현대사회와 다문화 제15권 3호(229~256) http://dx.doi.org/10.35281/cms.2025.08.15.3.229

Asian/American Identity Centrality and Health among Asian Americans in the United States : The Role of Ethnicity as a Moderator

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Abstract_Identities reveal important information about shared group membership and the various advantages and disadvantages that an identity entails. Health scholarship on Asian Americans in the United States, however, has paid relatively less attention to identity-related mechanisms. In response, I investigated the role of Asian and American identity centrality, respectively, in shaping self-rated health among a sample of Asian Americans in the United States (n=4,249). Importantly, I considered Asian ethnicity as a key moderator in the relationship. Findings revealed that Asian identity centrality is associated with self-rated health differently across Asian ethnic groups whereas American identity centrality is not significantly associated with health. Future studies should continue to advance knowledge on the mechanisms that underlie the importance of each identity, with a comparative perspective that enables identification of more elaborate patterns across population characteristics.

Keywords_Asian American, Health, Identity Centrality, Ethnicity, United States

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1. Introduction

The population of Asian Americans in the United States has increased over time, from approximately 12 million in 2000 to 25 million in 2023 (Pew Research Center 2025). As a result, Asian Americans comprise about 7% of the total U.S. population today. Together with the steady growth of the population, ethnic diversity also characterizes the Asian American population. While six Asian-origin groups (Chinese, Asian Indian, Filipino/a, Vietnamese, Korean, and Japanese) account for a majority of Asian Americans in the United States, about 19% of the population is composed of Asian Americans from about twenty distinct ethnic groups (Pew Research Center 2025). Such diversity indicates that ethnicity is an essential component to consider when examining the Asian American population in the United States.

Health scholarship on Asian Americans, however, has relatively less considered ethnic heterogeneity, oftentimes due to a lack of available data with detailed information on Asian ethnicity. In particular, research on identity centrality and health among Asian Americans has been limited to examinations of the population in the aggregate. Identity centrality refers to perceived importance of a social identity to an individual's self-concept (Ashmore et al. 2004; Stryker and Serpe 1994). It can be a useful measure for gauging group membership or a sense of belonging as it inherently involves relations between the individual, the group that one identifies with, and the larger society. At the same time, subjectivity is an integral component of the measure, allowing room for a variety of experiences and sentiments to intervene in evaluations of a given identity. From the perspective of diverse Asian ethnic groups, it implies that a shared Asian identity, for example, may be weighed differently as a reflection of varying migration histories, experience of prejudice or discrimination, socioeconomic status, and other factors that have shaped the status of an ethnic group. As a result, the importance of an Asian identity may vary across Asian ethnic groups with different mechanisms or reasons underlying the evaluation.

In recognition of such possibility, I consider ethnic diversity in the relationship between identity centrality and health among Asian Americans. Specifically, I utilize data from the 2016 National Asian American Survey (NAAS), which includes a variety of social psychological factors related to social integration of Asian Americans in the United States along with information on Asian ethnicity. I focus on measures of identity centrality among them and ask the following research questions: how is Asian/American identity centrality associated with health among Asian Americans? Is there any ethnic difference in how Asian/American identity centrality relates to health? I examine not only Asian but also American identity centrality to produce a balanced perspective on how racial and national identification, respectively, shapes the health status of the population.

Considering the increasing trend of the Asian American population in the United States along with considerable ethnic heterogeneity, taking a close look at how diverse Asian ethnic groups evaluate their racial and national identities and how such assessments are associated with health will be an important contribution to knowledge on the relationship between social integration and health among the population.

2. Literature Review

1) Conceptualizing Identity Centrality

Identities are socially meaningful categories that are constructed by a society to classify people, further accepted by individuals as integral to their self-concept (Thoits and Virshup 1997). Identities encompass a range of dimensions such as centrality or importance, self-categorization, subjective and objective evaluation, affective commitment, behavioral involvement, and attribution

of values and beliefs (Ashmore et al. 2004; Phinney and Ong 2007). Among them, identity centrality is considered an empirically distinct dimension of social identification, separable from similar concepts such as ingroup affect and ties (Cameron 2004), solidarity and satisfaction (Leach et al. 2008), private regard (e.g., positive/negative feelings toward one's ingroup) and ideology (e.g., normative beliefs and opinions about how one's ingroup should act) (Sellers et al. 1997) (see below for a conceptual model of identity centrality).

Methodologically, identity centrality can be examined via two different ways. The first of them is explicit identity centrality, which is defined as the degree to which an identity is subjectively evaluated by an individual as central (important) or peripheral to one's self-concept (Stryker and Serpe 1994). Scholars have measured explicit identity centrality with items such as "The fact that I am [_] is an important part of how I see myself" (Begeny and Huo 2017), "My ethnicity is of [minor to central] importance for my life" (Noh et al. 1999), and "Being [_] is an important part of how I see myself" (Leach et al. 2008). Implicit centrality or importance is measured through a slightly different approach. It is identified by the readiness of an identity to be invoked within an individual's hierarchically organized self-concept (Ashmore et al. 2004). For instance, it can be measured through the rank of identities that are invoked when an individual meets someone at a party for the first time or introduces oneself in a class (Stryker and Serpe 1994).

As a multitude of social group membership exists, identity centrality can be measured in relation to various social categories. Among them, the current study focuses on racial identity centrality, which can be understood as subjective appraisal of race as an important or central part of the self-concept (Sellers et al. 1998). Scholars have examined its relationship to health and wellbeing, such that a high racial identity centrality buffers against the negative impacts of discrimination (Cobb et al. 2019; Haeny et al. 2023), or that it conversely exacerbates the harmful association between discrimination and health (Perry et al. 2016) and triggers avoidant coping strategies (Szymanski and Lewis 2016).

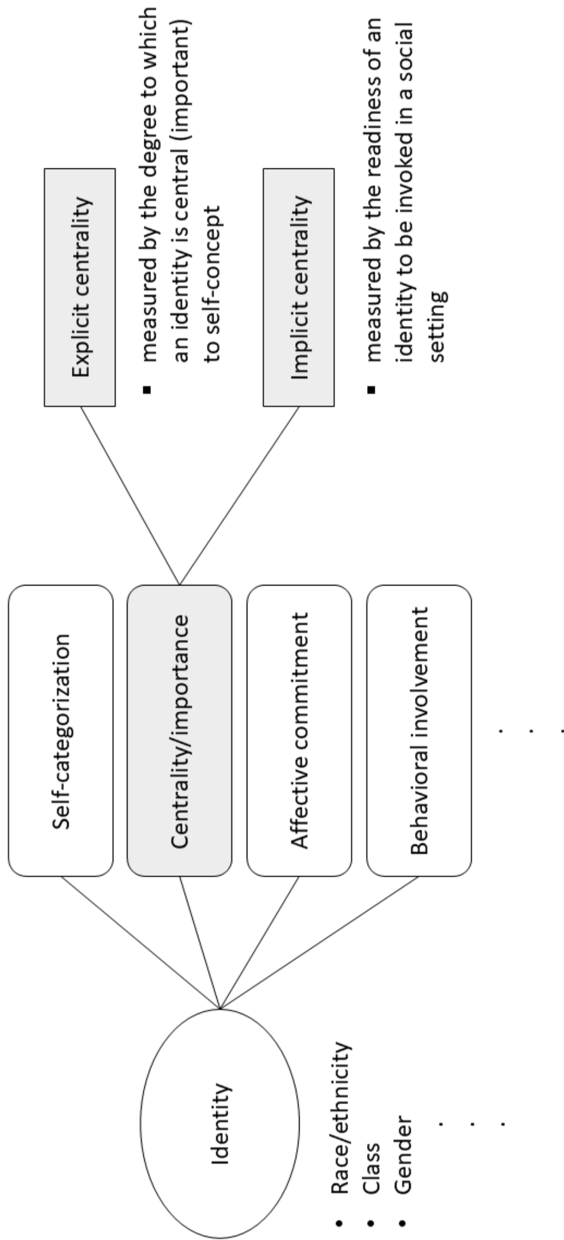

Figure 1. A conceptual model of identity centrality

However, more research is needed that documents any within-group difference in how such associations manifest among a racial group according to detailed population characteristics. As an effort to address such need, the current study focuses on identifying any ethnically distinct pattern in the relationship between racial identity centrality and health among Asian Americans.

2) Identity Centrality and Health among Asian Americans

Few studies on the health of Asian Americans have examined racial identity centrality and report mixed findings. On the one hand, Asian identity centrality has been identified as beneficial to health and wellbeing. For example, utilizing a global measure of Asian identification that not only includes centrality but also affirmation and belonging as well as behavioral commitment, Lee (2003) found that Asian identification directly promotes a variety of health and wellbeing outcomes such as self-esteem, social connectedness, and a sense of community. Asian identity centrality can also function as a health-protective moderator. Brittian et al. (2013) found that among young adult Asian Americans, higher ethnic affirmation is associated with better mental health, but more strongly among those with higher Asian identity centrality. It is important to note that Asian identity centrality can function as a resource to health as such because the perception of shared group membership can promote feelings of connectedness and facilitate exchange of social support (Cruwys et al. 2014; Greenaway et al. 2016). A shared social identity can promote health by providing meaning to life via shared collective values, motivation, and agency, as well as by engendering a sense of belonging and community. It can also encourage exchange of support in diverse forms, including emotional, intellectual, and material. Through such multiple pathways, social identification translates into a useful resource that is beneficial to health.

However, another strand of research on Asian identity centrality documents an opposite pattern. Studies in this strand suggest that Asian identity centrality

can operate as a risk to health. A shared perspective among the studies is that when an identity is central to an individual's sense of self, it enables perception of the world through that identity, creating more opportunities for the individual to perceive discrimination targeted toward one's own group. As increased perceptions of racial/ethnic discrimination can result in a state of hypervigilance (Eccleston and Major 2006) or the need to muster extra strength to deal with it (Brondolo et al. 2009), the suggested route can be detrimental to the health of many Asian Americans. Indeed, Asian identity centrality has been found to be adversely associated with mental health via increased perceptions of racial/ethnic discrimination (Begeny and Huo 2017). In a similar light, the positive relationship between racial discrimination and depression intensified among those with a stronger Asian identity centrality (Noh et al. 1999).

3) Gaps in the Literature

While the relative lack of research on identity centrality and health among Asian Americans is itself an important gap in the literature, the current study aims to fill in two other gaps. First, there has been a lack of attention to American identity centrality despite that it is conceptually distinct from Asian identity centrality as a measurement of the degree to which an individual shares a sense of peoplehood at the national level. Scholars indeed show that racial/ethnic and national identification are distinct concepts deserving an independent examination. For example, Berry and Sam (2016) identify orientation toward others of the same race/ethnicity and orientation toward dominant members of the mainstream society as conceptually and empirically distinct dimensions of psychological acculturation. Kunovich (2009) also differentiates between civic national identity and ethnic identity and finds that commitment to each are dependent on a variety of demographic and socioeconomic characteristics. Likewise, Verkuyten and Martinovic (2012) document national and ethnic identification as empirically distinct concepts. Few studies have examined the health

of Asian Americans from such a perspective and demonstrate that attachment to others of the same race/ethnicity or ethnic cultures and involvement in the mainstream society are differentially associated with health (Bulut and Gayman 2016; Hwang and Ting 2008; Kim and Gorman 2022). As such, a more elaborate examination of the relationship between identity centrality and health that simultaneously considers Asian and American identities is needed.

Moreover, prior research has tended to examine Asian Americans in the aggregate. As a result, relatively little is known about how the perceived importance of Asian and American identity, respectively, varies across different Asian ethnic groups, and even less about its relationship to health. Asian Americans, however, are a heterogeneous population, comprised of over twenty ethnic groups (Pew Research Center 2025) that vary considerably in migration history, socioeconomic status, and language use. Considering such heterogeneity, it is reasonable to expect difference across ethnic groups in how they conceive of their racial and national identities. Casarez et al. (2022), for example, show that the degree to which a racial or national identity is perceived as important varies by ethnicity among Asian Americans and that experience of discrimination differently shapes racial and national identity centrality across Asian ethnic groups. Farrell et al. (2022) similarly demonstrate that differences in racial and national identity centrality before and after the 2016 U.S. presidential election are dependent on ethnicity among Asian Americans. What remains to be further investigated, however, is how such ethnic variation in racial or national identity centrality shapes disparities in health among Asian Americans. In response, the current study takes an ethnically comparative perspective in examinations of how Asian/American identity centrality relates to health among Asian Americans in the United States.

3. Data and Methods

1) Data

I utilize data from the 2016 National Asian American Survey (NAAS), which aimed to collect nationally representative information from Asian Americans in the United States. Data is composed of adults who self-identify as Asian or Asian American and identify any family background from Asian countries, excluding countries from the Middle East (Ramakrishnan et al. 2020). The strengths of the data are that it includes detailed information about respondent's demographic and socioeconomic characteristics including immigrant background, political participation and knowledge, and economic involvement. Most importantly, the dataset includes a range of social psychological measurements relating to identity, intergroup relations, and discrimination. My analytic sample is limited to 4,249 Asian American adults with valid information on self-rated health and ethnicity.

2) Measures

My dependent variable is self-rated health, which is the only available health-related measure included in the survey. Self-rated health has been documented to be a strong predictor of physical and mental health as well as health behaviors (Garbarski 2016; Smith-Johnson 2024; Wuorela et al. 2020). In the original questionnaire, respondents were asked to rate their overall health in the past year on a five-point scale (excellent, very good, good, fair, or poor). I created a dichotomous measure with respondents classified as 1 = poor or fair self-rated health, and 0 = good, very good, or excellent self-rated health. Dichotomizing self-rated health enables a focus on the most disadvantaged health condition with little difference in results from ordered models (Manor et al. 2000) and even greater reliability of the measure (Zajacova and Dowd 2011).

My independent measures of interest are explicit measures of Asian and American identity centrality, respectively, as the survey does not include any measure of implicit identity centrality. In the original questionnaire, respondents were asked, “How important is being Asian to your identity?”, to which they could reply 1 = not at all, 2 = somewhat, 3 = very, and 4 = extremely important. As with Asian identity centrality, respondents were asked about their American identity centrality through the question “How important is being American to your identity?”, to which they could reply with the same response categories.

I consider the role of respondent’s ethnicity as a key moderator. Respondents were asked to report their ethnicity among the following categories: Chinese, Japanese, Korean, Filipino/a, Vietnamese, Cambodian, Hmong, Indian, Pakistani, and Bangladeshi. I adjust for a series of demographic, socioeconomic, and psychosocial characteristics. Demographic characteristics include age (range 18-85, top-coded), gender (1 = female, 0 = male), marital status (1 = married/partnered, 0 = widowed, divorced, separated, or never married), nativity (1 = born in the U.S., 0 = born outside the U.S.), and state of residence. Socioeconomic characteristics include education level (1 = high school or less, 2 = some college, 3 = college or more), employment status (1 = working for wages or self-employed, 0 = unemployed, student, homemaker, retired, or unable to work), and total annual household income in categories (1 = up to $20,000, 2 = $20,000 to $50,000, 3 = $50,000 to $75,000, 4 = $75,000 to $100,000, 5 = $100,000 to $125,000, 6 = $125,000 to $250,000, and 7 = $250,000 and over). To adjust for psychosocial characteristics, I include frequency of religious attendance (1 = more than once a week/once a week, 0 = once or twice a month/a few times a year/seldom/never) as a measure of social support. As a measure of stress, I include a summed score of discrimination across nine dichotomous items (e.g., “You receive poorer service than other people at restaurants or stores”) (range 0-9).

3) Analysis

All analyses were conducted using Stata 17.0. Using logistic regression predicting poor-to-fair self-rated health, I present a series of models beginning with the baseline model that only includes the two independent measures (Asian and American identity centrality) and respondent's ethnicity (Model 1). Sequentially, I add demographic characteristics (Model 2) and further account for socioeconomic characteristics (Model 3). In Model 4, which is the fully adjusted model, I add measures of social support and stress. Then I test for the moderating role of respondent's ethnicity in the relationship between Asian identity centrality and health (Model 5) and American identity centrality and health (Model 6), respectively, adjusting for all other covariates.

All analyses are weighted to represent the Asian American population in the United States, and all missing data were multiply imputed using chained equations in Stata.

4. Results

1) Sample Characteristics

Table 1 presents weighted sample characteristics for Asian American adults by respondent's ethnicity. It shows that the rate of respondents with poor-to-fair self-rated health is highest among Vietnamese Americans (about 31%) and lowest among Asian Indian Americans (about 11%). Among most other Asian ethnic groups, about a quarter report their health to be poor or fair. Average scores of Asian identity centrality are highest among Cambodian (3.14) and Hmong (3.04) Americans, while those for American identity centrality are highest among Hmong (3.26) and Bangladeshi (3.17) Americans. Respondents with South Asian ancestry (Hmong, Asian Indian, Pakistani, and Bangladeshi) tend

to be younger on average compared to their counterparts in other Asian ethnic groups. In terms of nativity, more than half of Japanese Americans (56%) were born in the United States whereas only about 8% are so among Bangladeshi Americans. As for socioeconomic status, a majority of Asian Indian Americans (77%) have at least a college degree while more than half of Cambodian (59%) and Hmong (52%) Americans have a high school or less level of education. Approximately 43% of Cambodian Americans have less than $20,000 annual household income whereas the rate is only about 6% among Asian Indian Americans. As to measures of social support and stress, more than half of Korean (58%) and Filipino/a (55%) Americans attend religious service frequently. In regard to stress, average scores of perceived discrimination are highest among Filipino/a and Bangladeshi Americans.

Table 1. Weighted Sample Characteristics, Asian Americans by Ethnicity

	Chinese	Japanese	Korean	
Poor-to-fair self-rated health, %	26.38	22.88	29.17	
Asian identity centrality, mean (range 1-4)	2.19 (1.02)	2.36 (0.95)	2.54 (0.95)	
American identity centrality, mean (range 1-4)	2.55 (1.02)	2.90 (0.89)	2.50 (0.92)	
Age, mean years (range 18-85+)	58.07 (18.84)	61.00 (18.79)	56.73 (20.16)	
Female, %	53.80	59.38	57.57	
Married/partnered, %	63.11	52.34	60.24	
Born in the U.S., %	20.41	56.15	17.61	
Education level, %				
High school or less	32.06	24.96	25.28	
Some college	13.12	11.50	8.55	
College or more	54.81	63.54	66.17	
Employed, %	56.16	44.39	54.24	
Total household income is less than $20,000, %	33.09	12.05	17.82	
Frequent religious attendance, %	14.76	23.11	58.12	

Discrimination, mean (range 0-9)	1.75 (1.82)	2.01 (1.59)	2.10 (1.61)	
Sample size	457	491	494	
	Filipino/a	Vietnamese	Cambodian	Hmong
Poor-to-fair self-rated health, %	11.93	30.90	29.49	23.90
Asian identity centrality, mean (range 1-4)	2.59 (0.95)	2.47 (0.83)	3.14 (0.94)	3.04 (0.88)
American identity centrality, mean (range 1-4)	2.96 (0.88)	2.92 (0.94)	3.12 (0.96)	3.26 (0.84)
Age, mean years (range 18-85+)	53.10 (20.74)	58.15 (16.53)	58.01 (15.18)	45.43 (16.98)
Female, %	58.52	52.57	56.01	50.16
Married/partnered, %	57.58	61.50	55.96	46.41
Born in the U.S., %	21.01	16.73	25.73	41.26
Education level, %				
High school or less	23.73	47.31	58.61	51.65
Some college	15.28	11.06	14.42	24.71
College or more	60.99	41.63	26.96	23.64
Employed, %	53.43	51.71	51.20	63.43
Total annual household income is less than $20,000, %	13.64	29.78	43.07	23.93
Frequent religious attendance, %	55.03	35.08	17.04	25.24
Discrimination, mean (range 0-9)	2.74 (2.11)	1.94 (1.63)	1.05 (1.68)	2.46 (2.24)
Sample size	479	498	399	346
	Asian Indian	Pakistani	Bangladeshi	
Poor-to-fair self-rated health, %	11.03	15.37	23.99	
Asian identity centrality, mean (range 1-4)	2.09 (0.93)	2.26 (0.95)	2.24 (0.96)	
American identity centrality, mean (range 1-4)	2.96 (0.84)	2.87 (0.95)	3.17 (0.80)	
Age, mean years (range 18-85+)	48.50 (17.43)	46.63 (18.60)	37.38 (16.02)	
Female, %	47.97	47.60	49.35	
Married/partnered, %	65.92	69.86	72.96	
Born in the U.S., %	12.48	15.15	7.52	

Education level, %				
High school or less	16.56	29.92	36.24	
Some college	6.90	8.66	14.10	
College or more	76.55	61.43	49.67	
Employed, %	69.46	57.73	57.47	
Total annual household income is less than $20,000, %	5.78	13.04	24.82	
Frequent religious attendance, %	29.30	49.40	36.95	
Discrimination, mean (range 0-9)	2.57 (1.71)	2.23 (1.94)	2.68 (2.05)	
Sample size	476	307	302	

Note: a) Standard deviations in parentheses. b) Proportions of respondents with total annual household income below $20,000 are shown for comparability purposes of the least advantaged condition.

2) Logistic Regression Models Predicting Poor-to-fair Self-rated Health among Asian Americans

Table 2 presents odds ratios from multivariate logistic regression models predicting poor-to-fair self-rated health among Asian Americans. Across Models 1 (baseline model) through 4 (fully adjusted model), a higher level of Asian identity centrality is associated with reduced odds of poor-to-fair self-rated health ($p<.01$). Conversely, a higher level of American identity centrality is associated with increased odds, though differences are not statistically significant. Filipino/a and Asian Indian Americans consistently have lower odds of poor-to-fair self-rated health than Chinese Americans, while Korean Americans have higher odds than Chinese Americans in the fully adjusted Model 4 (OR=1.58, $p<.05$). Native-born respondents consistently have reduced odds of poor-to-fair self-rated health than foreign-born respondents ($p<.001$). Indicators of socioeconomic status are in expected directions, with more advantaged status associated with reduced odds of poor-to-fair self-rated health. In terms of psychosocial characteristics, respondents who frequently attend religious service have lower odds of poor-to-fair self-rated health (OR=0.67, $p<.01$), and a higher score of

discrimination is associated with increased odds of poor-to-fair self-rated health (OR=1.08, p<.05).

Table 2. Odds Ratios from Logistic Regression Models Predicting Poor-to-fair Self-rated Health among Asian Americans (n=4,249)

	Model 1	Model 2	Model 3
Asian identity centrality	0.87	0.88	0.83**
American identity centrality	0.99	1.05	1.06
Ethnicity (ref: Chinese)			
Japanese	0.84	0.88	1.07
Korean	1.21	1.16	1.34
Filipino/a	0.40***	0.34***	0.41***
Vietnamese	1.31	1.32	1.15
Cambodian	1.31	1.58	1.20
Hmong	0.96	1.64*	1.17
Asian Indian	0.35***	0.40**	0.55*
Pakistani	0.52**	0.61	0.64
Bangladeshi	0.90	1.19	0.98
Age		1.02***	1.01*
Female		0.98	0.89
Born in the U.S.		0.41***	0.44***
Married/partnered		0.65**	0.84
Education level			0.84*
Employed			0.69*
Total annual household income			0.80***
	Model 4	Model 5	Model 6
Asian identity centrality	0.83**	0.95	0.83**
American identity centrality	1.07	1.06	1.10
Ethnicity (ref: Chinese)			
Japanese	1.08	1.35	1.74
Korean	1.58*	2.28	3.05*
Filipino/a	0.45**	0.64	0.51
Vietnamese	1.24	1.71	1.17
Cambodian	1.26	1.38	1.33
Hmong	1.20	0.17*	0.20
Asian Indian	0.56*	1.92	0.32
Pakistani	0.73	1.23	0.73
Bangladeshi	1.04	0.52	2.51

Age	1.01**	1.01*	1.01**
Female	0.92	0.92	0.92
Born in the U.S.	0.43***	0.42***	0.43***
Married/partnered	0.84	0.84	0.84
Education level	0.84*	0.83*	0.85*
Employed	0.68*	0.66*	0.67*
Total annual household income	0.79***	0.79***	0.79***
Frequent religious attendance	0.67**	0.69*	0.66**
Discrimination	1.08*	1.07*	1.08*
Asian identity centrality*Ethnicity			
Japanese		0.91	
Korean		0.85	
Filipino/a		0.86	
Vietnamese		0.86	
Cambodian		0.93	
Hmong		1.85*	
Asian Indian		0.56*	
Pakistani		0.79	
Bangladeshi		1.31	
American identity centrality*Ethnicity			
Japanese			0.83
Korean			0.77
Filipino/a			0.96
Vietnamese			1.02
Cambodian			0.98
Hmong			1.75
Asian Indian			1.20
Pakistani			1.00
Bangladeshi			0.75

Note: a) Models 2-6 adjust for respondent's state of residence. b) *p<.05 **p<.01 ***p<.001

In Models 5 and 6, I test whether respondent's ethnicity moderates the relationship between self-rated health and Asian and American identity centrality, respectively. I find that ethnicity is a statistically significant moderator only in the relationship between Asian identity centrality and self-rated health. For ease of interpretation, I graph the relationship using predicted probabilities in Figures 2 to 5. Results for all ten Asian ethnic groups are shown in Figures 2 and

3, with five ethnic groups presented in each figure to enhance visibility of the patterns. Looking across groups in Figure 2, I find that Asian identity centrality is modestly associated with the likelihood of poor-to-fair self-rated health, with mostly a negative association. Stronger relationships are identified in Figure 3, with both positive and negative associations. However, only results for Hmong and Asian Indian Americans revealed statistically significant difference across

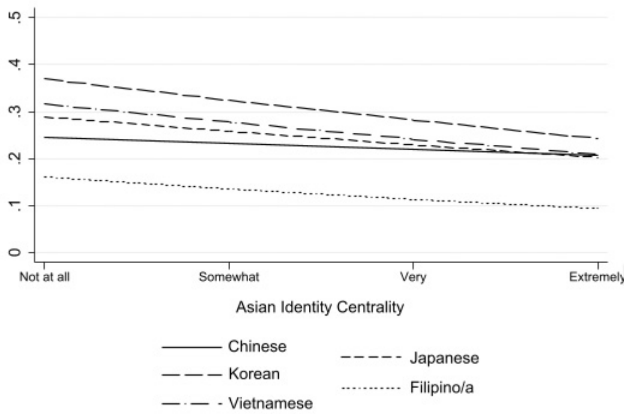

Figure 2. Adjusted Predicted Probabilities of Poor-to-fair Self-rated Health among Asian Americans

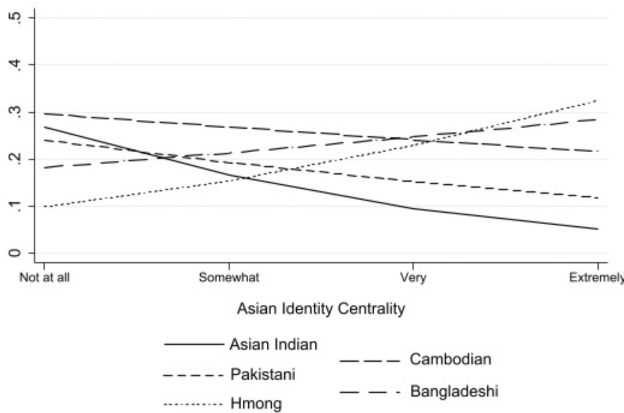

Figure 3. Adjusted Predicted Probabilities of Poor-to-fair Self-rated Health among Asian Americans

levels of Asian identity centrality, which I graph separately in Figures 4 and 5.

Figure 4 shows that among Hmong Americans, the likelihood of poor-to-fair self-rated health increases with stronger Asian identity centrality. Consequently, the likelihood of poor-to-fair self-rated health at the highest level of Asian identity centrality is significantly (p<.05) greater than the likelihood at the lowest level of Asian identity centrality. Such pattern indicates that Hmong Americans who perceive their Asian identity to be extremely important have a significantly higher likelihood of poor health status compared to those who perceive their Asian identity to be not at all important.

In Figure 5 that shows results for Asian Indian Americans, I find an opposite pattern. Among Asian Indian Americans, the likelihood of poor-to-fair self-rated health is highest at the lowest level of Asian identity centrality and decreases with greater Asian identity centrality. As a result, there exists a statistically significant (p<.05) difference between Asian Indian Americans who perceive their Asian identity to be not at all important and those who perceive

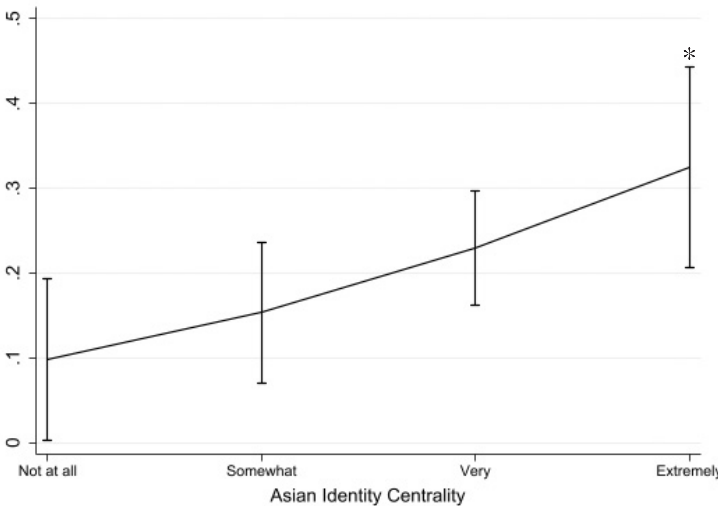

Figure 4. Adjusted Predicted Probabilities of Poor-to-fair Self-rated Health among Hmong Americans

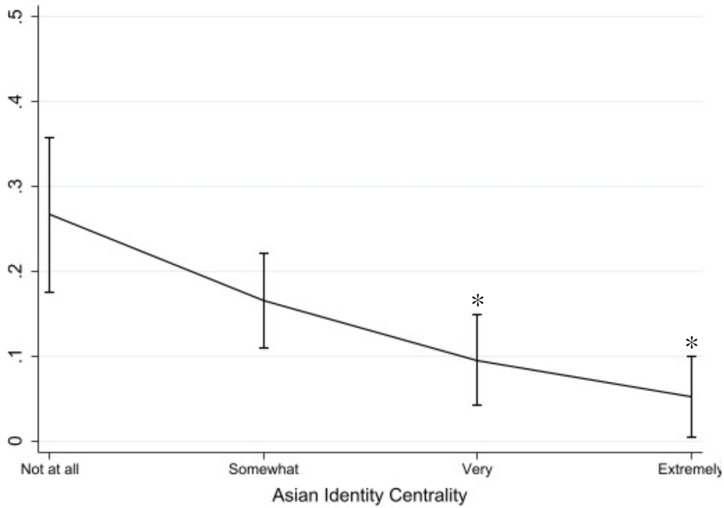

Figure 5. Adjusted Predicted Probabilities of Poor-to-fair Self-rated Health among Asian Indian Americans

their Asian identity to be very or extremely important (Asian Indian Americans with extreme Asian identity centrality also exhibited a significantly lower likelihood of poor-to-fair self-rated health than those who rated it as only somewhat important). Such findings imply that Asian Indian Americans who place great importance on their Asian identity tend to be significantly healthier than their counterparts who place relatively less importance on their Asian identity.

5. Conclusion

Identities are socially meaningful categories that reveal important information about an individual's self-concept. In particular, identity centrality can function as a useful barometer of shared group membership and the various advantages and disadvantages that it entails. Few studies on the health of Asian

Americans, however, have investigated the role of identity centrality as a potential risk factor or a beneficial resource among the population. While existing work demonstrates that Asian identity centrality can operate both as a risk and a resource, little is known about whether such relationships manifest similarly or differently across Asian ethnic groups. Moreover, studies have largely focused on examining Asian racial identity, and little work exists that simultaneously considers national identity as an American. In recognition of such gaps in prior research, I examined the relationship between identity centrality (both Asian and American) and health among Asian Americans, with a focus on ethnic diversity. Findings showed that the relationship between identity centrality and health is indeed dependent on ethnicity, with statistically significant difference identified among Hmong and Asian Indian Americans.

Among Hmong Americans, those who evaluated their Asian identity as extremely important reported a significantly higher likelihood of poor-to-fair self-rated health than those who regarded their Asian identity as not at all important. In fact, while Hmong Americans who rated their Asian identity as not at all important had the lowest likelihood of poor-to-fair self-rated health among all Asian ethnic groups, Hmong Americans who evaluated their Asian identity as extremely important had the highest likelihood of poor-to-fair self-rated health among all Asian ethnic groups. Descriptive results (not shown) suggested that Hmong Americans with the highest and lowest levels of Asian identity centrality may be integrated into mainstream U.S. society to varying degrees. For instance, about 46% of Hmong American respondents who rated their Asian identity as not at all important had at least a bachelor's degree whereas only about a quarter among Hmong American respondents who rated their Asian identity as extremely important had so. The former group also reported more frequent daily contact with White Americans (about 64% reported that they have a lot of contact with White Americans) than the latter group (about 33% reported to have a lot of contact with White Americans). Such a contrast signals that an Asian racial identity may carry less weight for Hmong Americans who

are more structurally and socially assimilated into mainstream U.S. society. It is possible that these Hmong Americans are navigating a more privileged social context in which their status as a racial minority is less a prime determinant of their lives, including health and wellbeing. Conversely, Hmong Americans who regard their Asian identity as extremely important may be less assimilated into the mainstream social structure of U.S. society and perceive their racial identity as a significant barrier. Many Hmong Americans indeed suffer from poverty (Xiong 2013), acculturative stress (Yang 2003), and trauma associated with forced migration to the United States (Vang and Flores 1999). Furthermore, unlike other Asian ethnic groups, Hmong Americans lack a vibrant and visible ethnic community as well as an ethnic economy with an entrepreneurial or professional base (Xiong 2013) that can buffer against such stressors. In this light, extreme importance placed on Asian identity among Hmong Americans in the sample may be a reflection of the various obstacles to social and economic integration that not only render their racial identity salient but also are detrimental to health.

Among Asian Indian Americans, Asian identity centrality was negatively associated with the likelihood of poor-to-fair self-rated health. As a result, Asian Indian Americans who evaluated their Asian identity as extremely important had the lowest likelihood of poor-to-fair self-rated health among all Asian ethnic groups. Compared to Hmong American respondents, however, there was relatively little difference in descriptive characteristics among Asian Indian Americans by levels of Asian identity centrality. It is possible that other unobserved contexts underlie the role of Asian identity centrality as a resource to health among the population. For example, high Asian identity centrality may encompass a sense of pride in or positive sentiment toward an Asian identity. This may be especially so considering the marked socioeconomic profile of Asian Indian Americans in the United States. Asian Indians are one of the most socioeconomically advantaged Asian ethnic groups in the United States, with about 77% having at least a bachelor's degree level of education (compared

to 56% on average among Asian Americans) and median annual household income of $151,200 that is considerably higher than an average household income of $105,600 among Asian Americans in general (Pew Research Center 2025). It is possible that such remarkable integration into the social and economic structure of mainstream U.S. society contributed to an affirmation of the Asian racial identity among Asian Indian Americans. Indeed, scholars find that Asian Indian American children tend to grow up in families and ethnic networks with a strong motivation for upward social mobility (Inman et al. 2007; Iwamoto et al. 2013; Tummala-Narra et al. 2024) and that such ethnic socialization and ethnic group membership are associated with a strong sense of pride as an Asian Indian (Daga and Raval 2018). Future research is needed that examines the relationship between Asian identity centrality and other dimensions of identity such as public and private regard and affective or behavioral commitment (Ashmore et al. 2004) in order to more accurately identify the mechanism shaping the association between Asian identity centrality and self-rated health shown among the current sample of Asian Indian Americans.

The lack of significant difference for American identity centrality indicates that racial identity may override national identity as a key determinant of health and wellbeing among Asian Americans. It is possible that Asian Americans perceive themselves primarily through the lens of racial systems in the United States, where social goods and nonmaterial resources such as prestige, power, and freedom are distributed differentially across racial categories (Phelan and Link 2015). Despite the primacy of race as such, more work is needed that investigates the role of both racial and national identification in shaping the health of racial/ethnic minority groups and further identifies any detailed within-group disparities. With the aim of filling in such gaps in existing literature, the current study examined how the perceived importance of Asian and American identity, respectively, is associated with health across Asian ethnic groups. As the results revealed, the relationship between Asian identity centrality and self-rated health was specific to Asian ethnicity, suggesting that a shared

racial identity may encompass different social meaning between ethnic groups or even within an ethnic group under discrete contexts. Future studies, particularly with larger and more recent data, should continue to advance knowledge on the various social contexts that underlie the importance of racial or national identity, with a comparative perspective that facilitates identification of difference across population characteristics.

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2025.07.16 접수, 2025.07.24 심사, 2025.08.20 게재확정

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아시아계 미국인의 인종적·국민적 정체성 중심성과 건강 간의 관계: 민족성의 조절효과를 중심으로

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요약_사회적 정체성은 집단에의 소속 및 그에 따른 각종 이익 및 불이익에 관한 중요한 정보를 제공한다. 그런데 아시아계 미국인의 건강에 관한 연구들은 정체성과 관련된 기제들에 대하여 충분한 관심을 기울이지 못하였다. 이러한 기존 연구를 보충하기 위해, 저자는 정체성의 중심성(identity centrality)이라는 개념을 활용하여 사회적 정체성에 대한 개인의 지각된 중요도를 측정하고, 그것이 아시아계 미국인의 건강과 갖는 연관성을 분석하였다. 구체적으로, 저자는 4,249명의 아시아계 미국인 표본을 대상으로 아시아인으로서 그리고 미국인으로서의 정체성 중심성이 각각 주관적 건강상태와 갖는 관계를 분석하였다. 특별히 그 과정에서 민족성의 조절효과에 주목하였다. 분석 결과, 아시아인으로서의 정체성 중심성이 주관적 건상상태와 유의미하게 연관되어 있음이 발견되었는데, 민족성에 따라 그 관계의 방향과 강도가 다르게 나타났다. 반면에 미국인으로서의 정체성 중심성은 건강과 유의미한 관계를 갖지 않는 것으로 드러났다. 향후 각 정체성의 중요도에 영향을 미치는 기제들에 관한 연구를 강조하는바, 특히 비교적 관점에서 인구학적 특성들에 따른 정교한 차이에 대한 관심이 요구된다.

주요어_아시아계 미국인, 건강, 정체성 중심성, 민족성, 미합중국

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