RAIS RESEARCH ASSOCIATION for INTERDISCIPLINARY STUDIES

DOI:10.5281/zenodo.22802074

Gendered "Model Minority" Stereotypes and Clinical Judgment: Implications for Asian American Women's Health Equity

Nara Kong[1], Xinyue Xie[2]

[1]*Stuyvesant High School, New York, USA, narak21004@gmail.com*
[2]*Stuyvesant High School, New York, USA, jessicaxieny@gmail.com*

Abstract: During the twentieth century, Asian Americans shifted in the public image from racial outsiders to a so-called "model minority." Popularized in the 1960s as a counter-narrative to the Civil Rights Movement, the term created a portrayal of Asian Americans as successful and compliant workers to marginalize disparities and structural racism. For Asian American women, the myth reinforced further harms, intersecting with outdated assumptions of submissiveness and sexual regulation. Situated within the broader context of postwar America and increased globalized interaction, these racial stereotypes pressured many Asian Americans to compromise their racial discomfort in an attempt to receive better social treatment or have their rights compromised by the government in sterilization precedents. In clinical settings, these stereotypes have the possibility to function as clinical heuristics, and encourage medical providers to view Asian American women as low-risk and compliant patients. Consequently, Asian American women may be more likely to have their mental health concerns, pain, and reproductive health minimized or overlooked. This paper examines how gendered "model minority" stereotype expectations influence clinical judgment and can contribute to health inequities within contemporary healthcare. By tracing the historical roots of these assumptions and analyzing their persistence in the modern world clinically, this study argues that seemingly "positive" stereotypes can continue to produce forms of medical neglect and systemic gaps in care.

Keywords: Asian American, clinical judgment, model minority myth, health inequity, pain minimization, patient-provider bias, women's health

Introduction

Health equity requires more than equal access to clinics and insurance coverage. Although less visible, it also demands recognition of need by clinicians, sufficient attention to reports of symptoms, and unbiased judgment in diagnosis and treatment, without relying on racialized or gendered assumptions. Recent national health-equity scholarship continues to argue and emphasize that racial and ethnic disparities persist partly because clinical encounters are not race-neutral in practice and because clinician stereotyping still shapes care quality. (National Academies of Sciences, Engineering, and Medicine [NASEM], 2024). For Asian American women, this problem can be especially difficult to identify, and is less visible than openly hostile discrimination, because it is often carried by seemingly "positive" assumptions. This includes being perceived as compliant, self-disciplined, emotionally restrained, academically or professionally successful, and ultimately a low-risk patient.

This paper argues that gendered model-minority stereotypes can function as clinical heuristics, or cognitive shortcuts, that have an impact in clinical spaces. The harm is not necessarily that clinicians consciously endorse racist or sexist beliefs. Rather, under the time pressure and uncertainty of clinical practice, providers may unconsciously use stereotypes as interpretive shortcuts. As a result, Asian American women may receive fewer follow-up questions, thinner explanations, less psychosocial screenings and probings, and a lower level of diagnostic urgency. For women already navigating gendered stereotypes of modesty, passivity, and deference, these assumptions can compound already existing barriers to care.

Rather than claiming that all Asian American women share the same health experiences, this paper focuses on how broad racial and gendered assumptions can interfere with individualized assessments that would be more precise. By focusing on how the myth can

operate through routine clinical shortcuts, we examine four sites where those shortcuts are especially consequential: mental-health screening, discriminatory healthcare encounters, pain assessment, and preventive/reproductive health. Across these areas, the central pattern is the same: Asian American women's needs may be under-recognized through stereotypes.

Methodology

This paper uses an integrative literature review method to synthesize scholarship across three areas: historical and policy research on the construction of the model-minority myth; psychological and medical literature on heuristics, bias, and clinical decision-making; and public-health studies documenting Asian American women's health experiences and outcomes. Because the direct causal relationship between model-minority stereotypes and specific clinical decisions has not been extensively measured, this review brings together adjacent bodies of evidence to identify plausible mechanisms of harm.

Historical Context of the "Model Minority" Myth

At the dawn of the twentieth century, Theodore Roosevelt championed the "strenuous life," a lifestyle driven by the individualist mandate of pulling oneself up by one's own bootstraps. This philosophy deliberately disassociated success from systemic privilege, framing societal achievements as purely a moral victory of the self-reliant. Decades later, this rhetoric would serve to construct the "model minority" myth, narrating Asian-American immigrant success into a mechanism of societal control.

For decades, Asian Americans were codified in American law to be unassimilable racial outsiders, as shown in the Chinese Exclusion Act of 1882. However, the geopolitical pressures of World War II forced a reconstruction of these racial perceptions, leading to the repeal of exclusionist legislation via the Magnuson Act of 1943. To project an image of democratic pluralism during the Cold War and to respond to the radical domestic nature of the Civil Rights Movement, white capitalists and corporate media promoted an image of Asian Americans as a "good, law-abiding minority" who achieved upward mobility through a purely merit-based compliancy as opposed to the political protests demonstrated by African Americans (University of Michigan, 2019). This narrative was first established in 1966 through foundational sociological texts like William Petersen's "Success Story, Japanese-American Style," which attributed Japanese American socioeconomic recovery to an inherent cultural stoicism (Petersen, 1966). Petersen's narrative was deliberately weaponized to validate Roosevelt's bootstraps meritocracy and insulate white supremacist structures by countering the Moynihan Report, which simultaneously stigmatized Black familial structures to blame African Americans for their own systemic poverty (Moynihan, 1965).

In response to this stereotype and the imperialist violence of the Vietnam War, radical activists sought to reclaim their political agency through racial unity. In 1968, just a few short years after the Free Speech Movement of 1964-1965, Yuji Ichioka and Emma Gee coined the political umbrella term "Asian American" as a way to replace the imperialist term "oriental" while founding the Asian American Political Alliance at UC Berkeley (Densho, 2017). Despite this history of resistance, the propagandized narrative of the "compliant" Asian American to delegitimize Black protests for equality reached a climax in the 1992 Los Angeles Uprising. Following decades of systemic disinvestment in Black neighborhoods, media coverage of conflicts like *People v. Soon Ja Du* positioned Korean immigrant merchants to stigmatize Black community outrage while establishing Asian property owners as a buffer to protect white systemic responsibility.

This political manipulation persists in present-day legal battles over higher education, where conservative legal groups employ the myth to dismantle race-conscious admissions. By positioning Asian American plaintiffs as the primary victims of affirmative action,

organizations like Students for Fair Admissions (SFFA) rely on the racialized premise that Asian students possess inherent academic superiority over underqualified Black and Latinx peers (Berkeley Political Review, 2023). While claiming to fight for colorblind equality, this framework minimizes the impact of systemic racism, drives anti-Black sentiments within Asian communities, and offers a false promise of proximity to whiteness in exchange for political compliance. Furthermore, by aggregating diverse ethnic subgroups into a single affluent monolith, the legal framework completely conceals severe socioeconomic disparities, allowing white Americans to dismiss both modern anti-Asian hate and deep-seated inequities (Berkeley Political Review, 2023).

The danger of this aggregated data is illuminated by modern demographic realities, which reveal that Asian Americans currently possess the largest income gap of any racial group in the United States (Hassan & Carlsen, 2018). While pop-culture representations, such as *Crazy Rich Asians*, often reinforce images of monolithic affluence, disaggregated metrics show that income growth for low-income Asian Americans has stagnated. In major urban centers like New York City, Asian Americans have emerged as the poorest immigrant demographic, experiencing a 44% increase in population living below the poverty line between 2000 and 2016 (Hassan & Carlsen 2018). By flattening the economic realities of Asian Americans and creating a single narrative about all Asian Americans, the model minority myth erases the vulnerabilities of working-class and refugee subgroups, reinforcing a clinical and social invisibility that leaves these systemic gaps overlooked.

Gendered Racial Tropes

The effects of the "model minority" myth are profoundly amplified when filtered through the female perspective. When evaluated through a critical race feminist framework, this stereotype restricts the professional and social mobility of Asian American women. Because the myth praises Asian Americans for being unthreatening and compliant to social hierarchy, Asian American women are routinely cast into a docile and passive caricature (Shih et al., 2019). This stereotyping is so noticeable that the term “glass ceiling,” originally to describe unofficial professional boundaries for the career advancement of women, deviated into the term “bamboo ceiling,” reserved only for Asian American women. For instance, within Silicon Valley, where Asian Americans represent the single largest professional cohort, Asian American women experience the lowest rates of executive promotion of any demographic group, lagging behind white men, white women, and other women of color (Shih et al., 2019). Even Asian women who slightly deviate from the stereotype are cast as the other extreme, the domineering and cold “tiger mother,” first sensationalized by Amy Chua’s *Battle Hymn of the Tiger Mother* (Shih et al., 2019). This binary framework erases the agency of Asian American women, at the same time that it masks the socioeconomic hurdles faced by the Asian American community in general.

Crucially, this contemporary professional marginalization is a direct result of historical legacies of Western colonialism and legalized forced sterilization that have shaped the socio-legal statuses of Asian women in the United States. Decades of imperialist expansion abroad drove the systematic fetishization of Asian women, reducing them to sexual commodities within the Western imagination (Oh, 2021). After the recruitment of mass numbers of Chinese men from overseas as cheap labor for the Transcontinental Railroad, exclusionary laws such as the Page Act of 1875 barred Asian women under the legal presumption of prostitution, but was truly intended to control the Chinese population in the Western frontier. Followed by the Chinese Exclusion Act of 1882 and the Immigration Act of 1917, these laws propagated a singular image of Asian women within the context of prostitution at the same time that it restricted Asian American men to bachelorhood. These historical precedents continue to yield severe real-world consequences in the present-day landscape. Between 2020 and 2021, the

tracking database *Stop AAPI Hate* recorded more than 3,800 anti-Asian hate incidents, with women targeted in over two-thirds of all documented cases (Oh, 2021). By continuing to superimpose the model minority myth, Western society routinely overlooks how these intersecting systems of racism and sexism shape daily encounters, leaving the narrative of Asian American women intentionally unaddressed.

Stereotypes as Clinical Heuristics

Clinical judgment is made under uncertainty, time pressure, and incomplete information. In such settings, research shows that people sometimes rely on heuristics, or mental shortcuts. Tversky and Kahneman (1974) argue that heuristics can simplify complex judgments but can also distort judgment and produce errors when decision-makers rely too heavily on incomplete or misleading cues. Dual-process models of reasoning help explain this process, as System I, or Fast intuitive processing can be useful, but it can also allow stereotypes to enter clinical judgment before slower-more analytical System II processing can correct them. The conditions prompting System I thinking, which include urgency, incomplete data, and strong affect, are common in clinical environments.

The danger is that stereotypes can become part of a pattern library that medical care providers draw from. Ho and Lawrence (2020) argue that social-cognitive processes shape medical decision-making with Asian American patients and can encourage clinicians to rely on "model minority" assumptions rather than individualized assessment. When those assumptions enter the encounter, they can change the provider's behavior. This includes less explanation because the patient is presumed to understand, less checking for confusion because the patient seems agreeable, less psychosocial screening because the patient appears functional, and less follow-up because the patient is assumed to be adherent. This is the clinical mechanism through which the seemingly "positive" stereotype can become medical neglect. This is especially important for Asian American women, who may be filtered through gendered racial stereotypes. Assumptions about sexual conservatism, modesty, deference, or self-sufficiency can shape what providers investigate. For example, a clinician may interpret an Asian American woman's quietness as comfort, her lack of objection as understanding, or her controlled affect as evidence she is coping well.

Preventive care illustrates well just how these assumptions can affect the encounter. A provider can read an Asian American woman as sexually conservative or low-risk and therefore spend less time discussing HPV, Pap smears, or cervical cancer screening. This is detrimental because Asian American women already face barriers to screening, including stigma around sexual health. Fang et al. (2011) report that 40% of Korean American women in California had never had a Pap test compared with 8% of California's general female population. The harm is not only the stereotype itself, but how it changes the clinical encounter.

Inequities Affecting Asian American Women's Health

Mental health is one of the clearest places where the model-minority myth becomes a clinical failure, not just a cultural stereotype. Lee et al. (2009) found that Asian American young adults often described intense pressure tied to academic expectations, bicultural conflict, discrimination, and the pressure to live up to the "model minority" image. Kim and Lee (2014) adds to this, showing that internalized model-minority beliefs predicted less favorable attitudes toward seeking professional mental health help, partly through emotional self-control. Together, these findings show why clinicians cannot equate high functioning with low need. The same behaviors that may prevent a patient from openly requesting support, such as shame, quietness, or self-control can also be misread by providers as signs of stability and show as evidence that no deeper screening is needed.

The clinical issue is when clinics allow controlled affect or achievement to shorten the encounter. A provider that fails to ask about family pressure, discrimination, stress, or support systems may never learn that a patient is struggling. Kim and Lee's (2021) systematic review strengthens this point by showing that Asian American mental-health help-seeking is shaped by stigma, language barriers, family influence, cultural beliefs, and access barriers. Lee et al. (2021) also found gaps in treatment receipts among Asian Americans who already perceived that they had mental-health problems. These findings suggest the clinical failure is twofold. Providers can under-detect distress during the encounter, and clinics may also fail to actively connect patients to care even when their concern is present. This demonstrates a passive model of care, which is waiting for patients to directly request therapy or repeatedly self-advocate, and it can reproduce the same barriers that already exist.

Women-centered discrimination research suggests that this under-recognition occurs within healthcare encounters themselves. Do et al. (2022) make this argument more concrete for Asian American women specifically. The study found that 32.0% of Asian American women reported discriminatory treatment in healthcare settings, and that many of these experiences were associated with worse health and functioning outcomes. This clearly displays that Asian American women's health inequity is not only happening outside the clinic through culture, stigma, or family pressure. It is also happening inside healthcare encounters. Being treated with less respect, having concerns minimized, receiving less explanation, or being forced to work harder to be believed are all discriminatory treatments. In the context of model-minority stereotyping, a provider may interpret deference as agreement, quietness as comfort, or competence as resilience.

Pain care provides another important example because pain depends heavily on credibility judgments. Ly et al. (2021) found that primary care physicians prescribed opioids for new low back pain more often to White patients than to Asian or Pacific Islander, Black, or Hispanic patients. This should not be read as a simple argument that more opioid prescribing is always better, especially given the risks of opioid treatment. Rather, it shows that even within the same physician's practice, pain treatment decisions varied by patient race and ethnicity. Since pain is often assessed through patient narrative, affect, and provider interpretation, stereotypes about stoicism, compliance, or emotional restraint can affect how a patient's pain is treated.

For Asian American women, this is especially significant because both race and gender can affect how pain is interpreted. If a patient presents calmly, minimizes her own symptoms, or does not aggressively self-advocate, a provider may underestimate the severity of her pain. The equity concern is whether her pain is fully elicited, documented, believed, and managed through appropriate options. A stereotype-shaped encounter may result in weaker symptom documentation, fewer treatment alternatives, less diagnostic workup, or inadequate follow-up.

Preventive and reproductive health show how stereotyping can operate through data systems, not only interpersonal judgment. Wagner et al. (2020) found that adverse maternal outcomes varied significantly across Asian ethnic subgroups, making it misleading to treat Asian women as one uniformly low-risk group. Aggregation can create a false clinical picture. When Asian subgroups are averaged together, the resulting category may appear healthier or lower-risk than some patients actually are. Clinics should not allow a broad racial label to replace individualized assessment. A provider who reads "Asian" as shorthand for low-risk, educated, or self-managing may spend less time asking about language access, prior pregnancy complications, family support, nutrition, insurance barriers, postpartum mood, or access to prenatal care. In this way, the model-minority myth can influence both interpersonal care and institutional data practices. Asian American women become difficult to see clearly because the category itself has been flattened.

Implications for Health Equity and Clinical Practice

The issue is not just the bias, but the repeated conversion of stereotypes into clinical routines. A stereotype is ultimately harmful no matter how "positive" it is when it shortens the appointment, reduces explanation, weakens follow-up, minimizes pain, or allows aggregated data to stand in for actual risk assessment. NASEM argues that meaningful progress on health inequity requires changes to care delivery, data practices, and accountability structures. For Asian American women, this means equity interventions must target the procedural moments where under-recognition occurs.

First, clinicians should treat "positive" stereotypes as potential risks for under-assessment. Apparent quietness, English fluency, politeness, or perceived compliance should not substitute for further screening. Providers should be trained to recognize that a patient who appears agreeable may still be confused, distressed, in pain, or unsure how to ask for help. Health systems should standardize communication practices so that all patients receive clear explanations. Standardization is important because it reduces the opportunity for stereotypes to determine who receives deeper questioning. Furthermore, clinics should strengthen follow-up and referral systems. The evidence on mental-health treatment gaps suggests that simply identifying concern is not enough. Patients may need active navigation and clear explanations of what treatment options mean. A system that waits for patients to repeatedly self-advocate risks privileging those who are already comfortable challenging medical authority.

Additionally, data systems must disaggregate Asian ethnic groups whenever possible. Aggregated Asian American data can hide subgroup disparities and allow model-minority assumptions to fill the explanatory gap. Disaggregation should be used to prevent broad racial categories from erasing real differences in risk, access, and outcomes.

Finally, interventions aimed at improving Asian American women's health equity must be explicitly intersectional. Generic antiracism efforts may overlook gendered assumptions about deference, modesty, sexuality, and emotional restraint. Generic women's-health frameworks may overlook the racialized expectation that Asian American women are compliant, self-sufficient, or low-risk. Effective clinical equity requires recognizing how these assumptions interact.

Limitations

This paper has a few limitations. This topic is underresearched and few studies directly measure clinicians' use of model-minority beliefs and link those beliefs causally to specific treatment differences for Asian American women, so this paper relies on synthesizing related evidence from clinical-heuristics research, mental-health studies, discrimination research, pain-care data, and reproductive-health outcomes. Also, many datasets aggregate Asian ethnic groups, making it difficult to identify which subgroups of Asian American women are most affected by particular forms of under-recognition. These limitations mean the paper cannot claim that model-minority stereotyping explains every disparity, but the evidence supports its relevance as one important mechanism through which "positive" stereotypes can produce unequal care.

Conclusion

The model-minority myth is often discussed as a social stereotype outside medicine, but it also has clinical consequences. For Asian American women, assumptions of compliance, self-sufficiency, emotional restraint, and low risk can distort medical judgment in ways that reduce explanation, narrow screening, minimize pain, and obscure mental-health or reproductive-health needs. These harms are often subtle, but that subtlety is part of what makes them durable. Improving health equity for Asian American women therefore requires more than recognizing overt discrimination, it also requires recognizing that "positive" stereotypes can also produce neglect. Better subgroup data, more deliberate screening, standardized communication,

stronger referral systems, and clinician awareness of stereotype-driven heuristics are all necessary steps toward care that is truly individualized. The goal is to prevent racialized assumptions from standing in for clinical attention, not to replace one stereotype with another.

References

Berkeley Political Review. (2023, December 9). *Affirmative action and the model minority myth*. https://bpr.studentorg.berkeley.edu/2023/12/09/affirmative-action-and-the-model-minority-myth/

Chu, J. M. (Director). (2018). *Crazy Rich Asians* [Film]. Color Force; Ivanhoe Pictures; SK Global; Electric Somewhere.

Densho. (2017, May 8). *Yellow power: The origins of Asian America*. https://densho.org/catalyst/asian-american-movement/

Do, Q. A., Gee, G. C., Kim, H.-Y., Tran, M.-N. C., & Nguyen, T. (2022). Centering Asian American women's health: Prevalence of health care discrimination and associated health outcomes. *Journal of Racial and Ethnic Health Disparities 10*(2), 797–804. https://doi.org/10.1007/s40615-022-01267-whttps://pmc.ncbi.nlm.nih.gov/articles/PMC8865180/

Fang, C. Y., Lee, S., Stewart, S., Chen, G., & Lee, G. Y. (2011). Overcoming barriers to cervical cancer screening among Asian American women. *North American Journal of Medicine & Science, 4*(2), 77–83. https://doi.org/10.7156/v4i2p077

Hassan, A., & Carlsen, A. (2018, August 17). How "Crazy Rich" Asians have led to the largest income gap in the U.S. *The New York Times*. https://www.nytimes.com/interactive/2018/08/17/us/asian-income-inequality.html

Ho, I. K., & Lawrence, J. S. (2020). The role of social cognition in medical decision making with Asian American patients. *Journal of Racial and Ethnic Health Disparities 8*(5), 1112–1118. https://doi.org/10.1007/s40615-020-00867-8

Kim, P. Y., & Lee, D. H. (2014). Internalized model minority myth, Asian values, and help-seeking attitudes among Asian American students. *Cultural Diversity & Ethnic Minority Psychology, 20*(1), 98–106. https://doi.org/10.1037/a0033351

Kim, S. B., & Lee, Y. J. (2021). Factors associated with mental health help-seeking among Asian Americans: A systematic review. *Journal of Racial and Ethnic Health Disparities*. *9*, 1276-1297. https://doi.org/10.1007/s40615-021-01068-7

Lee, M.-A., Chung, Y. B., Wang, Y.-C., & Takeuchi, D. (2021). Correlates of mental health treatment receipt among Asian Americans with perceived mental health problems. *The Journal of Behavioral Health Services & Research*, *48*(2), 199-212. https://doi.org/10.1007/s11414-020-09704-6

Lee, S., Juon, H.-S., Martinez, N., Hsu, C. E., Robinson, E. S., Bawa, J., & Ma, G. X. (2009). Model minority at risk: Expressed needs of mental health by Asian American young adults. *Journal of Community Health, 34*(2), 144–152. https://doi.org/10.1007/s10900-008-9137-1

Ly, D. P. (2021). Association of Patient Race and Ethnicity With Differences in Opioid Prescribing by Primary Care Physicians for Older Adults With New Low Back Pain. *JAMA Health Forum, 2*(9), e212333. https://doi.org/10.1001/jamahealthforum.2021.2333

Moynihan, D. P. (1965). *The Negro family: The case for national action*. U.S. Department of Labor.

National Academies of Sciences, Engineering, and Medicine. (2024). *Ending unequal treatment: Strategies to achieve equitable health care and optimal health for all*. The National Academies Press. https://doi.org/10.17226/27820

Nguyen, K. H., Law, A. V., Park, V. T., & Tseng, W. (2022). Trends in collection of disaggregated Asian American, Native Hawaiian, and Pacific Islander data in federal health surveys, 2011–2020. *American Journal of Public Health, 112*(10), 1429–1435. https://doi.org/10.2105/AJPH.2022.306969

Oh, S. (2021, May 10). *Racism, sexism, and the harmful "model minority" stereotype against Asian Americans*. Loyola Marymount University Newsroom. https://newsroom.lmu.edu/administrative/racism-sexism-and-the-harmful-model-minority-stereotype-against-asian-americans/

Petersen, W. (1966, January 9). Success story, Japanese-American style. *The New York Times*. https://www.nytimes.com/1966/01/09/archives/success-story-japaneseamerican-style-success-story-japaneseamerican.html

Roosevelt, T. (1899). *The strenuous life*. The Hamilton Club.

Shih, K. Y., Chang, T.-F., & Chen, S.-Y. (2019). Impacts of the model minority myth on Asian American individuals and families: Social justice and critical race feminist perspectives. *Journal of Family Theory & Review, 11*(3), 412-428. https://doi.org/10.1111/jftr.12342

Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. *Science, 185*(4157), 1124–1131. https://doi.org/10.1126/science.185.4157.1124

U.S. Department of Health and Human Services, Office of Minority Health. (2026). *Mental and behavioral health—Asian Americans*. https://minorityhealth.hhs.gov/mental-and-behavioral-health-asian-americans

University of Michigan. (2019). *Model minority*. AAPI History at the University of Michigan. https://aapi.umhistorylabs.lsa.umich.edu/s/aapi_michigan/page/model-minority

Wagner, S. M., Reece, E. E., Battarbee, C. M., & Keller, R. C. (2020). Disparities in adverse maternal outcomes among Asian women in the United States delivering at term. *JAMA Network Open, 3*(10), e2020180. https://doi.org/10.1001/jamanetworkopen.2020.20180