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EDITORIALS

Moving beyond the "model minority" myth to understand sleep health disparities in Asian American and Pacific Islander communities

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Although decades of research have documented racial health disparities, the disproportionate impact of coronavirus disease 2019 (COVID-19) in marginalized communities (eg, indigenous and people of color) has magnified public visibility of these disparities. For example, reports have clearly shown the disproportionate burden of COVID-19 on Black Americans (eg, infection and deaths; more severe sleep disruption, insomnia, and their downstream consequences),[1–5] which have been linked to decades of structural racism that has maintained the marginalization of Black Americans.[6–8] We have also seen a surge of violence toward Asian American and Pacific Islanders (AAPI) during the pandemic, spurred on in-part by the national anti-Chinese rhetoric around the coronavirus.[9,10] The assaults ranged from physical to economic violence (eg, hate-crimes against AAPI individuals, xenophobic boycotts of AAPI restaurants and businesses). While emerging evidence points to worse sleep in AAPI individuals,[11,12] this has been an understudied area of sleep health disparities. Because stress is a core contributor to adverse sleep health and sleep health disparities, it is important that we study the impact of anti-AAPI violence.

One historical barrier to understanding AAPI health disparities is the "model minority" myth, which purports Asian Americans as the exemplar minority who have overcome racism to enjoy parity with White Americans. Because of this myth, the real challenges faced by the AAPI communities often go unseen or ignored, resulting in significantly less attention and resources (including research studies and funding) dedicated toward solutions. For example, without the historical context of long-standing anti-AAPI violence in the United States, the COVID-19 era violence may be mistaken as a temporary anomaly as opposed to a retraumatization with deep roots. In fact, the COVID-19 era assault against AAPI communities are reminiscent of a multitude of past racial traumas. First, there is ample historical precedence for scapegoating AAPI bodies for disease outbreaks, resulting in repeated "precautionary" burning and quarantine of Chinatowns.[13–17] Other examples of AAPI violence include, but are not limited to, the Chinese Exclusion Act of 1882,[18] where federal law prohibited immigration of Chinese people, including laborers who were critical to building the US infrastructure (eg, the transcontinental railroad); the Japanese Internment[19] from 1942 to 1945 where Japanese-American citizens were imprisoned in concentration camps via executive order by President Roosevelt; the People v Hall[20] case in California that resulted in at least 20 years where individuals of Chinese descent were legally barred from testifying against White-Americans, making it significantly easier to commit crimes against Chinese Americans with impunity. This historical context is important and illustrates the long history of social disadvantage and racism—the fundamental cause of health disparities and sleep disparities—experienced by AAPI individuals.

Despite the unrelenting history of social and structural discrimination, deceptively positive narratives about AAPI communities began to emerge in the mid-1960s amid the racial unrest during the civil rights movement.[21–23] These included such titles as "Success Story, Japanese-American Style" and "Success Story of One Minority Group in U.S.", all lauding the phenomenal and turnkey success of Asian Americans.[22] More specifically, Asian Americans were suddenly celebrated for achieving the American dream via hard work, uncomplaining perseverance, and quiet accommodation, all of which contrasted starkly against the on-going civil rights protests.[21]

Though some understandably found this development a relief given the precedence of "yellow-peril" journalism, others recognized the "model minority" narrative as ammunition to discredit the protests and demands for social justice from Black Americans and other marginalized groups.[24] Indeed, this narrative did not represent nor resonate with the lived experiences of many AAPI individuals.[25] However, this narrative was solidified when the 1970 census appeared to show higher median education and household income for Asians as a group compared to the US population as a whole, despite closer analyses indicating that the model minority characterization of Asian Americans was inaccurate, misleading, and a gross overgeneralization.[22,26,27] For example, the higher Asian American household income was explained by (1) the higher proportion of dual-earner households, (2) higher prevalence of multigenerational families (eg, adult children with income), and (3) larger families.[22] Additionally, the "model minority" narratives do not portray the disproportionate cost of economic success, which often included disproportionately long work hours, depression, anxiety, and

suicide, which are all associated with sleep disturbances.[28] Because this myth also celebrates the "grin and bear it" path to success, it also increases mental health stigma and reduces health seeking behaviors when the myth is perpetuated and internalized.

To date, the "model minority" myth remains strong despite evidence to the contrary, and the missed opportunities have been abundant. It is incumbent on our community of sleep and circadian rhythms scientists and clinicians to understand and counteract these blind spots in our dedication to improving sleep health, reduce disparities, and optimize functioning. To improve sleep among AAPI individuals it is imperative to demystify the "model minority" narrative and conduct more thoughtful research in this population that consists of sufficient sample sizes, recognizes the heterogeneity of the population by including a diverse sample of AAPI individuals, and focuses on the social determinants such as racism, discrimination, violence, of sleep disturbances. By conducting more informed research as well as recognizing the potential structural and social barriers to sleep health among AAPI individuals, this will be a great start to reducing the burden of sleep deficiencies in this population.

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