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Mexican-Origin Women's Construction and Navigation of Racialized Identities: Implications for Health Amid Restrictive Immigrant Policies

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Abstract This study examines how Mexican-origin women construct and navigate racialized identities in a postindustrial northern border community during a period of prolonged restrictive immigration and immigrant policies, and it considers mechanisms by which responses to racialization may shape health. This grounded theory analysis involves interviews with 48 Mexican-origin women in Detroit, Michigan, who identified as being in the first, 1.5, or second immigrant generation. In response to institutions and institutional agents using racializing markers to assess their legal status and policing access to health-promoting resources, women engaged in a range of strategies to resist being constructed as an "other." Women used the same racializing markers or symbols of (il)legality that had been used against them as a malleable set of resources to resist processes of racialization and to form, preserve, and affirm their identities. These responses include constructing an authorized immigrant identity, engaging in immigration advocacy, and resisting stigmatizing labels. These strategies may have different implications for health over time. Findings indicate the importance of addressing policies that promulgate or exacerbate racialization of Mexican-origin communities and other communities who experience growth through migration. Such policies include creating pathways to legalization and access to resources that have been invoked in racialization processes, such as state-issued driver's licenses.

Keywords immigration enforcement, immigrant policies, racialization, racism, health

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Understanding and addressing structural racism is central to reducing health inequities (Ford et al. 2019). Racialization is the active and dynamic process by which systems, institutions, and agents create and maintain subordinate and dominant racial groups, assign differential value to racial groups, and leverage symbols of divergent value to justify inequitable rights, opportunities, access to resources, and treatment (Omi and Winant 2015; Schwalbe et al. 2000). Racialization processes, including the conceptualization and categorization of race and the creation of policies and practices grounded in racialization, vary over time and place and have enduring impacts (Omi and Winant 2015). Historical and contemporary racialization processes have unique implications for how Latina/o subgroups identify, are defined, and negotiate systems of classification; ultimately, they have implications for health (LeBrón and Viruell-Fuentes 2020). In this article, we examine Mexican-origin women's construction, negotiation, and management of racialized and gendered identities within the context of a complex and interconnected web of restrictive immigration and immigrant policies in a northern border US community. We leverage these findings to more fully understand the public health literature regarding racialization, immigration and immigrant policies, and health.

Immigration and Immigrant Policies

US immigration policies, which shape opportunities to lawfully migrate to and remain in the United States, and immigrant policies, which are designed to influence the lives of US immigrants and immigrant communities, are manifestations of historical and contemporary racism and xenophobia (LeBrón and Viruell-Fuentes 2020; Wallace and De Trinidad Young 2018). For example, the Immigration Act of 1924 formalized the social construct of "illegal alien," established numerical quotas for immigration, and augmented attention to the national border and interior regions as spaces of social control of immigrants (Ngai 2004). Together, these events contributed to the extension of border enforcement efforts and large-scale deportations (Ngai 2004). A focus on controlling the southern US border and administrative discretion to prevent deportation of socially desirable immigrants contribute to the enduring construction of Mexican-origin peoples as unauthorized foreigners (Chavez 2013; Ngai 2004). Restrictive immigration policy in the 21st century includes the proliferation of border enforcement apparatuses, mass hyperpolicing and detention of immigrants, and collaborations between local law enforcement and federal immigration enforcement agencies to police immigrant communities in

the interior of the United States (e.g., roadways, public transportation, occupational settings) (Coleman and Stuesse 2014; De Genova 2007; Miller 2014).

Restrictive immigrant policies are those that limit immigrants' rights, protections, opportunities, and access to resources on the basis of legal status (Wallace et al. 2019). The intersection of federal, state, and local immigrant policies shapes contexts of reception or exclusion for immigrants and immigrant communities (Wallace et al. 2019). A distinguishing feature of 21st-century immigrant policies is the infusion of immigrant policies into sectors that were previously relatively siloed from immigrant policies: health care, education, law enforcement, employment, and social welfare (Cruz Nichols, LeBrón, and Pedraza 2017; Pedraza, Cruz Nichols, and LeBrón 2017; Wallace and De Trinidad Young 2018). The extension of immigrant policies into these sectors is facilitated through technological advances that enable information sharing across agencies (Cruz Nichols, LeBrón, and Pedraza 2017; Pedraza, Cruz Nichols, and LeBrón 2017). Although immigrant policies purportedly focus on noncitizens, in practice these policies spill over to affect families, social networks, and broader communities that experience growth through immigration, regardless of legal status (Cruz Nichols, LeBrón, and Pedraza 2018; LeBrón et al. 2018a; Lopez 2019).

The impact of 21st-century restrictive immigration and immigrant policies and discourse on Latina/o and immigrant communities has been documented (Kline 2019; LeBrón et al. 2018a; LeBrón et al. 2018c; Lopez 2019; Novak, Geronimus, and Martinez-Cardoso 2017). In 2012–2013, 97% of persons deported from the United States were of Latin American origin, and almost 70% were Mexican nationals (TRAC 2014). De jure and de facto immigration and immigrant policies and practices conflate race with legal status, shaping societal ideologies, norms, institutional policies toward Latina/o immigrants, and ultimately Latinas/os' experiences of interpersonal discrimination, stigma, and mistrust (Hatzenbuehler et al. 2017; Romero 2011). Immigration raids, increased discrimination, and concern about deportation are linked with adverse mental, birth, metabolic, and cardiovascular outcomes (LeBrón et al. 2018c; Novak, Geronimus, and Martinez-Cardoso 2017; Torres et al. 2018). Restrictive immigration and immigrant policies deteriorate health through pathways including policies and institutional and systems practices that restrict health-promoting opportunities, racialized stressors, barriers to accessing health-relevant resources (e.g., government-issued IDs, welfare benefits), and reduced health care access (Castañeda et al. 2015; LeBrón et al. 2018a; LeBrón et al., 2018b; LeBrón et al., 2019a; Wallace et al. 2019). To date, few studies

(see, for example, Viruell-Fuentes 2007, 2011) have illuminated the health implications of how Latinas/os construct and negotiate their racialized identities amid the constraints of restrictive immigration and immigrant policies.

Racialization Processes and Policy Contexts

The scholarship on how Latinas/os form, contend with, and navigate their identities in the context of restrictive immigrant policies suggests that community-level and demographic variations may shape racialization processes and the strategies used to navigate those experiences. For example, Viruell-Fuentes and colleagues (2007) found that among Mexican-origin women living in a long-standing predominantly Latina/o neighborhood in a northern border community, relative to immigrant women, second-generation women recounted more frequent and painful experiences of discrimination and othering—a process of differentiating and stigmatizing a minoritized group (Grove and Zwi 2006; Viruell-Fuentes 2007). The authors theorized that second-generation women's activities outside their neighborhood and the cumulation of experiences with US institutions (e.g., schools) over the life course may shape their naming of and experiences with discrimination. More recently, Dreby (2013) found that when Latina/o children in an established Latina/o community experienced discrimination based on nativity, they deemphasized their place of birth or that of family members. In contrast, children in a town with a small Latina/o community who experienced race/ethnicity-based discrimination deemphasized their Mexican and Spanish-speaking backgrounds, regardless of their nativity. These findings suggest that processes of racialization and identity management strategies enacted may be shaped by the social context in which they unfold and by generational status.

Scholarship by LeBrón and colleagues (2018a) found that in their day-to-day interactions, Mexican-origin women navigated an intricate web of policies, institutions, and institutional agents in which authorities engaged multiple racializing markers or symbols of (il)legality to assess legal status. Driver's licenses were central racializing markers in these interactions, as were physical features (e.g., dark skin and hair), speaking Spanish or having an accent, being born outside the United States, and having an "ethnic" name. Based on assessments of legal status, institutional agents such as police, immigration officials, clerks who issue driver's licenses, and social welfare providers exercised authority over

women and members of their networks within their jurisdiction, often circumscribing access to health-promoting resources. At issue is how women negotiated their identities within a context that continually assessed and stigmatized their multiple identities, including race/ethnicity, gender, nativity, class, and legal status. While the aforementioned study examined how institutions and institutional actors racialized Mexican-origin women, this study queries how women navigated their identities amid this dynamic context of racialization and their interactions with legal institutions, with implications for health processes.

A gap in this literature is the study of how Latinas engage agency in racialization processes and implications for health, particularly under the constraints of multiple restrictive immigration and immigrant policies. This study heeds the call by Wallace and De Trinidad Young (2018: 437) to "place the impact of [immigrant] policies in historical context—including the racialization of immigrant policy politics—and incorporate the agency of immigrants and advocates in policy advocacy." Understanding how Latinas/os navigate their identities amid restrictive immigrant policies as a form of agency and resistance to racialization may enhance understanding of variations in how these processes affect Latinas/os' everyday lives and the implications for health. Another gap is the study of health as a process, considering how immigration and immigrant policies and responses to racialization may accumulate and shape health over the life course.

Health Implications of Women's Experiences with Exclusionary Immigration and Immigrant Policies

The growing literature regarding the gendered and health implications of restrictive immigration and immigrant policies for Latinas has largely focused on implications for prenatal and perinatal health care utilization and birth outcomes (Novak, Geronimus, and Martinez-Cardoso 2017; Rhodes et al. 2015; Toomey et al. 2014), which are important consequences that affect health across multiple generations. Additionally, data indicate that men (85%) constitute the majority of deportations of persons of Latin American origin in the early 21st century (Golash-Boza and Hondagneu-Sotelo 2013). Less is known about how Mexican-origin women manage their racialized and gendered identities in a context that stigmatizes their identities or how these experiences and responses to racialization may shape health over the life course. With some exceptions (see, for example, Lopez 2019), few studies to date have explicitly examined how women

from immigrant communities targeted by exclusionary immigration and immigrant policies contend with racialization processes linked with these policies and the implications for women's identities, health, and well-being over the life course.

Racialization and Immigrant Policies in Detroit

Reflecting ongoing race-based residential segregation in Detroit, Southwest Detroit is often dubbed "Mexicantown," highlighting race-based residential segregation and the long-standing and vibrant Latina/o community, many of whom are of Mexican origin (Data Driven Detroit 2013). Southwest Detroit is a largely low-income neighborhood along the US-Canada border, in a city that has experienced substantial economic disinvestment (Schulz et al. 2002; Sugrue 1996). An international bridge to Canada crosses through Southwest Detroit, rendering Southwest Detroit a site where enhanced interior and border immigration enforcement compound the surveillance of residents. Furthermore, in response to the REAL ID Act of 2005, in 2008 Michigan began denying access to driver's licenses and state-issued IDs for persons who could not prove their authorized US presence (Cox 2007).

In Detroit, low-income Mexican-origin residents have been found to have higher allostatic load—indicating stress-related dysregulation of multiple somatic systems—than Mexican-origin counterparts across the United States (Geronimus et al. 2020). One study found that from 2002 to 2008, immigrant Latinas/os in Detroit experienced greater increases in blood pressure linked with increased discrimination, relative to US-born Latinas/os (LeBrón et al. 2018c). This literature begins to illuminate the life course health impacts of multiple structural inequities for Latinas/os.

In this study, we examine how Mexican-origin women and their coethnics—members of the racial/ethnic group with which they identify—form, negotiate, and manage their racialized identities in a northern border community during a protracted period of restrictive immigrant policies (2013–2014), and within a context that blurs the boundaries between Latinas/os, immigrants, and unauthorized immigrants. This qualitative inquiry provides context to more fully understand the public health literature regarding racialization, restrictive immigration and immigrant policies, and health, through the lens of women's experiences. We address these questions using a grounded theory analysis of individual interviews with Mexican-origin women—themselves immigrants or children of immigrants—living in Southwest Detroit.

Methods

This study was born out of discussions with the Healthy Environments Partnership (HEP), a community-based participatory research partnership that has been working since 2000 to understand and address social inequities that shape cardiovascular inequities in Detroit (Schulz et al. 2005). Discussions of the heightened and pervasive system of immigrant policing in Southwest Detroit and implications for Latina/o residents' health and participation in physical activity were a crucial impetus for this study. The Detroit Hispanic Development Corporation (DHDC) is a founding and active member of HEP and has been serving the Latina/o community in Southwest Detroit and beyond since 1997. DHDC was a key partner in this study—shaping the research approach, guiding the data collection process, supporting recruitment, and interpreting and disseminating findings. To facilitate recruitment, we also collaborated with LA SED, a community-based organization (CBO) with two locations in Southwest Detroit.

Data Collection

Interviews were conducted from 2013 to 2014 with first- (n = 25), 1.5- (n = 10), and second-generation (n = 13) Mexican-origin women 18 years of age and older who lived in Southwest Detroit and were fluent in Spanish or English (table 1). Following Rumbaut (1994), *first generation* was defined as Mexico-born women who came to the United States when they were 12 years of age and older; *1.5 generation* includes Mexico-born women who came to the United States when they were younger than 12 years of age; and *second generation* comprises US-born women with one or both parents born in Mexico. The University of Michigan IRB approved this study in July 2013.

To recruit participants, the research team, including DHDC staff, identified community members who met the eligibility criteria and invited them to participate. The interviewers (AMWL, CG) shared information about the study at DHDC, and LA SED shared study information with clients who met the eligibility criteria. When speaking with clients directly and discussing the study with CBO staff, the research team described the study as an opportunity for eligible women to share their experiences with immigrant policies and to talk about their health. We noted that while the study may have limited benefits to participants, the findings had potential to inform recommendations for inclusive programs and policies to support immigrant communities. Following a snowball sampling approach (Patton

Table 1 Sociodemographic Characteristics of Study Participants: First, 1.5, and Second-Generation Mexican-Origin Women, Detroit, Michigan

	First generation (n = 25)		1.5 generation (n = 10)		Second generation (n = 13)	
	% (n)	Median (SD)	% (n)	Median (SD)	% (n)	Median (SD)
Age (years)		45.0 (11.3)		32.8 (14.5)		40.7 (19.0)
Interviewed in Spanish	96% (24)		40% (4)		23% (3)	
High school education or higher	48% (12)		80% (8)		69% (9)	
Employed in formal labor force	8% (2)		60% (6)		31% (4)	
Married or living with partner	96% (24)		50% (5)		38% (5)	
Live in household with 1+ child	88% (22)		70% (7)		77% (10)	
Self-rated fair or poor health	44% (11)		20% (2)		46% (6)	

1990), we asked participants and LA SED to share study information within their networks. Three quarters of participants were recruited through the networks of the study team and DHDC. The remaining one quarter were recruited through snowball sampling, facilitated by LA SED, and generally included women who identified as second generation and with more protected legal status. Interviews were completed at participants' homes or at one of the CBOs, according to participants' preferences.

Two authors (AMWL, CG) conducted semistructured individual interviews with participants. Both interviewers identified as Latina and are US citizens. The first author's identity as a Puerto Rican scholar and the third author's positionality as being of Mexican origin, personal experiences with immigrant policies, and connections to grassroots efforts in the local immigrant community may have facilitated connections with participants. We did not ask about legal status in an effort to safeguard participant information, but some participants chose to disclose their legal status or the status of someone they knew in the context of the interview. The interview guide was designed to include topics that could be addressed in an open-ended manner and in an order that was conducive to eliciting women's descriptions of their experiences. Discussion topics included experiences with immigration and immigrant policies, changes in immigrant policies and immigration enforcement practices, responses to immigrant policies and sentiments toward immigrants, experiences of discrimination, women's characterizations of their health, and recommendations for policy makers. During the verbal informed consent process, researchers asked the participants for permission to make an audio recording of the interview. At the end of interviews, women completed a brief closed-ended questionnaire. Participants received a $20 cash incentive and information about immigrant rights. In cases where particular needs arose, the research team provided information about relevant services.

Interviews ranged from one to three hours and were completed in participants' preferred language (Spanish: n = 31; English: n = 17). All audio-recorded interviews were transcribed verbatim. To protect participants, identifying information disclosed in the interview was not transcribed, and pseudonyms are used to refer to participants. The first author translated quotes from Spanish-language interviews.

Data Analysis

Following a grounded theory approach, we identified inductive themes by first applying an open coding scheme to initial interviews during data

collection (Charmaz 2012; Corbin and Strauss 2008; Glaser and Strauss 1967). The research team discussed emerging findings throughout the data collection and analysis process. This facilitated the development of an emerging coding scheme and provided opportunities to engage in expert checking and reflect on the possible influence of the research process on the accounts that women shared. We organized segments of text into codes that were then grouped into categories and themes. This coding structure was applied to subsequent interviews and updated as new codes emerged. We used axial coding to identify connections across codes and categories and examined patterns within and across interviews to iteratively identify, interpret, and refine the inductive themes (Charmaz 2012; Glaser and Strauss 1967). Women frequently described not only their own experiences and actions but also those of other family members and friends (including their husbands and sons), illustrating how network members protect against the disclosure of legal status. In presenting the findings below we include descriptions of the experiences and actions of members of women's social networks as well as the personal experiences of the women who participated in the interviews.

Findings

Women's narratives suggest that institutional agents and peers (agents of racialization who were not representing a particular institution) often did not discern between an unauthorized legal status and noncitizen legal statuses (e.g., legal permanent resident, temporary protected status, U-visa holders). Accordingly, women often navigated a false binary of legal statuses: that of US citizen or unauthorized immigrant. We use the term "symbols of (il)legality" to describe commonly invoked racialized indicators of unauthorized legal status, often interpreted using the false binary described here. Our focus is on efforts described to subvert or disrupt those interpretive frames. The theme *resistance to the symbolic construction as an "other"* encompasses strategies that participants described using to subvert processes that contribute to the construction of racially minoritized groups. This theme included data from interviews in which women described strategies that they or their social network members used to respond to or resist racialization. It is characterized by three categories: constructing an authorized immigrant identity, engaging in immigration advocacy, and resisting stigmatizing labels (table 2). In presenting our findings below, we illustrate the dynamic and contingent nature of women's negotiation of multiple intersecting identities and statuses. In the following

Table 2 Resistance to the Symbolic Construction as an "Other" Grounded Theory: Categories and Subcategories

Theme: resistance to the symbolic construction of an "other"	
Category	Subcategory
1. Constructing an authorized immigrant identity	■ Obscuring an unauthorized legal status ■ Embracing an ascribed authorized immigrant identity
2. Engaging in immigration advocacy	
3. Resisting stigmatizing labels	

sections, we present both the categories that constitute this theme and our interpretation of findings and potential pathways by which these processes may shape health.

1. Constructing an Authorized Immigrant Identity

Women described multiple strategies to construct an authorized immigrant identity by distancing themselves from or concealing an unauthorized legal status. Subcategories encompassed efforts to obscure an unauthorized legal status and embrace an ascribed authorized immigrant identity.

Obscuring an Unauthorized Legal Status. Women in the 1.5 generation (regardless of legal status) described strategic actions that they, or members of their social networks, used to actively hide their unauthorized legal status from institutional officials, employers, and (often white) peers. Often, this approach involved using and/or concealing symbols such as their ethnic identity, reasons for not having a current driver's license, and ankle monitors, often interpreted as signs of (il)legality. In several cases, this approach involved constructing narratives for why individuals did not have state-issued identification. This strategy was invoked at work, in police encounters, and when non-Latino neighbors or other peers explicitly queried about legal status.

The construction of an authorized identity was one strategy used to avert the "gaze" (Foucault 1977) of (often white) peers that inquired about legal status. Susana, a 46-year-old first-generation woman, shared her concerns about a neighbor who she believed called immigration officials on another neighbor:

> So, he would ask my son, "Uh do you all have papers?" [My son said] "Yes, my father has papers and he is fixing it for my mother." He said,

> "Yes, he is from Los Angeles and he has his papers and everything." And he said, "And the woman that lives in front too?" [And my son said] "Yes, she is also American." He [neighbor] said, "Why . . . doesn't she speak English?" He noticed everything, that man. He [neighbor] said, "And why doesn't she speak English?" He [son] said, "Because she married a Mexican man and the Mexican [man] taught her to speak Spanish and she likes Spanish" [laugh]. . . . And he [son] would say to us, "Mama! If the man asks you if you have your papers, tell him yes, right?" He [son] said, "Tell him yes because he is asking me if [another neighbor] also has her papers." And I told him, "Yes, we all have them, also those over there and . . . everyone."

Susana's narrative illustrates a strategy intended to quell peers' questions about legal status. Notably, Susana's US-born son contributed to the construction of a protected identity for his family and neighbors, illustrating the engagement of women's social networks as part of collective efforts to resist racialization.

Women also described constructing an alternative identity in efforts to ward off adverse consequences. Angela, a 1.5-generation woman, described her husband's active construction of a different narrative at work:

> You know if you don't have a license, you don't get paid. . . . Like, he [husband] told his boss he doesn't have a license 'cause he has a DUI, which he doesn't [laughs], but, he had to lie. He said he doesn't have a license because he has a DUI and they didn't let him renew it, so, his boss tells him, like, he's not able to drive the trucks or nothin,' so he doesn't get paid as well as he should be, you know, because of the license.

This narrative provides a plausible explanation for not having a driver's license, thereby avoiding disclosure of unauthorized status. While the narrative also has costs, resulting in lower pay and restrictions on work activities, they are perhaps less severe than the consequences of revealing unauthorized legal status. Furthermore, claiming a DUI rather than disclosing an unauthorized legal status points to efforts to maintain dignity amid a societal and policy backdrop that racializes and criminalizes unauthorized legal status.

Women whose driver's licenses had expired described interactions with officials in which they obscured the reasons for their lack of a valid driver's license. As Angela explained:

> It's scary [laughs]. I've been pulled over once and, by a state police . . . and, well I lied to him, I told him that, that I was staying in Chicago for a couple of months so, when I—I barely had come back and I couldn't

> renew my license, and he just gave me a ticket for that and he told me, "As soon as you go renew it, you won't have to pay nothin' so just go renew it and"—and back then you . . . would be able to just pay the ticket off, but now, they're making you go to court for it.

Officials serve as gatekeepers for critical health-relevant resources (e.g., social welfare assistance, driver's license), and encounters with officials in which unauthorized legal status is disclosed can lead to severe consequences (e.g., detention, deportation). The driver's license was the most common symbol of (il)legality described in encounters with police and in interpersonal interactions with coethnics and white peers. Strategies to hide unauthorized status are crucial to mitigating policies that racially minoritize Mexican-origin women. Women and their network members attempted to *prevent* encounters where an official (e.g., police) could threaten to or contact immigration officials. Outcomes depended on other resources available to women such as English fluency.

Other women described managing their identities to prevent discrimination and loss of access to employment. Dalilia, a 1.5-generation single mother, was required to wear an ankle monitor upon release from immigration detention. She explained:

> I was working with fake papers. If they realize that when you see someone with one of those bands [ankle monitors] on you, what is the first thing you think? That this guy did something. They killed, stole, or something they have it that way. And well what was the owner [boss] going to think? Of me? I mean I didn't want to attract attention for them and, and I had it, I had like all loose pants that were ugly on me [laughter] and um, I hid it.

Dalilia concealed the ankle monitor to prevent attention and avoid having to disclose her legal status to the public, her coworkers, and her employer. This strategy was also imperative for maintaining her job, which she obtained by misleading employers about her legal status. Dalilia also managed her identity against the criminalizing message of the ankle monitor among peers, reflecting concern that she would be stigmatized. Later in the interview, she recalled reaching a point where she said "okay I'm going to decide to ignore" others' opinions about the ankle monitor. This decision was undertaken in nonwork contexts in which her identity felt safer (e.g., religious celebrations, when with close friends who are coethnics). This illustrates the ways that women weighed the costs and benefits of obscuring an unauthorized immigrant identity, and the ways in which these costs and benefits were contextual and situation-specific.

Embracing an Ascribed Authorized Immigrant Identity. Women also described strategies that embrace an ascribed identity of having an authorized legal status, namely one ascribed by officials or peers. These actions often involved embracing ascribed racial/ethnic identities—and thus legal status, given the conflation of Mexican origin, nativity, and legal status—and assumptions made on the basis of having or not having a current driver's license. Immigrants leveraged this approach when working, when in the company of non-Latino peers, and when pursuing health and social services. Alicia, a 29-year old US citizen in the 1.5 generation whose dark-skinned husband was unauthorized until recently, explained his experience landscaping a US Border Patrol agent's house:

> [He] [d]oesn't look very Mexican. They didn't question it. And his name is . . . Arabic. Um, so when he introduced himself as [his name], he just says [husband's first name, name of company husband works for]. So, when I've talked to other people who are lighter skinned or who have resembled more Mexican features or on their trucks have the [Mexican] flag, or something, the stories that they tell me and the things that they share is that they have been more racially profiled. [They say] . . . "They looked at me, they pulled me over intentionally." My brother-in-law . . . looks very Hispanic, [like a] cowboy. He was like pulled over three different times on the same [emphasis] road, by the same [emphasis] cop. . . . I wonder if that has to do with how they are racially profiling people.

Alicia's account illustrates how peers invoke skin color and occupation as symbols of (il)legality. These socially constructed symbols also intersect with geography (i.e., residence near a large Arab American community). Generally, women perceived Arab Americans as subject to less immigrant-policing-related surveillance, and a few women described protections incurred by being classified as Arab American. Symbols included the racial background ascribed to their name and/or ambiguous physical features. However, generally women identified looking Arabic as protective for men, but not for women. The discussion section addresses this perceived gendered protective function of ascribed Arab identities, in a context in which Arab Americans have experienced high levels of anti-Arabic sentiments (Lauderdale 2006).

Rebecca, a 41-year-old first-generation woman, had a valid driver's license, which led to assumptions regarding her eligibility to vote. When those assumptions came into play at a local community health center, she did not challenge them:

> Well, when I show them my ID they think I have papers and they ask, "Are you going to vote for . . . ?" . . . I tell them no, but they don't ask me why, they just think that I have the right to vote.

In her interview Rebecca identified numerous social agents who equated a driver's license with US citizenship, including social welfare caseworkers and staff at a local community health center. In these situations, she routinely did not contest an assumed citizenship status, preventing questions about her legal status and the restriction of access to health care and social services. Consistent with the strategy of obscuring symbols of (il)legality, women managed their identities in the context of local "get out the vote" organizing efforts.

These strategies illustrate women's and men's efforts to prevent disclosure of unauthorized legal status by manipulating the very symbols of (il)legality (e.g., nativity, driver's license, physical features) used by agents of racialization. The relative success of obscuring an unauthorized legal status often varied by, for example, access to resources such as a valid driver's license, language use, physical characteristics, names, and demographic contexts. Specifically, women in the first and 1.5 generations who were unauthorized generally described engaging in these strategies. Immigrant women with an authorized legal status (e.g., citizen, resident, Deferred Action for Childhood Arrivals [DACA]) and those in the second generation with unauthorized immigrant family members likewise recalled family members engaging in these strategies as well as their own efforts to support these identity construction and management efforts.

Efforts to resist the symbolic construction as an "other" were continually engaged to resist or ameliorate stigmatizing perceptions of Mexican immigrants and immigration enforcement efforts that constructed their statuses and identities as an inferior "other." These strategies were also used to deflect encounters with individuals who they anticipated would construct them as different and consequently reinforce racialization. These strategies were ones that women chronically *anticipated* having to engage, reflecting women's attentiveness to and vigilance against the possibilities of encountering immigration officials, losing opportunities to work or receive services, or experiencing interpersonal discrimination. Thus, strategies such as obscuring a stigmatized identity were used to alleviate adverse consequences of racialization.

There are a number of important pathways through which strategic actions to hide an unauthorized immigrant identity may have health implications. Identity management processes (Goffman 1963) that seek to

maintain access to social and material resources linked to legal status can protect against unemployment and encounters with immigration enforcement. However, chronic and effortful construction of an alternative identity requires substantial psychosocial resources. Over time, exposures to stressful political and social contexts and the identity management strategies required to navigate them may contribute to the deterioration of mental health (Pearlin et al. 1981). In the longer term, physical costs of such efforts may include risk of cardiovascular and metabolic conditions linked to stress over the life course (Geronimus et al. 2020; Jackson, Knight, and Rafferty 2010).

2. Engaging in Immigration Advocacy

The category *engaging in immigration advocacy* includes action such as participating in immigration policy advocacy or deportation deferral marches or protests, or signing petitions regarding immigration enforcement practices or policies or the release of persons in immigrant detention. Among women who described engaging in immigration advocacy, the catalyst was often a coethnic's immigrant detention or the opening of a window of opportunity to shape inclusive immigration and immigrant policies. Sometimes, immigration advocacy was in support of members of women's social networks and/or broader community. Most commonly, this category emerged in interviews with women in the 1.5 and second generations. Several women reported engaging in this strategy on behalf of someone who had been deported or was vulnerable to deportation; others reported advocating for the broader Latina/o community in Southwest Detroit.

Targeted advocacy efforts emerged when women knew or knew of an individual facing deportation. Alicia, a 29-year-old woman, is a US citizen and has lived in the US since she was an infant. Her husband was an unauthorized immigrant until recently. She explained her response to witnessing a parent's arrest by immigration officials outside her child's school:

> [A] parent was followed [by immigration officials] to my child's middle school. I didn't know the parent, but just seeing all of that happen, I was emotional. So it made my son emotional. So he's like, "I don't know why I'm crying." I'm like, "I don't know why I'm crying too. But it's just emotional. That's somebody's dad. That's somebody's husband. That could have been your dad." So it's just really emotional. And it affected

> me in the entire day at work even though, um, I tend to leave home at home when I'm at work, but because that happened right in the transition of coming to work, I was kind of like, just . . . just distraught from the situation. Um, I don't know who the man was, but when they went to go advocate for him downtown—um, at the immigration, I went.

Alicia resonated with the experience through her witness of the arrest and her husband's own legal status, which was unauthorized until recently. Her emotional ties to her coethnics' experience contributed to her decision to participate in advocacy efforts to petition for the release of the student's father.

Fewer immigrant women who had an unauthorized legal status described engaging in immigration advocacy. For example, Rocio, a 36-year-old woman in the first generation who is an unauthorized immigrant, recalled, "Would you believe we went to Washington . . . like two years ago we went there for the marches . . . immigration." It is noteworthy that Rocio described participating in a national march hundreds of miles from Michigan, given her limited mobility because of restrictions on her ability to drive without a current driver's license. Rocio's participation may be understood in the context of her legal status. Her hope that she and her family might benefit from policy decisions related to advocacy efforts were reflected in her interview when she said, "I hope that when my son turns 21 that he can [change his legal status]."

Engaging in immigration advocacy may offer a way for women to connect to their community or identity in a *healing* manner, as opposed to strategies that seek to conceal their identity (Whyte 2014). This strategy may also offer a concrete way to support and advocate for themselves and/or coethnics (Cruz Nichols and Garibaldo Valdéz 2020). Thus, this strategy may reaffirm individual and collective identities vis-à-vis immigration and immigrant policies that racialize them and their coethnics and provide an opportunity to disrupt these processes.

Additionally, research indicates potential health benefits of some forms of political participation. Studies have linked political participation or activism with improved mental health outcomes for racially minoritized college students (Hope et al. 2018) and Black city council representation with favorable birth outcomes (LaVeist 1992). One study suggests that the salubrious benefits of political activism vary by form of activism (Klar and Kassner 2009). This literature theorizes that political participation may reflect strong community-level social organization; build sense of community, psychological empowerment, and/or community empowerment; and/or interrupt the pathways between racialized stressors such

as discrimination and stress responses, anxiety, and depressive symptoms (Hope et al. 2018; LaVeist 1992; Wallerstein 1992). However, this literature also hypothesizes that for some, political activism could be linked with increases in discrimination that could be health deteriorating (Hope et al. 2018).

3. Resisting Stigmatizing Labels

The category *resisting stigmatized labels* includes efforts to resist labels that construct women and their network members as racially minoritized and that promulgate processes of racialization. For example, several women distanced themselves from the label "Mexican American," emphasizing they are "Mexican" and not "American." As Isabella, a woman in the second generation, explained:

> Whether you're born or not born in the United States, everybody has their own rights. . . . I mean what, I was born in Chicago, I was born here but I'm not American. Both of my parents are Mexican. There is no American blood in me. I am Mexican. I mean just because they say I was born here, I am Mexican American? Just because I was born here, okay, I get it, I was born here. What about it? None of their blood is in me, none of their cultures are in me. What my cultures—the way I celebrate Christmas, the way I celebrate, it's not how Americans celebrate. I celebrate how Mexicans celebrate it. All my culture, all of that, it's more Mexican than anything.

Here, Isabella grapples with the dissonance between her birthright citizenship and her family's social and economic exclusion, which manifest through constrained mobility, policing, detention, and deportation of her loved ones. She recognizes that her US citizenship does not afford her the same privileges of other US citizens. This reference to non-Latino whites as "Americans" may indicate women's resistance to classifying themselves with this national identity in a country that they feel largely excludes them, instead they embrace identities such as their ethnic identity and/or national origin or descent. Embracing their non-American identity also illustrates how women worked to construct and maintain an affirming Mexican identity in response to a context that stigmatizes their Mexican heritage. As with Isabella, several women in the 1.5 and second generations emphasized that there is no "American" heritage in them. These statements were less common among first-generation women.

This approach may be understood as a way of asserting a self that resists stigmatizing labels attached to Mexican American identity. Emphatic

distancing from terms that may suggest superficial assimilation in the United States, such as "Mexican American," may reflect responses to experiences that racialize women as not belonging in the United States or as Americans. The health implications of this strategy of resistance may vary according to the typologies of racialization experienced. For example, earlier in the interview Isabella shared multiple consequences of immigration enforcement in her life: her mother's deportation, the separation of her family, and the imprisonment of her brothers. Her experiences may contribute to active construction of an identity that resists labels ascribed by institutions and individuals that create and reinforce the stigmatization of Mexican-origin peoples. Similarly, Viruell-Fuentes and Schulz (2011) reported a similar embracing of Mexican culture and identity among second-generation Mexican-origin women, while distancing from an identity as "American."

Women also engaged in direct acts of resistance to racialized stereotypes, while simultaneously asserting a valued identity as Mexican. Alice, a 50-year-old second-generation woman, explained the tensions between affirming her ethnic identity and resisting racialized stereotypes when encountering police in her neighborhood during a traffic stop:

> One time I was stopped by the police . . . and um the police as they are walking up on me . . . the police officer tells the police officer, "Uh, it's another one of those that doesn't know how to speak English." And then when she got to the [car] door I said, "Yes, I do know how to speak English, I speak English." And I think it's all because of the way I look. I look real Mexican, and people ask for my documentation. Basically, I'm always like in a hoodie, so I get that look, you know. I think it has to do with my appearance. The way I dress, the way I carry myself, but—I speak Spanish when I can, you know, with my kids and stuff, when . . . I listen to Mexican music, so people probably just assume that I don't know English.

As Alice implied, her efforts to assert and affirm her identity in her everyday life also heighten her risk of encounters with immigrant policing systems. Her account also illustrates how this active form of resistance is contingent on resources. Alice, who was born in the United States and is bilingual, possessed the linguistic skills to demonstrate her authorized legal status when visibly asserting her identity. Alternatively, for first-generation women, those who were primarily Spanish speakers, and those who were unauthorized immigrants, the risks associated with direct resistance to racialized stereotypes may have been much greater.

Legal Status, Situational Context, and Resistance to the Symbolic Construction as an "Other." These identities that women and members of their social networks actively managed provided a diverse set of malleable resources on which they could draw in responding to racialization. Their narratives suggest agency is itself shaped by the social structures in which they are embedded. Women and members of their networks who were unauthorized immigrants had access to a limited range of resources—including the same symbols of (il)legality and network members who could participate in these actions—to draw on when responding to racialization. The success of their efforts to negotiate these identities have implications for the preservation of work opportunities, access to health and social services, and preventing detention, deportation, and family separation. Women who had an unauthorized legal status or who had unauthorized network members generally reported greater effects of racialization on their lives than those with authorized legal statuses and described more constrained access to resources to resist the use of racializing markers in their day-to-day lives.

Discussion

Above, we describe themes that emerged from our analysis of Mexican-origin women's responses to racialization processes that unfolded during a period of increasingly restrictive immigration and immigrant policies and policing. Strategies varied according to the situational context and the resources women and other members of their social networks had available. Based on interpretation of the findings described above, the health implications of responses to processes of racialization may also intersect with other responses to affect health in the short and long term. Women's accounts illustrate the dynamic nature of socially structured opportunities and challenges and demonstrate their agency in actively managing identities and constructions within those contexts.

Health Implications of Resisting Symbolic Construction as an "Other"

Women negotiated racialization processes in part by resisting the construction of themselves as "other." They did so by leveraging the very symbols of (il)legality used by officials and peers. For example, women used the driver's license—a key racializing marker and symbol of legal status—to shield themselves and network members from scrutiny about

legal status and protect themselves against threats to health and social, economic, and political well-being. Additionally, some women transposed symbols of (il)legality such as their Mexican origin by asserting an affirming Mexican identity. Such actions countered the stigmatizing identities constructed by white-dominant social institutions and perpetuated by cultural racism, which often cast Mexican-origin communities as threats and undeserving, and therefore exploitable (LeBrón et al. 2018a). The health implications of these strategies are likely contingent on experiences with racialization processes, the resources on which women and their network members can draw, and other responses to racialization. Furthermore, some strategies may protect health in the short term but have health-threatening potentials in the intermediate and longer term. For example, efforts to hide an unauthorized immigrant identity may prevent immigrant detention and deportation, thus preserving access to social, economic, and material resources while also taking a toll on mental well-being. Over the longer term, prolonged engagement of strategies to prevent confrontations with the immigrant policing infrastructure may exact health consequences through the dysregulation of multiple biological systems (Geronimus et al. 2020). How these health consequences unfold may depend on contextual factors and individual and network resources (Geronimus et al. 2020; LeBrón et al. 2019b). We now consider and discuss mechanisms by which these processes may affect health.

Our findings suggest that particularly 1.5- and second-generation women asserted their Mexican identities, affirmed Mexican cultural practices, and preserved Spanish language use despite institutional officials using these factors as racializing markers. These forms of resistance emerged to subvert racial stigmatization and associated mistreatment (Sánchez Gibau 2005). One strategy to resist being symbolically constructed as "other" included constructing a valued social identity. Goffman (1963: 14) notes that a stigmatized individual is "likely to feel that [s]he is 'on,' having to be self-conscious and calculating about the impression [s]he is making, to a degree and in areas of conduct which [s]he assumes others are not." Thus, careful strategies to manage discreditable identities may be consequences of occupying a vulnerable place in a social hierarchy. While immigration and immigrant policies and associated ideologies racialized Mexican-origin women as inferior in the US racial classifications system, they actively worked to distinguish, preserve, and emphasize their Mexican identities. The stress process framework (Pearlin et al. 1981) suggests that these identity management processes may shape access to political resources, economic resources, social support,

and health care, all of which can shape health and render these negotiations matters of life, death, longevity, deportation, and/or family separation. Moreover, active and effortful practices to construct or preserve identities vis-à-vis racial classification systems may be a chronic response that poses longer-term health risks. For example, the John Henryism hypothesis (James 1994) suggests that the exertion of significant psychosocial resources to manage devalued identities may contribute to physiological dysregulation.

Engaging in immigration advocacy to resist processes of racialization may have multiple health-relevant implications. It may help to protect community members from deportation and/or mobilize social support in that process. It may impact policy decisions with implications for immigrant well-being. It is also possible that engaging in immigration advocacy can serve to enhance or activate social networks that are potential sources of emotional and instrumental social support. This form of resistance may operate to affirm women's identities in a context in which they are stigmatized. Additionally, participating in immigration advocacy may facilitate resistance of ascribed and stigmatized identities, offering positive and empowered identities as alternatives. Engaging in immigration advocacy may simultaneously expose women and/or their network members to stressors that derive from increased visibility and may enhance their risk for immigration enforcement.

Resisting labels and content associated with stigmatized identities also has complex implications for health. For example, women described efforts to construct and validate an affirming ethnic identity vis-à-vis the "American" identities from which they recognize they are largely excluded. In a heightened context of nativism and xenophobia, this strategy may offer a form of resistance to anti-immigrant racialization processes (Omi and Winant 2015). Thus, women's sense of belonging or not belonging and their use of the term "American" to refer to non-Latino whites may reflect their experiences of and resistance to racialization and the contexts in which women are located. For example, several unauthorized immigrant women perceived strategies to exercise and affirm their identity as increasing their risk for othering from police or immigration officials. In contrast, women with more protected legal statuses tended to describe explicit strategies to exercise their identity in relation to the immigration enforcement infrastructure, either in direct encounters with institutional officials or through immigration advocacy. Thus, both the ability to engage this strategy and its health implications may depend on the resources

women can use to prevent or resist racialization processes. These resources are shaped by social position, including but not limited to legal status.

Future Research

These findings illuminate several areas for future research. First, because women's experiences with and responses to racialization were contingent on their vulnerabilities to and protections from these processes, future studies should examine variations in experiences of and responses to racialization across and within Latina/o subgroups. Second, future research might empirically test hypotheses about the experiences of and dynamics between multiple racial/ethnic groups with immigration and immigrant policies, sentiments, and practices, and the implications for health, including the potentially gendered nature of these dynamics. For example, several women in this study perceived that Arab Americans in the Detroit area were less vulnerable to racialization than Latinas/os. In particular, participants described instances when male, but not female, coethnics who were racialized as Arab American averted interactions with immigration officials. It is plausible that these processes are gendered with, for example, Arab American and Latina women being more distinguishable through different forms of dress (e.g., hijab) or that indicators of Arab or Latino race engaged in racialization processes for men may be subtler and only apparent after closer interaction (e.g., a conversation). Other research indicates high levels of racial profiling and anti-Arab sentiments, particularly since 9/11 (Padela and Heisler 2010) and the 2016 change in presidential administrations (Lajevardi 2020), with these experiences associated with adverse health outcomes for Arab Americans (Lauderdale 2006; Padela and Heisler 2010). Thus, the perception that Arab Americans occupied a more protected social position than Latinas/os warrants further investigation. Third, studies are needed that explore gender differences in experiences of legal status inquiries and strategies to manage racialized identities. Such studies might explore gender differences in the frequency with and conditions in which legal status surfaces and the resources that are leveraged to respond to racializing encounters.

Strengths and Limitations

This study has several limitations. First, these findings are based on the narratives of a sample of Mexican-origin women in a largely low- to

moderate-income neighborhood along the US-Canada border (Schulz et al. 2002) and during a period of changing immigrant policies (e.g., DACA, driver's license). The immigrant and social policy landscape continuously changes. These findings should be understood within the time period of this inquiry, this community, and an increasingly restrictive immigrant policy environment (2013–2014). Moreover, this study examined the experiences of Mexican-origin women, the largest subgroup of Latinas/os in the United States. Future research is necessary to examine these experiences with greater depth with other Latina/o subgroups.

Second, the racialization processes discussed are relational and dynamic. They intersect with gender, socioeconomic position, immigrant generation, legal status, and other social locations as well as linguistic and physical characteristics of involved individuals. This study discusses the gendered nature of these experiences through the perspectives of women, and it does not include an analysis based on men's descriptions. Garcia (2017), studying Mexican-origin women's experiences with anti-immigrant sentiments in 2009–2013 in Texas, described how women were racialized by institutional actors (i.e., police, health care providers) as hyperfertile and hypersexual. The findings presented here build upon scholarship that indicates the consequences of Mexican-origin women's experiences with immigration policies and sentiments and that illuminates women's agentic responses to racialization processes. Research into the experience and health of men is needed, including the social statuses that may affect them.

Third, this study of women's experiences with restrictive immigrant policies does not include the perspectives of "implicated actors" (Clarke and Montini 1993) or key individuals or social groups implicated for their role in racializing Mexican-origin women, such as immigration officials, police, clerks who issue driver's licenses, social and health care service providers, men, or children. Ethnographic studies (Kline 2019; Lopez 2019) provide additional insights into how agents of racialization contribute to Mexican-origin women's experiences with racism and xenophobia.

Strengths of this study include the focus on women's responses to racialization, enriching a literature that has largely focused unidirectionally on the impact of immigrant policies on Latina/o communities but has not fully examined feedback loops (Castañeda et al. 2015). Additionally, this study contributes an intersectional analysis of the interplay of multiple social statuses (e.g., legal status, language use) in negotiating racialized identities. Notably, while studies of the health implications of restrictive

immigrant policies often focus on the American Southwest, new settlement communities, and states that have passed multiple restrictive immigrant policies, this case study sheds light on the experiences of women in a northern border community with an established Latina/o community.

Implications for Policy and Practice

These findings suggest several opportunities for intervention. First, this analysis highlights health implications of current policies that restrict access to political, economic, and social resources among those whose legal status is questioned. These policies and their health implications have impacts beyond those who are directly affected, with substantial social costs (Cruz Nichols, LeBrón, and Pedraza 2018; Pedraza, Cruz Nichols, and LeBrón 2017). Providing clear pathways to citizenship and other policies (e.g., driver's license, employment, welfare) that promote the full integration of Latina/o immigrants into US society are important tools with which to disrupt these currently costly dynamics (De Trinidad Young and Wallace 2021). For example, the temporary protected status provided to DACA recipients who migrated to the United States as young children has been linked with reduced stress and anxiety and improved cardiovascular and mental health, which could alleviate the social and economic burden of mental and cardiovascular health on the population (Giuntella and Lonsky 2020). Given the salience of legal status in women's daily lives, passage of immigration reform legislation that offers a clear pathway to citizenship holds strong potential for substantially improving health equity. Additionally, at the federal level, the American Public Health Association has called for the US presidential administration to enact inclusive immigrant policies, such as ensuring access to housing subsidies and other public benefits regardless of legal status, and to avoid linking use of public benefits with appeals for legalization (Benjamin 2019a, 2019b, 2021).

Second, a focus on inclusive state- and community-level policies can promote health and health equity. For example, providing access to driver's licenses for unauthorized immigrants may disrupt racialization and enhance access to social and economic resources. Policy and programmatic interventions (e.g., accepting a range of identifying documents for access to social and economic resources) that consider the health implications of racialization processes are urgently needed. Such changes hold potential for promoting the health of immigrant and US-born Latinas/os by alleviating stressful life contexts, affirming identities that have been

persistently stigmatized, and improving access to health-promoting resources (LeBrón et al. 2019a; De Trinidad Young and Wallace 2021).

Conclusions

Findings from this study demonstrate the importance of social, political, and geographic contexts for the racialized forces acting on populations that experience health inequities. Furthermore, they describe Mexican-origin women's strategic actions to navigate those processes, highlighting the dynamic, negotiated, and contingent nature of those actions. Public health interventions to reduce health inequities in communities affected by restrictive immigration and immigrant policies would benefit from contextualizing Latinas/os' experiences of and responses to racialization as complex, dynamic, and agentic. They amplify the public health implications of national immigration and immigrant policy and the importance of supporting communities that are experiencing—and resisting—racialization as central to the promotion of health equity as a national priority.

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