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Using Community-Based Participatory Research to Identify Health Issues for Cambodian American Youth

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Abstract

Lack of data disaggregated by ethnic group and the widespread perception of Asian Americans as “model minorities” often masks the health needs of specific groups within the Asian American population. Limited research focuses on health and psychological well-being among Cambodian American youth despite risk of negative educational and behavioral outcomes as well as high levels of trauma and psychiatric symptoms among first-generation Cambodian refugee adults. This article describes the development of a health survey with Cambodian American youth using community-based participatory research (and illustrates how youth can actively engage in research to inform change in health-related programs and policies.

Keywords

Cambodian Americans; community-based participatory research; health; youth participation

APPROXIMATELY 45% of all individuals younger than 18 years in the United States are children and youth of color, and estimates forecast that racial-ethnic minorities collectively will become the majority of children in the next 5 years.^{1,2} Asian Americans are among the fastest growing racial-ethnic groups in the United States—increasing at a rate of 45% from 2000 to 2010—and contribute to the nation’s growing diversity.³ As a whole, Asian American children and their families are characterized by tremendous heterogeneity with regard to ethnic origins, histories of settlement, and demographic and health patterns.⁴ However, this heterogeneity is often overlooked because of a lack of data disaggregated by

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ethnic group as well as the prominent perception of Asian Americans as “model minorities” —a stereotype that homogenizes diverse Asian ethnic groups and eclipses the challenges facing subgroups within this population.

Cambodians are among the more recent Asian American groups in the United States, with migration from Cambodia peaking during the 1980s as a result of policies easing refugee resettlement following the Vietnam War.⁵ As survivors of genocide and other atrocities (eg, torture, forced labor, starvation), many first-generation Cambodian refugees have endured severe levels of trauma and are at heightened risk of chronic physical and mental health problems.^{6,7} Currently, 53% of Cambodians in the United States are immigrants compared with 67% of Asian Americans overall who are immigrants, suggesting a growth in US-born Cambodian Americans.⁸ In addition, nearly a third of Cambodian Americans are below the age of 18 years, with 24% of all families with minor children living in poverty.⁸ Cambodian American youths face challenges in educational attainment⁹ and, considering their modest population size relative to other racial and ethnic minority groups, are overrepresented in crime and violence statistics¹⁰ and at risk of gang involvement.^{11,12} Still, there remains a paucity of research regarding the health and psychological well-being of Cambodian American youth.

Health researchers have increasingly recognized the value of community-partnered approaches to the research process in order to address health disparities, particularly among vulnerable populations for which little empirical evidence exists. Community-based participatory research (CBPR) is a research framework that involves community members in shaping the purpose, process, and dissemination of research for the benefit of both researchers and communities.¹³ The greater acceptance of community-driven research has emerged from the persistence and complexity of health disparities facing disadvantaged communities, suggesting that researchers’ knowledge can only be enhanced by the knowledge of communities that are themselves affected. In contrast to investigator-driven research that often foregrounds risks and deficits in vulnerable populations, CBPR acknowledges community strengths and aims to foster individual and collective empowerment for those involved. Accordingly, a CBPR approach values examination of community-driven research questions with the ultimate goal of using research findings to inform changes that improve the quality of life for communities. With scientific research more relevant to local community contexts, CBPR shows promise in enhancing the external validity of research findings.¹⁴ In addition, CBPR approaches can improve the translational capacity of research within health systems and cultural competency practices.¹⁵ Among the more immediate advantages for communities, CBPR helps develop community capacity to engage in research in order to systematically identify, evaluate, and address local health-related issues.¹⁵

Participatory research with youth has gained traction in fields including public health, nursing, education, social work, and community psychology as a strategy for incorporating youth perspectives and knowledge in research and advocacy efforts.¹⁶⁻¹⁸ Although the majority of published CBPR studies involve partnerships with adults, numerous CBPR studies have engaged youth as partners throughout multiple stages of the research process, beginning with partnership formation to identify problems and research questions, to data

collection and interpretive analysis, and finally to dissemination and presentation of research findings to inform change.¹⁶ Important elements of the participatory youth research process include shared decision making, enhanced youth control and ownership, and developmentally and contextually appropriate materials and mechanisms for active engagement in research.^{17,18} From a youth empowerment perspective, engaging youth as research partners contributes to youth's social development and sense of agency to understand and address broader community issues.¹⁹ Furthermore, allowing youths to shape the framing of health concerns and challenges provides them with opportunities to inform the research knowledge base with important contextual information regarding their lived experiences.¹⁶

This study describes a partnership between university and community partners to explore relevant health and cultural factors for Cambodian American youth in Southern California. Specifically, the goal of the study was to examine emotional well-being and health and safety issues for Cambodian American youth as well as explore factors that may be related to these outcomes at the individual, family, school, and community levels. The purpose of this article was to describe the development of a health survey instrument using CBPR with youth and to discuss preliminary outcomes and descriptive results of the study. By providing a model by which youth can engage in participatory research methods, we posit that youth involvement in research can inform the knowledge base within family and community health as well as increase community capacity to use research as a tool to inform change.

PARTNERSHIP DEVELOPMENT

This project began as a collaboration between the University of California, Los Angeles, and Khmer Girls in Action (KGA), a nonprofit organization in Long Beach, California, that works with and advocates for Cambodian American youths and their families to address health, civil rights, and community safety issues. KGA's prior involvement in participatory research with youths and community members demonstrated the capacity for research findings to successfully advocate for greater safety within schools.²⁰ A major motivation to pursue the present collaborative research partnership was to provide empirical evidence and greater visibility to Cambodian American adolescents' health and well-being needs.

The authors had various roles in the partnership development. To formulate the initial concept of the research project, KGA leadership (the second author) sought to engage in research to assess local Cambodian American youth's needs as well as inform KGA's strategic planning and programs. KGA staff then sought to partner with university researchers to further develop their research aims and to increase their capacity to engage in systematic research efforts. The university partners (the first and third authors) shared interests in psychological processes and outcomes relevant to Asian American children and their families and had experience working with community-based organizations. The community-university partnership was further facilitated by an existing working relationship the first author had with KGA as a former staff member and volunteer. KGA subsequently consulted with the Data-Center, a nonprofit organization that helps communities and groups develop research capacity to inform grassroots organizing efforts in order to ensure a community-driven research process. KGA was able to secure initial funding from the UCLA

Center for Community Partnerships, which supported academic-community partnerships engaged in research with implications for communities in the Los Angeles region.

STUDY DESIGN AND METHODS

The university partners and KGA devised a mixed-methods research design that began with a series of qualitative focus groups and led to the development of a quantitative community survey. The study began with focus groups to include a diverse array of local Cambodian American youth beyond the group of youths immediately involved in KGA's programs and activities. Subsequently, focus group themes informed the development of a community survey, codeveloped with youth researchers, intended to examine broader trends in a larger sample of Cambodian American youth. The community in which the study took place is part of a large Cambodian ethnic enclave in Southern California.⁵ Eligible participants for both focus group and survey portions of the study included self-identified Cambodian adolescents proficient in English between the ages of 13 and 18 years who had at least 1 parent of Cambodian descent. The university institutional review board approved both the focus group and survey research phases of the project.

Focus group research

The university partners and KGA staff were interested in exploring themes regarding identity, family, school experiences, and community dynamics in the focus group discussions. Convenience and snowball sampling techniques were used to recruit participants to the focus groups from local high schools and youth organizations, after which eligible adolescents provided parental consent to participate. Participants were ensured that their involvement in the focus groups was not related to or would not affect their involvement in school or the community organizations from which they were drawn. A total of 5 focus groups were conducted, with 3 all-female and 2 all-male groups. The purpose of gender-specific groups was to provide a "safe space" in which youth felt comfortable discussing personal stressors, family issues, and other social/cultural issues that might differ by gender. The university research team facilitated the focus groups, which were conducted in English and included 6 to 9 participants aged 14 to 18 years (24 females and 16 males in total). Focus group facilitators asked general questions related to the nature of youth's relationships and communication with parents as well as their experiences as young people growing up in their neighborhood and community. All focus groups lasted approximately 90 minutes and were video recorded for subsequent transcription.

The university partners used content analysis to guide focus group data analysis, which included determining criteria for meaning/codable units, coding (applying labels to meaning units), and creating categories and themes.²¹ Broad themes highlighted the salience of family and parental relationships, premigration trauma and postmigration adjustment among refugee parents, and experiences growing up in the community. KGA staff then prioritized the themes most salient to youth's health and well-being for inclusion in the survey instrument.

Survey research

To ensure youth participation throughout the survey phase of our study, KGA staff and university partners convened a team of youth researchers to share ownership of the study process. Forty youth researchers received training in research ethics, study procedures, and recruitment methods through a series of summer-intensive training workshops. These training sessions involved lecture, discussion, and role-playing to cover issues related to the research process such as confidentiality, consent/assent, and protocols for distribution and retrieval of the surveys. In addition, the training sessions included activities that centered the personal and family narratives of youth researchers within a sociohistorical context for understanding community-level challenges facing Cambodian Americans. This process encouraged youths to draw connections between their own lived experiences and broader health and social issues facing the Cambodian American community.

Within this group, 20 youth researchers developed survey items based on themes expressed in the focus groups. All of these youth researchers had engaged in KGA programs for at least 1 year, with a few youths who participated in prior focus groups. KGA staff facilitated this process by adapting focus group data into an activity, wherein focus group themes and corresponding excerpts/codes were visualized on banners for youth research team members to discuss. Youth researchers had opportunities to discuss classification of data, after which youths were able to describe in their own words how categories should be named. Staff facilitators assigned youth researchers into groups to brainstorm potential survey items based on identified categories; these groups rotated to allow for youth researchers to contribute questions to other categories. Both adult staff and youth researchers evaluated survey items at the end of each meeting. The university partners reviewed youth-generated questions as well as existing measures to include in the survey instrument. Through collaborative discussions, university and community partners changed the wording of questions and response categories, retaining most of the wording of the youth-driven questions to preserve youth perspectives as much as possible in the survey. KGA then pilot tested the instrument to identify potential issues with comprehension and survey distribution among several Cambodian American youth and made revisions accordingly.

Youth researchers gave presentations at schools and local community organizations to invite eligible youths to take part in the study. Teachers who sponsored Cambodian clubs provided access to Cambodian students at 2 different schools. Two other youth organizations serving Cambodian American youth permitted recruitment presentations during after-school programs. Additional strategies included a “survey party” that youth researchers organized in which KGA hosted an event that described the main goals of the study prior to its administration in order to enhance recruitment efforts.

The survey instrument was anonymous and did not require participants to provide formal consent/assent forms. Instead, participants were provided with an information sheet describing the study’s goals, procedures, and investigator contact information. The invitation script and procedures ensured that potential participants understood that involvement in the study was voluntary and not related to commitments at school or other community establishments. An additional measure was taken to verify that youths were not being sampled more than once at schools or other settings. All participants were entered in a raffle

to win a laptop; raffle entry forms contained participants' names, contact information, and had participant ID numbers that matched survey forms. The raffle forms were collected separately from surveys and then inspected to ensure that participants did not take the survey more than once. No participants duplicated the survey. This process resulted in 475 eligible participants taking part in the survey.

The average survey participant was 16 years of age. Females represented approximately 51% of the sample and 46% were male; the remaining 3% identified as transgender or did not provide information about gender. Most of the participants were born in the United States (95%) and attended high school (91%) at the time of the study. With regard to family, participants reported an average of 6 family members in the household, with the most common language spoken in the home being English (60%), followed by native Khmer (22%), and both English and Khmer (15%).

Measures

The survey instrument included several measures; the current analysis highlights selected health-related variables and items generated by youth researchers.

Health and safety—The survey used a 10-item measure of depressive symptoms based on the Center for Epidemiological Studies Short Depression Scale.²² Respondents reported feelings and behaviors related to depression in the last week, and responses ranged from 0 (*rarely or none of the time*) to 3 (*most of the time*). A cutoff score of 10 or greater with no more than 2 items missing suggests serious depressive symptoms.²² In addition, 4 youth-generated items assessed reproductive health knowledge in which participants indicated whether they had access to or knowledge about sexual health resources or services (ie, access to condoms or birth control; testing centers for pregnancy, sexually transmitted diseases, HIV/AIDS). Responses (*yes* = 1 or *no* = 0) were summed, wherein higher scores suggested greater knowledge. Finally, 3 youth-generated items related to safety at home, in school, and in one's neighborhood were included and ranged from 1 (*not at all safe*) to 5 (*extremely safe*).

Family and cultural variables—The survey included 17 youth-generated items related to language, identity, and cultural values. These items tapped into participants' reporting of parents' English proficiency, the importance of cultural identity, parental expectations, and cultural values. These variables were identified by our community partners as relevant to understanding Cambodian American youth's health and well-being.

Community environment variables—Youth researchers identified experiences of discrimination in peer, school, and police contexts as a salient aspect of their lived experiences. Eighteen items asked participants to rate the frequency of experiences in the last year attributed to being Cambodian (eg, threats from peers, assumptions about speaking English poorly at school, being stopped by the police). Items related to peer and police discrimination were youth generated, and school discrimination items drew from previous research on adolescent discrimination.^{23,24} Compelling research suggests that discrimination serves as a risk to healthy adjustment and psychological wellbeing for adolescents in

communities of color, yet a few studies have examined discrimination as a risk to health for Cambodian American youth.²⁴⁻²⁶

Data analysis

To maximize youth engagement in the quantitative data analysis process, we ensured that data were available in multiple formats. Although traditionally reserved for online survey data collection, we entered data from the pencil-and-paper survey into Survey-Monkey (www.surveymonkey.com) because it provides cost-effective, user-friendly tools for conducting descriptive statistics and for visualizing data. The program also enables data to be exported into Excel for conversion to Stata²⁷ and SPSS²⁸ statistical packages. KGA staff developed a series of workshops for youth researchers to discuss descriptive survey results and the use of results to inform prevention, intervention, and advocacy efforts. Subsequently, our community partners hosted a series of “listening sessions” to capture feedback on preliminary findings from youth in the community not directly served by KGA. Because our community partner worked primarily with young women and girls at the time of our study, our descriptive results explore gender differences.

RESULTS

Table 1 provides descriptive information on variables related to health and safety. Across health and safety variables, there were no significant gender differences. Overall, participants reported high scores on depressive symptoms ($M = 9.59$; $SD = 5.33$), suggesting that depression may be a concern in this sample population. Although females scored higher than males on reproductive health knowledge, scores did not differ significantly by gender. Participants overall indicated that they felt safe at home ($M = 3.97$; $SD = 1.04$) but comparatively less safe at school ($M = 3.47$; $SD = 0.98$) and moderately safe in their neighborhoods ($M = 3.01$; $SD = 1.14$).

The survey assessed youth and parent language proficiency, and no significant gender differences emerged across these variables. Overall, participants reported higher scores on parents' comprehension of English ($M = 3.07$; $SD = 0.77$) than parents' ability to speak English ($M = 2.85$; $SD = 0.80$). Participants overall rated their ability to understand their parents' native Khmer language as fair ($M = 2.95$; $SD = 0.74$), with lower scores in the ability to speak Khmer ($M = 2.64$; $SD = 0.78$).

To conserve space, Table 2 includes selected descriptive information regarding youth-generated items related to family and cultural variables. With regard to cultural identity, participants overall agreed on the importance of knowing Cambodian history and other cultural practices. Male participants scored significantly higher than females regarding the importance of knowing traditional Cambodian healing methods ($M_{\text{males}} = 3.85$; $SD_{\text{males}} = 1.20$; $t = 1.99$). Participants overall had fairly high scores for parental expectations, with females scoring higher than males in relation to parents' expectations about getting good grades in school ($M_{\text{females}} = 4.66$; $SD_{\text{females}} = 0.74$; $t = -2.28$) and going to college ($M_{\text{females}} = 4.68$; $SD_{\text{females}} = 0.73$; $t = -2.92$). Finally, females scored significantly higher than males on the importance of traditional cultural values, such as respecting elders

($M_{\text{females}} = 4.68$; $SD_{\text{females}} = 0.57$; $t = -2.12$) and honoring one's family ($M_{\text{females}} = 4.60$; $SD_{\text{females}} = 0.69$; $t = -2.16$).

Results for selected items related to participants' experiences of ethnic-based discrimination are shown in Table 3. Mean scores on these items ranged from 1.09 (for females, being taken to the police station) to 2.38 (for males, unfair expectations in school). Males reported higher average scores across all items related to peer, school, and police discrimination. Among the youth-generated items in peer and police domains, the highest scores for boys related to being called names and racial slurs ($M_{\text{males}} = 2.17$; $SD_{\text{males}} = 1.22$; $t = 3.52$) and getting pulled over by police ($M_{\text{males}} = 1.92$; $SD_{\text{males}} = 1.30$; $t = 7.95$).

DISSEMINATION OF RESULTS

Both community and university partners disseminated results through multiple outlets. On the basis of descriptive findings from the survey, our community partner produced a stakeholders report illustrating key demographic characteristics and scores on items related to depressive symptoms, access to reproductive health services, and safety issues.²⁹ Youth researchers led efforts to organize a community forum to discuss key findings of the survey with community stakeholders from schools, city council, local media, and other community organizations. To promote the research project and its key findings among other youths in the community, youth researchers created short video public service announcements that were later posted online and distributed through social media networks. The broad dissemination of findings via local newspapers, social media, and related community forums helped increase the visibility of issues affecting Cambodian American youth in the community at large and the broader region. Most notably, the findings provided a basis for the development of a longterm campaign to advocate for school-based health and wellness centers.²⁹ In addition to our community partner's achievements, several project outcomes benefited the university partners. A CBPR approach provided a structure for incorporating local perspectives on key study variables, increasing the relevance and validity of the research to the community. The university partners were able to use this survey as pilot data that served as the basis of presentations and publications.^{25,26} Importantly, our study helped provide university researchers enhanced access to a vulnerable youth population for which little empirical evidence exists.

DISCUSSION

Using a CBPR framework, our study successfully engaged youth as partners to develop a survey instrument that captures key health, safety, and sociocultural variables relevant to Cambodian American youth in Southern California. Despite existing research documenting alarming levels of trauma and other psychiatric symptoms among first-generation Cambodian refugees in the United States, a dearth of research has examined the health needs of Cambodian American youth in subsequent generations. Lack of data disaggregated by ethnic group for Asian Americans and the widespread perception of Asian American youth as "model minorities" have masked the health needs of this population. Our study helps fill a void in the existing research related to the experiences and contexts of health and development for Cambodian American youth.

Our descriptive results call attention to patterns in the health, cultural identity and values, and community experiences for Cambodian American youth that have implications for research, intervention, and broader policy changes. For example, our results suggest that the primarily US-born Cambodian youths in our sample report relatively high levels of depressive symptoms. Additional research is needed to ensure cross-cultural equivalence in the measurement of depressive symptoms and to examine the role of nativity and acculturative processes in the mental health of Cambodian American youth.^{25,26} Moreover, in light of pervasive physical and mental health concerns reported among Cambodian refugees, additional work is needed to understand and examine potential link between parents' trauma on family functioning and child outcomes.

With regard to family and culture, youth reported moderately high scores on parents' ability to understand English, with relatively lower scores on parents' ability to speak and be literate in English. This may have implications for parent-child communication, which influences intergenerational relationships and family processes.^{4,5} Furthermore, our sample reported high levels of cultural identity and adherence to traditional cultural values. Previous research has noted that strong ethnic and cultural identification may serve as a protective factor with regard to health and psychological outcomes.³⁰ Furthermore, our study identified aspects of Cambodian American youth's daily lives, such as experiences with discrimination in various contexts, that had not been the focus of the majority of prior research on health and behavioral outcomes for youth in this population. This is particularly noteworthy in light of existing research that has highlighted outcomes such as gang involvement and delinquent behavior.¹⁰⁻¹² Our research may help contextualize existing research that has highlighted negative behavioral and educational outcomes for Cambodian American youth.

In addition, we demonstrated that youth can actively engage in multiple stages of the research process. Collaborative partnerships with youth, alongside adults in the community, can aid in the development of culturally appropriate instruments and provide useful outcomes for research and community advocacy endeavors. Our youth researchers were actively engaged in survey development, survey data collection, and interpretive analysis of our results. Because of a commitment to the participatory process with youth, adult community members and university researchers aimed to ensure developmentally appropriate avenues for youth decision making and ownership of the project. Youth researchers maintained engagement via ongoing workshops and meetings during survey development, user-friendly programs to analyze data, and use of social media to disseminate results to the broader community. It is important to note that our community partner used the research findings to engage youth in a campaign to advocate for wellness centers and additional health services within schools.³⁰ Overall, community participation in the project helped develop research capacity among both adult and youth community members.

We acknowledge that our study has limitations. Our specific focus on Cambodian American youth in Southern California limits the generalizability of findings. The urban, multicultural community from which this sample was drawn may differ in demographic profile from rural or less culturally diverse communities. Patterns related to safety in one's neighborhood may or may not differ for Cambodian American adolescents in other regions. Still, we sampled

from a geographically concentrated Cambodian ethnic enclave and obtained a sufficient sample size that allows for meaningful interpretation within this population.

Our study has significant contributions. First, our research helped produce a survey instrument to assess health and safety issues as well as relevant family and cultural variables for Cambodian American adolescents, an understudied youth population with unique challenges and strengths. Second, our study can serve as a model for other CBPR projects that seek to engage youth as partners in research. Youth actively participated in survey development, data collection, interpretive analysis, and dissemination of findings to a broader community audience beyond traditional academic outlets. The presentation of key survey findings provided a creative outlet for youths to express their needs and buttressed their community advocacy work with empirical evidence. Finally, our study provided tangible outcomes and deliverables for both community and university partners that served to inform our work in both arenas. The research findings served as the basis for developing community-level health education and advocacy efforts for Cambodian American youth as well as exploration of relevant health and cultural constructs for future research and culturally grounded interventions. Overall, our study provides a model by which youth can actively engage as partners in research to inform change in programs and policies related to health.

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Table 1.Health and Safety Variables^a

Construct	Range	Total, <i>M</i> (SD)	Girls, <i>M</i> (SD)	Boys, <i>M</i> (SD)
Depressive symptoms	0-30	9.98 (4.96)	10.30 (5.08)	9.61 (4.79)
Reproductive health knowledge	0-4	3.09 (1.27)	3.16(1.50)	3.00 (1.40)
Safety at home	1-5	3.97 (1.04)	3.98(1.01)	3.98 (0.07)
Safety at school	1-5	3.47 (0.98)	3.46 (0.94)	3.49 (1.02)
Safety in neighborhood	1-5	3.01 (1.14)	2.95 (1.06)	3.08 (1.22)

^aN = 475 participants in the total sample. Participants who identified as transgender or had missing on gender (n = 6) were not included in analyses for females (n = 246) or males (n = 220).

Table 2.Family and Cultural Variables^a

Construct	Range	Total, <i>M</i> (SD)	Girls, <i>M</i> (SD)	Boys, <i>M</i> (SD)
Cultural Identity	1-5			
It is important to know Cambodian history		4.25 (0.94)	4.27 (0.94)	4.23 (0.95)
It is important to know traditional Cambodian religious practices		3.87 (1.18)	3.82 (1.21)	3.92 (1.13)
It is important to know traditional Cambodian healing methods		3.73 (1.24)	3.62 (1.27)	3.85 (1.20) ^b
Parental expectations	1-5			
My parents expect me to take care of my family, house, and siblings		3.78 (1.08)	3.78 (1.07)	3.79 (1.11)
My parents expect me to get good grades in school		4.58 (0.79)	4.66 (0.74) ^b	4.49 (0.84)
My parents expect me to go to college		4.57 (0.83)	4.68 (0.73) ^b	4.45 (0.91)
My parents expect me to support them financially in the future		3.87 (1.10)	3.87 (1.06)	3.85 (1.14)
Cultural values	1-5			
It is important to respect your elders		4.62 (0.72)	4.68 (0.57) ^b	4.54 (0.85)
It is important to honor your family		4.52 (0.80)	4.60 (0.69) ^b	4.44 (0.91)

^aN = 475 participants in the total sample. Participants who identified as transgender or had missing on gender (n = 6) were not included in analyses for females (n = 246) or males (n = 220).

^b*p* < .05, indicating significantly higher scores.

Table 3.Community Environment Variables^a

Construct	Range	Total, <i>M</i> (SD)	Girls, <i>M</i> (SD)	Boys, <i>M</i> (SD)
Ethnic-based discrimination from peers	1-5			
Name calling/racial slurs and comments		1.97 (1.12)	1.80 (1.00)	2.17 (1.22) ^b
Physical abuse/violence		1.50 (0.96)	1.27 (0.66)	1.78 (1.16) ^b
Ethnic-based discrimination at school	1-5			
You were wrongly disciplined		1.66 (0.99)	1.50 (0.84)	1.86 (1.12) ^b
You were given a lower grade than you deserved		1.61 (0.96)	1.46 (0.86)	1.78 (1.04) ^b
People expected more of you than they expected of others your age		2.27 (1.27)	2.17 (1.26)	2.38 (1.28)
Ethnic-based discrimination from police	1-5			
Stopped		1.53 (1.02)	1.23 (0.58)	1.88 (1.28) ^b
Harassed		1.40 (0.91)	1.15 (0.50)	1.68 (1.17) ^b
Taken to the police station		1.28 (0.77)	1.09 (0.39)	1.50 (1.00) ^b

^aN = 475 participants in the total sample. Participants who identified as transgender or had missing on gender (n = 6) were not included in analyses for females (n = 246) or males (n = 220). All items in this table were youth generated except school discrimination items, which were adapted from previous studies.^{23,24}

^b*p* < .05 indicating significantly higher scores.