THE M&M PARADOX: HOW THE SEEMINGLY POSITIVE MODEL MINORITY MYTH INHIBITS ASIAN AMERICAN COMMUNITIES WITHIN THE HIV/AIDS EPIDEMIC

A Senior Thesis
submitted to the Faculty of the
College of Arts and Sciences
of Georgetown University
in partial fulfillment of the requirements for the
degree of
Bachelor of Arts
in American Studies

By

Hyun “Harry” S. Lee

Washington, D.C.
April 19, 2017
THE M&M PARADOX: HOW THE SEEMINGLY POSITIVE MODEL MINORITY MYTH INHIBITS ASIAN AMERICAN COMMUNITIES WITHIN THE HIV/AIDS EPIDEMIC

Hyun “Harry” S. Lee

Thesis Adviser: John D. Kraemer, JD, MPH

ABSTRACT

For years Asian American communities and individuals have been largely overlooked by the public health system. Especially within the context of HIV/AIDS, Asian Americans have historically lacked a strong voice and representation in national conversations. Reasons for this have typically been based on matters of practicality and the notion that Asian Americans simply did not have the data and numbers to warrant more resources and services. Through the analysis of expert interviews, journal and newspaper articles, reports, primary sources, and secondary sources, this thesis takes a different approach by exploring and explaining this cultural phenomenon within the framework of the model minority myth. In this work, I examine the role of the model minority myth in regards to the relationships between Asian American communities, Asian Americans with HIV/AIDS, advocates, and federal policymakers. I argue that the normalization of the seemingly positive model minority myth perpetuated a cycle of cultural dissonance between Asian Americans and the American bureaucracy within the context of the HIV/AIDS epidemic. The seemingly positive stereotype inhibited Asian American communities due to 1) the political origins and motivations of the model minority concept, 2) the inherent falsity of the stereotype and its effects as an external factor to Asian American communities, and 3) the negative consequences following the internalization of the myth by Asian American communities.
ACKNOWLEDGMENTS

I would like to thank my adviser, Professor John Kraemer, for his help throughout the entire process of writing a thesis in addition to his overall guidance and insights these past several years. I would like to thank Professor Erika Seamon and Colva Weissenstein for all the support they have given me and all the work they put into the American Studies program. I would like to thank all the experts who allowed me to interview them for the sake of my thesis, despite their busy schedules. I would like to thank my fellow American Studies classmates who provided me with a solid support system over the past year. In particular, I would like to give a shout out to my friend Josh Dostal for allowing freshman me to take him to an interest meeting and convince him to major in American Studies with me because I did not want to do it alone. I want to thank Josh for all his support, jokes, and sass the past four years. Last but not least, I would like to thank my family, without whom none of this would have been possible and I would not be the individual that I am today.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter I: The Origin Story – Politics and Numbers</td>
<td>15</td>
</tr>
<tr>
<td>Chapter II: The Model Minority Myth – The Homogenization of Diversity</td>
<td>28</td>
</tr>
<tr>
<td>Chapter III: M&amp;M Consumption – The Internalization of the Myth</td>
<td>42</td>
</tr>
<tr>
<td>Conclusion</td>
<td>56</td>
</tr>
<tr>
<td>Bibliography</td>
<td>63</td>
</tr>
</tbody>
</table>
Introduction: Asian Americans, the HIV/AIDS Epidemic, and the M&M

Let us say that all your life, based on your hair color or some other physical trait, people have been telling you how great it must be to be you. They compliment you on how healthy, intelligent, and successful you are. Hearing all this — regardless of how true or false these statements are — chances are that you would not be too bothered by them. Odds are you probably will not go out of your way to argue with these people and claim that you are in fact unhealthy, unintelligent, and unsuccessful. If anything, you might actually appreciate and embrace the praise, especially if so many people are saying it.

Now, imagine that you suddenly become very ill. You turn to other people and those around you for help in hopes that they can provide you with some care and services that will remedy the situation. Instead, you find yourself isolated. To your horror, you discover that you are essentially invisible within the system. Due to the normalization of the idea that everyone like you is automatically healthy, successful, and do not require help, there are almost no services and resources catered to your needs. Suddenly, the words and beliefs that you once accepted as being harmless — or even positive — are the very things that are negatively affecting you.

This hypothetical is undoubtedly an oversimplification and does not address a lot of the nuances, but at its core, this is the situation that can be found at the intersection of Asian Americans and HIV/AIDS. For decades, Asian American individuals and entire communities have been routinely characterized as the model minority.¹ Subsequently, Asian Americans have had to explicitly and/or implicitly confront situations analogous to the one mentioned above.

¹ Chau Trinh-Shevrin, Nadia Shilpi Islam, and Mariano Jose Rey, Asian American Communities and Health: Context, Research, Policy, and Action (San Francisco, CA: John Wiley & Sons, 2009), 5-8.
They have historically been disregarded in the realm of American public health. Particularly within the context of the HIV/AIDS epidemic, the Asian American voice and narrative have been lacking. The question then is, “How exactly does the model minority concept, a positive stereotype, factor into all this?” What can the study of the model minority stereotype reveal about the social, cultural, and political dynamics surrounding Asian Americans and HIV/AIDS?

In this thesis, I will argue that the normalization of the seemingly positive model minority myth perpetuated a cycle of cultural dissonance between Asian Americans and the American bureaucracy within the context of the HIV/AIDS epidemic.

First, it should be noted that the terms Asian American and Pacific Islander themselves are very general terms. As it will be discussed in chapter two, within each of these groups, there are many different subgroups, each with their own culture, language, and a set of characteristics. For this thesis project, I will be grouping Asian Americans and Pacific Islanders together into one group and will refer to them as Asian Americans. In addition, provided the individuals live in the United States, a distinction will not be made between recent immigrants and American citizens. By using a single label, I will be overlooking nuances; however, I have decided to do this for several reasons. For one, studies on the intersection of Asian American communities and public health — especially in regards to the HIV/AIDS epidemic — are already fairly limited. Differentiating between each ethnic group or community and only focusing on one or two of them would reduce my overall access to relevant resources. Furthermore, it would appear that many of the relevant organizations and advocates involved in this field frequently come together

---


to identify themselves as Asian American and Pacific Islander (AAPI and/or A&PI). In addition, this thesis will attempt to explore the effects of the model minority stereotype within a public health context. It so happens that the stereotype also does not differentiate between subgroups and is associated with both Asian Americans and Pacific Islanders. As a result of all these reasons, I am inclined to believe that for the sake of this thesis, grouping the different populations together and calling the corresponding individuals Asian Americans would be acceptable.

The term cultural dissonance must also be explained and understood. Oxford University’s online dictionary defines cultural as “[r]elating to the ideas, customs, and social behavior of a society,” and dissonance as “[a] tension or clash resulting from the combination of two disharmonious or unsuitable elements.” Combined, “[c]ultural dissonance is the term commonly used to describe a sense of discomfort, discord or disharmony arising from cultural differences or inconsistencies which are unexpected or unexplained and therefore difficult for individuals to negotiate.” Within the context of this thesis, the term cultural dissonance will be referring to the disconnect experienced by Asian Americans within the country’s public health system as the

---


general public’s assumption of Asian Americans, their cultures, and health actually mask and run counter to the actual needs of Asian American communities.

Extensive amounts of work have been conducted within public health as an area of study. Such works on public health have ranged from analyses of specific healthcare legislations to epidemiological studies on a variety of diseases and conditions. Entire federal departments and agencies like the United States Department of Health and Human Services (HHS), the Center for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH) have also been created with the primary objective of researching and addressing issues pertinent to public health. Within the fiscal year of 2017 alone, the plan is to have almost a trillion dollars of federal funds be distributed to various public health agencies through the Prevention and Public Health Fund.9

Under the broader umbrella of public health issues, the HIV/AIDS epidemic of the 1980s and 1990s is a subject area that has been regularly studied and one that continues to be analyzed. From a more scientific and public health perspective, the disease is one that continues to garner interest due to a combination of its fatality, global nature, and the current lack of a cure.10 Over the years, the epidemic has also served as a window through which more historical, personal, and societal insights could be obtained. Such works on the disease and epidemic range from documentaries like Common Threads, that explore individual narratives, to informational books like HIV/AIDS: A Very Short Introduction, that provide a lot of the basic context, to books like

---


And the Band Played On, that chronicle the early histories of the epidemic from certain perspectives.

However, despite the volume of work done on HIV/AIDS, there is a lack of diversity in the storytelling. Besides the relatively new introduction of the African American and — the even more recent — Hispanic/Latinx narrative, the majority of the national dialogues surrounding the epidemic have primarily focused on the homosexual community for a while. This should come as little to no surprise as, according to the CDC’s website, African Americans, Hispanics/Latinxs, and homosexuals (not necessarily exclusive of one another) make up the majority of the population that is disproportionally affected by HIV/AIDS. Nonetheless, this does not mean that the other members of the population with HIV/AIDS and those indirectly affected by the disease should be overlooked. Their voices and interests should also matter and their stories should be told.

From African American studies to LGBTQ studies, cultural studies are another field of academia that is intensively studied and continues to draw attention. Over the years Asian American studies has also become fairly well established, with a growing number of institutions of higher institutions providing students with access to an actual Asian American studies major and curriculum, as well as relevant resources. On one hand, Asian American studies may appear superfluous. After all, it can be argued that this field falls within the more general realm of American studies. However, as much as Asian Americans are a part of American culture in

---


certain regards, they and their cultural intricacies have been overlooked within the more general claims and context of American studies. Subsequently, it must be remembered that the Asian American narratives are just as unique and valuable to the American story as the narratives and perspectives of other groups. Various books like *Asian American X: An Intersection of 21st Century Asian American Voices* and *Restoried Selves: Autobiographies of Queer Asian/Pacific American Activists* allow for the exploration of individuality within both the Asian American community and the larger general public. In doing so, these works provide an Asian American perspective on various issues.

A subject that is particularly pertinent to Asian Americans is the sociological concept of the model minority. The model minority idea stereotypes Asian Americans and pushes forward the notion that the inherent cultural qualities found in many Asian American individuals and communities were what enabled them to succeed in America.\(^\text{13}\) Since its introduction as a term to describe Asian Americans in the second half of the 20\(^{th}\) century, the model minority concept has produced many studies and papers — especially within the past few decades. Studies like “Asians as the model minority: Implications for US Government’s policies,” “The Model Minority and the Perpetual Foreigner: Stereotypes of Asian Americans,” and “Testing the Model Minority Myth” have collectively explored the stereotype, its validity, and its origins. They have all contributed to critically analyzing the consequences and potential effects of the stereotype on Asian American communities.

Having said that, the HIV/AIDS epidemic is an area of study that requires more attention from an Asian American studies perspective. A handful of scholars, researchers, and organizations have already produced a collection of both quantitative and qualitative studies on this particular subject — the intersection between Asian Americans and the HIV/AIDS epidemic.

\(^{13}\) Trinh-Shevrin, Islam, and Rey, 5-8.
Some studies have been based more on pure numbers, data, and statistics, while other studies have shown to be more qualitatively driven or a combination of both. For example, studies like “AIDS knowledge and education for South Korean-born college students attending Korean colleges and United States-born Korean American and South Korean-born students attending United States colleges in California” by Linda Kyung-Rae Chon and "Disclosure of HIV Status: Cultural Issues of Asian Patients" by Marianne R. Yoshioka and Amy Schustack have explored some of the cultural barriers that Asian Americans may face in dealing with HIV/AIDS. “Communion: A Collaboration on AIDS,” a collection of personal essays, also presents some more specific and individualized stories from the perspective of Asian Americans with HIV/AIDS.

However, these studies have remained pretty general in their context, or — in the case of the personal essays — are bound by a homosexual storyline. In particular, they have not examined the issues at hand within the framework of the model minority stereotype. There has yet to be any work that has conducted a comprehensive study on the intersection of Asian Americans, the HIV/AIDS epidemic, and the model minority stereotype. This may be because the very existence of a HIV/AIDS-centric narrative would run counter to the model minority concept.

Consequently, by incorporating the model minority stereotype to the Asian American and HIV/AIDS narrative, my project will contribute to this subject area by going beyond the more conventional narrative and exploring a potential perspective, approach, and explanation that have remained relatively unexplored so far. Ideally, I will subsequently be able to amplify the Asian American voice within the HIV/AIDS dialogue and expand on the broader Asian American and HIV/AIDS narrative.
In the beginning, I started out with a desire to explore the intersection between Asian Americans and the HIV/AIDS epidemic. Upon conducting some preliminary research, I decided to narrow my research by focusing on a specific time period, legislation, and a work group on the legislation. More specifically, I was looking to use the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and the 1994 Asian American work group discussion surrounding it as starting points from which I could better understand the dynamics regarding HIV/AIDS for Asian American communities specifically. Over the course of conducting further research and beginning to write, my question and thesis have taken a different trajectory. Through the following, I would like to provide an account of and an explanation for my research process.

In terms of my methodological approach, I found myself primarily conducting my research in categorical sections. Upon deciding to look into the topic of Asian Americans and HIV/AIDS, I started with a fairly narrow scope and focused on the federal report on the 1994 work group discussion for Asian Americans on the CARE Act. From there, I familiarized myself with the CARE Act through online summaries, federal government organizations, and an actual copy of the legislation. As this part of my research was more for some background information, the amount of analysis was limited. However, I always framed the process within the context of Asian Americans. For instance, in exploring the websites of certain city-centric HIV councils I made note of any mention of Asian Americans, or the lack thereof.

Soon afterward, I looked into specific Asian American individuals that were present at the meeting and their corresponding organizations. In addition to visiting the websites of various Asian American HIV/AIDS organizations, I tried reaching out to a number of individuals but was confronted with a bunch of dead ends, rejections, and/or cold shoulders. Thankfully, I
eventually managed to interview two individuals who were somehow involved in the intersection of Asian Americans and AIDS advocacy during the 1980s and 1990s. One of them was Asian American AIDS activist, Vincent Crisostomo, who had been present at the work group discussion. The second person was filmmaker Christine Choy, who had produced two documentaries on Asian Americans living with AIDS (interestingly enough, Vincent was actually the focus of one of the documentaries).

As the two interviews took place at relatively early points in my research process, the interviews were tailored to be more general in regards to the questions posed and topics discussed. However, as accomplished professionals in their respective fields, both Vincent and Christine also provided me with a collection of more specific insights, perspectives, and resources.

Both of my interviews took place over the phone and were fairly informal in nature. I prepared for the interviews by drafting interview guides. Although I tailored each guide according to the individual to an extent, I also made sure to include several overarching questions in both guides. My reasoning was that, when it was time to analyze the interviews, it would allow me to better support certain points if the two individuals had shared opinions and/or highlight interesting aspects that I could research further in the case that opinions differed. During the interview, nothing was recorded or transcribed verbatim. Although I referenced my interview guides at times, I allowed the interviews to flow more organically for the most part. Upon finishing each interview, I reread and reorganized my notes. If I found any sort of holes in my notes, I immediately sent follow-up e-mails for clarification.

The interviews highlighted two factors of the Asian American experience within the

---

14 Not a Simple Story, directed by Christine Choy (Filmakers Library, 1994); Out in Silence, directed by Christine Choy (Filmakers Library, 1994).
HIV/AIDS epidemic in particular: 1) the significance of cultural barriers and 2) the diversity within the Asian American population. Consequently, I shifted my attention from Asian American advocacy towards sources that looked more at the cultural aspects of Asian American communities. I initially restricted my searches to works that were also related to the CARE Act and/or work group discussion, but quickly found this to be too restrictive. As a result, I widened my scope to include Asian American cultural studies within a more general context of HIV/AIDS, and eventually even within the realm of public health as a whole. By this point, I had an assortment of sources ranging from dissertations to journal and newspaper articles to a few books, such as the article, “Confronting HIV/AIDS in the APA Communities: It’s Time to Be Culturally Competent” and the book, *Asian American Communities and Health: Context, Research, Policy, and Action*.

My method of analyzing my written sources largely consisted of first skimming the readings for certain keywords or terms like “HIV/AIDS,” “diversity,” and “cultural barriers.” Once I determined the source to be of use, I would do a more thorough second reading. From there, I would “pull on the string” to find another source or more nuanced topic. In analyzing my sources, I looked for repetition. Similar to the reasoning used for my interviews, my rationale was that notions that came up over and over again in various sources could be viewed as credible.

Overall, the more research I did on the intersection of HIV/AIDS policies and Asian Americans, the more explicit the importance of recognizing the diversity within Asian American communities became. Around this point, my tentative thesis statement was something along the lines of there being a cultural disconnect between Asian American communities and federal HIV/AIDS policies. However, this finding simultaneously presented me with a dilemma. My
research so far revealed the various issues stemming from the use of Asian American as a too general of a term, but I myself was also using the umbrella term for my project. In talking with my adviser, I eventually came to the conclusion that this would be okay, as the objective of my thesis is not necessarily to present a solution to the problem but to shed light on it.

Unfortunately, as I continued my research on the issue of diversity within the Asian American population, I was faced with another unexpected problem. The more research I did, the less substantial my thesis statement seemed. Contrary to what I had expected at the beginning, the issue of cultural competency and ethnic diversity seemed like a sort of given. My working thesis statement no longer seemed to “take a stand.” Subsequently, I strayed from my original plans and went through my notes again — including the ones based on preliminary research. This time I made a more conscious effort to dig deeper and to push back on some of the concepts instead of simply accepting them.

Eventually, a new and more three-dimensional thesis statement — still within the context of Asian Americans and HIV/AIDS — began to take hold. There appeared to be a case to be made for the effect of the model minority myth on the disconnect between Asian American communities and federal HIV/AIDS policies. Although I found my newer working thesis statement to be much more interesting, I also recognized that certain aspects of it remained shaky due to my lack of specific sources pertaining to the model minority myth. Consequently, I started to look into sources on the intersection of the model minority myth and health. The types of sources I came across ranged from articles in ethnic newspapers during the 1980s and 1990s to published journal articles.

I was excited to find that, although there was a significant amount of information available on the model minority myth in general and a few on the model minority in relation to
health, there were almost none to be found at the intersection of the stereotype and the HIV/AIDS epidemic. This meant that there was a hole that I could fill with my work. I was hopeful in my ability to fill in this space as it seemed like I had, or at least had access to, all the necessary pieces of the puzzle to produce a thesis on the subject.

Having said that, I was then fortunate enough to be able to interview Jeffrey Crowley (former Director of the White House Office of National AIDS Policy and Senior Advisor on Disability Policy for President Barack Obama) the day after my new thesis statement was put together. This interview was handled in a similar fashion to my two earlier interviews in that I made an interview guide and did not record or transcribe our conversation. However, unlike the other two, this conversation took place in person. Some of my questions were also altered to better relate to my newer thesis statement.

My interview with Mr. Crowley proved to be an invaluable experience. He was able to provide me with an insider’s perspective in regards to health policymaking, and an outsider’s perspective as a non-Asian American in regards to my subject of interest (i.e. the intersection of stereotypes, cultures, and federal health policies). He has also provided me with a number of people who I could try and contact for further insight. As I continued to shift through additional secondary sources and studies on the model minority stereotype for the sake of framing it within a public health and HIV/AIDS context, I used the leads Mr. Crowley gave me to reach out to several more experts.

I was subsequently able to speak with Dr. Moupali Das and Dr. Tri Do. These conversations also took place over the phone and occurred in a similar fashion to all the previous interviews. In addition to asking questions on overarching themes and notions, questions pertaining to the model minority stereotype were emphasized. Dr. Das is a public health activist
and an infectious disease specialist. She is currently working on HIV/AIDS trials and treatments at Gilead. Dr. Do is currently a UCSF faculty working on health disparities, HIV prevention, and treatments. He is also the Chief Medical Officer at API Wellness, a health organization located in San Francisco for LGBTQ and people of color. Both interviews also proved to be useful. In addition to confirming and reinforcing many of my original findings, Dr. Das and Dr. Do also presented me with certain information and perspectives that I have not considered or known before. They also provided me with additional resources that they believed might be useful. Soon after, I began wrapping up my research in preparation to begin writing.

Upon finishing the research process and organizing my findings, the scope of my work became clear. Through this thesis, I will be examining the intersection of Asian American communities, the model minority myth, and the HIV/AIDS epidemic. More specifically, to reiterate the central claim, I will assert that the normalization of the model minority myth resulted in a cycle of cultural dissonance between Asian Americans and the American bureaucracy within the context of the HIV/AIDS epidemic. With that said, my research and work will be divided into three primary points with each part corresponding to the three chapters of this thesis.

The objective of the first chapter will be to demonstrate how the political motivations of the model minority stereotype translate to the lack of cultural competency in federal policies — HIV/AIDS policies included. In this chapter, I will highlight the political origins and use of the model minority stereotype. I will emphasize the social position that the model minority myth placed Asian Americans in, and how this eventually hindered Asian American voices in national dialogues and within federal policies. The purpose of the second chapter will be to place an emphasis on the diversity found within Asian American communities and how labeling and
viewing the various Asian American communities as a singular model minority fails to recognize the true plurality of the Asian American population. In this chapter, I will disprove the notion that Asian Americans are a single “model minority” group and subsequently will acknowledge the population’s heterogeneity. In addition to more general examples, I will also provide examples that are more specific to public health and HIV/AIDS. I will then demonstrate how this can translate to culturally insensitive policies. In chapter three, I will be highlighting how, within the context of HIV/AIDS, misleading portrayals of Asian Americans as people with better than normal health outcomes creates a dangerous false sense of security within Asian American communities. I will explain how this can also result in a government that is less likely to address HIV/AIDS issues from the perspectives of Asian Americans. This chapter will underline the feedback loop of cultural dissonance that occurs between Asian American communities and federal health policymakers.
Chapter I: The Origin Story – Politics and Numbers

This chapter will highlight the political origins and use of the model minority stereotype. An emphasis will be placed on the social position that the model minority stereotype situated Asian Americans in, and how all this ultimately hindered the Asian American voice in national conversation on the HIV/AIDS epidemic.

The term “model minority” was first officially coined in 1966 by sociologist William Petersen in his article, “Success story: Japanese 1960s,” for the New York Times Magazine. In labeling Japanese Americans as the model minority, Petersen argued that the strong sense of family values, respect for authority, and work ethic ingrained and found in Japanese culture allowed them to succeed in America. According to Petersen, inherent cultural qualities were what enabled Japanese Americans to overcome racial prejudice and succeed where other non-white minorities have failed. They were subsequently able “to avoid becoming a ‘problem minority’” characterized by things like crime and poverty. The term model minority has since remained fundamentally the same in its definition, but has expanded in its connotations. Over the years, the model minority stereotype has evolved beyond the Japanese American community to romanticize the entire Asian American community “as a hardworking, successful, and law-abiding ethnic minority that overcome hardship, oppression, and discrimination to achieve great success.”

---

15 Trinh-Shevrin, Islam, and Rey, 5.


17 Petersen, 40-41.

18 Trinh-Shevrin, Islam, and Rey, 8; Ibid., 40.

Despite being a stereotype, at first glance the model minority label would appear to be harmless, if not actually something positive. However, a closer look at the array of possible political motivations and narratives surrounding the normalization of the term reveals the opposite. Within this framework, identifying the Asian American community as a model minority places Asian Americans in the awkward position of being part of the “other” within the societal and political context of America.

Despite the diversifying of America, especially with the influx of Asian and Latinx immigrants, the American narrative has historically adhered to the “conventional trope of ‘two nations, Black and White.’” Highly esteemed scholars like Gunnar Myrdal and Andrew Hacker, as well as political entities like the Kerner Commission, have emphasized the black and white binary over the last half-century. Within this context of a predominantly black and white political narrative, Asian American communities find themselves being racially triangulated. By identifying Asian Americans as both the model minority and “perpetual foreigners,” privileged individuals and groups of mainstream America have utilized Asian American communities for their own benefit as opposed to an Asian American cause; Asian Americans have been used to both dismiss accusations of racism and rationalize how members of other ethnic minority groups should act within a society characterized by systematic racism and white privilege. Simultaneously, as noted by Vincent Crisostomo, an Asian American HIV/AIDS advocate, such portrayals and political leveraging of Asian Americans have also estranged Asian

---


21 Ibid.

22 Lien, Conway, and Wong, 7.

American communities and their advocates from other minority groups. Even within the minority population, Asian Americans find themselves on the receiving end of racism and stereotypes.

The origins, development, and usage of the model minority concept are best understood when examined with an understanding of race relations during the second half of the 1900s. It is interesting to note that the year in which model minority was first used — 1966 — was the year that the phrase “Black Power” was popularized and when nonviolent movements began to be replaced by more radical approaches. The timing suggests that Asian Americans were being used to send the message that Blacks should stop causing “trouble” and simply follow the example established by Asian Americans — the model minority. The implication that Asian Americans managed to succeed without any sort of help served as a juxtaposition to the supposed laziness of Blacks and undermined the claim that the government should provide minorities with aid.

The political motivations underlying the idea of a model minority are further underlined in the 1980s when there was a strong conservative movement under the Reagan administration. Once again, Asian Americans as the model minority were used to push forward an ideology founded on “colorblindness” — the notion that America provided equal opportunities to all, regardless of one’s race. In conjunction with the false sense that Blacks were “culturally

---

24 Vincent Crisostomo, interview by author.
25 Ibid.
26 Kim, 119.
27 Ibid.
28 Ibid., 120.
29 Ibid.
deficient,” the model minority paradigm better equipped mainstream America and the privileged to go back on various key issues such as “civil rights, affirmative action, redistricting, and social welfare programs.”

On the other side of the valorization of Asian Americans and the model minority label is the exclusion of Asian Americans through the perpetual foreigner stereotype. The stereotype of Asian Americans as perpetual foreigners derives from the notion that all Asian individuals are ultimately foreign due to the “inherent” physical and cultural qualities of their race, and thus can never truly be or be seen as an “American.” The general association of whiteness with being American and the popular culture’s stereotypical portrayals of Asians (i.e. the depiction of Asian Americans as individuals with heavy accents and characters introduced by gong sounds) tie the Asian American image to a concept of foreignness. With that said, the simultaneous double standard of Asian Americans as the model minority and as perpetual foreigners is important to highlight the political motivations that potentially drive the Asian American stereotype as well as the subsequent negative effects it has on the community. While the perpetual foreigner label denies Asian Americans the status of being a “true American,” the model minority stereotype allows the dominant members of America to utilize the Asian American community as a sort of political tool and separates Asian Americans from other ethnic and racial minorities.

30 Ibid., 120-121.
31 Ibid., 107.
33 Lee, Wong, and Alvarez, 76-77.
Beyond the general disadvantages the model minority stereotype has on Asian Americans, this chapter will be addressing how within the realm of public health — and the HIV/AIDS epidemic in particular — the normalization of a stereotype with political motivations proved to have negative consequences. As the concept of the model minority can be characterized more by its political origins and motivations rather than its cultural accuracy, the cultural needs of Asian American communities, including those pertaining to HIV/AIDS, were lost to the political narrative.

Even in the context of health, it would appear that the political origins of the model minority stereotype result in the continual portrayal of Asian Americans in a seemingly positive light. Referencing older studies, the model minority stereotype suggests that Asian Americans are a racial group without any major health concerns and a minority with favorable health outcomes relative to other groups.\(^{35}\) As the concept of the model minority became normalized, an association of positive health outcomes with Asian Americans has become ingrained in American society.\(^{36}\)

The normalization of the stereotype and its effects extend beyond just the occasional interaction and event. As a stereotype, the model minority concept contributes to the perpetuation of institutional discrimination against Asian Americans across a variety of domains.\(^{37}\) These include “places of work and schools, in accessing public services, and in the administration of justice.” \(^{38}\) In cases pertaining to the bureaucracy, the model minority

\(^{35}\) Trinh-Shevrin, Islam, and Rey, 4-5.


\(^{37}\) Ibid.

\(^{38}\) Ibid.
“stereotype leads federal, state, and local agencies to overlook the problems facing Asian Americans.”

Although it is highly unlikely that any government official will confess to acting on stereotypes alone, it would be reasonable to assume that normalized stereotypes will have an indirect and/or direct effect.

Consequently, Asian American individuals who are facing health difficulties — such as HIV/AIDS — and thus breaking social expectations, are potentially rendered invisible and are not considered on a bureaucratic level. This then results in a sort of paradox and an unfavorable cycle between the Asian American community and the federal government. The argument can be made that as both the government and the public ignore the sick individuals and assume that the Asian American population is healthy, there is a significant shortage of health funds, services, and resources dedicated to Asian Americans. In this way, the model minority “stereotype undercuts the significance of health and social disparities experienced by Asian American communities and the need to devote resources to mitigate those disparities, and is marked by a dearth of health studies focused on Asian American communities.”

Subsequently, without significant amounts of data and statistics that would either encourage or necessitate the government to direct more attention towards Asian Americans, the government and political leaders continue to follow the pattern of disregarding the Asian American community within national health discourse.

---

39 Ibid.

40 Tri Do, phone interview by author; Ibid.

41 Chao, Chiu, and Lee, 45.

42 Yi, Kwon, Sacks, and Trinh-Shevrin, 135.

43 Ibid.
HIV/AIDS care and services are no exception. In the case of the HIV/AIDS epidemic, the perpetuation of the model minority stereotype in combination with the general lack of interest in Asian Americans arguably led to a lack of data highlighting the experience of Asian Americans with HIV/AIDS within the health care system. The lack of data then hindered — and continues to hinder — any attempts by Asian American advocates to convince both the government and public otherwise. For example, the absence of interest in HIV/AIDS and Asian Americans is made evident by the fact that Asian Americans were not even given their own category in official AIDS reports until June 1987. Even then, the identifying of AIDS cases amongst Asian American was allocated to a footnote of a monthly surveillance report where the CDC reported that hidden within the “other” racial category, there were 232 total AIDS cases among Asian Americans.  

Within the context of public health and the HIV/AIDS epidemic, another problem with the use of the model minority stereotype in describing Asian Americans is that providing greater federal assistance to the Asian American population may result in cognitive dissonance. Cognitive dissonance occurs when two opinions, beliefs, or information contradict each other, “are inconsistent, or if, considering only the particular two items, one does not follow from the other.” When this occurs, due to the discomfort that derives from dissonance, “there will arise

---


46 Gock, 252.

pressures to reduce or eliminate the dissonance.” Subsequently, people experiencing cognitive dissonance will look to try at least one of the three things:

The person may try to change one or more of the beliefs, opinions, or behaviors involved in the dissonance; to acquire new information or beliefs that will increase the existing consonance and thus cause the total dissonance to be reduced; or to forget or reduce the importance of those cognitions that are in a dissonant relationship.

Subsequently, people experiencing cognitive dissonance will look to try at least one of the three things:

The person may try to change one or more of the beliefs, opinions, or behaviors involved in the dissonance; to acquire new information or beliefs that will increase the existing consonance and thus cause the total dissonance to be reduced; or to forget or reduce the importance of those cognitions that are in a dissonant relationship.

In the aforementioned situation, the two things that would run counter to one another would be the providing of federal assistance and the model minority stereotype. The stereotype highlights the idea of Asian Americans managing to overcome adversity through their own hard work. Assistance in the medium of various federal services and resources may appear to contradict this idea. In addition, given the stigma HIV/AIDS carried as a “gay disease” and the stereotyping of homosexuals as hypersexual, providing HIV/AIDS services and resources, and thus essentially acknowledging HIV/AIDS as a problem in the Asian American community would clash with the traditional and conservative qualities that the model minority stereotype associates with Asian culture.

However, it should be noted that over the years, the model minority stereotype in relation to the health status of Asian Americans has been repeatedly tackled, criticized, and refuted. In particular, beginning with an article published by Dr. Jane S. Lin-Fu in 1988, critics of the model minority stereotype have argued that many of the original studies were flawed, and have

---

48 Ibid.
49 Ibid.
50 Chao, Chiu, and Lee, 44.
53 Trinh-Shevrin, Islam, and Rey, 8.
subsequently worked to dispel the stereotype’s misleading findings. Some of the possible explanations as to the cause of the original misleading conclusions will be further explored in the following chapters.

Despite studies disproving the stereotype of Asian Americans having favorable health outcomes, there continues to be an overlooking of Asian Americans in regards to issues pertaining to health and the HIV/AIDS epidemic in particular. This divide between the Asian American population and the federal government is reflected in federal HIV legislation. Certain aspects of the reasons for the disconnect were addressed in a 1994 work group done on Asian Americans and the Ryan White CARE Act.

The work group underlined the limited understanding and data on the various issues surrounding Asian Americans and the HIV/AIDS epidemic. For the most part, the report produced by the work group underlined cultural and structural barriers Asian Americans faced in the realm of public health and HIV/AIDS. Issues addressed ranged from language barriers, to cultural stigmas, to the limited amount of infrastructure (i.e. the lack of aggregate data, A&PI agencies, and policy representation) that could support Asian American advocacy.

_________________________

54 Ibid.
55 Trinh-Shevrin, Islam, and Rey, 4-8.
56 Sunmin Lee, Hee-Soon Juon, Genevieve Martinez, Chiehwen E. Hsu, E. Staphanie Robinson, Julie Bawa, and Grace X. Ma, “Model Minority at Risk: Expressed Needs of Mental Health by Asian American Young Adults,” J. Community Health 34: 144; Le, 95.
57 U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Bureau of Health Resources Development (BHRD), 1-46.
58 Ibid., 15-20.
solutions in addition to policy recommendations.\(^{59}\) He admitted there was a level of irony here.\(^{60}\) Faced with obstacles and other inconveniences, Asian American advocates still managed to make due, and thus exemplified the model minority.\(^{61}\)

However, can this disconnect be attributed primarily to the stereotype? Can a causative relationship between the stereotype and the uphill battle faced by Asian American advocates be established? Perhaps it was not the normalization of the model minority stereotype that resulted in the lack of attention directed towards Asian Americans within the context of HIV/AIDS. It can be argued that, like a lot of the other issues pertaining to the government and legislations, the lack of HIV/AIDS services and resources for the Asian American community was simply the result of reasons founded on issues of practicality.

When it comes to the HIV/AIDS epidemic and those affected, everyone wants funding, and ideally, everyone and every group that requires resources would receive them.\(^{62}\) Unfortunately, the reality of the situation is that there never seems to be enough funds to satisfy everyone.\(^{63}\) Consequently, given the limited availability of resources and services, a reasonable thing for the government to do would be to distribute resources on a sort of demonstrated needs-based basis. In other words, allow the money to follow the available numbers, data, and statistics.\(^{64}\)

---

\(^{59}\) Vincent Crisostomo, phone interview by author.

\(^{60}\) Ibid.

\(^{61}\) Ibid.


\(^{63}\) Ibid.

\(^{64}\) Ibid.
Reports have shown that by the end of 1994, out of the 441,528 cumulative AIDS cases reported in America, 2,991 of them pertained to individuals that were Asian American.\textsuperscript{65} This translates to roughly 0.7 percent of all reported cases and is the lowest rate of AIDS in comparison to any of the other racial groups.\textsuperscript{66} This pattern of Asian Americans exhibiting some of the lowest prevalence and incidence rates of HIV/AIDS has continued into the 21\textsuperscript{st} century. In 2014 Asian Americans accounted for 1,047 of the roughly 45,000 new HIV diagnoses and 353 of the roughly 21,000 new AIDS diagnoses.\textsuperscript{67} This equates to roughly two percent of the new HIV diagnoses and new AIDS diagnoses in 2014.\textsuperscript{68}

With Asian Americans representing such a small portion of the population affected by HIV and the numbers becoming even smaller when the different ethnicities are accounted for, at first glance, it seems like it would be reasonable for them to receive less funding and services. However, there are a couple problems with this line of thought. For one, simply basing all decisions on incidence and prevalence rates alone presents a bias; one that is perhaps further reinforced by and reinforces the notions perpetuated by the model minority stereotype. Despite Asian Americans exhibiting some of the lowest rates of HIV/AIDS, the annual rate of increase within the Asian American community is similar to, if not greater than, that of other minority groups.\textsuperscript{69} In fact, in metropolitan areas with large concentrations of Asian Americans like San Francisco and Los Angeles, Asian Americans — in comparison to other races and ethnicities —

\textsuperscript{65} U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Bureau of Health Resources Development (BHRD), 12.

\textsuperscript{66} Ibid., 12; Gock, 252.


\textsuperscript{68} Centers for Disease Control and Prevention, "HIV Among Asians."

\textsuperscript{69} Gock, 252.
actually exhibited “the highest rate of increase in reported AIDS cases.” However, as such facts would run counter to the model minority stereotype, it is possible that these details are entirely ignored or given less weight relative to other available data.

In addition, as long as the percentage is not zero, a small percentage does not mean that the people that fall within that statistic can be ignored for “matters of practicality” or “convenience.” Doing so would only further highlight a normalization of the stereotype that Asian Americans are a model minority in regards to their health. Furthermore, it would perpetuate the practice of rendering individuals that do not fall into the stereotypical category invisible.

A parallel can be drawn to the early years of the HIV/AIDS epidemic when the stereotyping of homosexual communities and gay individuals hindered public health efforts and proved to be a disaster in the long run. However, it is interesting to note that the stereotype that inhibited homosexual communities is the exact opposite of the model minority stereotype; homosexuals were viewed as being too promiscuous. Back then, officials, experts, and the public also cited the limited amounts of evidence of demonstrated need, as well as budget issues, as a rationale for not channeling resources to the cause. History has shown that this lack of prioritizing was both a costly and deadly mistake. This then raises the question, how much more “data” and “statistics” are required in order to provide the Asian American community with a voice? How many more Asian Americans have to be diagnosed with HIV/AIDS in order for

70 Ibid.
72 Ibid., 709.
73 Ibid., 25.
74 Ibid., 1274.
the model minority stereotype to be successfully refuted? In the long run, would it not be both socially and economically more efficient to provide resources and services to prevent future cases? All of these questions should be taken into account.

With that said, it should be noted that all this is not to say that I would like to disregard all aspects of realism, efficiency, and practicality in addressing the situation at hand. I understand that when addressing matters of public health, the logistics of it all are significant and legitimate in their own right. I also do not have the solution to the dilemma, as I am neither an expert on federal budgets and allocating funds nor running a bureaucracy. Nonetheless, this does not automatically invalidate the claims of this chapter and thesis.

Despite the seemingly positive connotations of the model minority concept, at its core, the notion of the model minority is a stereotype — especially when paired with the image of the perpetual foreigner — that can be primarily characterized by its political origins and motivations. The intention behind the model minority stereotype is not one centered on the praising of Asian Americans, but actually on the utilization of Asian Americans as a source of political utility and leverage. The stereotype allows the question of, “If Asian Americans can do it, why can’t you?” to be directed at other minority groups. As a consequence of the political agenda behind it, the stereotype and the normalization of it ultimately result in the drowning out of the Asian American voice and the lack of attention towards cultural sensitivities (i.e. quantifying Asian Americans for “practical” reasons).
Chapter II: The Model Minority Myth – The Homogenization of Diversity

The fact that the model minority stereotype is a falsehood was touched upon briefly in the previous chapter. Chapter two will look to address why the stereotype is inherently flawed and will make the transition from calling the model minority concept a stereotype to referring to it as a myth. In order to accomplish this, this chapter will emphasize how the oversimplifying and viewing of Asian Americans as a singular model minority, fails to acknowledge the diversity within Asian American communities. This in turn potentially inhibits federal HIV/AIDS policies from being relevant to the distinct ethnic groups and communities found under the Asian American category.

Within the next few decades following 1966 when William Petersen first coined the term “model minority,” a small group of Asian Americans began to mobilize and push back on the stereotype.75 People began to realize that the health of Asian Americans and their communities were being overlooked. This was in part due to the general lack of understanding of Asian American communities as exemplified by the perpetuation of the model minority myth.76 One of the original critiques and more notable works was a study published in 1988, in which the author, Lin-Fu, “condemned the notion of Asian Americans [being] a model minority, particularly with regard to their health status.”77

Lin-Fu’s article differed from the works of other scholars in that, while other critics and scholars have primarily argued against the model minority stereotype within a mental health context, “Lin-Fu’s article, which was widely disseminated and discussed, argued that the research that had been conducted on this population was both fundamentally inadequate and

75 Trinh-Shevrin, Islam, and Rey, 8.
76 Ibid.
77 Ibid.
misleading.”78 Lin-Fu noted that the data on Asian Americans were used to advance the model minority myth, and thus previous research that perpetuated the model minority myth were inherently flawed. “[T]he majority of the data on [Asian Americans] was derived from epidemiological migrant studies and was limited to comparisons between native-born Japanese, Japanese in Hawaii, and the general U.S. population.”79 Subsequently, the resulting studies often risked over-extrapolating their results onto other ethnicities, provided an inadequate perspective, and failed to address actual health issues in regards to the rest of the Asian American population.80

Beyond providing an incomplete perspective, studies such as this one may also produce biased and misleading results due to what is known as the healthy immigrant effect. A study comparing the body mass index (BMI) across various Asian ethnicities and nativity (foreign-versus native-born) found that Asian Americans born in the United States were more likely to be overweight than foreign-born immigrants.81 Furthermore, it was implied that the longer the Asian American individual resided in the United States, the more likely they were to be overweight.82 The findings suggest that people that are healthy enough to immigrate and work are probably healthier than those that do not. Although this specific study just examined BMI as an indicator of health, there have been other studies — particularly on Latinxs and immigrants in Canada —

78 Ibid.
79 Ibid.
80 Ibid.
82 Ibid.
that have demonstrated the greater likelihood of immigrants having better outcomes than native populations in regards to various health issues such as mortality and mental disorders.\textsuperscript{83}

On that note, a fundamental problem with the model minority myth derives from the fact that its use homogenizes a very heterogeneous population.\textsuperscript{84} “The Asian American population is ethnically and socioeconomically diverse, with uneven population size, growth rate, and socioeconomic achievement.”\textsuperscript{85} There are over a hundred different ethnicities, cultures, languages, and dialects that fall under the umbrella term “Asian American.”\textsuperscript{86} Consequently, even the term “Asian American” can be viewed as exhibiting bias. In fact, some Asian American advocates have actually worked to separate Pacific Islanders from the umbrella term Asian American.\textsuperscript{87}

The differences do not stop at the ethnic level. There are regional distinctions within the Asian American population (i.e. between different cities) and differences between the more recent immigrant populations and more Americanized communities.\textsuperscript{88} There are also even religious differences between the various ethnic groups.\textsuperscript{89} There is also the constant issue surrounding whether or not all these differences can even be neatly categorized given the fact that rather than a sort of dichotomy (i.e. immigrant versus American/naturalized) many of the


\textsuperscript{84} Kobayashi, 3.

\textsuperscript{85} Lien, Conway, and Wong, 8.

\textsuperscript{86} Vincent Crisostomo, phone interview by author; U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Bureau of Health Resources Development (BHRD), 11.

\textsuperscript{87} Vincent Crisostomo, phone interview by author.

\textsuperscript{88} Lien, Conway, and Wong, 10.

\textsuperscript{89} Le, 96.
differences greater resemble a sort of gradient (i.e. the notion of the 1.5th generation Asian American).

Within the context of the HIV/AIDS epidemic, it is critical to acknowledge all of these differences as they affect HIV/AIDS care within the various Asian American communities. In particular, “[c]ultural sensitivity needs to be taken into consideration at all levels of outreach.”

For instance, individuals who are open about their sexuality or members of a gay advocacy group may be far more educated about AIDS. How recently an individual had immigrated to America should also be considered as it often parallels his or her English proficiency and how accessible certain health services would subsequently be. In addition, in terms of regional differences, studies have shown that Asian American individuals located in urban areas are also at greater risk and exhibit higher rates of HIV/AIDS.

With all that said, the case for the need to acknowledge both the inherent falsity of the model minority myth and the diversity found within the Asian American population is perhaps made most convincingly by some of the available data and numbers. Amongst Asian American communities, AIDS prevalence rate differs by ethnicity. In 1991, in California, the AIDS rate was “123 per 100,000 for Filipinos, 11 for Japanese, eight for Chinese and down to less than two for Laotians and Cambodians.”

Why do these differences matter? Asian American HIV/AIDS advocates like Vincent Crisostomo stress the importance of acknowledging the diversity within the Asian American


91 Ibid.

92 Lien, Conway, and Wong, 10.

93 Poma, 14.

It is important to stop homogenizing an entire race and recognize the differences, as it would be the first step in providing more efficient HIV/AIDS care to Asian American individuals. In this regard, the normalization of the model minority myth hinders federal policymakers and public health officials from implementing and providing services and resources that are truly culturally sensitive. Instead of benefiting Asian Americans, the seemingly positive myth actually perpetuates cultural barriers when it comes to Asian Americans and HIV/AIDS.

The cultural insensitivity of the federal HIV/AIDS policies is made evident within the framework of language. The linguistic isolation of Asian Americans, as a result of the majority of surveys being provided in only English and/or Spanish, exemplifies how federal public health and HIV/AIDS policies remain culturally insensitive. Consequently, one of the issues that the 1994 work group on Asian Americans and HIV/AIDS addressed was the fact that there were numerous languages amongst Asian American communities. In particular, the work group recommended the development of “language-specific educational materials” and the ensuring of language appropriate services. The implementation of such changes would essentially allow for the refuting of the model minority myth, as the myth is characterized by its homogenization of different Asian American communities and the overlooking of the many cultural differences found within the Asian American population.

With all that said, it would appear that the most reasonable solution to the problem at hand would be to exhibit greater cultural sensitivities by recognizing and differentiating between

---

95 Vincent Crisostomo, phone interview by author.
96 Trinh-Shevrin, Islam, and Rey, 12.
97 U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Bureau of Health Resources Development (BHRD), 15.
98 Ibid., 32.
all the various languages, ethnicities, and communities. However, the questions of practicality and slippery slopes inevitably arise. On a bureaucratic level, how practical would it be to differentiate between all the numerous ethnicities and cultures within the Asian American category and subsequently provide culturally tailored resources and services? Given the fact that the racial category of “Asian” is just one of several other umbrella categories, like “Hispanic” and “Black,” that have multiple ethnicities within it,\(^99\) why should only the differences between Asian American communities be recognized? If the various differences within the other racial categories were to also be acknowledged and catered for, how economically feasible and effective would all this be? What sorts of investments will have to be made to implement all these changes?

In addition, in addressing the problem of homogenizing an incredibly heterogeneous group by differentiating between the various ethnicities, there remains an issue in regards to the political voice and power of Asian Americans. In the previous chapter, the nature of public health issues being a numbers game and how Asian Americans have difficulty quantitatively supporting their cause were touched upon. The Asian American population had and continues to have, some of the lowest rates of HIV/AIDS ranging from about 0.7 percent by the end of 1994 to two percent in 2014.\(^100\) Given the fact that Asian Americans as a single population already lack HIV/AIDS data and statistics, reducing the sample size by dividing the Asian American population into different ethnicities will serve as an even greater handicap to the voices of Asian American advocates in the realm of public health.\(^101\) In other words, there are political


\(^{100}\) U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Bureau of Health Resources Development (BHRD), 12; Centers for Disease Control and Prevention, "HIV Among Asians."
advantages to different Asian American communities coming together and identifying themselves as a collective group of Asian Americans.\footnote{102}{Vincent Crisostomo, phone interview by author.}

As valid as these counterarguments may be — or may have been — they do not discredit the significance of the issue at hand. In fact, the issues regarding having disaggregated data are no longer all that effective, as many of the more recent federal surveys have actually begun to differentiate between subgroups within the original racial and ethnic categories.\footnote{103}{"Standards for the Classification of Federal Data on Race and Ethnicity," National Archives and Records Administration, accessed April 18, 2017. https://obamawhitehouse.archives.gov/omb/fedreg_race-ethnicity/; Centers for Disease Control and Prevention, "2018 Questionnaire Redesign," Centers for Disease Control and Prevention, February 03, 2017, accessed April 18, 2017. https://www.cdc.gov/nchs/nhis/2018_quest_redesign.htm.} This allows for access to both aggregated and disaggregated data. However, with that said, there is still room for improvement. The model minority myth continues to perpetuate a cycle of cultural dissonance that proves to be deleterious to Asian American communities. Even if accommodating all the 100+ differences may not be realistic, settling for the status quo demonstrates willful ignorance and should be avoided.

Especially within the context of HIV/AIDS services, even providing one or two additional language options besides just English and Spanish, like Chinese, and acknowledging that “[e]very culture has its own sexual repertoire” would prove to be a significant step in breaking the cycle of dissonance.\footnote{104}{Hong and Lim, 1.} Additionally, it should be noted that while different groups of Hispanics and Latinxs share Spanish as a common language, Asian Americans do not share a single language. In addition, previously mentioned counterpoints to the notion of public health issues being driven primarily by numbers still stand. How many people of specific Asian
ethnicities must acquire HIV/AIDS for the government to exhibit a greater willingness to provide culturally tailored services and resources? Is it ethical to quantify individuals and ultimately ignore them by citing matters of practicality in the first place?

The homogenizing nature of the model minority myth is not as straightforward as one might expect. Beyond generalizing different communities into one, the myth sometimes actually results in the complete exclusion and misclassification of certain Asian American communities from the category of Asian American.\textsuperscript{105} It has been noted that during the earlier years of the epidemic that, “Filipinos or Asian Americans from Latin America are incorrectly categorized as ‘Hispanic.’”\textsuperscript{106} In other instances, South Asians and individuals with a mixed Asian background have also been classified and reported as other races.\textsuperscript{107} Although it is difficult to deduce the exact causative reasons for such errors in classification, it is possible that these misclassifications were in part due to these groups not matching the homogenized model minority image founded on the “analysis” of East Asians. All these errors accumulate to contribute to the further deflating and skewing of available HIV/AIDS statistics on Asian Americans, in addition to the inflation of the data corresponding to other racial categories such as “Black,” “White,” “Other,” or “Missing.”\textsuperscript{108}

Given the context of public health discussions being predominantly defined and advanced by numbers and Asian Americans often lacking the necessary data, another option of addressing the HIV/AIDS epidemic within Asian American communities would be to focus on prevention and HIV/AIDS education. Rather than just providing culturally sensitive HIV/AIDS care and

\textsuperscript{105} P Y. Lau, “AIDS in NY’s Asian American Community,” \textit{AsianWeek}, June 10, 1994, 4.

\textsuperscript{106} Ibid.

\textsuperscript{107} Ibid.

\textsuperscript{108} Ibid.
treatment services, emphasizing services that work to prevent future diagnosis and incidence of HIV/AIDS should be just as significant, if not more. If the HIV/AIDS rates are already low amongst Asian Americans, preventing the increase of prevalence may be a far more effective method than retrospectively handling a situation with higher rates of HIV/AIDS. However, in order to be truly effective, these services must also demonstrate cultural sensitivity and awareness when it comes to serving the Asian American population.

In order to be successful, such programs and initiatives must recognize the numerous differences between languages amongst the various Asian American communities. Studies have shown that amongst the different Asian ethnic groups, differences in language and limited English proficiency serve as a major barrier for Asian Americans in accessing preventative care and health education amongst other things, such as primary care and mental health services.\(^\text{109}\) According to Dorothy Tan of the Asian AIDS Project, “The primary barrier to educating” the Asian American population on HIV/AIDS is language.\(^\text{110}\)

Asian Americans are the most linguistically diverse amongst the various racial groups in the United States, and as of 2009, there were over 4 million Asian Americans who had limited English proficiency.\(^\text{111}\) According to the census from 2000, “73 percent of Asian Americans spoke a language other than English in their home, a rate that is four times higher than the national average (18 percent) and more than twelve times the rate for whites (6 percent).”\(^\text{112}\) When further examined by ethnicities, the data revealed that within seven of the Asian American

\(^{109}\) Trinh-Shevrin, Islam, and Rey, 326.

\(^{110}\) Hong and Lim, 1.

\(^{111}\) Trinh-Shevrin, Islam, and Rey, 324.

\(^{112}\) Ibid.
communities, “over 90 percent spoke a non-English language at home.” However, with that said, it should be noted that this does not necessarily mean that all the individuals that reportedly speak a non-English language at home are unable to demonstrate English proficiency. It is plausible that, especially amongst the younger generations, individuals are capable of speaking in more than one language.

Faced with such circumstances, languages services — in the form of language interpreters and translators — serve as a critical point in regards to healthcare access, and thus access to HIV/AIDS care, for many members of the Asian American population. Without these services, many Asian American households find themselves linguistically isolated within general everyday life and the public health setting in particular. This point is further reinforced by the fact that a qualitative study on Chinese and Vietnamese immigrants revealed that individuals within the sample population tended to prefer professionals to family members when it came to interpretations and translations in the healthcare setting. This is probably even truer when framed within the context of sexual health and a sexually transmitted disease like HIV/AIDS. One can imagine how uncomfortable it may be for some people to talk about sex via an underage child. Consequently, a lack of professional services may further dissuade already linguistically isolated Asian Americans, who do not want to burden their families, from entering the system of care.

113 Ibid.
114 Ibid.
115 Ibid., 325.
116 Ibid., 326.
The Census Bureau has defined linguistically isolated households “as households where no person fourteen years of age or older speaks English very well.” According to the census, there were roughly 900,000 linguistically isolated Asian American families. However, the question then is, what do these numbers mean and are they of any significance? To put the raw numbers into perspective, “Asian Americans were almost twenty-five times more likely to be living in linguistically isolated households than whites . . . and six times more likely than the general population.” Twenty-five percent of Asian Americans lived in linguistically isolated households, whereas only one percent of whites and four percent of the general American population were characterized as experiencing linguistic isolation.

When it comes to HIV/AIDS prevention and education, it is also important to recognize the differences in culture between the various groups. Here, critics may argue that the model minority myth is not all entirely wrong in that, it would appear that there are a handful of cultural aspects that are shared by different Asian American communities. It has been noted in a survey of Asian Americans that, “about half of respondents see different Asian groups in America as [being] culturally very or somewhat similar to each other.” An equivalent proportion of respondents also expressed the belief that what happened to other racially Asian individuals and communities in the United States would affect and reflect what happened to them.

---

117 Ibid., 325.
118 Ibid.
119 Ibid., 326.
120 Ibid.
121 Lien, Conway, and Wong, 17.
122 Ibid.
However, this sort of argument must be reframed. Although the majority of Asian Americans demonstrate pan-ethnic solidarity when it comes to “policy concerns affecting the minority community” and may share cultural similarities, most of them still prefer their ethnic identities to their pan-ethnic identity.\textsuperscript{123} “Each ethnic community within Asian American populations [continues to have] a unique set of issues and priorities.”\textsuperscript{124} For instance, within the context of health, one study found that Japanese and Filipino Americans had a significantly greater chance of having a high-risk BMI than Vietnamese Americans.\textsuperscript{125} Simultaneously, binge drinking was more prevalent amongst Korean and Filipino Americans than Chinese Americans.\textsuperscript{126}

Additionally, in terms of cultural sensitivity, a distinction can be made between Asian American communities that differ in other aspects besides ethnicity. For instance, a differentiation between the more recent immigrant and more Americanized communities should be made. It has been noted that compared to the immigrant population, Asian Americans are better educated in regards to HIV/AIDS.\textsuperscript{127} This difference in education could be explained by what one would assume to be differing levels of English proficiency.

Another reason as to why the distinction should be made is because immigrants tend to seek health services from private practices due to language barriers, which subsequently results

\textsuperscript{123} Ibid.

\textsuperscript{124} Ibid., 15.


\textsuperscript{126} Ibid., 893.

\textsuperscript{127} Hong and Lim, 1.
in a delay in reporting when compared to the reports made by public practices. This may skew the available data. In addition, “many immigrants seek help on medical issues from indigenous folk medicine practitioners for both linguistic and cultural reasons.” This too could affect public health data and records pertaining to Asian Americans.

Furthermore, as mentioned before, religious differences could also be a factor. Asian Americans from communities that generally tend to be more Christian or Catholic, such as certain Filipino and Vietnamese immigrants communities, are more inclined to “shy away from sexual education because of church teachings on birth control and abortion.” In addition, “[a]mong some Southeast Asian subgroups, the construction of Buddhist karma may not provide an individual with the proper incentives to modify potentially HIV-risky behavior.” After all, HIV/AIDS patients, who also happen to be believers of karma, can find comfort in their suffering not through treatments and changing behavior, but by looking forward to their next lifetime.

Another issue with the model minority myth lies in the fact that, while generalizing a very diverse group, the myth only cherry picks the aspects of “Asian culture” that reinforce and fall in line with the model minority image. It would appear that other cultural aspects of Asian American communities are overlooked, despite the fact that a more extensive understanding of the various cultures would actually enable policymakers, policies, services, and resources to demonstrate greater cultural competence.

128 Gock, 255-256.  
129 Ibid., 256.  
130 Le, 96.  
131 Ibid.  
132 Ibid.
For instance, the cultural barriers and taboos that Asian Americans tend to associate with HIV/AIDS are examples of this.\textsuperscript{133} While playing up the notion that Asian Americans have better than average health outcomes and have low HIV/AIDS prevalence rates, the myth ignores the various cultural taboos and barriers prevalent amongst Asian Americans.\textsuperscript{134} Perhaps more importantly, it overlooks the fact that such cultural traits are passed down generations by Asian Americans more frequently in comparison to other racial groups. This would subsequently hinder prevention and treatment efforts.\textsuperscript{135} “These include fostering attitudes that emphasize sexuality only as it relates to the perpetuation of [the] family line and that discourage [the] uninhibited expression of sexuality such as HIV-related interpersonal communication and homosexuality.”\textsuperscript{136}

Within just the context of health, as demonstrated by multiple studies, there are several different reasons as to why the model minority concept is ultimately a myth. Amongst these reasons, the fact that the model minority myth homogenizes a very diverse population is one that sticks out. It can be argued that by overgeneralizing a heterogeneous population through the disregarding of the different ethnicities and languages, and subsequently normalizing an image of homogeneity, the myth essentially eliminates the need for HIV/AIDS policies, services, and resources that demonstrate cultural sensitivities.

\textsuperscript{133} Ibid., 95; Vincent Crisostomo, interview by author; Christine Choy, interview by author.

\textsuperscript{134} Le, 95.

\textsuperscript{135} Ibid.

\textsuperscript{136} Ibid.
Chapter III: M&M Consumption – The Internalization of the Myth

The two previous chapters have discussed how the model minority myth serves as an external factor that negatively affects Asian American communities in light of the HIV/AIDS epidemic. This chapter will look to address how the perpetuation of the myth also served as a detriment from within Asian American communities. In order to accomplish this, chapter III will expand on how the model minority myth misleadingly portrays Asian Americans as a group with better than normal health outcomes, and how — within the context of HIV/AIDS — this perpetuated a false status quo within Asian American communities. Ultimately this misguided sense of security reduced the pressures on Asian Americans themselves to take action as well as the government to address HIV/AIDS as it pertains to Asian Americans.

As a model minority, Asian Americans are generally believed to be healthy and to have favorable health care outcomes.\(^{137}\) However, as addressed in previous chapters, this notion advanced by the model minority myth — that Asian Americans generally do not experience health problems — is undeniably false.\(^{138}\) Unfortunately, in the case of HIV/AIDS, this did not and does not stop the general public from continuing to normalize the perception and belief that HIV/AIDS is not a problem for the Asian American population.\(^{139}\) This misconception not only proves deleterious because of how it positions Asian American within the context of national public health and HIV/AIDS dialogue, but also because Asian American individuals themselves began to buy into the false narrative.

Many Asian Americans — particularly during the peak of the epidemic — viewed HIV/AIDS as a non-issue as they believed that they could not get or would not be affected by the

\(^{137}\) Trinh-Shevrin, Islam, and Rey, 5-8.

\(^{138}\) Ibid., 4.

\(^{139}\) Poma, 14.
Several articles and studies reinforce how prevalent such beliefs once were amongst Asian Americans. For example, a 1998 study on 412 Vietnamese American college students revealed that thirty-one percent of respondents believed that they would not acquire HIV/AIDS due to the belief that "Asians are immune to HIV because it is a western epidemic that does not affect Asians." 

This sort of general obliviousness towards and silence on the disease arguably perpetuated a dangerous cycle of ignorance and stigmatization of HIV/AIDS within Asian American communities, which in turn further hindered the already limited public health HIV/AIDS initiatives aimed at assisting Asian Americans. As Asian American individuals and communities continued to approach and view HIV/AIDS and the epidemic as non-issues, it reinforced the seemingly positive imagery of the model minority myth, the denial of HIV/AIDS as a threat, and the overlooking of specific cultural aspects that were perpetuating a negative feedback loop in regards to HIV/AIDS-prevention efforts.

Especially during the earlier years of the epidemic, given the context of numbers driving the national dialogue on HIV/AIDS, the misconception that Asian Americans were somehow immune to HIV/AIDS or less prone to the disease was widespread. In fact, in 1985 — years before the development of some of the first successful HIV/AIDS treatments — citing low


142 Yi, 37-42.


144 Le, 96.
prevalence rates of HIV/AIDS in Asian American homosexuals, some scientists looked into the possibility of there being something specific to Asian Americans that made them biologically more resistant to the disease.\textsuperscript{145} As a result, the U.S. Department of Health and Human Services allocated $293,000 in funds to back a three-year study on the possibilities behind the low rates of HIV/AIDS amongst homosexual Asian American men in Hawaii.\textsuperscript{146}

The emphasis some scientists and the government placed on race in their research is interesting to note as it implies that they were viewing the social and political construct of race, and the Asian identity in particular, as something far more biological than it actually was and continues to be (as exemplified by how it homogenizes a very diverse population). If this were the case, this could prove to be detrimental as it may potentially reinforce the model minority myth — which is established on the concept of race — with a false level of “scientific credibility,” and thus make it harder to refute.

On one hand, it was surprising that the false belief that Asian Americans were not susceptible to HIV/AIDS persisted. Especially given the circumstance that in one year, between 1987 and 1988, national data acquired by the CDC revealed that the incidence of AIDS within the Asian American population jumped 39.5 percent.\textsuperscript{147} Conversely, it was unsurprising given how normalized the model minority myth within the context of health had become and the fact that the available data could be easily manipulated to fit a different perspective. For instance, although the AIDS incidence amongst Asian Americans did increase by nearly forty percent, this change was not as striking when viewed as a raw value. “The CDC reported 237 Asian AIDS

\textsuperscript{145} Patrick Andersen, “Scientists eye Asians and AIDS Low incidence may be "major breakthrough," in researchers' war against the disease,” \textit{Asian Week}, March 15, 1985, 1.

\textsuperscript{146} Ibid.

\textsuperscript{147} Lyons, 5.
cases in August 1987 but in June of [1988] reported 392 cases of Asians with AIDS nationwide.”

The aforementioned false sense of security and opinions of detachment — as a result of the perpetuation of the model minority myth — are in part exemplified in a 1991 article written by Arthur Hu for Asianweek. In his article, “AIDS and Race,” Hu utilizes the Asian American population as a sort of model minority to which he compares other racial groups. In his defense, it can be argued that Hu is simply working off of the data available to him; Asian Americans did and do have lower rates of HIV/AIDS than other racial groups. He also does acknowledge that Asian Americans are not immune to the disease. “Asian gays, drug users or busy heterosexuals are certainly not immune to AIDS, no matter how small their relative numbers. One unsafe act is enough to do the job.”

However, Hu perpetuates the model minority myth by generalizing the cultures of the entire Asian American population into one. Whether this was his original intention or not, he does this by making the sweeping statement that the low HIV/AIDS prevalence amongst Asian Americans can be explained by the lower instances of promiscuity and drug use — relative to other racial groups — commonly attributed to Asian Americans. In doing so, Hu bolsters the cultural stigmatization of aspects associated with HIV/AIDS and consequently further hinders efforts to educate and break the cycle ignorance. Furthermore, by oversimplifying the diverse

148 Ibid.
149 Hu, 9.
150 Ibid.
151 Ibid.
152 Ibid.
153 Ibid.
population of Asian Americans and quantifying them, he, perhaps unknowingly, is contributing to the ignoring of Asian American individuals with HIV/AIDS who do not fit into the model minority niche, and — in certain regards — positions homosexual or drug-using Asian Americans as being less “Asian.”\(^\text{154}\)

Citing data and numbers, critics may still argue that at the end of the day, the status of Asian Americans as a sort of model minority within the HIV/AIDS epidemic is not necessarily wrong. The available facts and information can be used to claim that HIV/AIDS ultimately is not an Asian American concern and/or at least should not be a priority.\(^\text{155}\) For example, according to the CDC, “[a]t the end of 2005, less than 1 percent of the estimated number 476,095 persons living with HIV/AIDS in the thirty-three states with confidential name-based HIV infection reporting since 2001 were Asian Pacific Americans (APAs).”\(^\text{156}\) Additionally, Asian Americans only represented two percent of the total new AIDS diagnoses in 2014.\(^\text{157}\)

However, available data can easily be reframed to argue the opposite. For instance, “the estimated number of HIV/AIDS cases among [Asian Americans] almost doubled from 2001 to 2005 — the highest annual percentage change in each of those years, according to the CDC.”\(^\text{158}\) In addition to highlighting the significance of HIV/AIDS in Asian American communities, such statistics also suggest the possibility of successful prevention and treatment strategies taking place in other populations while Asian Americans continue to be neglected. Additionally, according to the CDC website, “Between 2005 and 2014 the Asian population in the United

\(^{154}\) Ibid.

\(^{155}\) Le, 95.

\(^{156}\) Ibid.

\(^{157}\) Centers for Disease Control and Prevention, "HIV Among Asians."

\(^{158}\) Le, 96.
States grew around 24% . . . During the same period, the number of Asians receiving an HIV diagnosis increased by nearly 70%.”\textsuperscript{159} Within that same timeframe, “HIV diagnoses among Asian gay and bisexual men in the United States increased 101%.”\textsuperscript{160} In addition, it should be remembered that there are no guarantees that the low rates of HIV/AIDS characteristic of the Asian American population will decrease and ideally become obsolete, let alone stay the same. This especially holds true given the fact that, contrary to what the model minority myth might have one believe, there are a significant amount of intravenous drug use taking place within Chinese, Southeast Asian, and Filipino American communities.\textsuperscript{161} “[This] in itself has the potential of spreading AIDS further into the [Asian American] community.”\textsuperscript{162}

With that said, as touched upon in the previous chapters, the best way to further reduce and/or maintain low rates of HIV/AIDS would be through a combination of education, prevention, and treatment. Unfortunately, within the general context of dealing with a disease like HIV/AIDS, cultural stigmatizations of the disease and associated aspects such as sex, sexuality, and drug use serve as major hurdles from an overall public health perspective. Although it is difficult to make the claim that the model minority myth directly resulted in the stigmatization of things like HIV/AIDS, sex, sexuality, and drugs within Asian American communities, it can be rationalized that a normalization of the myth might have reinforced and/or magnified the already existing cultural stigmas and ignorance found in the Asian American population.

\textsuperscript{159} Centers for Disease Control and Prevention, "HIV Among Asians."

\textsuperscript{160} Ibid.

\textsuperscript{161} Poma, 14.

\textsuperscript{162} Ibid.
Before going any further, it should be noted that there is a sort inconsistency inherent to this chapter. The previous chapter underlined the heterogeneity of the Asian American population and why Asian Americans should not be homogenized. Now an assumption and generalization are being made that, when it comes to matters like HIV/AIDS, sex, and drugs, Asian Americans communities typically demonstrate greater amounts of cultural stigmatization. However, the general consensus according to both academic studies and anecdotal evidence appears to be that, although the intricacies are different, many Asian Americans do seem to stigmatize and distance themselves from notions of illness, sex, and drugs.163 As I am looking to address how the model minority myth affects various Asian American communities as a whole, it would appear that a generalization, within reason and for practical purposes, could be made. Perhaps the most significant rationale also lies in the fact that as many — if not most — academic studies and anecdotes on this matter refer to the general Asian American population, and my argument rests on these sources, I too will most likely have to generalize in crafting my argument.

An understanding of the cultural stigmatization of HIV/AIDS and other related aspects within Asian American communities is critical to dismantling the model minority myth and ultimately giving a voice to Asian Americans within the national HIV/AIDS dialogue. In order to accomplish this, what sorts of cultural stigmas exist must be first recognized and understood. Some of the cultural values relevant to HIV/AIDS found amongst Asian Americans include the perception of sexuality and sex only within the context of family making/building, the

disapproval of “uninhibited expression of sexuality,” the denouncement of drugs, and the emphasis on not becoming a source of shame or burden on one’s family.¹⁶⁴

Why and how are these principles associated with Asian Americans significant? In tackling the HIV/AIDS epidemic, there is a level of need for “HIV-related interpersonal communication.”¹⁶⁵ And as HIV is transmitted through certain bodily fluids and intimate acts,¹⁶⁶ this means that individuals must demonstrate a level of willingness to open up and have honest conversations on potentially sensitive topics such as sex, homosexuality, and drug use “in order to prevent the spread of HIV infections.”¹⁶⁷ However, if an individual’s culture has taught him or her otherwise and has influenced him or her to actively avoid such topics, conversation pertaining to HIV/AIDS becomes that much harder amongst Asian Americans. After identifying such cultural principles and their consequences, one can see how the viewing of Asian Americans as a model minority that succeeded primarily as a result of their conservative, traditional, and family values might further reinforce the cultural beliefs that continue to hinder any efforts to address the HIV/AIDS epidemic in relation to Asian Americans.¹⁶⁸

The cultural barriers are further magnified by the fact that the stigmas associated with HIV/AIDS are not restricted to a micro level. As they stem from the culture itself, it can be assumed that the principles perpetuating stigmatization are not simply limited to being internalized by individuals, but have also been adopted by entire families and communities. This

¹⁶⁴ Le, 95; Poma, 14.

¹⁶⁵ Le, 95.


¹⁶⁷ Poma, 14; Ignatius Bau, “APAs and AIDS: We Are Not Immune; Evidence mounts to refute our collective denial about the AIDS crisis,” AsianWeek, January 5, 1996, 7.

¹⁶⁸ Trinh-Shevrin, Islam, and Rey, 5-8; Chao, Chiu, and Lee, 44; Yi, Kwon, Sacks, and Trinh-Shevrin, 135.
in part stems from the fact that these aforementioned “cultural taboos and cultural barriers . . . are relatively more ‘inherited’” in Asian American communities compared to other communities.\textsuperscript{169} This suggests that without proper intervention in the form of some sort of education, the stigmatization of HIV/AIDS and individuals with the disease will continue to persist throughout the Asian American population.

Subsequently, the rational and seemingly simple thing to do would appear to be to educate Asian Americans and normalize conversations on issues like sex, disease, and drugs. This would disrupt and disprove the false status quo on Asian American health being perpetuated by the model minority myth and would also inevitably benefit Asian Americans with HIV/AIDS. Unfortunately, there is a sort of catch-22. Past efforts to reach out to Asian American communities about HIV/AIDS have proven to be fairly unpromising, as various Asian American communities generally do not perceive public forums to be appropriate settings in which they can talk about potentially personal things like sex, illness, and death.\textsuperscript{170}

At this point, there is only so much a handful of advocates, organizations, and policymakers can do to help communities whose members themselves are not willing to participate. When it comes to addressing the HIV/AIDS epidemic, a certain level of responsibility lies with the Asian American individuals, families, and communities. They must recognize and acknowledge that HIV/AIDS should be a matter of concern. Based on the assumption that individuals and communities generally understand themselves the best, one way in which this could be accomplished is by having each of the different communities and their members realize that they are not immune to the disease and have them address the problem from within the community. This will inevitably go against the model minority stereotype and

\textsuperscript{169} Le, 95.

will require them to realize that the model minority concept is a myth. However, this will be tough to do, as it would necessitate a significant amount of people to push back on a seemingly positive stereotype.

Common sense dictates that it would be difficult to argue against something that is assumed by many as “good” and “positive.” Nonetheless, in this case, it must be done. Underneath the surface, the model minority myth continues to be harmful to Asian Americans within the context of HIV/AIDS. If the majority of the communities themselves agree that HIV/AIDS is a non-issue for them, there is significantly less pressure and incentive for politicians to account for the Asian American population while making and addressing federal HIV/AIDS policies. This, in turn, will lead to the overlooking of Asian Americans that are already affected by the disease.

For instance, circumstances like the one mentioned, provide government health agencies with little incentive to actively create and fund culturally sensitive programs that encourage Asian Americans, “whose testing rates are relatively low even among at-risk populations,” to seek out HIV testing, “as well as [increase] the limited use of HIV case management services among [Asian Americans].” Consequently, there will continue to be a perpetuation of the cycle characterized by a scarcity of HIV/AIDS resources and services tailored to Asian Americans, limited data and statistics on Asian Americans (aggregated and disaggregated), and lack of Asian American voices within national dialogue on the epidemic. This would then render invisible any Asian American individuals that have HIV/AIDS or view the disease as a concern, and thus further deter people from working to disprove the model minority stereotype.

Within the framework of a numbers game, available data and reports also support the notion that the model minority myth and corresponding cultural values are negatively affecting

---

171 Le, 96.
Asian American individuals with HIV/AIDS. In part due to the general lack of understanding and knowledge on HIV/AIDS within Asian American communities, “[o]f the 15,500 Asians estimated to be living with HIV in the United States in 2012, 21% (3,200) were undiagnosed. By comparison, 13% of all persons living with HIV in the United States were undiagnosed.” The lack of education and the cultural stigmatization “may explain why [Asian Americans] have one of the highest rates of late AIDS-related intervention.” In other words, Asian Americans with HIV/AIDS tend to receive treatment later than individuals of other racial groups.

The continuing cultural stigmatization of HIV/AIDS in Asian American communities — reinforced by the model minority myth — has arguably also impacted individuals who have already been diagnosed with HIV/AIDS. Various scholars have noted in their works and studies that Asian Americans have a greater tendency to actually hide their HIV status. Perhaps to better align themselves with certain aspects of the model minority identity, such as not bringing shame to one’s family. Many Asian Americans with HIV/AIDS have been found “to intentionally use HIV/AIDS services located far from their homes and their ethnic communities.”

Furthermore, out of the total number of Asian Americans having been diagnosed with HIV/AIDS in 2012, forty-seven percent of them did not receive continuous HIV/AIDS care and ultimately were not retained in the system of care. In addition, a little less than half (46%) of

---

172 Centers for Disease Control and Prevention, "HIV Among Asians."

173 Le, 95.

174 Ibid.; Lau, 4; Christine Choy, interview by author; Not a Simple Story, directed by Christine Choy (Filmakers Library, 1993), VHS tape (1994).

175 Le, 95; Poma, 14.

176 Le, 95.
Asian Americans diagnosed with HIV/AIDS failed to suppress their viral load.\textsuperscript{178} It should be noted that these retention and viral suppression rates, despite being fairly large, are comparable to those observed in other minority groups around this time.\textsuperscript{179}

However, this should not take away from the significance and alarming nature of the data. If anything, it should underline that, in certain regards, Asian Americans within the context of HIV/AIDS are in similar positions as other minority groups. Asian Americans also require attention. The CDC suggests that such disappointing numbers can at least be partially explained by some Asian Americans actively avoiding testing, counseling, or treatment because of cultural barriers such as “fear of discrimination, the stigma of homosexuality . . . or fear of bringing shame to their families.”\textsuperscript{180}

To make matters worse, due to the lack of proper education and general understanding found within many Asian American communities, Asian American individuals with HIV/AIDS found themselves in communities characterized by widespread paranoia and uninformed assumptions. For instance, a newspaper article titled, “Experts Decry AIDS Hysteria Among Asians,” recounts a panel event on Asian Americans and HIV/AIDS where Bertie Mo — a former co-chair of the Asian AIDS Task Force — told a story about a woman and her family who were ostracized by their close-knit Asian American community.\textsuperscript{181} Mo explained that the woman had acquired HIV/AIDS through a blood transfusion, and when the news got out, both

\begin{itemize}
\item \textsuperscript{177} Centers for Disease Control and Prevention, "HIV Among Asians."
\item \textsuperscript{178} Ibid.
\item \textsuperscript{180} Centers for Disease Control and Prevention, "HIV Among Asians."
\item \textsuperscript{181} Jay, 5.
\end{itemize}
her and her family were shunned based solely on the false belief that “AIDS was easy to 
catch.”\textsuperscript{182} Even after the woman passed away, the community continued to distance themselves 
from the husband and five kids out of fear.\textsuperscript{183} In a different scenario, an elderly Chinese man 
who worked as a dishwasher “took the AIDS antibody test because the person who sat in the bus 
seat before him was a homosexual.”\textsuperscript{184} On a grander scale, at one point, an Asian American 
contractor had his bid to renovate the building of an organization helping people with AIDS 
approved. However, upon finding out the building had people with HIV/AIDS, he refused to go 
through with the work.\textsuperscript{185}

With that said, critics may point out that, especially during the earlier decades of the 
epidemic, these instances of paranoia and discrimination were not specific to just Asian 
Americans, but actually fairly widespread.\textsuperscript{186} However, an argument can be made that in the case 
of Asian American communities, the internalization of the model minority myth and the 
reinforcement of the associated cultural stigmatization made the educating of Asian Americans 
on HIV/AIDS that much harder. As previously mentioned, many HIV/AIDS prevention and 
education efforts in Asian American communities may have been hindered due to an assortment 
of qualities — such as cultural taboos on sex, drugs, and disease — presumably inherent to 
various Asian American cultures.\textsuperscript{187}

\textsuperscript{182} Ibid.

\textsuperscript{183} Ibid.

\textsuperscript{184} Ibid.

\textsuperscript{185} Ibid.

\textsuperscript{186} Gregg Gonsalves and Peter Staley, "Panic, paranoia, and public health—the AIDS epidemic's lessons for 

\textsuperscript{187} Centers for Disease Control and Prevention, "HIV Among Asians"; Gock, 255; Le, 95; Lau, 4; Hong 
and Lim, 1; Koh, "Ten Reasons to Address HIV/AIDS in Asian American and Pacific Islander Communities"; 
Christine Choy, phone interview by author; Tri Do, phone interview by author.
All these factors combined to hinder the collecting of accurate data on Asian American communities.\(^{188}\) The shame and loss of face associated with contracting a highly stigmatized disease probably contributed to underreporting.\(^{189}\) This is supported by data that show that Asian American communities have higher rates of HIV transmission through blood transfusions when compared to other groups.\(^{190}\) This suggests that, within the context of Asian American communities and their cultural values, it might be more socially acceptable to report the disease when it is contracted through a more neutral medium, like a blood transfusion, as opposed to the likes of drugs and sex.

In analyzing the negative effects that the model minority myth has on Asian American communities in regards to HIV/AIDS, chapters one and two examined the myth as a sort of external source of detrimental consequences. In this chapter, the model minority myth was examined as an internal source of problems. By becoming normalized within the general public, the myth — as a positive stereotype — was eventually also adopted and perhaps even intentionally perpetuated by Asian American communities. This arguably resulted in more cultural dissonance, and thus led to the hindering of the Asian American voice within the HIV/AIDS narrative and the discouraging of acknowledging the truth. As much as the myth is a sort of external force, Asian Americans must also address the model minority myth as an internal force within their communities.

\(^{188}\) Gock, 255.

\(^{189}\) Ibid.

\(^{190}\) Ibid.
Conclusion

For years Asian American communities and individuals have been largely overlooked by the public health system. Especially within the context of HIV/AIDS, Asian Americans lacked a voice in the corresponding national dialogue. This can be explained within the framework of the normalization of the model minority myth. The myth spread and reinforced the notion that HIV/AIDS were not viewed as matters of concerns and/or importance by and for Asian Americans. After all, the myth pushed forward the notion that Asian Americans were healthier than members of other racial groups and that they generally exhibited greater than average health outcomes. Subsequently, the model minority myth led to the perpetuation of cultural dissonance between Asian American communities, Asian Americans with HIV/AIDS, advocates, and federal policymakers.

The reasons behind the significance of the model minority myth within the context of Asian Americans and HIV/AIDS can be divided into three primary categories: the origins of the myth, the myth as an external factor, and the internal effects of the myth. In addition, all three parts serve as a detriment to Asian American communities as they contribute to the problem of the HIV/AIDS epidemic and corresponding response efforts largely being a game defined by numbers. In other words, the myth perpetuates a lack of data and statistics on Asian Americans, which in turn hinders attempts to give more weight to Asian Americans within the national HIV/AIDS dialogue. This then limits any effort to provide services and resources to collect more data and further reinforces the status quo.

For one, the purpose and motivations behind the model minority myth prove to be detrimental to Asian Americans. The original political motivations behind the myth prevent and inhibit efforts to demonstrate any sort of cultural sensitivity. This then results in the continuation
of the trend where Asian American communities are used to denigrate other minority groups, such as African Americans, while also continuing to be marginalized in regards to certain issues like the HIV/AIDS epidemic.

Secondly, the myth sustains the practice of “outsiders” homogenizing the numerous Asian American communities into one group and acts as an external factor that limits the acknowledging of cultural details and demonstrating of sensitivity. Subsequently, the effects and effectiveness of general HIV/AIDS services and resources are hindered within Asian American communities.

Lastly, the perpetuation of the model minority myth, a seemingly positive stereotype of Asian Americans, may even result in the propagation of the myth within Asian American communities themselves. This would inevitably amplify the negative public health effects of the myth. As the myth becomes more and more normalized, it renders Asian Americans that are both either directly or indirectly affected by HIV/AIDS invisible. It discourages Asian Americans from advocating for their HIV/AIDS rights and eliminates the pressures on the bureaucracy to provide HIV/AIDS services and resources specifically for Asian Americans.

With all that said, the validity of the counterargument centered on notions of pragmatism must be recognized, acknowledged, and understood. There are advantages and disadvantages to every approach. In the case of arguments motivated by issues of practicality, there is a rationale behind prioritizing resources and services for communities that appear to need them the most based on available data and reports. Although in an ideal world there would be an unlimited amount of available funds, the truth is that funds are finite and numbers provide a sense of objectiveness to the decision making process.
With that said, it is easy to see the appeal behind promoting a sort of “colorblind” society. On paper, especially within the context of the HIV/AIDS epidemic, the push for colorblind policies appears to be the most egalitarian approach. The virus does not demonstrate a preference for people of one race over another, so why should HIV/AIDS policies, services, and resources be tailored to certain racial groups? Subsequently, over the past several decades, HIV/AIDS advocacy movements have shifted from community-based organizations and methods to a more biomedical approach. This also makes further sense when examined in combination with the historical trajectory of the disease and the movement for HIV/AIDS advocacy.

During the 1980s and early 1990s, there were no effective treatments for HIV/AIDS and acquiring the disease was the equivalent of a death sentence. The deaths of numerous amounts of people galvanized people from all over the country who had been directly and/or indirectly affected by the disease. Within this sort of political climate, a number of different community-based HIV/AIDS advocacy organizations were established and began to grow. Amongst them were a lot of organizations that were tailored to people of color and heavily affected minorities. Then around the years 1995 and 1996, when effective HIV/AIDS treatments were introduced, there was a change to provide more culturally competent care and the American population continued to see the positive effects of treatments well into the 2000s. During the late 2000s pre-exposure prophylaxis (PrEP), a drug “that reduces the risk of getting HIV from sex by more than 90%” and by more than seventy percent amongst intravenous drug users

---

191 Tri Do, phone interview by author.
192 Ibid.
193 Ibid.
194 Ibid.
195 Ibid.
became available. Consequently, there was a shift away from race and ethnic minority funding to a more generalized response (i.e. the biomedical model) as a greater amount of emphasis began to be placed on prevention in addition to treatment, rather than just treatment.

For instance, more recently, the concept of “community viral load” has attracted attention after being developed and experimented with. Instead of applying the approach that has historically used in the study of HIV/AIDS where the prevalence of the disease is typically examined in relation to demographic variables, such as sex, race, and lifestyle, the community viral load approach adopts the total HIV viral count of particular districts and neighborhoods as the deterministic factor in the study and treatment of HIV/AIDS. A higher viral count generally equates to the disease being that much more infectious and widespread. An individual’s, and thus a district’s, viral count can be lowered through proper medication, treatment, and care. In this regard, the use of community viral count allows for the gauging of general HIV/AIDS prevalence rates and how successful certain prevention and treatment efforts are.

However, as enticing as a strategy primarily based on pragmatism is, the flaws of such an approach must also be acknowledged. In a scenario where only numbers dictate the decisions made in the realm of public health, the smaller and “softer,” but equally significant details are frequently at risk of being ignored. As a result, simple solutions and potential improvements that

---


197 Tri Do, phone interview by author.


199 Ibid.

200 Ibid.

201 Ibid.
require just a basic level of awareness and understanding, such as the implementation of language services, are unfortunately overlooked. All these things further highlight the importance of incorporating an interdisciplinary attitude. In this case, in order to produce an ideal solution, a sort of balance must be established within the quantitative versus qualitative dichotomy.

Upon recognizing the detrimental effects and falsity of the model minority myth, an obvious next step from here would be to explore in depth exactly how a seemingly positive stereotype can be efficiently and successfully countered. In the case of the model minority myth, will it have to be first eliminated from the general public or will it be a matter of having Asian American communities and individuals themselves realizing the negative effects of the myth and abandoning it? If it is the latter, would this be an easy and straightforward task to accomplish or would it be near impossible due to the cultural context and qualities associated with many different Asian American communities? This then inevitably raises broader questions about the position Asian Americans hold within the general American society. In what ways is the normalization of the model minority myth a reflection of the greater power structures and systems of oppression found within society that Asian Americans are both knowingly and unknowingly subjected to?

Having established all that, in the future, it would be of interest to adjust the scope of the study. With the knowledge that the model minority myth affects entire communities and individuals with respect to the overall system, it would be interesting to explore whether or not the significance of the myth could be studied within other more specific subject areas. This would allow for a better understanding of the greater societal implications of a stereotype.

202 Tri Do, phone interview by author.
For instance, future work may be conducted on individual patient-physician interactions. Do inherent biases about Asian Americans being a model minority affect the care an HIV-positive individual receives? Are there differences in care between when the physician is Asian American versus when the patient is? In addition, it would be interesting to take the framework used for this thesis in regards to Asian Americans and the model minority stereotype and using it to analyze other racial and marginalized groups.

After all, if further studies do connect stereotypes to a greater societal structure, it would be noteworthy to analyze their impact across a variety of groups and communities. For example, are there stereotypes associated with Blacks and/or Latinxs that negatively affects the HIV/AIDS care and resources they receive? What sorts of commentary can be made in regards to the concept of benevolent sexism — “a set of interrelated attitudes toward women that are [fundamentally] sexist . . . [but] subjectively positive in feeling [and] tone”203 — and the effects it might have within a health setting?

If there is one broader theme that my research and thesis underlines, it is the notion that social and political constructs, such as a racial identity or a stereotype, are both directly and indirectly very extensive in who, what, and how they influence. They will not necessarily be confined to the original “category” (i.e. a political issue can become a social issue, which in turn may become a health issue). It is highly likely that these societal constructs will have far greater influence than originally thought.

Various notions such as the model minority myth with its seemingly positive connotation and terms like Asian American created for matters of practicality, all have effects well beyond their perceived intentions. In this particular case, there are legitimate concerns to be raised in

regards to the real and deleterious effects a concept like the model minority can have on the health outcomes of actual individuals and communities. How is the model minority myth a reflection of greater societal trends and influences at work? Looking into the future, we must broaden our perspectives and adopt multidisciplinary approaches. Only then will we be able to start seeing and addressing problems that are otherwise overlooked and often taken for granted.
Andersen, Patrick. “Scientists eye Asians and AIDS Low incidence may be "major breakthrough," in researchers' war against the disease.” AsianWeek, March 15, 1985.


Bau, Ignatius. “APAs and AIDS: We Are Not Immune; Evidence mounts to refute our collective denial about the AIDS crisis.” AsianWeek, January 5, 1996.


Bibliography


67


