The health of the Asian American community is intimately entwined with their immigration history and experience. Asian Americans are the fastest growing racial group in the United States, growing over four times as fast as the total U.S. population and expected to more than double to over 47 million people by 2060 (U.S. Department of Education, 2016). Despite this tremendous growth, Asian Americans in the United States remain understudied in health psychology research.

Asian Americans are a predominantly immigrant and heterogeneous community comprising 20.4 million people with origins in the East Asia, Southeast Asia, and the Indian subcontinent, comprising India, Bangladesh, Pakistan, Sri Lanka, Nepal, Bhutan, and other Himalayan states. As such, Asian Americans represent over 20 countries with diverse cultures, languages, social values, economics, and religions (Lopez, Ruiz, & Patten, 2017; Pew Research Center Report, 2013). Chinese, Filipino, Indian, Vietnamese, Korean, and Japanese people comprise 83% of the total Asian American population in the US. Prior to 1960, Japanese individuals comprised the largest subgroup; currently, Chinese individuals comprise the largest group, followed by Indian and Filipino immigrants (Lopez et al., 2017).

Immigration from Asian countries to the United States occurred in two large-scale immigration waves: the first wave, comprised of unskilled laborers, miners, and plantation workers, occurred 150 years ago; the second wave, comprised of educated and skilled workers, occurred after the 1965 Immigration and Nationality Act (Pew Research Center Report, 2013). In addition to the diverse origins of the various Asian American subgroups, the diversity of cultures and backgrounds of immigrant communities adds a layer of complexity to understanding the health of this very complex ethnic and cultural group (Lau et al., 2013).

In the following sections, the general health status of Asian Americans will be highlighted, followed by an overview of psychological and social factors that affect the health of this community. We conclude with a discussion of barriers to optimal health and well-being.

The Health Status of Asian Americans

Mortality and Life Expectancy

Asian Americans have the highest life expectancy of all Americans (86.3 years), nearly eight years more than non-Hispanic White Americans (78.5 years) (Acciai, Noah, & Firebaugh, 2015; Hastings...
et al., 2015; Torre et al., 2016). At the same time, there is greater mortality due to Alzheimer’s disease for all Asian Americans compared with other racial/ethnic groups (Hastings et al., 2015).

However, these statistics obscure the variation among Asian American subgroups. When the 2003–2011 mortality data of non-Hispanic Whites (NHW) and the six largest Asian American subgroups (Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese) are disaggregated, significant heterogeneity is observed. For example, during that time period, the leading cause of death was heart disease for Asian Indians, Filipinos, and Japanese adults but not for other Asian American subgroups, including Chinese, Korean, and Vietnamese (Hastings et al., 2015). Disaggregating the data further by gender, the leading cause of death among Asian American women was cancer, but for women from the Indian subcontinent, it was heart disease. Cancer also was the leading cause of death among Chinese, Korean, and Vietnamese American men, but for Asian Indian, Filipino, and Japanese men it was heart disease. Other trends among the subgroups include increased cancer and diabetes mortality among Asian Indians and Vietnamese; increased stroke mortality among Asian Indians, and increased suicide mortality among Koreans (Hastings et al., 2015).

Disease Prevalence

Comparative data on disease prevalence between Asian Americans and other ethnic groups in the U.S. shows a complex picture. For example, in a sample from Ohio, Hepatitis B was higher among Asian Americans (6.2%) compared to African Americans (3.8%) and Whites (0%) (Misra et al., 2013). The presentation of disease and risk factors also differs. For example, Asian Americans are 30% more likely to have type 2 diabetes compared to non-Hispanic Whites, even though they have a lower body mass index and lower alcohol consumption, and smoking rates compared to non-Hispanic Whites (Lee, Brancati, & Yeh, 2011). Nativity moderates this relationship. Rates of type 2 diabetes are higher among foreign-born versus U.S. born Asian Americans, regardless of how long ago they immigrated (Echeverría et al., 2017). And subgroup differences exist: for example, there is a higher rate of coronary heart disease among Asian Indians compared to other Asian subgroups (Palaniappan, Araneta, & Assimes et al., 2010). Subgroup differences may be a function of differences in environmental exposure to infections, behavioral risk factors, and utilization of health care services, particularly services related to screening and preventive health care.

Health Care Utilization

There are differences in health care utilization between Asian Americans and other ethnic groups. For example, rates for colorectal cancer screening are 62% among Non–Hispanic White compared to 47% among Asian Americans (Liss & Baker, 2014); controlling for socioeconomic status and access to care had no impact on these rates. Lower health literacy may explain variability in preventive health care. In one study, Asian American undergraduate women had lower rates of health literacy and were less likely to complete the human papilloma virus (HPV) vaccine regimen compared to non–Hispanic White women (38.6% versus 60.7%, respectively) (Lee, Kwon et al., 2015).

Psychological and Social Factors Affecting Asian American Health

Acculturation

Acculturation is a complex process that unfolds when groups or individuals from different cultures are exposed to each other through continuous or intermittent, firsthand or indirect contact leading to changes in the original culture patterns of one or both cultures (Ferguson, 2013; see Chapter 21).
Acculturation is associated with both costs and benefits to health. For example, acculturated individuals in the U.S. may adopt risky habits such as overeating (leading to obesity), alcohol abuse, or smoking, which can lead to increased morbidity and mortality; benefits include greater exercise and physical activity (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006). Acculturation in the globalized world of today has taken on different and more complex forms than previously, with immigrants retaining in close contact with their culture of origin and continuing to feel its influences (Suchday, 2015). At the same time, physical and mental health are influenced by connections to the host culture as well as the culture of origin (Jang, Park, Chiriboga, & Kim, 2017).

**Discrimination**

Data from multiple studies indicate a link between experience of discrimination and physical and mental health for Asian Americans (Nadimpalli & Hutchinson, 2012; Ong, Cerrada, Lee, & Williams, 2017). Awareness of being discriminated against and internalizing negative stereotypes may lead to health behaviors and interactions with the health care system that fulfill those stereotypical images (George, Duran, & Norris, 2014). For example, Asian men are frequently emasculated in stereotypes, which has been shown to lead to compulsive exercise and increased risk for eating disorders (Kelly, Cotter, Tanofsky-Kraff, & Mazzeo, 2015).

Although Asian Americans may not experience overt racism, micro-aggressions (e.g., “foreigners”) and micro-insults (e.g., “must be good at math and science”) are fairly widespread and have repercussions for health and functioning (Ong et al., 2017), including somatic symptoms and negative affect (Ong, Burrow, Fuller-Rowell, Jr, & Sue, 2013). Physical characteristics such as dark skin and wearing glasses may lead individuals to become the targets of micro-aggressions and have been associated with psychological distress (Lee & Thai, 2015).

Some Asian American subgroups have been referred to as model minorities. The model minority stereotype, albeit positive, also can have a harmful effect on health. Although this term may imply success and a privileged status, the term minority suggests that these individuals are not a part of mainstream American society (Yi, Kwon, Sacks, & Trinh-Shevrin, 2016). The implication of being classified as a minority group, including implications that one is underrepresented in economic and educational spheres and not integrated into society (which are features of minority status) is not appropriate for Asian Americans. The term model minority masks the sociocultural challenges experienced by many Asian Americans, such as inequity and poverty, particularly during the initial years after immigrating to the U.S. Classification of Asian Americans as a model minority assumes self-sufficiency and may preclude many individuals from getting the medical care they need (Ibaraki, Hall, & Sabin, 2014).

Discrimination also may influence participation in health care because of experiences with a lack of culturally competent care and trust in the system (Kim et al., 2014). The challenge of providing culturally competent care for Asian Americans is the difficulty in determining what would be culturally appropriate care for this disparate community. For example, having a bicultural and bilingual physician does not always lead to better care, especially if cultural norms that the bicultural physician follows are not health protective. For example, one study showed that cervical cancer screening occurs at a reduced rate among Vietnamese physicians compared to White physicians (Ho & Dinh, 2011). Many of the Vietnamese physicians in the sample were trained in Vietnam, where preventive care is not emphasized as much as it is emphasized in the US. Another possible explanation is the hesitancy of male Vietnamese physicians to perform gynecological exams, which may make women uncomfortable or violate modesty norms.

Studies examining discrimination and chronic health problems among Asian Americans show that language discrimination, particularly among immigrants who have been in the U.S. for more than...
10 years, has been associated with chronic health conditions that are exacerbated by stress, including essential hypertension, type 2 diabetes, coronary heart disease, asthma, obesity, depression, and anxiety (Yoo, Gee, & Takeuchi, 2009).

**Socioeconomic Disparities**

Despite the economic affluence of Asian Americans, in general, income, education, and status disparities exist and have a significant influence on health and mortality (Hastings et al., 2015). Recent data from the Pew Research Center (Lopez et al., 2017) indicate that the median income of Asian Americans ($73,060) is significantly higher than the US median income ($53,600). Indians ($100,000) have the highest median income followed by Filipinos ($80,000), and Japanese, and Sri Lankans ($74,000 each). However, Bangladeshis ($49,800), Hmong ($48,000), Nepalese ($43,500), and Burmese ($36,000) have a median income below the US median income.

A little known fact is that Asian Americans face high levels of occupational health hazards in the workplace (Leong & Mak, 2014). Some of these include injuries experienced by Chinese restaurant workers (Tsai & Salazar, 2007), neck and back pain among female sewing operators in Los Angeles (Wang, Harrison, Yu, Rempel, & Ritz, 2010), respiratory and skin problems among Vietnamese immigrants employed in nail salons (Roelofs, Azaroff, Holcroft, Nguyen, & Doan, 2008), and physical abuse of women working in massage parlors (Nemoto, Operario, Takenaka, Iwamoto, & Le, 2003).

**Cultural Values**

**Collectivism and Social Cohesion**

Most Asian cultures are collectivist and the United States is a strongly individualist country. The defining features of Asian collectivism are the strong social bonds, cohesion, and importance of family in defining identity and life choices, family loyalty, and sense of duty and responsibility toward family members (Leong et al., 2013; Liu, 2015). Given that a significant proportion of Asian Americans are recent immigrants, health problems must be understood with respect to the collectivist values that they bring with them (Liu, 2015). For example, traditional Chinese culture emphasizes guanxi, where personal connections serve as the basis of instrumental support in personal and business spheres. Renqing, the maintenance of reciprocal relationships, is a moral duty and an obligation (Li et al., 2015).

These values do not always work in the same fashion. Data from the Chinese community indicate that although proximity to family and larger social networks is a source of support and have a beneficial impact on health and reduce stress, large family size and engagement in voluntary organizations also can have the opposite effect and increase stress, as social, emotional, and physical resources are depleted by social and familial obligations (Li et al., 2015). A consequence of the strong pressure within Asian American families not to discuss familial issues or problems outside the home (Meyers, 2006) is that Asian Americans are less likely to ask for social support, or to benefit from support, unless it does not require self-disclosure about stress or emotional reactions to stress (Kim, Sherman, & Taylor, 2008).

**Norms for Emotion Regulation**

Emotional expression is strongly regulated within Asian cultures, and Asian parents reward the suppression of emotion (Morelen & Thomassin, 2013; Soto, Lee, & Roberts, 2016) in an attempt to maintain harmonious social relationships (English & John, 2013). As a result of this cultural norm, situations that require emotional regulation are less physiologically harmful for Asian Americans.
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compared to White Americans (Soto et al., 2016). However, emotion suppression may carry harmful social and emotional consequences of its own. Suppression of emotions may create difficulties in developing and maintaining close interpersonal relationships and less satisfaction with relationships in Asian cultures because of the perceived lack of authenticity between internal experience and external presentation (English & John, 2013). The expression of anger may actually provide an advantage to Asian Americans because it is counter to expectations and therefore it proves to be stronger signal of displeasure (Adam & Shirako, 2013). Asian parents’ socialization of emotion regulation in their children has been associated with emotional mental health symptoms such as anxiety later in life (Morelen & Thomassin, 2013).

Gender Roles

Within the Asian American community, gender roles tend to be traditionally defined. There is sometimes significant pressure on women by family and friends in traditional Asian families to maintain secrecy around health issues such as domestic abuse or behavioral problems such as alcoholism (Meyers, 2006).

Asian American women often prioritize their husbands and children’s health and needs over their own health (Ahmad, Rai, Petrovic, Erickson, & Stewart, 2013; Lm, Park, Lee, & Yun, 2004). Immigration can lead to a change in the traditional balance of power among men and women as they learn the language, find jobs, and acculturate to their adopted land (Meyers, 2006). This may result in increased stress and even potentially physical and emotional abuse within the household (Ahmad et al., 2013). Research on intimate partner violence among various ethnic subgroups including Black African American, Native Americans, Hispanic/Latina, and Asian American women has shown that Asian American women who experienced intimate partner violence were more likely to experience poor physical health, chronic pain such as headaches and backaches, gastrointestinal concerns, burning during urination, increased depression, and suicidal attempts and ideation due to stress and trauma from past abuse compared to women who did not experience intimate partner violence (Stockman, Hayashi, & Campbell, 2015).

Barriers to Optimal Health and Well-Being Among Asian Americans

Barriers are typically grouped as individual or structural (Kim, Keefe, & Linn, 2014).

Access to Care

Access to care, particularly preventive care, is strongly affected by insurance coverage in the United States (Kim et al., 2014). In 2015, Asian Americans’ rate of health insurance coverage was high (92.5%) and comparable to non-Hispanic Whites (93.3%) and Blacks (88.9%) (Barnett & Vornovitsky, 2016). However, insurance coverage within the Asian American community is variable: the percentage of those who had private insurance ranged from 55% for Hmong to 78% for Filipino and for those with public insurance (Medicare and Medicaid), 25% for Filipino to 43% for Hmong. The percentage of those uninsured ranged from 8% for Hmong to 12% for Thai (U.S. Department of Health and Human Services, n.d.).

Immigration status, may serve as a deterrent to obtaining health care, particularly being an undocumented immigrant. Asian Americans who are U.S. citizens are more likely to be insured and to utilize preventive care (Stevens, West-Wright, & Tsai, 2010). The physical health of immigrants who migrate at older ages is worse than the physical health of younger immigrants (Lam, Yip, & Gee, 2012). Immigrants’ social status in their country of origin is usually higher than their status in the U.S., which also may have a significant impact on health (Yeung & Chang, 2002).
Even when insured, many Asian Americans do not have a personal physician (84% of 45 to 64-year-olds; Liu & Sharpe, 2014). A comparative study of three Asian American groups examining the influence of poverty and insurance on whether one had a usual source of care found that both factors predicted whether Chinese immigrants have a usual source of care, whereas poverty predicted usual source of care among Koreans and insurance status among Vietnamese (Lee, Choi, & Jung, 2014).

**Cultural Competence of Health Care Providers**

The cultural competence of the health care provider is an important determinant of the quality and effectiveness of health care, particularly when health care providers are able to build trust with patients and their families (Kim et al., 2014). Intriguingly, cultural competence may overlap with the ethnicity of the physician in determining care; for example, an Asian physician is less likely to encourage cervical screening compared to a White physician (Ho & Dinh, 2011; Ibaraki et al., 2014) perhaps because of the cultural beliefs, as described earlier.

The model minority stereotype frequently leads to an underrepresentation of Asians in research, either because of perceptions that they are a small minority group and not worth studying, or that they are an affluent group and therefore do not experience inequities in health care (Yi et al., 2016). Even when data on Asian Americans are available, they often reflect the aggregation of data from several Asian countries or groups, and may not represent an accurate picture of any specific group (Yi et al., 2016).

Health care providers may not be aware of or sensitive to culturally based syndromes. This was illustrated in depth in the book *The Spirit Catches You and You Fall Down* (Fadiman, 1997), which illustrated the clash of Hmong culture and Western medicine in diagnosing and treating a child with epilepsy. For the Hmong, epilepsy is a spiritual syndrome, not a disease, yet the doctors ignored that and focused only on Western medicine.

**Low Health Literacy**

Health literacy may affect health through language barriers and cultural factors (Lee, Rhee, Kim, & Ahluwalia, 2015). Data comparing non-Hispanic Whites, Latino, Chinese, Koreans, and Vietnamese indicate that health literacy may interact with linguistic proficiency to influence health, so that low health literacy and low English proficiency are highly correlated with poor self-rated health across all subgroups (Sentell & Braun, 2012). In this study, low health literacy and poor English proficiency for the Asian subgroups ranged from 68.3% for Chinese individuals to 35.6% for Koreans, and 29.6% for Vietnamese. In comparison, only 18.8% of Whites showed low health literacy and poor English proficiency.

The relation of linguistic and cultural barriers to poor health outcomes may be a result of multiple challenges in “routine” tasks, including scheduling appointments and communicating with health care providers (Mayeno & Hirota, 1994). Additional challenges posed by language barriers include reading prescription labels and consent forms, and making medical decisions (Kim et al., 2014). Another aspect of health literacy may be lack of information. For example, in one study, only 14.8% of first generation, elderly Korean women had heard of mammography screening (Juon, Kim, Shankar, & Han, 2004).

Cultural values may also complicate the effects of health literacy and language on health status. Immigrants coming to the U.S. have their own health belief systems and these belief systems may not necessarily be consistent with the U.S. system of health care; such inconsistency may make communication with health care providers challenging (Shaw, Huebner, Armin, Orzech, & Vivian, 2009).
In sum, linkages between health literacy and health may occur due to difficulties in interacting with the health care system posed by language or cultural values.

Cultural Orientation

People of Asian origin frequently neglect their health and are less likely to participate in preventive health care such as screening for cervical and breast cancer (Park, Lee, & Yun, 2004), Hepatitis B (associated with liver and lung cancer; Lin, Chang, & So, 2007), and helicobacter pylori (associated with stomach cancer; Horner et al., 2009). Forty percent of sexually active Vietnamese women do not obtain routine Pap smears, in part because of a belief that only married women have Pap smears (Ho & Dinh, 2011). Despite high rates of cancer, Chinese, Vietnamese, and Cambodian women have lower screening rates for breast or cervical cancer compared to national averages (Kim, Chandrasekar, & Lam, 2014). This delay in accessing medical care can have significant consequences. For example, breast cancer mortality rates among Asian Americans compared to other ethnic groups are elevated due to lack of diagnosis until the breast cancer is at a fairly advanced stage (Smigal et al., 2006).

Complementary and Alternative Medicine

An outcome result of cultural orientation is the preference for complementary and alternative medicine (CAM) among Asian Americans (Lai & Chappell, 2007). CAM may be more culturally consonant with beliefs and preferences, and often eliminates language and cultural barriers. Traditionally U.S. health care has traditionally viewed mind and body as distinct entities, although recent trends have been moving toward an integration of mind-body health, combining traditional and complementary and alternative approaches under integrative medicine (Eisenberg, et al., 2016). Asian American culture always has integrated mind-body health, with some subgroups, such as Asian Indians, also integrating spirituality (Suchday, Santoro, Ramanayake, Lewin, & Almeida, 2018).

There is a burgeoning interest within health psychology in the relation of religion and spirituality to health (Koenig, 2015). Asian Americans are highly diverse with respect to religious and spiritual beliefs with 26% unaffiliated, 22% Protestant, 19% Catholic, 14% Buddhist, 10% Hindu, 4% Muslim, and 1% Sikh. Overall, 39% of Asian Americans report that religion is important in their lives, compared to 58% of other Americans (Pew Research Center Report, 2013). Although there is paucity of data on Asian Americans as a group, data on specific subgroups, such as Asian Indians, indicate the significant importance of spirituality and religion in health and coping with health conditions.

Despite the heterogeneity of spiritual and religious affiliation, there is a strong affinity for CAM approaches to health and healing. Some of these approaches integrate traditional systems of mind-body-spirit wellness that are native to Asian cultures such as mediation, yoga, and acupuncture. There has been a dramatic increase in the use of CAM approaches to health and wellness in the U.S. general population, with non-mineral and non-vitamin dietary supplements being the most popular therapy used. The practice of tai chi, qi gong, and yoga also have increased over time, with yoga accounting for 80% of the CAM therapies used in the general US population (Clarke, Black, Stussman, Barnes, & Nahin, 2015).

Use of CAM therapies is extremely widespread among Asian Americans: three-quarters of Asian Americans reported the use of CAM therapies within the past 12 months (Hsiao et al., 2006). Asian Indians reported the lowest use of CAM (67%) and Chinese Americans the highest use (86%). Interestingly, spirituality was the strongest predictor of CAM use among Asian Americans in this study. In another study, 47% of Chinese immigrant cancer patients used some form of CAM (Ferro et al., 2007).
Conclusion

Asian Americans are a highly diverse and fast growing ethnic population in the United States, with many subgroups. Challenges to providing quality health care and maintaining health in this community stem from Asian Americans being perceived as a unified group that is an immigrant, model minority. Other challenges stem from the diversity of origin, cultures, ethnicity, and class that precludes the creation of a unified approach to health among Asian Americans. The increase in chronic diseases such as cancer and heart disease among Asian Americans suggests it is time to design culturally tailored prevention and intervention programs (Trinh-Shevrin, Sacks, Ahn, & Yi, 2017).

References


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