



## Review

## More than culture: Structural racism, intersectionality theory, and immigrant health

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### ABSTRACT

Explanations for immigrant health outcomes often invoke culture through the use of the concept of acculturation. The over reliance on cultural explanations for immigrant health outcomes has been the topic of growing debate, with the critics' main concern being that such explanations obscure the impact of structural factors on immigrant health disparities. In this paper, we highlight the shortcomings of cultural explanations as currently employed in the health literature, and argue for a shift from individual culture-based frameworks, to perspectives that address how multiple dimensions of inequality intersect to impact health outcomes. Based on our review of the literature, we suggest specific lines of inquiry regarding immigrants' experiences with day-to-day discrimination, as well as on the roles that place and immigration policies play in shaping immigrant health outcomes. The paper concludes with suggestions for integrating intersectionality theory in future research on immigrant health.

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### Introduction

Beyond selectivity and methodological explanations for immigrant health patterns in the United States, scholars often invoke culture to explain these patterns. We contend that cultural explanations mask the effects of social inequalities on immigrant health outcomes, and argue for a shift from individual culture-based frameworks to perspectives that consider the role of structural factors in producing health inequalities among immigrants. In particular, we propose that a richer understanding of the social determinants of immigrant health requires an intersectional approach—one that considers the simultaneous and mutually constitutive effects of the multiple social categories “of identity, difference, and disadvantage” that individuals inhabit (Cole, 2009, p. 171; Crenshaw, 1991). To these ends, we first highlight key shortcomings of cultural explanations as currently employed in much of the immigrant health literature. We then discuss intersectionality theory and review research that examines two intersecting social categories: race and immigrant status. We build on our review of this literature to suggest specific lines of inquiry regarding immigrants' experiences with day-to-day discrimination, as well as the roles that

place and immigration policies play in shaping immigrant health outcomes. We conclude with suggestions for how to better integrate intersectionality theory in future research on immigrant health.

### The limits of cultural explanations for immigrant health outcomes

Cultural explanations for immigrant health outcomes in the United States typically propose that culture influences social norms and individual health behaviors—such as, smoking, drinking, and dietary patterns—to impact health outcomes (Lara, Gamboa, Kahramanian, Morales, & Hayes Bautista, 2005). At the core of these explanations lies the assumption that, as immigrants shed cultural characteristics presumably associated with their country of origin and adopt those of the receiving society, their health changes for the worse (Escarce, Morales, & Rumbaut, 2006).

In examining these assertions, scholars often rely on the concept of acculturation—typically defined in U.S. health research as an individual-level process through which individuals acquire the “behaviors, attitudes and values prevalent within American society” (Lopez-Class, Castro, & Ramirez, 2011, p. 1558). Although some scholars point to acculturation as a set of processes, in practice, most use the concept to quantify the extent to which individuals adopt so-called “American” cultural traits via acculturation indices and proxy measures, such as nativity, generational status,

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language, citizenship status, length of residence in the United States, and age at arrival.

Increasingly scholars have noted the limitations of the concept of acculturation, with some calling for discontinuing its use in health research (Escobar & Vega, 2000; Hunt, Schneider, & Comer, 2004). A core criticism highlighted by some scholars is that employing acculturation as the central concept in the examination of immigrant health outcomes in the United States ignores the socio-historical contexts of migration, the racialization of contemporary immigrants, and the role these factors play in the differential social integration of immigrants (Gonzalez-Lopez, 2005; Hunt et al., 2004; Miranda, Schulz, Israel, & Gonzalez, 2010; Viruell-Fuentes, 2007, 2011). Indeed, as Zambrana and Carter-Pokras (2010) concluded, the “[p]ersistent use of individual or culture-driven models in public health...ignores the effect of residence in low-resource communities, low SEP [socioeconomic position], the social construction of marked cultural identities, and institutional patterns of unequal treatment, all of which contribute to health disparities” (p. 21). (For other aspects of the concept’s critique, see Acevedo-García & Bates, 2008; Carter-Pokras & Bethune, 2009; Hunt et al., 2004; Kao, Hsu, & Clark, 2004; Santiago-Irizarry, 1996; and Viruell-Fuentes, 2007.)

In response to this criticism, some scholars have proposed that the concept be broadened to account for the impact of social contexts—such as social networks, neighborhoods, and discrimination—on cultural change (Lopez-Class et al., 2011). However, several significant caveats remain within these proposed revisions. Despite work that has challenged it, with few exceptions the implied definition of culture as a set of individual-level traits, attitudes, values, and behaviors remains prevalent in much of the public health literature. Indeed, largely absent from current formulations of culture in immigrant health research are those that consider the cultures of societal institutions that reproduce inequalities (Geronimus & Thompson, 2004), or those that consider the collective strategies that groups targeted with racism develop to cope with and resist the effects of structural racism (Geronimus, 2000; Hannerz, 2004; Rosner Kornhauser, 1978).

Furthermore, even expanded acculturation-based frameworks continue to analyze the effects of structural contexts on health outcomes through the lens of individual-level cultural changes and ignore other more powerful pathways. These remaining conceptual caveats in the public health literature have multiple implications for immigrant health research. Notably, even expanded acculturation models still do not account for the notion that structural factors likely impact health in broader ways than simply influencing an individual’s cultural orientation. In other words, frameworks that delimit attention on structural factors to whether they impact individual cultural change remain problematic because they continue to detract attention from advancing the scholarly understanding of how factors such as immigration policies, labor practices, neighborhood characteristics, and racialization processes intersect and affect the economic and social integration of immigrants. In addition, conceptual frameworks that focus on individualized cultural responses to structural factors obscure the role that institutional actors and policies play in (re)producing poverty, racial discrimination, and nativist reactions to immigrants—all of which likely influence the health of immigrants above and beyond the influence of such factors on cultural traits.

The use of static definitions of culture in public health research risks essentializing and homogenizing entire ethnic and/or immigrant groups and perpetuating racial/ethnic stereotypes (Hunt et al., 2004), thereby “inadvertently promoting victim-blaming explanations” (Viruell-Fuentes, 2007, 2011, p. 38). The logic behind this treatment of culture is problematic because in the case of Latino health, for example, where culture is often invoked as

“therapeutic panacea,” this same line of thinking could just as easily slip into casting culture as “a source of dysfunction” (Hester, 2009; Hunt et al., 2004; Santiago-Irizarry, 1996; Viruell-Fuentes, 2007). This reversal has occurred in research, for instance, on Arab Americans, where “lack of acculturation” has at times been pathologized as a “risk factor” for poor health among Arab immigrants (Jaber, Brown, Hammad, Zhu, & Herman, 2003). Thus, while culture may indeed play a role in shaping immigrant health outcomes, examining the ways in which immigration intersects with race, class, and gender is crucial to gaining a better understanding of change in these outcomes. As such, intersectionality theory can serve as a guiding framework in shifting the focus away from individual-level conceptualizations of culture in immigrant health research, to structural examinations that take into account the power dimensions of race, class, gender, and immigrant status hierarchies, and how these shape health inequities.

### Intersectionality, immigration, and health

Intersectionality theory has its roots in the writings of U.S. Black feminists who challenged the notion of a universal gendered experience and argued that Black women’s experiences were also shaped by race and class (Collins, 1990; Davis, 1981). Contrary to articulating gender, race, and class as distinct social categories, intersectionality postulates that these systems of oppression are mutually constituted and work together to produce inequality (Cole, 2009; Collins, 1990; Crenshaw, 1991; Schulz & Mullings, 2006). As such, analyses that focus on gender, race, or class independently are insufficient because these social positions are experienced simultaneously. Whereas intersectionality has had an impact on both feminist theory and Critical Race Theory, its integration into the health inequalities literature has been limited (for some exceptions, see Ford & Airhihenbuwa, 2010; Kelly, 2009; Rosenthal & Lobel, 2011; and Schulz & Mullings, 2006). This limitation is most noticeable in immigrant health research where the acculturation paradigm dominates and examinations of how immigrant health trajectories are shaped simultaneously by race, class, and gender-based systems of hierarchy are, by and large, absent. Below, we begin mapping out a research agenda that moves away from the cultural change paradigm to one that accounts for the interplay and impact of immigration and other social locations on health outcomes. To this end, in the next section, we review research that has begun to address the effects of a subset of these intersections on health: racism and immigration.

### Racism, immigration, and health

Scholars examining the social determinants of health have long stressed racism’s central role in the production of health inequalities (Williams & Collins, 1995). Racism reliably produces and reproduces social and economic inequities along racial and ethnic lines, and, as such, it is a fundamental cause of disease (Link & Phelan, 1995), which intersects with other forms of oppression and marginalization to influence the health of immigrants. Scholarship in this area has highlighted multiple dimensions of racism, with a growing number of works focusing on the relationship between individually mediated racism and health. Specifically, scholars have called attention to how day-to-day experiences of racism or unfair treatment impact health (Gee, Ro, Shariff-Marco, & Chae, 2009; Krieger, 1999; Williams & Mohammed, 2009; Williams, Neighbors, & Jackson, 2003).

Only recently, however, have the intersections between perceived discrimination, immigration, and health begun to receive attention. Findings on discrimination and health among immigrants largely parallel the broader literature in that, even though

some results are mixed, there is growing evidence that perceived discrimination is associated with lower levels of physical and mental health; poor access to quality health care; and certain deleterious health behaviors across several immigrant groups, including Latino, Asian, and Black immigrants (Bernstein, Park, Shin, Cho, & Park, 2011; Finch, Hummer, Kol, & Vega, 2001; Finch, Kolody, & Vega, 2000; Gee, Ro, Gavin, & Takeuchi, 2008; Gee, Ryan, Laflamme, & Holt, 2006; Panchanadeswaran & Dawson, 2011; Perez, Sribney, & Rodriguez, 2009; Potochnick & Perreira, 2010; Ryan, Gee, & Laflamme, 2006; Tran, Lee, & Burgess, 2010; Yip, Gee, & Takeuchi, 2008). But when immigration is added into the mix, additional complexities emerge, pointing to important unanswered methodological and theoretical questions that deserve attention. For instance, some studies indicate that immigrants are more likely to report experiences of discrimination than their U.S.-born co-ethnics (Lauderdale, Wen, Jacobs, & Kandula, 2006; Yip et al., 2008). However, the results of other studies suggest that, compared to their U.S.-born co-ethnics, immigrants are less likely to report experiences of discrimination (Cook, Alegría, Lin, & Guo, 2009; Perez, Fortuna, & Alegría, 2008; Perez, Sribney et al., 2009). In addition, the strength of the association between discrimination and health among immigrants appears to vary both by length of time in the United States and age at migration. Some studies find that the association between discrimination and health is stronger for U.S.-born minority group members than immigrants of the same race/ethnicity (Finch, Kolody et al., 2000; Perez, Sribney et al., 2009), or that the association is greater for immigrants with longer residence in the United States, as compared to those who had lived in the country for a shorter time (Gee, Ro, Gavin et al., 2008; Gee, Ryan et al., 2006).

Scholars have observed that, methodologically, consensus is lacking as to the optimal measure of perceived discrimination (Williams & Mohammed, 2009), and this is reflected in the diversity of measures we found in studies examining the relationship between perceived discrimination and health among immigrants. Indeed, differences in measures may, in part, explain some of the mixed findings evident in the literature. In the case of immigrants, measures that assess discrimination based on language and citizenship status, as well as on race/ethnicity are needed for understanding how these dimensions of immigrants' experiences interact to impact health (Gee, Ro, Shariff-Marco et al., 2009; Yoo, Gee, & Takeuchi, 2009). Future research, preferably in the form of a meta-analysis, is necessary to help consolidate our understanding of the association between perceived discrimination, immigrant status, and health. Because a systematic assessment of the methodological complexities that underlie this literature is beyond the scope of this paper, and because resolving methodological issues requires close attention to conceptual considerations, we thus focus here on several conceptual issues that can help guide future research on how race and migration intersect to influence health outcomes.

#### *Racialization processes and immigrant health: conceptual considerations*

At the conceptual level, the literature suggests the need to attend to how racialization processes unfold among immigrants and their U.S.-born co-ethnics. Some studies—such as those that find that U.S.-born minority group members, compared to immigrants, experience higher levels of perceived discrimination and a stronger association between discrimination and health—might be indicative of the cumulative effects of discrimination on health. Specifically, this pattern may reflect earlier and longer exposure to the racialized structure of the United States and its deleterious health effects among the U.S.-born (Viruell-Fuentes,

2007). These findings may also reflect some immigrants' reluctance to use words like *discrimination* to describe their experiences with unjust treatment, and the fact that “explicitly identifying experiences as discriminatory is a learned process” (Viruell-Fuentes, 2007, p. 1532). In contrast, studies that find immigrants to be more vulnerable to the deleterious effects of discrimination on health may be indicative of the increase in anti-immigrant policies and sentiments in the last two decades (Chavez, 2008; Gee & Ford, 2011; Lauderdale, 2006; Viruell-Fuentes, 2011; Williams & Mohammed, 2008).

The complexities in the literature highlight the need for an intersectional approach that allows for a more thorough examination of these patterns and for more nuanced theorizing of the interactions between immigration, racialization processes, and health. Because structural racism and its underlying ideologies produce individual experiences of day-to-day discrimination, attention to such ideologies is necessary. Nativist ideologies have historically functioned to define certain immigrant groups as inassimilable “others” (Sanchez, 1997), determining who qualifies for citizenship along racial lines (Collins, 1998; Gualtieri, 2009; Ignatiev, 1995; Ong, 1996). As several scholars have noted, “othering” processes produce and reproduce “marginalization, disempowerment and social exclusion” (Grove & Zwi, 2006, p. 1933; Schwalbe et al., 2000).

For Latino, Asian, and Black immigrant groups, “becoming American” involves contending with ideologies that render them racial “minorities” and the stigmatized meanings that the racialized society ascribes to their specific group (Viruell-Fuentes, 2007, 2011; Waters, 1994). Recent works, for instance, suggest various ways in which exposure to implicit and explicit messages that render certain groups of immigrants as racialized “others” may impact health. At the structural level, “othering” processes produce and reproduce inequality, in part, by “differentially locat[ing] individuals [and groups] within the ethnoracial hierarchy of the United States” (Viruell-Fuentes, 2007, 2011, p. 46). Groups that are ascribed a lower status on this hierarchy experience limited access to life opportunities, with negative consequences for their health, including those related to well-documented stress-response physiological processes (Kaestner, Pearson, & Geronimus, 2009; McEwen & Lasley, 2002; Pearson, 2008). Further, “othering” processes and the stigma they produce represent the backdrop against which immigrants attempt to construct a sense of ethnic belonging. As some scholars have suggested, “in attempting to arrive to a positive sense of self, [immigrants] engage with and actively resist [the] negative meanings” ascribed to their group (Viruell-Fuentes, 2011, p. 46). The active coping, vigilance, and tensions that arise in these processes may also impact health (James, 1994; Pearson, 2008; Viruell-Fuentes, 2011). Detailed examinations of how different groups of immigrants of color contend with the racial hierarchy of the United States and how these processes impact their health, however, is necessary.

In addition, becoming White in the United States is also a racialization process that some immigrant groups experience. As an invisible construct, Whiteness often goes unexamined in the literature on health disparities (Daniels & Schulz, 2006). However, given its strong association with privilege and social mobility, it is imperative for the next wave of research on immigrants to interrogate this construct and examine its relationship with health disparities. The experience of Arabs in the United States, for example, illustrates the importance of examining racialization processes across the spectrum of the U.S. racial/ethnic hierarchy.

In the United States, individuals of Arab descent are ascribed a White racial status. Like Irish, Italian, and Jewish immigrants before them in the first half of the twentieth century, Arab immigrants actively engaged in a “racial formation project” to become

White in order to gain citizenship status (Gualtieri, 2009; Majaj, 2000; Samhan, 1999). As such, Arabs have lived in the United States for decades as White subjects, rather than as racialized “others”. However, because Whiteness intertwines with national identity formation in the United States (Omi & Winant, 1994), recent cohorts of Arab immigrants have increasingly experienced the ambiguity of being symbolically included in the White racial category but excluded from its ensuing benefits (Naber, 2000). Analyzing the precarious position of Arab immigrants vis-à-vis Whiteness may be an alternative to cultural explanations and may better explain the inconsistent results in health studies on this group.

While studies examining individual experiences with discrimination represent an important line of inquiry, explorations of the ways in which structural racism impacts immigrant health are also needed. Structural racism refers to the ideologies, practices, processes, and institutions that operate at the macro level to produce and reproduce differential access to power and to life opportunities along racial and ethnic lines (Gee & Ford, 2011; Geronimus & Thompson, 2004; Jones, 2000; Powell, 2008). Because structural racism is embedded in societal-level institutions, policies, and practices, it influences health through multiple pathways. In the following sections, we highlight the importance of attending to immigration policies and residential segregation as manifestations of structural racism for understanding the link between immigration and health.

### Residential segregation, immigration, and health

Abundant evidence has revealed that residential segregation, through its attendant concentration of poverty, lack of resources, and exposure to environmental risk factors, affects physical and mental health, as well as access to care (Acevedo-García, 2000; Acevedo-García, Lochner, Osypuk, & Subramanian, 2003; Echeverría, Diez-Roux, Shea, Borrell, & Jackson, 2008; Gaskin, Price, Brandon, & LaVeist, 2009; Gresenz, Rogowski, & Escarce, 2009; Kirby & Kaneda, 2005; Mair, Roux, & Galea, 2008; Pickett & Pearl, 2001; Prentice, 2006; Williams & Collins, 2001; Williams & Sternthal, 2010). However, compared to the attention acculturation has received in the immigrant health literature, research on how place and migration intersect to influence health outcomes has been relatively recent. Studies that have taken up these issues raise important questions for future research.

One question this literature raises is whether higher neighborhood concentration of immigrants and/or co-ethnics (immigrant/ethnic enclaves) is protective or detrimental to health outcomes. Some scholars propose that immigrant/ethnic enclaves may be protective of health because they contain sets of relationships, institutions, and social resources that facilitate the day-to-day survival and functioning of immigrants and buffer the negative effects of social disadvantages (LeClere, Jensen, & Biddlecom, 1994; Portes, 1998). Ethnic/immigrant enclaves have been associated, for example, with lower intake of high-fat foods (Osypuk, Roux, Hadley, & Kandula, 2009); lower levels of depression (Vega, Ang, Rodriguez, & Finch, 2011); and improved access to health care (Gresenz et al., 2009). Other evidence, however, suggests that the beneficial aspects of ethnic enclaves are not without their limits. For instance, negative impacts of ethnic/immigrant enclaves on immigrant health have been found for several outcomes, such as physical activity (Osypuk, Roux et al., 2009); access to hypertension care (Viruell-Fuentes, Ponce, & Alegría, *in press*); and cancer incidence (Chang et al., 2010). And while some studies have found positive impacts of ethnic/immigrant enclaves on lower levels of certain conditions like obesity (Park, Neckerman, Quinn, Weiss, & Rundle, 2008), others have documented the opposite (Wen &

Maloney, 2011). Furthermore, living in ethnic and/or immigrant enclaves might have different meanings and effects depending on immigrant and generational status, language skills, socioeconomic position, and other markers of immigrant integration (Frank, Cerda, & Rendon, 2007; Mason, Kaufman, Emch, Hogan, & Savitz, 2010; Osypuk, Bates, & Acevedo-García, 2010).

As with the studies on discrimination and health, findings such as these suggest that a variety of methodological factors and conceptual issues may underlie the links between residential characteristics and health outcomes among immigrants. At the conceptual level, for some, such as U.S.-born racialized groups, living in immigrant/ethnic enclaves may reflect limited opportunities for social, economic, and residential mobility (Osypuk et al., 2010; Portes & Rumbaut, 2001). In addition, the socioeconomic disadvantages associated with high concentrations of immigrants and/or co-ethnics mean that individuals in these neighborhoods may be exposed to higher levels of violence and concentrated poverty; live in poorer housing conditions; and lack access to recreational facilities and other resources important for mental and physical wellbeing (Lee, 2009; Osypuk, Galea, McArdle, & Acevedo-García, 2009; Osypuk et al., 2010). Future research is necessary to better understand whether, how, for whom, and under what conditions immigrant enclaves are health protective. In addition, measuring and examining the specific pathways through which enclaves are hypothesized to impact health outcomes among immigrants is necessary; for instance, assessing the contributions of various neighborhood dimensions such as socioeconomic status, gentrification, and levels of social support, among others, are important next steps.

Lastly, while in some cases ethnic/immigrant enclaves in traditional urban immigrant gateway areas may provide a supportive environment for immigrants, the growing dispersion of immigrants to new and predominantly rural destinations means that many immigrants are settling in areas with little to no history of immigration. Many of these new immigrant destinations lack health infrastructures to serve immigrants, particularly those who speak languages other than English (Andrade & Viruell-Fuentes, 2011). This geographic dispersion also means that the racialization processes and “othering” experiences immigrants face in these new destinations may be both qualitatively and quantitatively different than those faced by immigrants who settle in more traditional immigrant destinations. Future research is, thus, necessary to better understand how racialization processes unfold within and across geographic locations and how these intersect with class and gender to impact health outcomes.

### Immigration policy as health policy

From a social determinants of health perspective, it is generally acknowledged that social and economic policies are synonymous with health policy (House, Schoeni, Kaplan, & Pollack, 2008). However, with the exception of their effect on immigrant access to health care, the health implications of immigration policies have received considerably less attention (Gee & Ford, 2011; Hester, personal communication).

Historically, immigration policies have served to reproduce ideologies that define national belonging along racial/ethnic lines and, in the process, have racialized immigrant groups deemed to be undesirable (Sanchez, 1997). Several scholars have also highlighted the ways in which public health and immigration policies have intersected at specific historical periods to racialize and construct particular groups of immigrants as a threat to the nation's health (Molina, 2006; for a fuller discussion of these issues, see Chavez, 2008; Gee & Ford, 2011; Molina, 2006; Ngai, 2004; and Sanchez,



1997). Indeed, as Gee and Ford (2011) suggest, exclusionary immigration policies represent a type of structural racism.

In the contemporary period, immigration policies have continued the historical trend of defining national belonging, with race and ethnicity remaining central in this process. In the first quarter of 2011 alone, 1538 immigration-related policies were introduced at the state level across the nation (Carter, Lawrence, & Morse, 2011); although some are intended to facilitate immigrant integration, many are aimed to restrict the rights of immigrants—particularly the undocumented. At the national level, a number of policies have escalated the militarization of the border and the criminalization of immigrants (Andreas, 2000; Inda, 2011; Rosas, 2006). All together, these policies are likely to have multiple negative effects on the health of immigrants (and anyone suspected of being one).

Anti-immigrant policies produce a barrage of messages and practices that racialize and construct immigrants as undesirable others and a threat to the nation (Chavez, 2008). In addition to the well-documented effects that immigration policies have had on limiting access to health and social services for immigrants, those policies also directly impact the fundamental causes of disease by shaping access (or lack thereof) to life opportunities, such as access to higher education and well remunerated employment opportunities. The effects of anti-immigrant policies can, thus, be far reaching in their ability to undermine the health and wellbeing of undocumented immigrants, their families, and communities. However, although immigration scholars have long documented the ways in which undocumented status impinges on the social and economic wellbeing of immigrants (Chavez, 1998), there is a dearth of research on how the construction of undocumented immigrants as “illegal” and the day-to-day challenges this social position poses for immigrants shape their health outcomes. We recommend that future research address these issues directly.

Furthermore, because anti-immigrant policies have heightened the racialization of anyone perceived to be an immigrant, their effects are likely to extend to documented immigrants and their U.S.-born co-ethnics. For instance, in the case of Latinos, race/ethnicity and immigrant status are often conflated, such that, in the popular imagination all Latinos are perceived to be Mexican, all Mexicans are seen as immigrants, and they, in turn, are all cast as undocumented. These connotations mean that anti-immigrant sentiments aimed at undocumented immigrants translate into a hostile environment for entire groups of people, regardless of their immigrant status. This has become evident in the increase in hate crimes against certain groups. Latinos, for example, have been targeted because of their presumed “illegal” status (Leadership Conference on Civil Rights Education Fund, 2009). And—following Homeland Security measures post-9/11—people who look “Arab” or “Muslim” have been targeted as well (Hagopian, 2004). In addition, immigrant families are often composed of members who hold different immigrant statuses, as is the case of undocumented parents of U.S.-born children, for instance. Future research that examines the ways in which anti-immigrant sentiments impact the health of immigrants, their children, and their U.S.-born co-ethnics is necessary.

Although research on the health effects of immigration policies is sparse, several studies point to their importance for health. For instance, Lauderdale (2006) found that, in the six-month period following 9/11 when anti-Arab sentiments surged, women who had Arab- or Muslim-sounding names in California experienced a rise in poor birth outcomes. Williams and Mohammed (2008) suggested that, compared to previous years, the decline in health that immigrants experienced in California in 2001 might be explained by the anxiety and fear associated with the increase in anti-immigrant sentiments and related imminent policies at play at

the time. Similarly, another study found a link between “the social, economic, political and historical circumstances” into which Mexican immigrants arrived in the United States and the number of depressive symptoms they experienced later on in their lives (Miranda et al., 2010, p. 706).

As several immigration scholars have recently indicated, the weight of immigration policies is such that immigrant legal status and citizenship have become central dimensions of stratification in U.S. society (Gee & Ford, 2011; Massey, 2007; Menjivar, 2010). Thus a deeper understanding of immigrant health outcomes requires careful examination of the effects of immigration policies on the health of immigrants and subsequent generations.

## Conclusion

In this paper, we have argued that a richer understanding of immigrant health patterns requires a shift in focus from individual-level cultural explanations to research that provides a broader, more in-depth analysis of racism as a structural factor that intersects with other dimensions of inequality, such as gender and class, to impact immigrant health outcomes. This shift is necessary because explanations that “place the onus of culture on the individual... are likely to lead to individual-centered interventions at the expense of addressing the structural contexts that reproduce social and economic inequities” (Viruell-Fuentes, 2007, p. 1533). Such a shift would involve an expanded examination of the impact of racialization processes, discrimination, residential segregation, and immigration policies on immigrant health outcomes. In particular, we recommend that future research examine the racialization of immigrants across the full spectrum of the U.S. ethno-racial hierarchy and across place. Such examinations would help shift the focus from immigrant cultures to the racial ideologies, policies, and day-to-day “othering” practices that serve to assign privilege to some groups and strip others from health-promoting resources. In particular, we suggest that analyses that treat immigration policies as health policies are imperative.

The literature we reviewed on the intersections of race and immigration represent an important example of immigrant health research moving away from cultural explanations toward an examination of structural factors. At the same time, it is important that future works examine the ways racialization and immigration processes influence and are influenced by class and gender, because the “failure to attend to how social categories depend on one another for meaning renders knowledge of any one category both incomplete and biased” (Cole, 2009, p. 173). Such an approach would help scholars better theorize about the various processes that may underlie puzzling (and at times contradictory) findings in the immigrant health literature.

Intersectionality theory calls scholars to attend to the unequal power relations that underlie social categories, such as race, class, and gender, and to move beyond treating them merely as demographic variables (Caldwell, Guthrie, & Jackson, 2006). As Cole (2009) suggests, applying this theory does not mean that every study has to include an exhaustive combination of the above (or other) social identities; rather, the theory encourages scholars to approach their work as being grounded in socio-historical contexts. We argue, as Cole (2009) does, that applying intersectionality to immigrant health research would necessitate a conceptual shift in the way social categories are currently viewed and understood by scholars. In the public health literature, immigration-related variables—such as nativity, generational status, language use, length of time in the United States, citizenship status, and age at migration—are often interpreted as proxies for acculturation. Applying intersectionality theory to the study of immigrant health would thus require fuller theorizing about the *meaning* of these

markers under specific contexts, and about how these meanings are mutually influenced by race, class, gender and other social hierarchies. For instance, in some cases generational status may be less a marker of individual-level cultural shifts and more a marker of distinct positions with respect to historical and structural gender, class, and racialized constraints that influence integration into the United States (Hurtado, Gurin, & Peng, 1994; Viruell-Fuentes, 2007). Similarly, under some conditions, immigrants who are proficient in the English language may choose to communicate in their mother tongue to signal cultural pride and resistance to pervasive, negative racial and gendered stereotypes that associate their ethnic group with violence, for instance (Abdulrahim & Baker, 2009).

Amidst increasing anti-immigrant environments, a focus on the structural factors that influence the lives of immigrants and those of subsequent generations is necessary to better develop multi-level interventions that promote the successful, healthy integration of immigrants and their children into the country.

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