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Authors
LeBrón, Alana MW
Viruell-Fuentes, Edna A

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Chapter 14
Racial/Ethnic Discrimination, Intersectionality, and Latina/o Health

Alana M. W. LeBrón and Edna A. Viruell-Fuentes

Abstract In this chapter, we summarize the existing literature on self-reported experiences of racial/ethnic discrimination and health status among Latina/o persons in the USA, explore the implications for Latina/o/x health, and identify future directions of research in this critical area. We reviewed 25 peer-reviewed articles that quantitatively examined the association between self-reported discrimination and mental or physical health, published between 2000 and 2016. The reviewed studies were primarily cross-sectional and few compared Latina/o subgroups. We encourage researchers to examine the health impacts of racial/ethnic discrimination on Latina/o health through intersectionality theory to assess discrimination across multiple intersecting social statuses. We also recommend that researchers examine the longitudinal health consequences of structural forms of racism such as carceral policies, educational policies, environmental quality, immigration enforcement, residential segregation, and health care access and quality across spatial contexts.

Keywords Discrimination · Immigration policies · Intersectionality theory · Latinx health · Racism

Anti-immigrant and anti-Latina/o/x ideologies and policy proposals advanced following the 2016 election of Donald J. Trump as President of the USA illustrate the persistent and dynamic context of racialization of Latina/o/x persons in the twenty-first century. In the month following the election, the country experienced a sharp increase in hate incidents in public and private spaces, 29% of which were anti-immigrant in nature and 14% of which were classified as anti-Latina/o/x (Southern Poverty Law Center, 2016). Hate incidents represent one important aspect of racism in

A. M. W. LeBrón (✉)
Department of Population Health and Disease Prevention and Department of Chicano/Latino Studies, University of California, Irvine,
CA, USA
e-mail: alebron@uci.edu

Department of Chicano/Latino Studies, University of California, Irvine, CA, USA

E. A. Viruell-Fuentes
Department of Latina/Latino Studies, University of Illinois, Urbana-Champaign,
IL, USA

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the USA, joining other forms of personally mediated racism and institutional racism as components of structural racism. In 2016, 52% of Latina/o/x persons reported regular or occasional experiences of discrimination linked with their racialized status (Krogstad & Lopez, 2016). These reports varied by nativity, age, and educational attainment, indicating the intersectional nature of racism (Krogstad & Lopez, 2016). These processes have important implications for health inequities[1] and for health patterns among Latina/o/x persons.

As a structural determinant of health, racism operates through institutions and policies that shape access to health-promoting resources, such as housing; community social and economic resources; exposure to physical environments; educational and employment opportunities; and the opportunity to reside in the USA (Jones, 2000; Viruell-Fuentes, Miranda, & Abdulrahim, 2012; Williams & Mohammed, 2013). Racism also structures and is reinforced by ideologies and representations that reify policies that negatively shape the opportunities of communities targeted with racism and emboldens personally mediated racism (Jones, 2000; Viruell-Fuentes et al., 2012; Williams & Mohammed, 2013). Racism thus not only shapes access to resources that are fundamental to promoting health, but also serves as a profound and persistent life stressor that has cumulative effects on health and well-being (Lewis, Cogburn, & Williams, 2015; Williams & Mohammed, 2013).

Variations in health patterns among Latina/o/x persons discussed in other chapters in this volume necessitate an examination of the contributions of racism to these patterns. While an increasingly prominent line of inquiry has established linkages between racism and physical and mental health for non-Latina/o Black persons (henceforth, *Black persons*), the literature regarding the health implications of racism for Latina/o persons, and variations in these associations by social statuses, is still emerging. The primary goal of this chapter is to summarize and synthesize the existing literature on self-reported experiences of racial/ethnic discrimination and health status among Latina/o persons in the USA, discuss implications for the health of Latina/o/x populations, and identify future directions for research in this critical area.

The literature on racism and health reviewed in this chapter is based on responses by Latina/o persons' to validated surveys that assess experiences of discrimination that individuals attributed to their racial/ethnic status, as well as general experiences of discrimination that individuals did not restrict to their racial/ethnic status. It is difficult to separate multiple, intersecting social statuses when examining the experiences with racism among Latina/o persons (Viruell-Fuentes et al., 2012). Accordingly, we conceptualize measures of both racial/ethnic discrimination and general discrimination as capturing experiences with racism. Additionally, we conceptualize other measures (e.g., subscales of the Hispanic Stress Inventory and indicators of fear of deportation) as assessing a subset of experiences with and vigilance toward racism (Cavazos-Rehg, Zayas, & Spitznagel, 2007; Cervantes, Fisher, Padilla, & Napper, 2016; Cervantes, Padilla, & Salgado de Snyder, 1991). While there is a body

[1]We define health inequities as differences in health that are systematic, preventable, unjust, and actionable (Whitehead, 1991).

of literature that addresses acculturative stress among Latina/o persons (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006; Abraído-Lanza, Chao, & Flórez, 2005; Abraído-Lanza, Echeverría, & Flórez, 2016), which, as noted, sometimes includes subscales related to discrimination, our review is focused on the literature that explicitly sought to address the links between discrimination and health, conceptually and empirically.

Racialization Processes and Racial Categories

Race/ethnicity are socially constructed categories that capture the historical and contemporary consequences of differential access to social, political, and economic opportunities (Almaguer, 2009; Omi & Winant, 2015). Throughout the latter part of the 20th century and the beginning of the 21st century, the term *Latina/o* (as opposed to Hispanic) has been used to foreground the histories of colonization of, and contemporary foreign policy towards, some Latin American countries or territories by the US, all of which have contributed to the presence and position of Latinas/os within the US racial/ethnic structure.

As an intrinsic component of racialization processes, racial/ethnic categories are created, contested, inhabited, transformmed, and eventually destroyed (Omi & Winant, 2015). Currently, social movements are elevating intersectional and queer analyses and strategies to understand and address racialization processes. Accordingly, there is a growing discussion of strategies to incorproate a range of gender and queer identities when referring to persons of Latin American origin or descent. One such strategy involves moving away from the term *Latino* (intending to encompass women and men, though linguistically a masculine term) and towards labels that include cis-women (e.g., *Latina*), cis-men (e.g., *Latino*), and persons who do not identify along gender binaries (e.g., *Latin@* or *Latinx*).

Consistent with racialization processes, these discussions, practices, and responses are ongoing and dynamic. For example, as in this edited volume, the term *Latinx* is increasingly being used to refer to persons of Latin American origin or descent. Affected community members and members of dominant social structures have responded to this movement in a range of ways, including but not limited to: embracing the term Latinx to refer broadly to people of Latin American origin or descent; recognizing queer identities by specifically referring to queer persons or populations as Latinx; and/or resisting practices that refer to cis-Latinas and cis-Latinos as Latinx.

Our review encompasses literature on racial/ethnic discrimination and the health of people in Latin American descent or origin published between 2000 and 2016, at which time, the literature largely lacked an intersectional and queer analytic lens. We use the term *Latina/o* when referring to findings from specific studies to reflect the state of this literature. When discussing health patterns at the population level, we include queer identities by using the term *Latina/o/x*. Recognizing great heterogeneity within the Latina/o/x population, we refer to specific country or territory of

origin or descent whenever possible. We return to these issues in our conclusion, wherein we call for scholarship that advances intersectional and queer lenses to the study of racial/ethnic discrimination and health among individuals and communities of Latin American origin and descent in the United States.

Racism Trickles Down to Matters of Health

Racism is a dynamic social process through which racial/ethnic meanings and differences are constructed and reconstructed across historical moments and social contexts, with deleterious consequences for those targeted with racism (Almaguer, 2009; Omi & Winant, 2015; Schwalbe et al., 2000). Ascribed racial/ethnic meanings produce and are used to justify social, economic, and political inequities that are patterned by race/ethnicity and profoundly shape access to health-promoting resources and institutions (Jones, 2000). Often unfolding in the form of ideologies, institutional practices or policies, and interpersonal processes, racism serves to limit access to health-promoting resources according to an individual's or group's ascribed, (de)valued status and produce race-related stressors (Almaguer, 2009; Jones, 2000; Omi & Winant, 2015; Schwalbe et al., 2000). Processes of racism also invoke other social statuses, such as gender, socioeconomic position, nativity, and citizenship (Viruell-Fuentes et al., 2012). These processes that shape social hierarchies and identities are fluid and relational, while also obdurate, and interact over time and within particular contexts (Collins, 1990, 2012; Crenshaw, 1989; Ford & Airhihenbuwa, 2010; Hankivsky, 2012).

Consistent with processes of racism that ascribe social labels and statuses, the US Office of Management and Budget (OMB), designated Latina/o/x persons as a "Hispanic" social group[2] (OMB, 1997) and as the only recognized "ethnic" group in the USA, regardless of country or territory of origin or descent. Latina/o/x persons have a longstanding and complex history with racism in the USA (Acuña, 2011; Almaguer, 2009). However, partly due to the above-mentioned state-driven processes of labeling Latina/o/x persons as an ethnic group, rather than a racial group, the development of scholarship focused on the health implications of racism for Latina/o/x persons is still emerging. That is, studies that center on ethnicity motivate attention to cultural distinctions across groups and on attributions of health differentials to cultural processes. In contrast, studies that highlight "race" seek to attend to how the multiple dimensions of racism, such as the role of institutional and interpersonal racism, shape health and well-being. Consequently, while Latina/o/x persons as a group, and subgroups within this heterogeneous population, have experienced historical and contemporary racism, the great majority of the Latina/o health liter-

[2] Some individuals and communities with social, historical, and/or birth ties to Latin American countries or colonized territories identify with the term *Latina/o/x* as a strategy to resist government-driven racial/ethnic labels and embrace their political status and history as a social bloc, rather than identify with their colonizer (i.e. Spain) (Alcoff, 2005; Hayes-Bautista & Chapa, 1987).

ature has focused on culture and acculturation to explain health outcomes among Latina/o persons (Hunt, Schneider, & Comer, 2004; Viruell-Fuentes, 2007; Viruell-Fuentes et al., 2012).

Structural racism, including ideologies, policies, and institutional and interpersonal practices, often finds expression in day-to-day experiences (Viruell-Fuentes et al., 2012),[3] some of which are captured in existing quantitative measures of self-reported discrimination[4] (Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005; Williams & Mohammed, 2009, 2013). While some of the literature involving quantitative measures of discrimination characterizes these reports of discrimination as "perceived discrimination," we conceptualize these reports as "self-reported discrimination." As Krieger and colleagues (2005) explain, "While self-reported experiences must be perceived, not all perceived experiences are necessarily reported, depending on individuals' willingness or ability to report them" (p. 1578). Additionally, nomenclature of "perceived discrimination" may erroneously be interpreted as the experience not having occurred or as not being discriminatory, and risks minimizing the structural conditions that give rise to experiences of discrimination. Furthermore, referring to quantitative measures of discrimination as "self-reported discrimination" acknowledges that the process of interpreting discriminatory experiences is shaped by exposure to contextually specific racialization processes and thus identifying and articulating experiences of discrimination within that context.

What follows is a review of the literature examining the social patterning of discrimination and associations between discrimination and health for Latina/o persons. We begin by describing the most common quantitative measures of discrimination, then summarize the literature regarding the patterning of discrimination among Latina/o persons, and synthesize the literature examining associations between discrimination and health. We conclude with an analysis of this literature and provide recommendations for future research.

Measuring Racial/Ethnic Discrimination

Racial/ethnic discrimination is conceptualized as capturing exposure to processes that restrict access to resources such as quality education, employment, housing, health care, goods, and services, and the opportunity to remain in the USA and/or outside of carceral institutions on the basis of race/ethnicity (Almaguer, 2009; Nagel, 1994; Omi & Winant, 2015; Schwalbe et al., 2000). In addition to capturing exposure to the production of inequalities through restricted access to institutional, material, and social resources and opportunities, several measures of discrimination capture exposure to psychosocial stressors associated with these processes (Lewis et al., 2015; Williams & Mohammed, 2013).

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[3]For a discussion of the health implications of internalized racism and stereotype threat, please see (Williams & Mohammed, 2013).

[4]Throughout this chapter, we refer to self-reported discrimination as *discrimination*.

Several widely available quantitative scales capture micro- and macro-level aspects of experiences of discrimination (Bastos, Celeste, Faerstein, & Barros, 2010; Lewis et al., 2015; Paradies et al., 2015; Pascoe & Richman, 2009; Williams & Mohammed, 2013). One of the most common scales applied in the literature on discrimination and health among Latina/o persons that we reviewed is the Everyday Unfair Treatment Scale (Williams, Yu, Jackson, & Anderson, 1997), which assesses exposure to day-to-day indignities (e.g., being treated with less courtesy or respect) and inferior service or treatment (e.g., receiving poorer service than others, people act as if they are afraid of you) (Williams et al., 1997). The experiences captured in the Everyday Unfair Treatment Scale are conceptualized as being rooted in systems of oppression, but are not necessarily linked with a particular institutional source or setting. Studies involving the Everyday Unfair Treatment Scale often query about experiences of unfair treatment or discrimination generally, then ask the respondent to attribute their experience(s) to a range of social statuses (e.g., gender, age, socioeconomic position, where they live, language use, nativity, race, ethnicity, sexual orientation, and ability). Some studies restricted survey questions or analyses to experiences of discrimination that respondents specifically attributed to their racial/ethnic identity or national origin or descent. Other studies considered experiences of discrimination regardless of attribution, and yet other studies evaluated the health implications of discrimination that respondents attributed to multiple social statuses or identities.

Other scales used in the articles we reviewed, albeit far less frequently than the Everyday Unfair Treatment Scale, include: the Experiences of Discrimination Scale (Krieger, 1990; Krieger et al., 2005), the Reactions to Race module (Purnell et al., 2012), the Perceived Racism Scale for Latinos (Collado-Proctor, 1999), the Perceived Ethnic Discrimination Questionnaire (Brondolo et al., 2005), and subscales of acculturation scales (e.g., Acculturation Stress Subscale of the Social, Attitudinal, Familial, and Environmental Scale) (Mena, Padilla, & Maldonado, 1987). This range of scales used to assess Latina/o persons' experiences with discrimination reflects the multiple life domains in which different forms of discrimination may unfold.

Overall, these measures attempt to capture processes that are involved in the construction and maintenance of inequalities that are associated with and reinforce systems of racial oppression. Although some of these scales were developed based on an understanding of the racialized experiences of Black persons in the USA in the 1990s, these measures have proven useful in our understanding of the links between discrimination and health among Latina/o persons.

Social Patterning of Self-reported Discrimination

Consistent with intersectionality theory (Collins, 1990, 2015; Crenshaw, 1991), Latina/o among persons the prevalence of self-reported discrimination varies by several social statuses and identities, with some patterns varying according to the specific characteristics of the sample and the measure used to assess discrimination. A consistent finding across studies is that younger Latina/o persons report more fre-

quent experiences of discrimination than their older counterparts (Finch, Kolody, & Vega, 2000; LeBrón et al., 2014, 2017; Pérez, Fortuna, & Alegría, 2008) after accounting for socioeconomic position, gender, nativity, and/or indicators of length of US residence or citizenship status. This finding of more frequent reports of discrimination among younger Latina/o persons suggests that social factors associated with age may pattern experiences of discrimination and/or the likelihood of reporting them. Younger Latina/o/x persons may encounter more frequent discrimination than older adults, perhaps attributed to stigma associated with both their racial/ethnic identity and age, or to structural patterns of their day-to-day lives (e.g., employment or caregiving responsibilities).

Gender may also shape the patterning of self-reported discrimination, although evidence is mixed. Finch and colleagues (2000) found that Mexican American and Mexican immigrant men in California were more likely than women to report discrimination attributed to their racial/ethnic subgroup, after accounting for nativity, social and economic characteristics, and geographic context. Similarly, Pérez and colleagues (2008) found that in a national sample, Latino men were more likely than Latina women to report discrimination, controlling for nativity, Latina/o identity, age, and socioeconomic position. In contrast, LeBrón and colleagues (2014, 2017) found no gender differences in the reported frequency of discrimination for Latina/o adults with diabetes in Detroit, MI, after accounting for nativity and social and economic status. One possible explanation for these different patterns may have to do not only with the specific scales used to measure discrimination, but also with the geographic context in which these studies took place. That is, these differing findings suggest that there may be differences in the patterning of discrimination linked with contextual characteristics of communities that have had longstanding and large Latina/o/x populations, relative to community contexts with smaller Latina/o/x populations, and new destination communities where the Latina/o/x population has experienced recent growth. Studies that examine gender differences in discrimination across geographic contexts and alongside other social statuses (e.g., age, nativity, and socioeconomic position) are needed to better understand how gender shapes experiences and/or reporting of discrimination.

The social patterning of discrimination by educational attainment is also mixed. For a nationally representative sample of Latina/o adults (Pérez et al., 2008) and a study of Latina/o adults from a Midwestern city (LeBrón et al., 2014), Latina/o persons with more than a high school education or at least a high school education, respectively, reported more frequent discrimination than their counterparts with lower educational attainment. In contrast, Finch and colleagues (2000) reported that among Mexican American and Mexican immigrant adults in California, the patterning of reported discrimination by educational attainment was more nuanced: Adults with 7–11 years of education reported more frequent discrimination attributed to their racial/ethnic subgroup than adults with lower educational attainment, and no difference in these patterns for adults with a high school education or higher. Further complicating these patterns, LeBrón and colleagues (2017) found that for Latina/o adults in Detroit, MI, the patterning of educational attainment with racial/ethnic discrimination varied by the specific type of discriminatory experiences: Greater

educational attainment was associated with more frequent reports of poorer service and being treated as if the participant was not smart due to their racial/ethnic subgroup. In contrast, educational attainment was not associated with experiences of being treated with less respect, treated unfairly, or threatened or harassed due to their racial/ethnic subgroup. The authors posited that the context of discrimination in which race/ethnicity *and* educational attainment may be salient—such as educational settings, workplaces, or settings in which one's intelligence or knowledge may be invoked—may have shaped the salience of educational attainment in these dimensions of racial/ethnic discrimination.

Together, these patterns suggest the importance of including more nuanced measures of educational attainment in considerations of the social patterning of discrimination for Latina/o/x persons. These differences across studies may be shaped by the aggregation of Latina/o subgroups in the former studies; differences in the social, political, and economic contexts across study locations (e.g., national sample, Midwest, California); and/or differences across measures (i.e., general discrimination vs. discrimination attributed to specific racial/ethnic group and/or to the specific type of experiences of discrimination).

Another important dimension of the experience and reporting of discrimination is immigrant generation or nativity and, for immigrants,[5] length of US residence or age at migration. Pérez and colleagues (2008) report that while they found no difference in reports of discrimination by immigrant generation, Latina/o adults who arrived to the continental USA between ages 7 and 24 (as opposed to their age at the time of the survey) were less likely to report discrimination than those who arrived to the continental USA at a younger age. LeBrón and colleagues (2014) found that US-born Latina/o persons and Latinx Latina/o immigrants who resided in the USA for a longer period reported more frequent discrimination than immigrants with a shorter time period in the USA. In addition, another study of Latina/o adults in Detroit, MI, found that US-born Latina/o persons reported more frequent racial/ethnic discrimination than their immigrant counterparts, though the strength of these associations was non-linear and contingent upon length of US residence for Latina/o immigrants and the specific dimension of discrimination assessed (LeBrón et al., 2017). The authors posited that the immigration policy context upon entry to the USA might shape these non-linear associations of length of US residence with racial/ethnic discrimination for immigrant Latina/o persons relative to US-born Latina/o persons. That is, non-linear associations of length of US residence with reports of discrimination may reflect length of exposure to racialization processes in the USA as well as cohort effects of immigration policies or contexts of reception when Latina/o immigrants migrated to the USA given that immigration policies and sentiments toward Latina/o persons vary according to the sociopolitical context (Chavez, 2013; Viruell-Fuentes et al., 2012).

[5]Our use of the term "immigrant" refers to individuals and communities born outside of the United States who have or may be perceived to settle in the United States, or who migrated to the USA with the intent of settling. Due to their birthright citizenship, we refer to Puerto Ricans as "migrants" when referencing to studies involving Puerto Ricans who were born in Puerto Rico and resided in the continental USA at the time of the study.

Taken together, the association of immigrant generation and, for (im)migrants, length of US residence or age at migration, with self-reported discrimination may reflect the implications of coming of age in the USA for exposure to racialization processes and/or ways of understanding the US racial/ethnic structure that may be learned over time or through experiences with US institutions (Viruell-Fuentes, 2007). Additionally, these patterns may reflect cohort effects of immigration policies or other social and economic policies that may shape Latina/o persons' experiences and reporting of discrimination (LeBrón et al., 2017). Indeed, Finch et al. (2000) found that patterns of discrimination that respondents linked with their racial/ethnic subgroup vary by a complex interplay of nativity, citizenship status, and language use.

Measures of discrimination have been developed with the goal of capturing multilevel, dynamic systems of racial oppression (Krieger et al., 2005; Williams et al., 1997). Accordingly, patterns of discrimination may vary across policy contexts, including national, state, and local policies and the extent to which such policies are inclusionary or exclusionary toward Latina/o/x populations. As indicated in this review of the literature, it is difficult to capture self-reported experiences with structural forms of racism that limit a person's due process, cause material deprivation, restrict access to other health-promoting resources, and which serve as profound stressors. Studies that take historical, national, state, and local sociopolitical contexts into account in the study of racial/ethnic discrimination begin to address this challenge.

For example, given the historical construction of Latina/o persons as perpetual foreigners (Chavez, 2013), an emerging body of literature has considered the role of increasingly restrictive immigration policies in processes that racialize Latina/o persons. Almeida, Biello, Pedraza, Wintner, & Viruell-Fuentes (2016) report that for a national sample of Latina/o adults, those residing in states with more anti-immigrant policies implemented between 2005 and 2011 reported greater discrimination than their counterparts in states with fewer anti-immigrant policies passed over the same period. Patterns of discrimination linked with the state immigration policy context varied by country or territory of origin and immigrant generation. The positive association of anti-immigrant policies and discrimination was strongest for third-generation Latina/o persons relative to first- and second-generation Latina/o persons and for Latina/o persons of Mexican, Cuban, or any other country of origin compared to Puerto Ricans. These findings suggest that state-level anti-immigrant policies that have unfolded in the early twenty-first century heightened the context of discrimination for Latina/o persons, with adverse effects that extend beyond immigrants to US-born Latina/o persons, and with particularly acute effects for Latina/o persons with ties to Mexico and other Latin American countries.

Together, these variations in discrimination across several social statuses suggest important differences within the Latina/o/x population. The social patterning of discrimination discussed above may reflect differences in interpretation or readiness to characterize encounters with racism, internalized racism and other aspects of Latina/o/x racialized status. Attending to differences in the reported frequency of discrimination is important because such differences may contribute to differen-

tial effects of discrimination on health, or to differential estimations of the health implications of self-reported discrimination.

Self-reported Discrimination and Health

We identified and reviewed 25 peer-reviewed articles that quantitatively examined the association between self-reported discrimination and mental or physical health. Studies included in this review were published between 2000 and 2016 and included at least 30 Latina/o adults (aged 18 and older), in order to make inferences of the reported associations to the Latina/o/x population. For the purposes of this review, we excluded studies where health care discrimination was the only measure of discrimination. The majority of the identified studies were national in scope and/or from cities or metropolitan areas in the Southwestern or Northeastern USA, with a handful of studies conducted with samples from the Midwest. Though this literature varies in the specific scales used to assess the frequency of self-reported discrimination or discrimination-related stress, the most common scale utilized in these studies was the Everyday Unfair Treatment scale (Williams et al., 1997). In the sections that follow, we characterize the literature evaluating associations between discrimination and health for Latina/o persons and consider mechanisms by which discrimination may shape the health of Latina/o/x persons.

Self-reported Discrimination and Mental Health

Twelve out of the 25 studies we reviewed examined associations of discrimination and indicators of mental well-being for Latina/o persons. This literature suggests a consistent and robust association of discrimination with adverse mental health outcomes. Discrimination, in general, was positively associated with psychological distress for a national sample of Latina/o persons (Molina, Alegría, & Mahalingam, 2013); symptoms of post-traumatic stress disorder for a multiracial sample of pregnant women in Michigan (Seng, Lopez, Sperlich, Hamama, & Reed Meldrum, 2012); psychotic experiences for a national multiracial sample, including Latina women (Oh, Yang, Anglin, & DeVylder, 2014); anxiety and depressive disorders for a national sample of Latina/o immigrants (Leong, Park, & Kalibatseva, 2013); number of poor mental health days for Latina/o persons in New York City (Stuber, Galea, Ahern, Blaney, & Fuller, 2003); and diabetes-related distress and depressive symptoms for Latina/o persons with diabetes in Detroit, MI (LeBron et al., 2014).

Other studies have examined the mental health implications of discrimination that Latina/o persons attribute to their specific racial/ethnic subgroup. Discrimination that respondents linked with their racial/ethnic subgroup was positively associated with depressive symptoms for Mexican Americans and Mexican immigrants in California (Finch et al., 2000; Flores et al., 2008); psychological distress for a sample of

Latina/o persons (predominantly Cubans and Puerto Ricans) in Florida (Moradi & Risco, 2006) and in a sample of Mexican and Central American immigrant day laborers in a southwestern city (Negi, 2013); poorer mental health status for a multiracial sample in New Hampshire (Gee, Ryan, Laflamme, & Holt, 2006); and elevated symptoms of depression and anxiety for a multiracial sample of men who have sex with men in Los Angeles, CA (Choi, Paul, Ayala, Boylan, & Gregorich, 2013).

The strength of the association of self-reported discrimination with mental well-being may be shaped by multiple intersecting identities. Two studies identified in this literature review (Choi et al., 2013; Seng et al., 2012) suggest that discrimination that respondents attributed to multiple marginalized identities may be more strongly associated with poor mental health. Similarly, the mental health implications of discrimination may be stronger for Latina women relative to Latino men. Finch and colleagues (2000) reported that the positive association of discrimination attributed to racial/ethnic subgroup with depressive symptoms was stronger for Mexican women than Mexican men. Likewise, Molina and colleagues (2013) reported stronger associations of discrimination with psychological distress for Mexican women relative to Cuban and Puerto Rican men. The authors conjecture that these differential impacts of discrimination on mental health by gender and Latina/o subgroup may be linked with Mexican women's management of multiple chronic stressors, some of which were encompassed within the measure of discrimination. Additionally, the authors note that Puerto Rican men in this sample reported high levels of discrimination, while Cuban men in this sample reported low levels of discrimination. Though the authors do not disentangle these associations for Mexican women relative to Mexican men, this study illustrates the need to consider the role of multiple social statuses in shaping experiences with discrimination and its health impacts. This literature suggests complex dynamics between experiences of discrimination, discrimination attributed to racial/ethnic subgroup, gender, and mental well-being. To better understand these complexities, research is needed that considers the ways in which racialized experiences are gendered (and vice versa) and their implications for health outcomes.

The mental health implications of experiences of discrimination may be compounded by or operate through stress responses to discrimination. Indeed, Gee et al. (2006) reported that greater discomfort with discrimination linked with racial/ethnic subgroup was associated with worse psychological well-being for a multiracial sample that included Mexican Americans, Latina/o adults of other countries of origin or descent, and Black adults in New Hampshire.

Self-reported Racial/Ethnic Discrimination and Self-reported General or Physical Health

As with indicators of mental well-being, several studies suggest a consistent association of discrimination more generally and discrimination attributed to racial/ethnic

subgroup with: adverse self-rated general health (Flores et al., 2008); poor self-rated physical health (Finch, Hummer, Kol, & Vega, 2001; Molina et al., 2013; Ryan, Gee, & Laflamme, 2006); higher number of days of poor general health (Otiniano & Gee, 2012); higher number of days with activity limitations (Otiniano & Gee, 2012); lower quality of life (Seng et al., 2012); and higher number of self-reported indicators of acute physical symptoms (Flores et al., 2008; Lee & Ferraro, 2009; Pilver, Desai, Kasl, & Levy, 2011). Each of these studies included Latina/o persons and controlled for several social and economic characteristics. However, for a multiracial sample, Stuber and colleagues (2003) did not find support for the hypothesis of an association of discrimination attributed to racial/ethnic subgroup or discrimination more generally with days of poor physical health.

Though this association of discrimination with self-reported general or physical health was robust across eight of the nine identified studies, only a handful of studies examined potential variations in the association of discrimination and self-rated health for Latina/o persons by gender. Flores and colleagues (2008) reported that the inverse association of discrimination with self-rated general health was stronger for Mexican-origin men than women. In more specific tests of intersectionality, Seng and colleagues (2012) found that for a multiracial sample of pregnant women, discrimination, and a greater number of marginalized identities that respondents attributed to their experiences of discrimination, were associated with worse quality of life. Pilver and colleagues (2011) report that the intensity and attribution of experiences of discrimination shape the association of discrimination and health for a non-stratified multiracial national sample. Discrimination on the basis of gender and racial/ethnic subgroup was more strongly associated with premenstrual dysphoric disorder, and there was a stronger association of more subtle forms of reported discrimination with premenstrual dysphoric disorder than blatant forms of discrimination.

In terms of variations in self-rated health by social statuses or identities related to migration (i.e., nativity, length of US residence), Finch, Hummer, Kol, and Vega, (2001) found no differences in these associations for a sample of Mexican American or Mexican immigrant adults. With regard to differences in self-reported health by Latina/o subgroup, in a more specific examination of the association of discrimination with physical health symptoms, frequency of discrimination was positively associated with acute physical symptoms (e.g., headaches, chest or heart pains, upset stomach, hot or cold spells, feeling week, and back pain) for Puerto Rican and Mexican American adults in Chicago, IL (Lee & Ferraro, 2009). These studies, as a whole, highlight the need to examine patterns by Latina/o/x subgroup and other social experiences, such as citizenship, nativity, and length of US residence.

Self-reported Discrimination and Anthropometrically or Clinically Assessed Indicators of Health

Discrimination may also shape health by adversely affecting clinically and anthropometrically assessed indicators of physical health, although evidence of these associations, based on nine studies identified in this review, is mixed. The majority of iden-

tified studies examining how discrimination becomes embodied are based on multiracial samples that include Latina/o persons. Racially stratified models suggest no cross-sectional association of discrimination with blood pressure for a national sample of middle-aged Latina women (Brown, Matthews, Bromberger, & Chang, 2006), blood pressure for unionized Latina/o workers in the greater Boston area (Krieger et al., 2008); nor overweight, obesity, and waist circumference for Latina/o adults in Chicago, IL (Hunte & Williams, 2009).

Some studies involving aggregated multiracial groups suggest that discrimination is associated with cardiovascular and metabolic risk. Ryan and colleagues (2006) reported a U-shaped association of racial/ethnic discrimination with systolic blood pressure, but not diastolic blood pressure for US-born and immigrant Black and Latina/o immigrants in New Hampshire. That is, adults reporting the lowest and the highest levels of racial/ethnic discrimination had higher systolic blood pressure than adults reporting some experiences of discrimination. These associations did not differ for Black adults relative to Latina/o adults.

The patterning of discrimination with indicators of cardiovascular risk also varies jointly by age and indicator of health. For example, Moody and colleagues (2016) reported that racial/ethnic discrimination was more strongly associated with elevated diastolic blood pressure for middle- and older-aged Black and Latina/o adults compared to younger adults, and discrimination was positively associated with nocturnal systolic blood pressure, regardless of age.

The association of discrimination with health may also vary by gender and indicator of cardiovascular health. McClure, Martinez et al. (2010) and McClure, Snodgrass et al. (2010) report that among a sample of predominantly Mexican immigrant farmworkers in Oregon, racial/ethnic discrimination-related stress predicted elevated systolic blood pressure (SBP) among men but not women, controlling for age and length of US residence. Additionally, racial/ethnic discrimination-related stress was more strongly associated with elevated systolic blood pressure for men of lower socioeconomic position relative to men of higher socioeconomic position (assessed by indicators of educational attainment, personal income, and household income).

It is possible that the implications of discrimination for cardiovascular or metabolic health may manifest over a longer period of time. We identified only one study that included Latina/o persons that examined the longitudinal association of discrimination with a clinical indicator of health (Kwarteng et al., 2016). Kwarteng et al. (2016) found that baseline frequency of discrimination was positively associated with increases in central adiposity over a six-year period for an aggregated sample of Latina/o Black, and non-Latina/o white adults (white adults) in Detroit, MI.

In cross-sectional studies, discrimination may be more visible for indicators of health that may be more responsive to racialized stressors in the short term, such as immune function. Indeed, Bogart, Landrine, Galvan, Wagner, & Klein (2013) found that among HIV-positive Latino men who have sex with men, discrimination across multiple domains was associated with greater severity of anti-retroviral medication side effects and more AIDS symptoms. Similarly, McClure, Martinez et al. (2010) report that for a sample of predominantly Mexican-origin farm workers in Oregon,

racial/ethnic discrimination-related stress predicted elevated levels of Epstein-Barr virus antibodies (an indicator of immune function) among men, but not women. Further, this association was stronger for men of higher socioeconomic position compared to men of lower socioeconomic position. If the health implications of discrimination are visible for immune responses in the short term, it is possible that the immune response triggered by discriminatory experiences may be a bellwether for subsequent responses to stressors that affect other physical health outcomes (e.g., metabolic and cardiovascular risk) later in the life course. Together this literature suggests that the associations of discrimination with anthropometric indicators of health status are mixed, with some findings varying by age, gender, and by the intensity and timing of experiences of discrimination relative to the assessment of health status.

Mechanisms by Which Discrimination Shapes Health and Health Inequities for Latinx Persons

The self-reported discrimination measures described above and the conceptual frameworks that guide the body of literature reviewed here point to multiple mechanisms through which discrimination affects health. Indeed, the studies reviewed above rely on several theoretical frameworks that seek to tease out the social, psychological, and physiological mechanisms through which discrimination affects health. Several studies characterize discrimination as a vulnerability for adverse health outcomes that operates through biopsychosocial and stress processes. For instance, "the biopsychosocial model" approaches health with the understanding that biological, psychological, and social factors comprise a complex system that influences health (Engel, 1977). In a more specific extension of the biopsychosocial model, "the stress process framework" posits that marginalized social statuses increase exposure to stressors and that stress processes catalyzed by responses to stressors may accumulate to adversely affect health (Lazarus & Folkman, 1984; Pearlin, Menaghan, Lieberman, & Mullan, 1981). It follows from this framework that discrimination is a stressor—the exposure to which (including the form, frequency, and intensity of the exposure) and its health consequences are shaped by social statuses, such as race/ethnicity.

Building upon stress process theories (Lazarus & Folkman, 1984), some of the studies we reviewed are informed by the Minority Stress Model (Meyer, 1995, 2003). This model posits that racial/ethnic "minorities" experience stressors outlined in stress process frameworks, as well as stressors that are unique to "minorities" due to racist structures and processes. As such, the Latina/o/x population—a racialized group—are exposed to stressors related to their ascribed racialized status. This model also proposes that communities disproportionately burdened by racism may develop individual and collective strategies to cope with and overcome these stressors. In sum, this model suggests that discrimination-related stressors heighten vulnerability for adverse health outcomes for Latina/o/x persons and that variations in these

associations within the heterogeneous Latina/o/x population, as well as access to psychosocial and institutional resources to buffer or disrupt the effects of discrimination, may contribute to complex associations between discrimination and health.

With regard to the measurement of discrimination, some measures capture experiences that may alter opportunities for social and economic opportunity and advancement—that is, fundamental determinants of health (House, Kessler, & Herzog, 1990; Link & Phelan, 1995; Phelan, Link, & Tehranifar, 2010)—while others assess day-to-day barriers and indignities experienced by stigmatized racial/ethnic populations.

The experiences of discrimination captured in these measures point to the physio-psychosocial stress pathways through which discrimination may affect health, outlined by the conceptual frameworks discussed above. Notably, the findings from emerging literature reviewed above suggest that the health implications of reported discrimination may be visible more immediately for mental well-being, self-reported health, and immune function. As such, this literature suggests that discrimination may shape mental health, self-reported health, and immune function through physio-psychosocial stress pathways. That is, the psychological distress brought about by experience(s) of discrimination, effortful coping with discrimination, and/or other stressors catalyzed by restricted access to resources and/or threats to an affirming identity (Geronimus, 2000; James, 1993) not only directly impact mental well-being and assessments of one's health, but also physiological processes related to immune function.

The evidence base analyzed in this chapter also suggests that discrimination is inimical for the cardiovascular and metabolic health of Latina/o persons. In particular, the mixed literature regarding the association of self-reported discrimination with cardiovascular and metabolic risk suggests that the health implications of discrimination may cumulate over time to manifest in poor cardiovascular and metabolic risk later in the life course. Further work, however, is needed to better understand the cumulative effects of discrimination over the life course.

The measures of discrimination used in the reviewed studies capture reported experiences of discrimination assessed at the individual level and may not necessarily capture mechanisms through which more structural forms of discrimination affect health. Additionally, these measures do not assess contemporary forms of racialization that have escalated in recent years, such as escalations in racializing hate speech and hate crimes that have been perpetrated in primary education settings, college campuses, neighborhoods, religious institutions, and in social media and political rhetoric. Additionally, an emerging literature links increasingly restrictive immigration policies, a component of structural racism, with reduced access to health-promoting resources and declines in health for Latina/o persons (Gee & Ford, 2011; Kline, 2016; LeBrón, Schulz, & Mentz, 2018; Lopez et al., 2016; Novak, Geronimus, & Martinez-Cardoso, 2017; Pedraza, Cruz Nichols, & LeBrón, 2017; Rhodes et al., 2015). Anti-immigrant ideologies, policies, and practices and their expression at multiple levels represent structural-level mechanisms that affect health—all of which require further theorizing and empirical assessment.

Methodological Issues, Limitations, and Future Considerations

The literature reviewed here should be considered within the context of several limitations, all of which point to important areas of future research. First, the self-reported measures of discrimination used in the studies we reviewed capture more visible forms of racism, including discrimination initiated by persons or by individuals at the interface of institutions. These measures do not fully capture structurally embedded forms of racism, such as race-based residential segregation, racial ideologies, immigration policies and practices, racial profiling, carceral policies and practices, environmental quality, educational opportunity patterned by residential segregation or state education policies, and healthcare access and quality, among others. Studies examining the health implications of these structural forms of racism are important to consider as they provide critical insights into the health consequences and legacies of institutional systems of racism such as restricted access to housing that shapes the persistence of race-based residential segregation; exposure to environmental risk factors; and educational quality (Schulz et al., 2017; McConnell, 2012). It would also be important to examine the health consequences of community and family separation, or the threat thereof, through policing of Latina/o/x communities and restrictive immigration policies that have heightened immigration-related detentions and deportations affecting Latina/o/x communities (Cox & Miles, 2013; Golash-Boza & Hondagneu-Sotelo, 2013; McConnell, 2013; Rios, 2011).

Relatedly, findings reported here indicate further need to theorize and consistently examine the health implications of discrimination across social contexts, such as traditional gateway communities with longstanding and sizable Latina/o/x populations, new destination communities characterized by recent and substantial growth of the Latina/o/x population, and communities with a smaller, though well-established Latina/o/x population. For example, in an examination of Southern new destination regions with sizable and well-established white and Black communities, Marrow (2011, 2009) finds that Latina/o persons manage complex racial structures and racialization processes in the midst of increasingly restrictive immigration policies that have emerged in response to the growth of the Latina/o immigrant population. Addressing how racialized practices and expressions of structural racism unfold in different spatial contexts would enhance our understanding of the variations in the association between discrimination and health by geographic context found in our review.

Second, the cross-sectional nature of the majority of the above-mentioned studies has important implications. As with all cross-sectional designs, the associations between discrimination and health reported herein, while strongly suggestive, do not demonstrate causality. In addition, such designs may contribute to an underestimation of the magnitude of the effect of discrimination on certain physical health indicators. That is, it is possible that discrimination may contribute to more immediate effects on mental health, self-rated health, and immune function, while taking longer to become expressed in physical health, such as cardiovascular and metabolic risk. Several stud-

ies we reviewed used scales that queried about experiences of discrimination in the past year or over the life course, and as such, it is possible that these studies capture some of the cumulative effects of discrimination on health. Nevertheless, studies are needed that enable us to better understand the effects of discrimination on conditions that take longer to manifest, as well as its overall cumulative effects on health.

Third, this relatively small emerging literature demonstrating an association of reported discrimination and health was most consistent for self-reported indicators of mental and physical health. While self-rated health is a robust measure of morbidity and mortality (Idler & Benyamini, 1997; Latham & Peek, 2013; Schnittker & Bacak, 2014), use of self-reported measures of both the independent (i.e., self-reported discrimination) and the outcome variables (i.e., mental health, self-reported general, or physical health) is subject to same-source bias (Mitchell, 1985; Podsakoff & Organ, 1986; Thorndike, 1920). In addition, when assessing self-reported health among Latina/o/x persons, attention to the language of interview is necessary to avoid methodological biases due translation (Viruell-Fuentes, Morenoff, Williams, & House, 2011). Furthermore, self-reported measures of discrimination are subject to a number of processes, including naming and reporting discrimination (Viruell-Fuentes, 2007). These reporting processes may overshadow the reporting of forms of racism that may be less visible on a day-to-day basis or which individuals may be less prepared to name.

Fourth, while some studies identified in this review advance an intersectional analysis of the social patterning of discrimination and implications for health, the characteristics of the samples used in the studies we reviewed impede the development of a more robust intersectional assessment of the association of discrimination and Latina/o/x health. Several studies, for instance, included multiracial samples, and many of these multiracial samples included a relatively and numerically small sub-sample of Latina/o/x persons. The ability to extend an intersectional analysis to these studies was often precluded by the relatively small size of the Latina/o sample and/or the aggregation of Latina/o participants with other racial groups. Therefore, an analysis of how gender and gender identities, citizenship status, class, sexuality, and other social statuses may intersect with race/ethnicity are not systematically addressed in the discrimination and Latina/o health literature, as of yet.

In addition, the majority of studies we reviewed included a sizable proportion of Mexican American or Mexican immigrant adults, reflecting the largest Latina/o/x subgroup in the USA (Stepler & Brown, 2016). Due to small sample sizes of Latina/o persons representing other Latin American countries or territories, several studies aggregated Latina/o persons into a pan-ethnic category, preventing a comparison of the social patterning of discrimination across groups and contributing to the homogenization of the Latina/o population.

Fifth, while some studies examined the health implications of discrimination that participants attributed to race/ethnicity, national origin, or gender, none of the studies we reviewed examined the health implications of language as a racializing marker. This omission in the literature may contribute to a limited understanding of the processes by which racism operates to shape access to resources, opportunities for advancement, and exposure to psychosocial stressors. In the case of Latina/o health

research, language is typically subsumed under the concept of acculturation; the limitations of which have been highlighted by multiple scholars (Hunt et al., 2004; Viruell-Fuentes, 2007; Viruell-Fuentes et al., 2012). Future research that places language within a racialization framework is needed to gain a fuller picture of the multiple ways in which racism operates to impact the health of Latina/o/x persons. Relatedly, because the goal of our review was to assess and characterize our understanding of the racism and health literature, we focused our review on studies that explicitly and directly used discrimination as a guiding conceptual framework. As such, we did not review possible related literature, such as the health effects of acculturative stress.

Sixth, for the purposes of this chapter, we interpreted general discrimination measures as markers of racial/ethnic discrimination, although these are holistic measures of discrimination and may not be (exclusively) capturing racial/ethnic discrimination. It is possible that reports of "discrimination" that are not restricted to race/ethnicity might be often understood as racial/ethnic discrimination by racialized groups. Nevertheless, future research that explicitly assesses experiences of discrimination across multiple intersecting social statuses is necessary.

Additionally, it is possible that some reports of discrimination captured in the literature reviewed above may pertain to experiences of discrimination perpetrated by within-group members. However, the majority of studies reviewed did not include survey items that explicitly asked about the social status(es) of the perpetrator(s) of discrimination, such as the perpetrator's institutional role (e.g., institutional agent or bureaucrat), the perpetrator's peer group membership (e.g., neighbor, student, patient), nor the perceived race/ethnicity of the perpetrator. Because within-group discrimination is an expression of larger structural racism (Jones, 2000; Viruell-Fuentes, 2011); from a population-health perspective, we argue that these questions are only useful to the extent to which they elucidate mechanisms to shift institutional and cultural environments to eliminate, reduce, or disrupt structural racism.

Recommendations for Future Research

Studies are warranted that evaluate racism as a structural determinant of health, considering the ways in which racism toward Latina/o/x persons is (re)produced in the twenty-first century. This includes, for example, examining the health implications of housing, educational, employment, environmental, immigration, and social welfare policies and practices that shape day-to-day life opportunities, for individuals and communities. In addition, a further theorizing and empirical examination of how experiences of racialization unfold across spatial contexts would help shed light on the findings from the emerging literature reviewed in this chapter. While we did not examine emerging research on anti-immigrant environments and health (see Kline & Castañeda, Chap. 12), it is important to underscore that immigration policies are part and parcel of the country's long history of racialized nativism, and as such merit careful attention.

Additionally, studies are needed that assess the health implications of vigilance toward racism and spillover effects of racism toward important peers, communities, or a particular population. Future research is necessary that follows Latina/o/x persons over time and assesses exposure to the multiple ways in which racism unfolds, considering variation in and frequency and intensity of exposures, as well as pathways to health and health inequities over the life course.

In addition, more research is needed on the kinds of social institutions and resources that buffer the effects of racism on health. The health impacts of psychosocial or institutional buffers may vary according to the form of racism and/or health indicator. It is possible that some social buffers may temporarily promote mental health, but have longer-term consequences for other somatic symptoms. Future research is warranted that explores psychosocial and institutional resources on which Latina/o/x persons may draw to protect against the adverse health implications of racism.

Theoretically, a fuller application of intersectionality theory (Collins, 1990, 2015; Crenshaw, 1991) in examining the links between discrimination and health among Latina/o/x persons is critical. In other words, studies that examine the intersections between racism and other forms of marginalization, such as gender, class, citizenship status, sexual orientation, among others, would greatly enhance our understanding of the patterns outlined herein. Indeed, advancing the study of the health implications of racialization processes as they relate to peoples' multiple identities necessitates a queer analytic approach (Anzaldúa, 2009).

In addition, research regarding the association of discrimination and Latina/o/x health would be strengthened by considering population-based theories about the implications of racism for health inequities. For instance, Chae, Nuru-Jeter, Lincoln, and Francis (2011) advance a socio-psychobiological framework for studying how enduring and contemporary systems of racial oppression become embodied and produce racial differences in health. The socio-psychobiological framework builds on previous frameworks to posit that racism (rather than race) shapes health through the psychological, behavioral, and biological embodiment of social inequalities. Studies that examine the health implications of discrimination for Latina/o/x persons informed by such theories and frameworks would situate this area of inquiry within the racialized sociopolitical context in which Latina/o/x persons navigate. In addition, studies that consider cumulative effects of discrimination on health over the life course, and in relation to other stigmatized social locations are also necessary.

Relatedly, given the limitations of quantitative discrimination measures described above, qualitative studies that examine experiences of racism as they intersect with multiple identities and statuses are needed to better understand the mechanisms by which racism shapes health. For example, some qualitative studies indicate a possible underreporting of discrimination among Latina/o persons, a pattern that is shaped by exposure to and understanding of the US racial structure (Tovar & Feliciano, 2009; Viruell-Fuentes, 2007). Additionally, an emerging qualitative literature focused on the health implications of restrictive immigration policies for Latina/o communities is beginning to implicate structures in these processes (LeBrón, Schulz, Gamboa, Reyes, Viruell-Fuentes, & Israel, 2018; Garcia, 2017; Kline, 2016), and contributes

to strengthening our understanding of the dynamic nature of experiences with structural racism and variation across social statuses.

Further, structural and intersectional inquiries of the health impacts of racism for Latina/o/x persons through systems affecting housing, policing, education, occupational settings, and health care are necessary. Furthermore, the literature reviewed above calls for future health research that considers various dimensions of exposure to discrimination including age of exposure and length of exposure over the life course, particularly given that, for immigrants, exposure may vary depending on their age of arrival in the USA. Moreover, few studies included in this review consider the health implications language as a racializing marker (Viruell-Fuentes, 2011). Future studies, that evaluate the health implications of discrimination based on language use, and the intersection of language-based discrimination with racial/ethnic discrimination, are warranted.

Conclusions

This chapter provides a review of the emerging literature that evaluates the health implications of discrimination for Latina/o persons in the early twenty-first century. By characterizing the breadth and depth of this literature, as well as variations in findings across studies, often according to measure of discrimination, health indicator, sample, or social statuses, this chapter sheds light on the health implications of racial/ethnic discrimination. This chapter also offers future directions for research regarding discrimination and Latina/o/x health. Novel aspects of this chapter include disentangling the literature according to measure of discrimination (e.g., general or race/ethnicity-specific), and its attention to these patterns within the heterogeneous Latina/o population.

Given the historical and current contexts of racism in the country, it remains of critical importance to consider the health and health equity implications of racism against Latina/o/x persons. Strategies to dismantle racism, and the inequalities that are symptomatic of these processes, are of critical importance for promoting the social and economic well-being and health of Latina/o/x persons, the fastest growing racial/ethnic group in the USA. As we advance scholarship, policies, and practices to dismantle racism, we encourage scholars and practitioners to carefully consider the social statuses and identities that racial labels make visible and those which they obscure. The use of intersectional labels, such as Latinx, needs to be accompanied by an analytical stance that contributes to eliminating all forms of oppression.

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