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COVID-19 Racial Discrimination and Mental Health of Korean Americans: Role of Ethnic Identity and Coping Strategy

Seungbin Oh[1], Stacey Diane Arañez Litam[2], and Catherine Y. Chang[3]

[1] Department of Psychiatric and Graduate Medicine Science, Boston University

[2] Department of Counseling, Educational Leadership, and Adult Learning, Cleveland State University

[3] Department of Counseling and Psychological Services, College of Education and Human Development, Georgia State University

The onset of COVID-19 has resulted in higher rates of racial discrimination toward Asian American and Pacific Islanders, including Korean Americans. This study used moderated mediation analyses to examine the relationship between COVID-19-related racial discrimination and anxiety, depression, and life satisfaction among Korean Americans (KA; $N = 270$) and explored the buffering effect of ethnic identity and coping strategies. Experiences of pandemic-related racial discrimination were linked to the severity of anxiety and depression levels among KA, which resulted in lower levels of life satisfaction. Coping strategies moderated the link between depression and life satisfaction but not between anxiety and life satisfaction. Ethnic identity exacerbated the relationship between racial discrimination and levels of anxiety and depression. The significance of these findings highlights the important role of coping strategy and ethnic identity in mental health among KA during the pandemic. Based on these findings, implications for professional counselors are outlined.

Keywords: COVID-19, Korean Americans, mental health, ethnic identity, coping strategies

The Asian American and Pacific Islander (AAPI) population includes over 40 distinct subgroups, and although commonalities may exist across AAPI subpopulations, each group embodies distinct heterogeneity across culture, language, religion, and immigration history (Chang & O'Hara, 2013; Litam, 2020). It is important to understand and acknowledge the diversity within AAPI populations while simultaneously appreciating the cultural commonalities that may exist among distinct AAPI subgroups. The extant body of research has identified core values that are often shared across AAPI cultures. These core shared values include filial piety (respecting one's parents), a collectivistic orientation (emphasis on interdependence), achievement-oriented mentalities, hierarchical relationships, and emotional restraint (Chang & O'Hara, 2013). The extent to which AAPIs adhere to these cultural core values is influenced by various factors including ethnic identity (Chang & O'Hara, 2013). The ways in which cultural values impact the mental health and well-being of AAPI ethnic subgroups must be taken into consideration when conducting research with any ethnic minority groups (O'Hara et al., 2021).

The call for more ethnicity-specific research has been established (Choi et al., 2017; O'Hara et al., 2021; Oh & Litam, 2022). Specifically, a dearth of studies exists that examine the within-group variability of racial/ethnic groups (Yoon et al., 2008). Within AAPI populations, the Korean American (KA) subgroup is one of the fastest growing ethnic groups in the United States and has steadily increased by 39% between 2000 and 2010 (Hoeffel et al., 2012). Currently, over 1.9 million individuals of Korean descent reside in the United States (Pew Research Center, 2021). Although most Koreans who reside in America are U.S. citizens, half are foreign-born (50%; Pew Research Center, 2021). Despite the growing number of KA in the U.S., little empirical research exists about their mental health and life satisfaction in the face of adverse events.

Experiences of racial discrimination are not new for AAPIs who live in the U.S. However, the AAPI community has experienced higher rates of racial discrimination and hate crimes since the outbreak of COVID-19. According to Stop AAPI Hate, a total of 10,905 hate incidents against AAPI individuals were reported between March 2020 and December 2021 (Yellow Horse et al., 2022). According to the Center for the Study of Hate and Extremism (2020), rates of anti-Asian hate crimes increased by almost 150% across U.S.'s largest cities in 2020. Approximately 40% of AAPI adults have encountered various forms of racial discrimination since the COVID-19 outbreak, including verbal harassment, physical violence, and workplace discrimination (Congressional Asian American Pacific American Caucus, 2020; Jeung & Nham, 2020). Across AAPI ethnic subgroups, Korean American respondents were the second highest subgroup to report instances of hate crimes and encompassed 15.7% of reports (Jeung & Nham, 2020). False narratives that scapegoat AAPI's as responsible for the COVID-19 outbreak have fueled this increase in racial discrimination and perpetuate the belief that AAPIs are the perpetual foreigners (Li & Nicholson, 2021). This increase in racial discrimination will have long-lasting effects on the mental health of AAPI.

Experiences of COVID-19-related racial discrimination have been associated with greater rates of depression and anxiety and lower levels of life satisfaction among diverse AAPI ethnic subgroups, including Chinese and Chinese Americans (Litam & Oh, 2020), Filipino Americans (Litam & Oh, 2022), and international Asians residing in the U.S. (Litam et al., 2021). Despite the

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Seungbin Oh https://orcid.org/0000-0003-4350-229X

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Correspondence concerning this article should be addressed to Seungbin Oh, Department of Psychiatric and Graduate Medicine Science, Boston University, 72 East Concord Street, Boston, MA 02118, United States. Email: ohsb@bu.edu

detrimental effect of COVID-19-related racism, some researchers have reported that higher levels of ethnic identity can buffer the impact of COVID-19 racial discrimination on life satisfaction for Chinese Americans (Litam & Oh, 2021) and that greater use of coping strategies reduced the mediated effects of racial discrimination via depression on life satisfaction for Filipino Americans (Litam & Oh, 2022). Despite the growing body of research on pandemic-related discrimination on the mental health and life satisfaction of AAPI ethnic subgroups, no empirical studies have been conducted to understand the impact of COVID-19-related racial discrimination on the mental health of Korean Americans (KA). Given their unique history of U.S. immigration and cultural values that may be distinct from other AAPI subgroups (Kim, 2013; Yeh & Inose, 2002), KA may have different ways of experiencing and responding to COVID-19-related racial discrimination. Taken altogether, this study was designed to address the research gap by examining the path in which COVID-19-related racial discrimination impacts life satisfaction among KA via depression and anxiety and explores the moderating roles of coping and ethnic identity in the path.

Effects of Racial Discrimination and Mental Health

Racial discrimination refers to the unfair treatment of individuals based on race or ethnicity (Carter et al., 2019) and has demonstrated adverse effects on the mental health, coping, and overall well-being of AAPI individuals (Lee & Ahn, 2011). Racial discrimination can include covert acts (e.g., physical attacks, verbal harassment) as well as more subtle types of discrimination (e.g., being treated with disrespect, institutional racism; Gee et al., 2009). Though within-group variability exists, experiences of discrimination among AAPI subgroups were related to higher levels of depressive symptoms (Lee & Ahn, 2011; Litam & Oh, 2020, 2022; Mossakowski, 2003; Nadimpalli et al., 2016), higher levels of anxiety and psychological distress (Hwang & Goto, 2008; Nadimpalli et al., 2016), increased substance use (Le & Iwamoto, 2019), and lower levels of life satisfaction (Tummala-Narra et al., 2018). The buffering effect of ethnic identity and coping strategies on the relationship between discrimination and the mental health of Asian Americans has been mixed (see Choi et al., 2017; Lee, 2005; Lee et al., 2015; Litam & Oh, 2020) and requires further investigation.

Ethnic Identity and Coping Strategies

Ethnic identity refers to the extent to which individuals perceive themselves to be associated with a community consisting of people who share common cultural traditions, values, and descendants (Phinney, 1990). Across various dimensions of ethnic identity (e.g., centrality, affirmation; Rivas-Drake et al., 2008), the dimensions of identity exploration and commitment (Phinney, 1992) have primarily been examined. Phinney (1992) contended that ethnic identity develops over time through the processes of identity exploration and commitment and that these dimensions are distinct and yet interrelated. Identity exploration is the degree to which one examines values, meanings, and experiences about their ethnicity, whereas identity commitment refers to the extent to which one identify a membership of their ethnic group as a component of self-perception (Phinney & Ong, 2007). Studies that examined whether ethnic identity moderates the relationship between discrimination and well-being among AAPIs have yielded mixed results. Whereas some studies identified ethnic identity as a protective factor between racial discrimination and depression and anxiety (Choi et al., 2017; Litam & Oh, 2021; Mossakowski, 2003; Oh & Litam, 2022; Yoo & Lee, 2008), others have reported ethnic identity exacerbated the relationship between racial discrimination and life satisfaction (Lee et al., 2004), mental health (Yoo & Lee, 2008), depression (Noh et al., 1999), adjustment, and substance use (Lee, 2005; Lee et al., 2015). Yip et al. (2008) posited that ethnic identity exacerbated the relationship between discrimination and psychological distress for Asian Americans in their 30s and those over 51 but was a protective factor for those in their 40s. To our best knowledge, no studies have investigated the possible protective role of the identity exploration and commitment dimensions of ethnic identity among KA. Given this paucity of research, it is warranted to further explore these dimensions of ethnic identity in the path between racial discrimination and mental health distress among KA.

Ethnic identity and other cultural factors may influence how Asian Americans cope with experiences of racial discrimination (Litam, 2020; Litam & Oh, 2021, 2022; Oh & Litam, 2022; Tweed & Conway, 2006). Coping strategies are behavioral and cognitive tactics that individuals utilize to deal with crises and stressful situations. Coping strategies are broadly categorized as engagement and disengagement coping responses (Tobin et al., 1989). Whereas engagement coping involves active responses that seek to alleviate stressors through direct problem-solving or help-seeking behaviors (social support), disengagement coping involves passive strategies that seek to adjust one's emotions and behaviors to avoid stressors (e.g., social withdrawal; Tobin et al., 1989).

Although research has identified how coping responses are an important psychological and sociocultural resource that mitigates the negative impact of stressors (Hobfoll, 2001), the buffering effect of coping strategies becomes more complicated and nuanced by cultural influences (Tweed & Conway, 2006). For example, one's cultural attitudes and beliefs can influence their preferred styles of coping because culture impacts how individuals respond across social contexts and relationships (Tweed & Conway, 2006). For example, Asian Americans who strongly adhere to their ethnic identity and value collectivistic orientations are more likely to prefer disengagement coping strategies (e.g., social withdrawal and problem avoidance; Chang, 2001; Lei & Pellitteri, 2017) that align with cultural values prioritizing social harmony and avoiding conflict (Litam & Oh, 2021; Tweed & Conway, 2006).

Empirical studies that examined the role of coping in the path between racial discrimination and mental health among AAPIs have posited that disengagement coping strategies may be a culturally embedded coping response. Disengagement coping responses were associated with higher levels of life satisfaction via increased self-compassion among Filipino college students (Centeno & Fernandez, 2020). Similarly, both engagement and disengagement coping responses significantly mitigated the impact of COVID-19-related racial discrimination on anxiety and depression among Filipino Americans (Litam & Oh, 2022). Furthermore, disengagement coping strategies significantly moderated the relationship between COVID-19-related racial discrimination and stress-related growth among international AAPIs (Oh et al., 2022), whereas engagement coping responses significantly worsened the mental health outcomes for Asian Americans following racial discrimination (Yoo & Lee, 2005). To date, however, no studies exist that examine the relationship between engagement and disengagement coping responses in the link

between COVID-19-related racial discrimination and mental health outcomes among KA.

The Present Study

This study addresses research gaps by examining the associations of COVID-19-related racial discrimination on anxiety, depression, and life satisfaction among KA. Additionally, this study explores how ethnic identity and coping strategies among KA may impact these relationships. Based on the literature, the following hypotheses were developed:

Hypothesis 1: The relationship between COVID-19-related racial discrimination and life satisfaction will be mediated by anxiety and depression, after controlling for gender. Greater experience of racial discrimination will be associated with higher levels of anxiety and depression, which in turn will lead to lower levels of life satisfaction among KA.

Hypothesis 2: Ethnic identity (i.e., overall ethnic identity and each dimension of ethnic identity) will moderate the relationship between COVID-19-related racial discrimination and anxiety and the relationship between COVID-19-related racial discrimination and depression among KA, after controlling for gender. Given the mixed results of previous research on the moderating role of ethnic identity, a specific moderation hypothesis was not made.

Hypothesis 3: Coping strategy (i.e., overall coping and each dimension of coping) will moderate the path between anxiety and life satisfaction as well as depression and life satisfaction, after controlling for gender among KA. Based on the existing literature, the relationship between anxiety, depression, and life satisfaction will be weaker for KA who report greater overall coping strategies, or who employ a greater use of disengagement coping strategies.

Method

Participants

Institutional review board (IRB) approval was obtained prior to data collection. Prospective participants were recruited through electronic flyers via emails to KA community organization leaders (n = 72) and through Amazon MTurk (n = 284). Inclusionary criteria required participants to identify as KA and have experienced or witnessed racial discrimination following the COVID-19 pandemic. Although a total of 356 KA completed the survey, 52 participants were excluded from data analysis due to incorrect responses on two screening items. In addition, 30 cases completed less than 50% of the survey items and were removed. An additional two cases answered all items with an identifiable pattern of response (e.g., selected "strongly agree" for all response items) and were removed. Last, two multivariate extreme cases were identified and excluded (i.e., Mahalanobis distance value > 31.264 at α = .001), resulting in a final sample of 270 KA participants (75.8% useable response rate). The final sample of 270 participants exceeded the sufficient sample size for path analysis (N > 134; O'Rourke & Hatcher, 2013) at α = .01 to identify medium effect size. Participants recruited from the MTurk received $0.50 as a monetary compensation for their completion of the survey.

The age participants ranged from 18 to 69 years old (M = 34.25, SD = 9.77). Most participants identified as male (58.1%; n = 157) followed by female (41.9%; n = 113). A total of 149 (55.2%) participants reported experiencing COVID-19-related racial discrimination at least once, 65 (24.1%) of participants reported experiencing pandemic-related discrimination twice, and 10 (3.7%) participants reported experiencing COVID-19-related racial discrimination more than twice. In addition, 50.4% of participants reported witnessing pandemic-related racial discrimination at least once (n = 136), 29.6% (n = 80) reported witnessing discrimination twice, and 15.2% (n = 41) reported witnessing COVID-19-related racial discrimination more than twice. In terms of educational background, most participants reported having a bachelor's (n = 121, 44.8%) or master's (n = 100, 37%) degree, followed by an associate degree (n = 14, 5.2%), doctorate degrees (n = 12, 4.4%), professional degrees (n = 11, 4.1%), some college credits (n = 8, 3%), and high school or no diploma (n = 4, 1.5%).

Measures

Beck Anxiety Inventory

The Beck Anxiety Inventory (BAI; Beck et al., 1988) is a 21-item scale that measures the severity of anxiety symptoms. Respondents rate each item on a 4-point Likert-type scale, ranging from 0 (*not at all*) to 3 (*severely—it bothered me a lot*), with higher scores representing greater anxiety symptom severity. The internal reliability was α = .92 for the BAI total scale, with test–retest reliability of α = .75 over a week (Beck et al., 1988). Convergent validity for the BAI score was established through moderate association with other anxiety and depression scales (rs = .51 and .25; Beck et al., 1988). In the present study, the reliability for the BAI score was α = .97.

Coping Strategies Inventory–Short Form

The Coping Strategy Inventory–Short Form (CSI-SF; Addison et al., 2007) is a 15-item scale that measures types of coping strategies. The CSI-SF has two dimensions of coping strategies (disengagement and engagement) that are further split into four subdimensions: problem-focused engagement, problem-focused disengagement, emotion-focused engagement, and emotion-focused disengagement (Addison et al., 2007). Respondents rate each item on a 5-point Likert-type scale, ranging from 1 (*never*) to 5 (*almost always*). The internal reliability ranged from α = .58 to α = .72 for scores across each of the four subscales (Addison et al., 2007). The total scale and four subscales were utilized in this study, producing an internal reliability of α = .88 for the total score, with subscale scores ranging from α = .71 to α = .78.

Center for Epidemiologic Studies Depression Scale–Revised

The Center for Epidemiologic Studies Depression Scale–Revised (CESD-R; Van Dam & Earleywine, 2011) is a 20-item, self-report instrument that measures depressive symptoms. The CESD-R is designed to assess two features of depression: functional impairment and negative mood. Respondents rate each item on a 5-point Likert-type scale ranging from 1 (*not at all or less than one day*) to 5 (*nearly every day for 2 weeks*), with higher scores indicating more

severe depressive symptoms. The internal reliability for the CESD-R total score was α = .92 (Van Dam & Earleywine, 2011). In the present study, the total scale of CESD-R was utilized, producing an internal consistency of α = .97.

Everyday Discrimination Scale

The Everyday Discrimination Scale (EDS; Williams et al., 2008) is a unidimensional, nine-item scale that measures one's daily experience of discrimination. For this study, a specific prompt was added (i.e., "Many Asian Americans and Pacific Islanders have experienced increased rates of discrimination since the COVID-19 outbreak. How often have you personally experienced the following COVID-19 related forms of racial discrimination?") before each item to assess participants' experience of racial discrimination in the context of the COVID-19 pandemic. Each item is rated on a 5-point Likert-type scale, ranging from 1 = *never* (0%) to 5 = *always* (100%), with higher scores indicating greater experiences of COVID-19-related racial discrimination. The internal reliability was α = .97 for scores on the EDS total scale (Litam & Oh, 2020). In the present study, reliability for the EDS total score was also found to be α = .97.

Multigroup Ethnic Identity Measure–Revised

The Multigroup Ethnic Identity Measure–Revised (MEIM-R; Brown et al., 2013) is a six-item scale that was revised from the original MEIM scale (Phinney, 1992). The MEIM-R assesses two dimensions of ethnic identity: identity exploration and commitment. Respondents rate each item on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores indicating a stronger sense of ethnic identity. An example item is "*I have a clear sense of my ethnic background and what it means for me*." The internal reliability was α = .88 for the total score as well as α = .82 and .90 for scores of the exploration and commitment subscales, respectively (Brown et al., 2013). In the present study, internal reliability was α = .64 for the MEIM-R total score and α = .65 and .57 for the identity exploration and commitment subscales.

Satisfaction With Life Scale

The Satisfaction with Life Scale (SWLS; Diener et al., 1985) is a five-item scale that measures life satisfaction. Respondents rate five items on a 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores representing greater life satisfaction. An example item is, "*In most ways my life is close to ideal*." The internal reliability was .87 for the SWLS total score, with test–retest reliability of .82 (Diener et al., 1985). In the present study, the internal reliability was .84 for the SWLS score.

Demographic Questionnaire

The demographic questionnaire included participants' gender, age, and level of education as well as one question that asked whether participants directly experienced, indirectly witnessed, or both experienced and witnessed COVID-19-related racial discrimination.

Data Diagnostics

Data were examined for missing values, which may cause inflated results (Tabachnick & Fidell, 2019). Approximately 98% of participants did not have missing values in any items, and no items included 2% or more of missingness. Further investigation of the pattern of missing data indicated no-identifiable pattern of missingness from a matrix of the estimated mean, supporting the randomness of the missing values in data, missing at random (MAR). Given the randomness and the small proportion of missingness in data, we proceeded with imputing missing values via multiple imputation (MI), a data imputation method to deal with missing data without causing inflated results (Osborne, 2013).

Next, data were tested for assumptions of normality, linearity, homoscedasticity, and multicollinearity. The acceptable range of absolute skewness (range = −1. 12–1.36) and kurtosis (range = −1.90–1.73) values was found for all items (Garson, 2012). A visual investigation of the *p*-plot suggested a moderated skewedness of the data, which were further supported by the significant result of a Shapiro–Wilk test ($p < .001$) for each item. Collectively, the data were not normally distributed at the univariate level, which also suggested nonmultivariate normality. However, a linear regression analysis (e.g., path analysis) is robust to nonnormality of data, especially the moderated violation of normality that generates insignificant results with any estimation methods of linear regression analysis (Hayes, 2018). Linearity of the data was supported by the observed residuals reasonably lying in a linear line. The assumption of homoscedasticity was also met as the residuals were centered around the zero point. The absence of multicollinearity in data was satisfied, as evidenced by all values of variance inflation factor (VIF) being less than 10 and all tolerance values being greater than .1 (Tabachnick & Fidell, 2019). Therefore, despite the moderated nonnormality, data in the present study were deemed appropriate for path analysis (Tabachnick & Fidell, 2019).

Analytic Strategy

To examine multiple mediation (Hypothesis 1) and moderated mediation models (Hypotheses 2 and 3), Hayes' (2018) PROCESS macro (Models 4 and 21, respectively) was conducted. Specifically, 10,000 bootstrapping resampling method was utilized to generate 95% confidence intervals (CIs) for the indirect and moderate effects. The indirect and moderate effects were significant if the CIs excluded zero (Hayes, 2018). To better understand the moderate effect in each path, the recommendations by Preacher et al. (2007) were used for examining moderation of three conditional indirect effects. To that end, we used three conditional values of moderators (Hayes, 2018; Preacher et al., 2007), including low value of the moderator (the mean of the moderator − 1 *SD*), the mean of moderator, and high value of the moderator (the mean of the moderator + 1 *SD*). Bonder's (Bodner, 2017) formula was used to estimate the effect size for the conditional moderating effect for three moderator values. Prior to analysis, all predictors and moderators were mean centered to produce meaningful interpretations (Hayes, 2018). Because a relationship exists between gender and racial discrimination (Hahm et al., 2010), gender was controlled for in the present study.

Results

Preliminary Analyses

Table 1 presents details regarding descriptive characteristics and correlations among all study variables. Within our sample, male KA (n = 157) reported a higher mean score of racial discrimination experiences (M = 29.17, SD = 8.79) compared to their female counterparts (n = 113, M = 25.78, SD = 9.99). Similarly, male participants reported higher mean scores of anxiety and depression (Ms = 52.92, 61.71, SDs = 17.22, 20.79) than their female counterparts (Ms = 48.37, 56.30, SDs = 17.22, 21.33). Actual difference between male and female KA in the scores of racial discrimination, anxiety, and depression represented a small effect size (d = .27–.36; Cohen, 1998). Bivariate correlation analyses indicated that there were significant positive or negative relationships between all study variables, except between ethnic identity and coping strategy (r = –.05, p = .435) as well as ethnic identity and life satisfaction (r = –.08, p = .215). As expected, experience of COVID-19-related racial discrimination had significantly positive correlations with depression and anxiety (rs = .73.and .61, respectively). Of special note, ethnic identity scores were positively correlated with scores of racial discrimination, anxiety, and depression, ranging in magnitude from r = .22 to .39.

Multiple Mediation Model

Results of the multiple mediation model indicated both anxiety, B = −.134, SE B = .023, t = −5.948, 95% CIs [−.179, −.090], and depression, B = −.048, SE B = .021, t = −2.247, 95% CIs [−.090, −.006] mediated the link between experience of COVID-19-related racial discrimination and life satisfaction, after controlling for gender. Thus, greater experiences of pandemic-related racial discrimination were associated with higher severity levels of anxiety and depression, which in turn resulted in lower levels of life satisfaction. An indirect effect of anxiety on life satisfaction −.149, 95% CIs [−.205, −.100], and an indirect effect of depression −.078, 95% CIs [−.144, −.007] was found, which resulted in a total indirect effect of −.227. A significant direct effect of racial discrimination on life satisfaction was not found, B = .004, SE B = .044, t = .083, 95% CIs [−.082, .089]. The multiple mediation model explained 31.8%, R^2 = .318, F(4, 265) = 30.956, p < .001, of the total variance, providing support for Hypothesis 1.

Moderated Mediation Model

Detailed results from the moderated mediation model (Figure 1) are presented in Table 1. Overall, ethnic identity significantly moderated the relationship between COVID-19-related racial discrimination and anxiety (Path a1) as well as COVID-19-related racial discrimination and depression (Path a2). Specifically, overall ethnic identity strengthened the positive relationships between racial discrimination and levels of anxiety, B = .065, SE B = .026, t = 2.474, 95% CI [.013, .117], and depression, B = .131, SE B = .027, t = 4.895, 95% CI [.079, .184]. In other words, KA with high levels of ethnic identity were more susceptible to the deleterious effects of COVID-19-related racial discrimination as evidenced by greater severity of anxiety and depression symptoms. Three conditional values of the moderator (i.e., ethnic identity) were further tested to explore the nature of the moderating effect. COVID-19-related racial discrimination was significantly related to more severe anxiety and depression among KA with low levels of overall ethnic identity (mean of the moderator—1 SD, B = .850), at the mean of ethnic identity (B = 1.084), and with levels of high ethnic identity (mean of the moderator + 1 SD, B = 1.318), but this relation became stronger when overall ethnic identity was high. An increase of two standard deviations in ethnic identity (i.e., low vs. high ethnic identity) resulted in a .03 and .06 change in the effect of racial discrimination on anxiety and depression, respectively, which represented small effect in the magnitude (Bonder, 2017). Last, both dimensions of ethnic identity (identity exploration and commitment) were further examined to better understand the moderating role of each dimension of ethnic identity. Identity exploration strengthened the link between racial discrimination and anxiety, B = .129, 95% CI [.051, .206], and depression, B = .220, 95% CI [.140, .299]. Identity commitment strengthened the link for depression, B = .138, 95% CI [.039, .236], but not for anxiety, B = .022, 95% CI [−.073, .116].

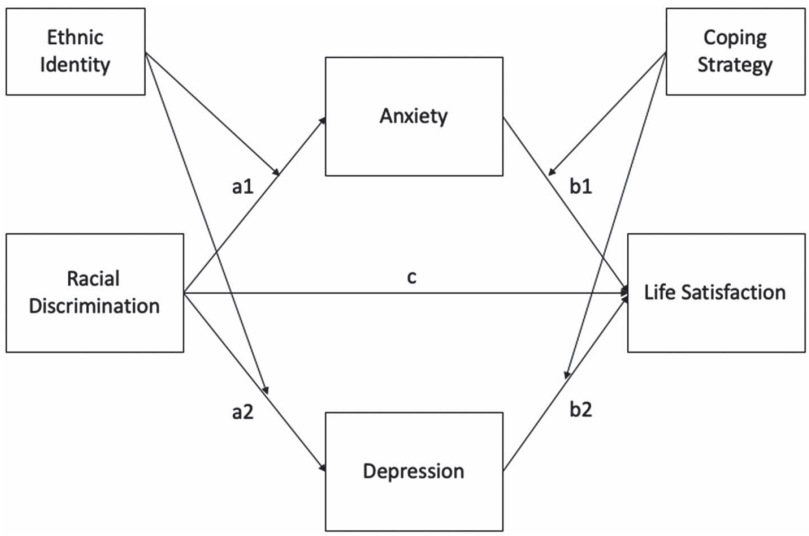
Table 1
Bivariate Correlations Among All Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. RD	—											
2. Anxiety	.608**	—										
3. Depression	.725**	.693**	—									
4. Life satisfaction	−.377**	−.545**	−.470**	—								
5. EI-Total	.387**	.224**	.332**	−.076	—							
6. EI-E	.218**	.073	.188**	.016	.882**	—						
7. EI-C	.468**	.330**	.398**	−.157**	.846**	.496**	—					
8. CS-Total	−.223**	−.426**	−.289**	.533**	−.048	−.028	−.057	—				
9. CS-PFE	−.233**	−.363**	−.254**	.403**	.020	.041	−.010	.821**	—			
10. CS-PFD	−.279**	−.436**	−.384**	.485**	−.028	.038	−.095	.803**	.627**	—		
11. CS-EFE	−.136*	−.345**	−.169**	.501**	−.054	−.041	−.052	.867**	.600**	.553**	—	
12. CS-EFD	−.065	−.217**	−.126*	.307**	−.100	−.141*	−.025	.716**	.379**	.407**	.586**	—

Note. RD = racial discrimination; EI-Total = Ethnic Identity Total Scale; EI-E = Ethnic Identity Exploration Subscale; EI-C = Ethnic Identity Commitment Subscale; CS-Total = Coping Strategy Total Scale; CS-PFE = Coping Strategy Problem-Focused Engagement Subscale; CS-PFD = Coping Strategy Problem-Focused Disengagement Subscale; CS-EFE = Coping Strategy Emotion-Focused Engagement Subscale; CS-EFD = Coping Strategy Emotion-Focused Disengagement Subscale.
* p < .05. ** p < .01.

Figure 1

Moderated Mediation Model Depicting Direct and Indirect Relations of the Study Variables



Hypothesis 3 was partially supported in our study. Although overall coping did not moderate the link between anxiety and life satisfaction, Path b1, $B = .000$, 95% CI [−.004, .004], it did significantly moderate the relationship between depression and life satisfaction (Path b2). Specifically, overall coping weakened the negative link between depression and life satisfaction, $B = .004$, $SE\ B = .002$, $t = 2.543$, 95% CI [.001, .007]. Thus, KA with greater usage of overall coping reported less severe effects of depression on their life satisfaction, which in turn led to a smaller decrease in their levels of life satisfaction. Furthermore, an analysis of three conditional values of the moderator (i.e., coping strategy) indicated that depression still produced a significant negative effect on life satisfaction among KA with low levels of coping strategy, $B = -.086$, $SE\ B = .025$, $t = -3.482$, 95% CI [−.135, −.038], but the negative effect became nonsignificant for those who engaged in high coping strategies, $b = -.01$, 95% CI [−.056, .036]. An increase of two standard deviations in coping strategy (i.e., low vs. high ethnic identity) produced .02 changes in the effect of depression on life satisfaction, which were small effect sizes (Bonder, 2017). Last, two dimensions of coping strategy (i.e., engagement and disengagement) and their subdimensions (i.e., problem-focused engagement and emotion-focused engagement vs. problem-focused disengagement and emotion-focused disengagement) were tested to further understand the role of each coping strategy dimension. As presented in Table 2, both engagement and disengagement coping responses (and all of their subdimensions) significantly weakened the link between depression and life satisfaction but not the link between anxiety and life satisfaction. Of special note, the moderated mediation analysis also reported that the mediation effect involving depression differed as a function of coping strategy. Depression mediated the negative relationship between racial discrimination and life satisfaction when coping strategy was low, $B = -.130$, 95% CI [−.214, −.042] and at the mean, $B = -.072$, 95% CI [−.133, −.007]. However, the mediation effect became nonsignificant when overall coping strategy was high, $B = -.015$, 95 CI% [−.075, .061], regardless of three conditional values of ethnic identity.

Discussion

This study examined the relationship between COVID-19-related racial discrimination on anxiety, depression, and life satisfaction among KA and explored the buffering effect of ethnic identity and coping strategies. Similar to past studies (Hwang & Goto, 2008; Litam & Oh, 2021; Nadimpalli et al., 2016; Zhou et al., 2021), there was a positive and significant relationship between racial discrimination and anxiety and depression. COVID-19-related racial discrimination also had negative impacts on life satisfaction via increased levels of depression and anxiety. Specifically, higher levels of COVID-19-related racial discrimination among KA were related to increased scores of anxiety and depression, resulting in poorer levels of life satisfaction. A stronger sense of overall ethnic identity exacerbated the impact of racial discrimination on anxiety and depression, whereas greater use of overall coping weakened the negative impact of anxiety and depression on life satisfaction.

Our multiple mediation analysis revealed that pandemic-related racial discrimination exacts deleterious effects on life satisfaction via increased depression and anxiety. The indirect effects for anxiety and depression suggest that racial discrimination puts some KA at a higher risk for anxiety and depression, and higher levels of anxiety and depression are associated with poorer life satisfaction. Our findings are consistent with previous studies indicating that Asian Americans reported higher levels of depression (Litam & Oh, 2020; Nadimpalli et al., 2016; Zhou et al., 2021), higher levels of anxiety (Litam & Oh, 2022; Nadimpalli et al., 2016; Zhou et al., 2021), and lower levels of life satisfaction (Tummala-Narra et al., 2018), following experiences of racial discrimination. Our results contribute to the existing literature and provide mental health professionals with critical insight into

Table 2
Results From Moderated Mediation Model

Criterion and predictor variable	*B*	*B SE*	*t*	LLCI	ULCI
Anxiety					
RD	1.084**	.098	11.080	.891	1.276
EI	−.222	.260	−.854	−.733	.289
RD × EI (moderator)	.065*	.026	2.474	.013	.117
RD × EI-E (moderator)	.129**	.039	3.262	.051	.206
RD × EI-C (moderator)	.022	.048	.449	−.073	.116
Gender	−1.064	1.727	−.616	−4.465	2.336
Depression					
RD	1.501**	.100	14.998	1.304	1.698
EI	.063	.265	.236	−.460	.585
RD × EI (moderator)	.131**	.027	4.895	.079	.184
RD × EI-E (moderator)	.220**	.041	5.414	.140	.299
RD × EI-C (moderator)	.138**	.050	2.759	.039	.236
Gender	−.132	1.767	−.075	−3.610	3.346
Life satisfaction					
RD	.007	.039	.173	−.070	.084
Anxiety	−.086**	.021	−4.039	−.128	−.044
Depression	−.048*	.019	−2.541	−.086	−.011
CS	.216**	.029	7.398	.158	.273
Anxiety × CS (moderator)	.000	.002	.188	−.004	.004
Anxiety × EC (moderator)	−.002	.003	−.562	−.008	.005
Anxiety × PFE (moderator)	−.006	.006	−.960	−.017	.006
Anxiety × EFE (moderator)	.000	.005	−.051	−.011	.010
Anxiety × DC (moderator)	.003	.005	.664	−.007	.013
Anxiety × PFD (moderator)	.003	.007	.338	−.012	.017
Anxiety × EFD (moderator)	.006	.009	.750	−.011	.024
Depression × CS (moderator)	.004*	.002	2.543	.001	.007
Depression × EC (moderator)	.007**	.003	2.816	.002	.012
Depression × PFE (moderator)	.013**	.005	2.820	.004	.023
Depression × EFE (moderator)	.010*	.004	2.439	.002	.019
Depression × DC (moderator)	.009*	.004	2.334	.001	.017
Depression × PFD (moderator)	.018**	.006	2.932	.006	.029
Depression × EFD (moderator)	.014*	.007	2.014	.000	.027
Gender	−.879	.509	−1.726	−1.882	.124

Note. *SE* = standard error; LLCI = lower limit confidence interval; ULCI = upper limit confidence interval; RD = racial discrimination; EI = Ethnic Identity Total Scale; EI-E = Ethnic Identity Exploration Subscale; EI-C = Ethnic Identity Commitment Subscale; CS = Coping Strategy Total Scale; EC = Engagement Coping Subscale; DC = Disengagement Coping Subscale; PFE = Coping Strategy Problem-Focused Engagement Subscale, PFD = Coping Strategy Problem-Focused Disengagement Subscale; EFE = Coping Strategy Emotion-Focused Engagement Subscale; EFD = Coping Strategy Emotion-Focused Disengagement Subscale.
* $p < .05$. ** $p < .01$.

the specific mental health needs of KA who experience adverse events, such as COVID-19-related racial discrimination.

Our moderated mediation analysis indicated that ethnic identity exacerbated the relationship between racial discrimination and anxiety and depression. The relationship between racial discrimination and anxiety and depression was strongest for KA with a stronger sense of overall ethnic identity. Our study contrasts findings by Mossakowski (2003) and Litam and Oh (2021) that asserted ethnic identity was a protective factor that reduced the effects of discrimination on depressive symptoms. Our results are consistent with other studies that indicated ethnic identity strengthened the relationship between discrimination and depression and negative effect (Noh et al., 1999; Yoo & Lee, 2005). One possible explanation for these results may be that endorsing a stronger connection and commitment with the Korean identity may result in greater awareness of ethnic differences, therefore, increasing the distress associated with racial discrimination. Self-categorization theory (Turner et al., 1987) also posits that higher levels of commitment and engagement with one's ethnic group may heighten one's awareness of racial discrimination. This can ultimately result in greater hypervigilance and more intense reactions when instances of discrimination occur. Interestingly, both dimensions of ethnic identity (identity exploration and identity commitment) moderated the relationship between discrimination and depression and anxiety in our study, but identity commitment only moderated the connection between discrimination and depression. These results illuminate how different dimensions of ethnic identity play different roles and identify the importance of assessing both dimensions separately instead of relying on a total composite score.

The moderating effect of overall coping and different types of coping (i.e., engagement and disengagement) in the link between anxiety, depression, and life satisfaction was mixed. Greater usage of overall coping strategies buffered the negative impact of depression on life satisfaction but not the impact of anxiety on life

satisfaction. Specifically, the negative relationship between depression and life satisfaction became weaker as use of overall coping strategy increased. The negative effect of depression on life satisfaction became nonsignificant with greater use of overall coping strategy, regardless of KA's ethnic identity level. Our findings are consistent with a previous study that reported higher levels of coping strategies buffered the negative impact of depression on life satisfaction among Chinese Americans (Litam & Oh, 2021). It is possible that KA with greater use of overall coping may be more successful in mitigating the effects of external adversity in ways that buffer depression and protect life satisfaction.

Furthermore, as in the overall coping, both engagement and disengagement coping strategies significantly mitigated the deleterious effect of depression on life satisfaction. However, coping subscales and overall coping did not reduce the effect of anxiety on life satisfaction. Our findings are incompatible with the existing empirical and theoretical literature that supports disengagement coping responses as being more culturally effective and preferable for Asian Americans (Chang, 2001; Lei & Pellitteri, 2017; Tweed & Conway, 2006). Our findings may offer unique insight that the protective effects of coping strategy among KAs may differ depending on the type of mental health problem (e.g., anxiety vs. depression), as opposed to different types of coping responses. Despite some comorbidity between depression and anxiety, the underlying mechanisms of anxiety and depression are believed to be different and distinctive. It is possible that KAs tend to be better equipped with knowledge or experience to handle some symptoms of depression regardless of whichever coping strategies they use. The researchers did not find any previous literature that analyzed differences between how Asian Americans or KAs interpreted or experienced depression and anxiety, which warrants further investigation.

Another possible explanation may be that the compounding stress of anxiety, simultaneous COVID-19-related racial discrimination, and hypervigilance led to an unprecedented level of psychological distress (anxiety) among KA participants in our study. Despite a long history of racism and xenophobia in the past, the number and intensity of racially motivated attacks toward individuals of Asian descent during the COVID-19 pandemic results in added complex and nuanced stressors in their daily lives. The added stress and anxiety caused by COVID-19-related racial discrimination has led to KAs and others AAPI ethnic subgroups with phenotypically East Asian features to perseverate about the safety of everyday activities and to constantly brace themselves from ongoing experiences of everyday racial discrimination across a wide variety of settings.

Limitations and Future Directions

Limitations existed in our study. First, data were collected through a cross-sectional correlational design, convenient sampling method, and self-report scores. Despite the theoretical basis of our mediation model with the previous literature, our research design undermines the validity of directionality in our model. Future studies could benefit from considering a longitudinal or experimental study where the study variables are measured separately at different time points to better understand the cause and effect relation among the variables. Another limitation includes low internal reliability of MEIM-R total score ($\alpha = .64$) and subscale scores ($\alpha = .65$, .57 for identity exploration and commitment). Readers must therefore be cautioned from overstating findings about the moderating role of ethnic identity. It is possible that the MEIM-R may not have accurately captured KA's ethnic identity development process as it was designed to measure a sense of membership in any ethnic group, not a specific racial or ethnic group. Future research would benefit from including different measurements of ethnic identity that better capture the multidimensionality of KA's ethnic identity development and assess the appropriateness of these scales with KAs. Future studies are additionally needed to examine other variables that might be associated with AAPI ethnic identity, psychological well-being, coping strategy, or life satisfaction, including acculturative stress, intergenerational trauma, generational or immigration status, resilience, locus of control, and perceived social support. Last, recognizing that we are more than our ethnicities, future studies will want to explore intersectionality of identities (O'Hara et al., 2021).

Implications for Practice

The results of our study have important implications for supporting KA individuals in therapeutic counseling settings. Given that the majority of our participants reported experiencing COVID-19-related racial discrimination, professional counselors must understand how discrimination impacts the mental health and life satisfaction of KA and be prepared to help clients mitigate the effects of discrimination by enhancing coping strategies and recognizing the relationship between ethnic identity and wellness. Professional counselors must be cautioned from engaging in counseling interventions that emphasize an exploration and commitment to ethnic identity following experiences of racial discrimination, as higher levels of ethnic identity exacerbated the relationship between discrimination and depression and anxiety in our study.

Professional counselors working with KA clients may help them identify and amplify the coping strategies that already exist within their purview. Professional counselors must additionally consider how coping responses may be influenced by cultural notions and values (Litam, 2020; Tweed & Conway), and challenge the existing notions that active, problem-focused coping responses are more helpful than other forms of coping. Indeed, AAPI individuals employ a variety of cultural coping responses that align with collectivistic values, such as adjusting one's feelings to fit the environment, avoiding disclosure of emotions and problems to avoid conflict (Litam, 2020; Oh & Litam, 2022; Tweed & Conway, 2006), and substance use (Le & Iwamoto, 2019).

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