and health risk behaviors among youth, whereby psychosocial, behavioral, linguistic and ideological changes resulting from continuous contact between two cultures increases risk behavior and maladaptive coping styles (Sanchez, Rice, Stein, Milburn, & Rotheram-Borus, 2010; Lee & Ham, 2010). Asian and Pacific Islander students do not exist in a social vacuum when it comes to engaging in risky sexual behaviors. Although fewer API students reported lifetime sexual intercourse, Lee and Rotheram-Borus (2009) found that consistently fewer API students reported condom use during their last sexual intercourse (48.9%), compared to their Hispanic (55.2%), White (58.6%), and African American

(65.7%) peers. Data from the National Longitudinal Study of Adolescent Health similarly show that API youth are less likely to use condoms at first intercourse than all other racial/ethnic groups (Dye & Upchurch, 2006). Hahm, Lee, Ozonoff, and Amodeo's (2007) examination of Vietnamese American college students further found that those who were sexually active had significantly less HIV knowledge than those who were not sexually active. The results of these studies, coupled with significantly lower testing rates, suggest the importance of recognizing Asian and Pacific Islander young adults as a group at continually high risk for HIV and other sexually transmitted infections.

Prior research has consistently found lower rates of alcohol consumption and binge drinking among Asian and Pacific Islanders, compared to cross-ethnic peers. Substance Abuse and Mental Health Services Administration (SAMHSA) data indicate that, at 34.5%, Asian and Pacific Islanders are less likely than all other racial/ethnic groups to report current alcohol use (Substance Abuse and Mental Health Services Administration, 2014). Wu and Blazer's (2015) examination of data from the National Survey on Drug Use and Health similarly indicate that, among those 18 years and older, Asian Americans have a lower past-month prevalence of binge alcohol use than the national average - 13.2% versus 24.5%. Pacific Islanders, in contrast, experienced the highest rates (24.7%). Lowry et al. (2011) further reported the 30-day prevalence of both alcohol and episodic heavy drinking to be similar between Pacific Islander and White students, yet significantly lower among Asian American students. Highly correlated with illicit drug use, excessively alcohol consumption has similarly predicted increased sexual risk taking, discussed previously (Wu et al., 2013; Scott-Sheldon et al., 2009).

Despite reporting significantly lower rates of drug abuse compared to their cross-ethnic peers, longitudinal data suggest that the 30-day prevalence of inhalants, cocaine, hallucinogens and MDMA among Asian and Pacific Islander students has steadily risen between 2011 and 2014 (Miech, Johnston, O'Malley, Bachman, & Schulenberg, 2015). Compared to cross-ethnic peers, research has similarly indicated a significantly increasing prevalence of marijuana use among Asian and Pacific Islander students. By 2005, API students reported the second highest level of lifetime marijuana use (Lee & Rotheram-Borus, 2009). When disaggregated, the past year prevalence of marijuana use among Native Hawaiians and Pacific Islanders (18.8%) is higher than that of Whites (11.8%) and Asian Americans (4.9%).

Although unable to disaggregate the data by Asian/Pacific Islander subculture, the present findings parallel a growing body of literature indicating a statistically significant increase in alcohol consumption and drug use patterns among Asian and Pacific Islander students, and similarly suggest greater assimilation to social and behavioral norms that exist on college campuses (Substance Abuse and Mental Health Services Administration, 2015). Given the associated risks of unprotected sex after excessive alcohol consumption and drug use, it is imperative that interventions aimed at reducing high-risk sexual behaviors and drug abuse among college students include, and in some instances specifically address Asian and Pacific Islanders. This is particularly noteworthy, given present findings that Asian and Pacific Islanders engage in sexual behaviors which not only challenge the model minority stereotype, but similarly magnify risks of pregnancy and transmission of infection.

## **CONCLUSION**

### Limitations

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The present study's findings are not without limitations. Despite comprising a sample size which is representative of students nationally (6.3% of the sample identified as either Asian or Pacific Islander), a small sample limits the predictive value of the findings (National Center for Education Statistics, 2013). Smaller sample sizes impact statistical power, reducing the likelihood that statistically significant results reflect a true effect. The consequences of this may include overestimates of effect size and low reproducibility of results (Button et al., 2013). Similarly, data was collected via convenience sampling of students enrolled at three institutions in the mid-Atlantic region of the United States. As such, generalization to other regions or populations is limited. Lastly, because all data was self-reported, bias is a concern, particularly given the sensitivity of questions.

#### Implications for Practice

Despite such limitations, the current study illuminates the numerous behavioral risks among Asian and Pacific Islander students, and challenges the notion that API young adults are a model minority. Data indicates that Asian and Pacific Islanders engage in sexual risk behaviors at similar rates to their cross-ethnic peers, and often in excess of their cross-ethnic peers. Significantly greater risks of alcohol abuse among Asian and Pacific Islander students may further enhance the likelihood of negative outcomes, as condom use becomes inconsistent after consuming alcohol (Zablotska et al., 2006). Even when attempting to mitigate risk by engaging in safer sexual practices, drinking before sexual activity is associated with a greater likelihood of condom failure (Eaton et al., 2015). Such findings, coupled with prior research, affirm the need for the design and implementation of targeted, culturally and ethnically appropriate behavioral risk reduction efforts among Asian and Pacific Islander students. Effective programs should further consider factors unique to Asian and Pacific Islander students, based upon socialized inhibition or assimilation, which compromise their utilization of counseling and/or mental health services (Brice et al., 2014).

As noted in the findings, engagement in sexual and other health risk behaviors among Asian and Pacific Islander students is not limited to males. Despite the fact that, compared to the national average, female Asian and Pacific Islander high school students are less likely to have engaged in sexual intercourse, among those API who were sexually active, consistently fewer report condom use during their last sexual intercourse (Lee & Rotheram-Borus, 2009; Bridges, 2007; Hahm, Lahiff, & Barreto, 2006). Coupled with a statistically significant decreasing trend in parental HIV and other STI communication among API students, the data suggest that institutions of higher learning would do well to adopt models of prevention that are not only culturally-specific, but similarly gender-specific (Lee & Rotheram-Borus, 2009). Acculturation likewise has a greater influence on young API females' sexuality than that of API males – young API females with greater levels of acculturation (e.g., speaking English in the home, having a higher number of years of U.S. residence, and/or preferring American entertainment) are more likely to be sexually active than young women who are less acculturated (Hahm, Lahiff, & Barreto, 2006). Responsive, tailored interventions that are consistent with cultural values, beliefs, and practices, while similarly recognizing gender-based variability in risk behaviors, may aid in filling the sexual health information gap among Asian and Pacific Islander college students.

At a macro level, both researchers and practitioners would do well to disaggregate data and information related to the health risk behaviors and corresponding outcomes among Asian

and Pacific Islanders. Combining health risk behavior data obscures important differences between the more than 48 ethnicities and 300 spoken languages among those who identify as Asian or Pacific Islander (Teach for America, 2016; National Council of Asian and Pacific Islander Physicians, 2015). Several provisions in the Affordable Care Act have focused on standardizing, collecting, analyzing, and reporting data on health disparities, requiring the disaggregation of data across seven Asian subgroups and four Native Hawaiian and Pacific Islander subgroups, in addition to collecting data based on sex and primary language (Asian and Pacific Islander American Health Forum, 2012). Disaggregating data will not only aid in deconstructing the model minority myth, but similarly allow for a greater understanding of the needs of the Asian and Pacific Islander student community. By doing so, colleges and universities may advocate for and create programs which close gaps in both health and academic outcomes among API students.

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