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AMERICAN DREAMS ASKEW:
HEALTH-RELATED ADAPTATIONS OF U.S. TRANSNATIONAL IMMIGRANTS FROM THE CARIBBEAN
Analysis of Emotional, Social and Structural Factors Shaping Diet and Physical Activity Practices

by

Sakinah Carter Suttiratana

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Sociology

in the

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of the

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Dedication and Acknowledgements

This dissertation is the product of many years of professional field experience and informal inquiry turned formal research. Central to my interests in social and cultural aspects of health status and health outcomes are stories that still swirl in my mind as I wonder and ask are there things that we can do to make even the simplest aspects of health care and services easier and better. This research project was specifically inspired by a woman that I met in Guatemala, Dona Risa, while conducting health and environmental conservation research as well as my participation in Community Interventions for Health, a program of the Oxford Health Alliance.

In brief, Dona Risa's story demonstrated the power of social scripts and social isolation in shaping one's health outcomes. Dona Risa, a Guatemalan Garifuna, spent most of her life in Livingston, Izabal, Guatemala, but spent thirteen years working as a domestic worker in Los Angeles (LA), CA where her son continued to reside when she returned home. I rented a room from her while conducting research in Livingston. When I received word about her death about a year after my time in her home, my mind constantly returned to one story she told me about visiting a clinic in LA. Dona Risa's first language was Spanish and her second language was Garinagu; her English was quite broken. In LA, Dona Risa was able to get by with little English. Her circle of friends was mostly Garifuna or other Latinx. She went to the clinic near her apartment for an exam—despite her attempts to explain in Spanglish what she wanted—she left without an exam. The front desk staff looked at her skin and assumed she was African American or an African immigrant and kept telling her to go to another clinic since they primarily served monolingual, Hispanic patients. She explained that she was Guatemalan; the front desk people were curt and kept handing her a sheet of paper with another clinic's name. Despite her speaking Spanish (even if it was an accent with which they were unfamiliar), they decided that she did not fit their population. She left frustrated. Two weeks later she went to the other clinic, but the staff there couldn't understand her and referred her back to the original clinic she visited. She never returned to either clinic—she went to the emergency room when she had a minor work injury. Dona Risa died of an advanced and aggressive cervical or uterine cancer—the email message I received wasn't sure which. I wondered whether her

cancer might have been detected sooner if she had better relationships with health care providers and clinics during her time in the U.S., a significant portion of her life.

Neither tragic nor sorrowful, CIH and its efforts to implement structural interventions to address non-communicable diseases in five countries, also demonstrated the potential of social relationships to shape health for better or worse. In this case, participants were texting and emailing recipes and diet fads across national boundaries—some of the transnational ideas contradicted educational interventions being delivered in communities and workplaces. I wondered, "What other seemingly simple ideas undermine efforts to measure and change health-affirming aspects of our environments?" Realizing that unexamined elements of individual routines and habits may have more sway than researchers' recognize, I embarked on ways to surface such taken-for-granted ideas and acts.

Beyond intellectual inspiration, I am ever grateful to participants in both the pilot and current research project for sharing stories from their lives with me. I hope that I've been able to share similarities and differences in their experiences without over-interpreting their narratives of migration and adaptation. I am also grateful for the guidance and advice provided by my Dissertation Chair, Howard Pinderhughes, and Committee Members, Shari Dworkin and Ian Whitmarsh. I would also like to acknowledge the contributions of other faculty and staff during my time at the University of California, San Francisco including Janet Shim, Zachary Zimmer, Adele Clarke, Kirsten Bibbins-Domingo, Alice Chen, Soo Jeong Lee, Susan Kools, Brandee Woleslagle Blank, Cynthia Mercado-Scott, and Regina Gudelunas. During the months of my dissertation research and writing, I was also fortunate to benefit from the fellowship and advice of staff at the Yale University Equity Research and Innovation Center especially Marcella Nunez Smith, Terri-Ann Thompson, Carol Oladele and Karen Wang. From the earliest days of my interest in global and transnational communities, I have always admired the work of mentors Claudia Fishman Parvanta and Patricia Pessar. Further, my research and professional aspirations have benefited from ongoing support of past and present supervisors Jai Lee Wong, Denise Stevens, Brenda Fenton, Diana Naranjo and Korey Hood, as well as my cohort members and other doctoral students. Various aspects of

my research also benefitted from reviewers and critics attending meetings of the Pacific Sociological Association, and the Eastern Sociological Society including Dwaine Plaza.

Finally and most importantly, I am thankful for the support of my family and loyal friends who made it possible for me to complete this research project and my doctoral degree. I won't name everyone, but my mother (Alecia Jackson), sisters (Naeemah Staggs and Jameelah Carter), husband (Eddie Suttiratana) and son (Elan Suttiratana) deserve special mention for enduring the ups and downs of graduate school. May this accomplishment serve as an example, Elan; hard work, talent, helpers, mental toughness and a little finesse make lots of things possible in this world. Dream big!

Abstract

Migration represents a critical period during which individual behaviors, practices, social networks and circumstances are established anew. Moreover, as a persistent gradient between health and social position has been noted over centuries, immigrant health amidst sometimes poor or unstable economic and social conditions foregrounds lessons about optimizing health and well-being with limited resources. U.S. immigrants represent an increasing share of the U.S. population, have influence over growing numbers of U.S. citizens (as parents, grandparents and partners), and embody an unknown portion of the future's health related risks and burdens associated with chronic diseases. Using a sociological lens to analyze the lived experiences of US immigrants, this study seeks to identify the range of factors that contribute to immigrant adaptation in the areas of diet and physical activity, two risk factors for myriad health conditions and outcomes.

This dissertation extends migration and lifestyles scholarship through theorizing about relationships between migration, health, adaptation, and citizenship based on the analysis of the personal, social, and institutional processes that comprise immigrant adaptation to U.S. notions of health within a Caribbean diaspora population. Weaving together complementary research from sociology, psychology, social geography and epidemiology, this project theorizes a sociological concept of immigrant health adaptation or health acculturation—constellations of factors and processes associated with immigrant adaptation to dominant (US) notions of health and health care—a potentially productive lens through which social integration and wellbeing may be examined. Building on lessons about the complexity of immigrant adaptation as well as growing interest in social and environmental determinants of health, this study proposes two innovations to immigration and sociology of health and illness research: 1) breaking down the "black box" of acculturative processes into more specific steps or phases which may be targeted for future research; and 2) using everyday practices and norm re-formation related to diet and physical activity to illuminate health-relevant pathways of adjusting to new environments including meso-level (non-individual) contextual factors.

This research draws upon in-depth interviews, surveys, observation and archival review in order to shed light on acts and ideas that constitute immigrant adaptation in the U.S. More specifically, in-depth study of *how* specific elements of diet, physical activity, and sedentary behavior interact with contextual circumstances describes immigrant experiences of adaptation, health degradation and health maintenance. This study advances understanding of various contextual factors that shape to practices and routines when one's geographic or political environment changes. Peering beyond economic and political experiences of migration and adaptation, this study highlights emotional, sociocultural and structural factors influencing Caribbean immigrants' quotidian practices and examines how those practices relate to health and citizenship. This study elaborates steps in the process of people moving between poles of healthy immigrants and potentially vulnerable citizens by identifying specific factors influencing immigrant health adaption as well as diet and activity practices and processes instigated by their migrations.

Among this immigrant sample, health is understood as effortful achievement rather than simply an abstract, general state of being to which everyone is entitled. Health is multifaceted and described as interacting with many systems including: medicine, media, economic, labor, social, political, housing, and transportation. While participants were generally knowledgeable about the ways in which food and physical activity are considered risks across the health professions, participant identified risks to health were more complex. Diet and activity are embedded within social, cultural and environmental relationships and are not necessarily easily modified. Moreover, the low salience of health at individuals' point of decision about food and eating suggests that touting the health benefits of foods as a means of behavior change for this population may be ineffectual. Findings further suggest that consumption of US ideas about food, activity, health and responsibility support specific types of social citizenship and incorporation. This project identified numerous social factors beyond residency, language and marriage that may contribute to immigrant health such as social isolation, role pressure and mistrust of institutions.

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Chapter 1: Introduction and Statement of Problem

Introduction

Recent epidemics of communicable (infectious) diseases have raised concerns about foreign bodies as risky or dangerous—potentially harboring and transporting catastrophic illnesses. While infectious diseases garner much public and political attention, non-communicable or chronic diseases are responsible for most deaths worldwide. Of the 57 million global deaths in 2008, 63% (36 million) were attributable to non-communicable diseases (NCDs) with 80% of those deaths occurring in low- or middle-income countries (World Health Organization 2011: 5). From an epidemiological perspective, four conditions are responsible for the majority of the global NCD burden: cardiovascular diseases, cancers, diabetes and chronic lung diseases (ibid). Moreover, four risk factors: unhealthy diet, sedentary lifestyle, tobacco use, and alcohol use have been associated with 50-80% of these main causes of NCD-related mortality globally (World Health Organization 2009). Within the Americas, NCDs are not only the leading causes of death (heart disease, cancer, stroke, diabetes), but they also represent the highest disease burden (PAHO/CARICOM, 2006). Rapid social and environmental changes including urbanization, industrialization of some sectors (like food and agriculture), and circular migration are considered macro-level contributors to epidemic rates of NCDs and an emerging childhood obesity problem (Pan American Health Organization (PAHO), 2011; PAHO/CARICOM, 2006). Compared with 35% of premature deaths (deaths prior to age 70) in high income countries of the Americas (e.g. USA) attributable to NCDs, Trinidad and Tobago and other upper middle income countries in the region experience approximately 50-60% premature death (PAHO, 2014). The major causes of premature death in the Caribbean have been linked to common underlying risk factors of unhealthy diet, physical inactivity, obesity, tobacco and alcohol use and inadequate use of preventive health services (PAHO/CARICOM, 2006).

The various relationships between migration and NCDs have been minimally analyzed. In fact, public discussions frequently rely on assumptions that NCDs are socially and politically driven by lifestyle characteristics such as diet, physical activity patterns and weight preferences even when

scientific evidence equivocates. Under modern capitalist systems, lifestyle characteristics have frequently been ascribed to individuals or labelled social groups and intertwined with ideas about power, freedom, choice and responsibility. Further, as costs (social and health care) and concerns about NCDs have increased, diet and activity patterns have become intensely scrutinized as among the most preventable risk factors potentially contributing to chronically ill populations. Moreover, borrowing from campaigns in higher income countries, several developing countries have begun implementing public health communications and interventions promoting healthy eating and active living as means of reversing or addressing obesity and cardiometabolic conditions. More specifically, numerous interventions—ranging from the behavioral to the pharmaceutical and surgical—have emerged to support healthy diets and active, rather than sedentary, living. Less attention has been placed on relationships between epidemiological risk factors and global/regional health inequities or country-specific drivers of the risk factors themselves.

This research seeks to explore the relationships between migration and two risk factors associated with the development and progression of multiple non-communicable diseases—diet and physical activity—while also contributing to understandings of how everyday practices are shaped and manifest in people's lives based on immigrant accounts of adaptation. From a social science perspective, it may be that the nuanced contextualized activities that culminate in everyday practices and routines are less familiar among health researchers than the individualistic lifestyle concepts to which many are accustomed.

This dissertation proposed multi-site, ethnographic exploration of the formation of diet and physical activity practices through comparative analysis of interview and contextual data collected among transnational immigrants from the Caribbean region living in the United States. By recontextualizing immigrant health within lived experiences of migration and adaptation, this research seeks to understand how transnational immigrants interpret health messages and take action in two NCD risk domains—diets/eating and physical activity. This research also seeks to situate immigrant health beliefs and

practices within broader historical and social contexts where migrants are critical agents, adopters and adapters of beliefs, practices and lifestyles.

For the purposes of this research transnational immigrants or transnationals refers to "those whose networks, activities and patterns of life encompass both their host (new) and home society. Their lives cut across national boundaries and bring two societies into a single social field" (Schiller, Basch and Blanc-Szanton 2006). This definition has been operationalized as: people who migrate to the U.S. from another country, and maintain ties or interests (family, property, visits, shipments of goods or money, regular communications) in their home country. This study seeks to theorize about how identity, social interaction and interpretations of science and citizenship shape health beliefs and behaviors for individuals and transnational collectivities. Grounded by the experiences of diverse participants, this study will describe how transnational immigrants incorporate popular health concepts into their beliefs and behaviors related to diet, physical activity and risk for future health problems.

Transnational immigrants represent a specific subsection of immigrants within the US; not all immigrants are able to or interested in maintaining ties with their home countries. Transnationals provide a unique opportunity to examine the establishment and maintenance of everyday practices since their daily interactions potentially elevate the salience of rules, norms, and things taken-for-granted among people negotiating and establishing new habits and routines based on changes in geography. Conducting research among transnational immigrants from the Caribbean provides a different perspective on intra-American (regional) transitions related to migration and globalization beyond more common considerations of Mexico, Central and South America. Caribbean states have developed alongside other American nations and their small populations, geography, and macro-political engagements have ensured long-standing migration experiences with the United States including those of return migration. Shared historical, linguistic and cultural connections as well as ambiguity about the role of racialization/ethnicization among second-generation (and subsequent) descendants in terms of both health and social status provide analytic opportunities to thoroughly explore migration and settlement patterns and the development of "healthy lifestyles." Moreover, analysis of Caribbean migration experiences may

help illuminate the variety of factors involved in shaping new norms, health identities, and roles within societies increasingly characterized by prevalent, non-communicable diseases and aging populations.

The word “immigrant” is used throughout this paper to refer to those who move from one recognized geopolitical, sovereign state, usually a nation or country, to another. Although the term migrant is frequently used outside of the U.S., migrant carries connotations of specific types of laborers in the U.S. In order to avoid confusion, the U.S. convention will be used, but it should be noted that this category of immigrants includes people who move from one nation to another for many reasons including employment, family reunification, conflict, fear, etc. Herein, the use of immigrant does not describe an official legal status or categorization.

Background and Context

Current experiences of health and illness exist amidst numerous global realities. Three major developments impacting health include global disease transitions, shifting responsibility for attaining and maintaining health, and the ongoing broad scale movement of populations (migration). First, the global disease transition refers to a change in the burden of disease whereby morbidity and mortality caused by communicable diseases is being replaced or supplemented by morbidity and mortality due to non-communicable diseases (World Health Organization 2011). Global efforts to address NCDs, long considered lifestyle conditions of high-income nations, often emphasize the role of epidemiological risk factors and individual-level behaviors as the drivers of the burgeoning health and economic crises forming around non-communicable diseases (Abegunde et al. 2007; Strong et al. 2006). Less attention has been paid to the socio-historical and structural contours of this dynamic, local-global issue.

Second, economic pressures from the global advance of market capitalism as well as other types of globalization have led many developing nations to begin shifting once centralized (public) health costs to individual users (Mackintosh and Koivusalo 2007). Therefore, while health care experiences remain dramatically different and highly unequal around the world, there has been some convergence in the

search for health care solutions. The global advance of capitalism and neo-liberal political frameworks within diverse political systems has favored market-based solutions that typically shift responsibility away from governments to individual citizens (Mackintosh and Koivusalo 2007). Moreover, the introduction and acceleration of private health insurance in developing economies has been encouraged and occasionally required by financial stakeholders like The World Bank and International Monetary Fund. While several social science accounts of changing conceptualizations of risk and responsibility for health and life problematize simplistic understandings of individual choice, illness prevention and healthy lifestyle activities targeting individuals as patients and consumers persist (Clarke et al. 2003; Lupton 1999). Moreover, the practice of public health in many countries has long disseminated and popularized individual-level prevention messages originally developed for U.S. or European audiences (Ruger 2005).

Third, human movement around the globe has accelerated for numerous reasons including technological advances, reorganization of labor markets, conflict and improved access to the various resource inputs required to move from one geographic place to another. Human migration is one of the most dynamic social, economic and political forces shaping global society, affecting inter-state relations, intra-state relations, labor, the environment and health. An estimated one out of 33 people (or 214 million people) in the world are migrants with 42.9 million of these people being categorized as internally displaced persons or refugees (International Organization for Migration (IOM), 2012). The United States is home to approximately 20% of the world's migrants, 42.8 million people, and provides the largest outflow of remittances of approximately $48.3 billion (IOM, 2012). While the physical movement of people over land and political boundaries and the dynamic flows of money are important markers of migration, they are also relatively easy to measure and monitor. Researchers interested in comprehensive investigations of migration must transcend ease of measurement; the social and cultural dimensions of migration are profound, variable and ever emergent.

The nexus of these trends implies dynamism in terms of risks and behaviors, as well as changes in lay perceptions of the role of individuals in health care and health maintenance no matter where one is located in the world. Among those who migrate, the complexity of the health arena may be complicated

by acculturation, adaptation, or enculturation processes and challenges accessing prevention resources, health care and other services.

While an “immigrant health advantage” has been described for some groups in the U.S., the heterogeneity of immigrant experiences as well as limited access to resources lead some groups to experience health disparities (Acevedo-Garcia et al. 2012a). Immigrant health research documents barriers to access and utilization of health care and prevention services among some immigrant groups (Goel et al. 2004; Gordon-Larsen et al. 2003). Moreover, research on acculturation and health have revealed poor understandings of U.S health systems and expectations among many immigrants, but relatively better health status and outcomes among those who have had *less* contact with the U.S. health care system. Initially labeled the “healthy immigrant effect” based on studies among Mexican immigrants, this paradox accounts for a significant proportion of the published immigrant health literature today (Singh and Siahpush 2001; Stephen et al. 1994). Other research focuses on the reduction or prevention of specific diseases/conditions associated with perceived risks for specific immigrant groups based on their national origin or living conditions (Goel et al. 2004; McArthur, Anguiano and Gross 2004).

There is an abundance of qualitative literature on migration and health although much of it: a) explores “folk traditions” and cultural conceptions of illness/disease attributed to a specific immigrant population and b) obscures within group diversity and negotiations between “Western” and “non-Western” that may take place within individual decisions and habits. This observation does not intend to devalue the literature which has shed light on many important issues and conceptual disconnects for immigrants e.g. female genital cutting and simultaneous use of indigenous medicines and cures; however, there is room for additional research. This research attempts to move beyond simple “familiar-foreign” (home country-U.S, traditional-assimilationist) paradigms to consider processes of information incorporation as well as the influence of transnationalism on health beliefs and behaviors that may be critically important for long term health allocations and outcomes in the future.

As immigration to the U.S. diversifies and as global interactions create pluralities of migration and diaspora experiences, better understandings of how disrupted routines are re-established, supported or undermined could shed light on important public health and immigrant adaptation issues for the near future. While promoting health is of interest at the national population level, the potential deterioration of immigrants' health status in the U.S. underscores challenges with social, political and economic integration and longer term concerns with the "fitness" of the physical bodies and capabilities that comprise the body politic. This research is interested in bringing together multi-disciplinary threads of social science and public health literature and practice in order to explore relationships between migration experiences, embodied migration adaptation, health and two risk factors for multiple NCDs—diet and physical activity.

Health as a status may be evaluated at any point in one's life, but some risk factors for chronic disease development are thought to be cumulative. Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948). While this definition is embraced in public health and some branches of biomedical science, many social scientists might refine this definition by viewing health as a product and achievement continuously created through interactions between individuals, collectivities, institutions and structures under advanced capitalism. Health achievement and maintenance have become socially and politically important characteristics for average U.S. citizens. Health may also be viewed as a form of currency or capital that has social exchange and use values in societies concerned with social position, stratification and accumulations of power. Despite rhetorical and political emphases on individual, behavioral contributions to health, significant evidence suggests that health may be more related to less malleable biological and structural factors than behavioral factors (Kuzawa and Sweet 2009; Link and Phelan 1995; Solar and Irwin 2010).

Problem Statement

The everyday practices of everyday individuals as they relate to health and illness remain under-theorized within health research, despite recognition about the role of practices and habits in shaping environments and conditions that bolster health and/or illness. Quotidian dimensions of life have long been described as having intangible, unconscious, or taken-for-granted qualities which may be excluded or diminished in significance by asking topic-specific questions (Bourdieu 1979/1984; Bourdieu 1980/1990; Bourdieu 1983/1986; Giddens 1991). Due to health researchers' emphasis on more overt measurements of individuals' attitudes, beliefs, perceptions and reported behaviors, thorough examinations of practices have rarely taken place among researchers concerned with health promotion. Within social science disciplines such sociology and anthropology, musings, analyses and theorizing about everyday life and its relationships to humanity and social actions are sub-specialty areas that date back decades (Adler, Adler and Fontana 1987; de Certeau 1984; de Certeau and Mayol 1998; Pink 2012). Social scientists frequently study practices embedded within specific contexts and histories while also emphasizing interpretive meaning associated with such practices. This project seeks to bridge the expertise and theoretical insight of ethnographers and other social scientists that have spent more time examining taken-for-granted elements of life and the practical concerns of public health practitioners and implementation scientists who seek to operationalize knowledge gained in incremental projects to promote health and social order.

Within a life course perspective on health and aging, migration represents a critical period during which individual behaviors, everyday practices and social circumstances are established anew. As immigration to the US diversifies creating multiple migration and social incorporation experiences, there is much to learn about the strategies used by individuals to build lives and health amidst dynamic social, economic and cultural conditions. Moreover, given growing consensus that for many immigrant groups, time in the US increases their health risks, a particular urgency drives research interest in understanding the mechanisms and processes that shape health-related acculturation and other processes that may influence immigrant health and social status.

Reviews of relevant literatures suggest that disciplinary boundaries, as well as epistemological and methodological differences prevent migration and health research from advancing despite voluminous, promising research directions posited by experts. While feasibility is a critical consideration for any research, this research seeks to contextualize topical investigation about NCD risk factors by combining multiple methods and research strategies in order to highlight the influence of taken-for-granted elements of everyday life. Transnational immigrants navigating multiple social expectations and norms provide an interesting opportunity to examine migration as a critical event in individuals' lives as well as to elicit salient accounts of how new routines and habits are formed since drastic changes in geography forces one to re-evaluate life's assumptions, while simultaneously forming new ways of living and being. How do transnational immigrants make sense of their dynamic lives and contexts and enact decisions and practices related to diet and physical activity? Using health risk factors as foci, the research seeks to explicate and describe processes used by immigrants making lives amidst such dynamism.

Migration as Critical, Disruptive Life Event

This project asserts that there is something unique and special about migration processes. My hypothesis is that the salience of changes in context allows immigrants and those concerned with society and social production to see how things come to be. Migration spans numerous processes, spaces and times revealing much about social experiences and human-environment and human-structure relations. Immigrants lose most if not all social and circumstantial bearings when they move from one country to another. As one's neighborhood, geography, and political designation change, so change the social norms, expectations and material culture in which one lives. As necessary quotidian practice, eating (and food) is one of the arenas where biographical disruption is quite pronounced—foods once familiar may be regarded as inedible and cherished norms and rituals around eating are displaced and regarded as strange or rude. Similarly, patterns of physical activity or inactivity are woven into one's days short on time and full of work, caring and commuting. The taken for granted assumptions underlying former lives in other locales have been ruptured, initiating reflexive and interactive processes of biography and identity

reassessment and "work" to recreate selves, norms and expectations fitting of one's new environs and situations (Felde 2011; Nettleton 2005). Immigrants may undertake significant biographical and identity work as part of their adaptation (Hochschild 1979; Mamo 1999). Findings from my 2013 pilot research among transnational immigrants from various regions of the world suggested that biographical and identity work are pervasive and includes the management of cognitive, emotional and physical realignments (Hochschild 1979; Mamo 1999).

Among transnationals who, intentionally and unintentionally, cobble identities and practices borrowing from at least two national identities; considerations of more fluid, asynchronous and uneven processes of acculturation are warranted. Rather than experiencing one biographical disruption followed by discrete responses, individuals likely experience multiple biographical disruptions of variable magnitudes and intensities affecting multiple practices and actions. Transnationals appear to engage with both continuities and discontinuities in their life experiences. Some things stay the same, while other things change tremendously.

Beyond conceptions of straight-line assimilation or acculturation, I am interested in the processes used to define and achieve health and enact strategies for everyday living under the weight of ecological (or higher order) changes. In order to better understand the complex social circumstances that shape and are simultaneously shaped by immigrants' diet and physical activity practices, this project seeks to highlight relationships between the taken-for-granted and the social/structural in the development of routines among transnational immigrants to the U.S. Despite being the product of environments, discourses and institutions; everyday practices also structure and shape individual choice and agency. Since diet and activity are epidemiological risk factors that are interwoven with several aspects of everyday life, consideration of their relationships with health reveal one perspective on the processes undergirding the formation, disruption, reformation, and reproduction of everyday practices. This study relies on lay experiences to challenge simplistic representations of biochemical and rational connections between health and individual risk factors of interest.

For transnationals moving to the U.S., recognizing, understanding, adopting and/or modifying U.S. norms have practical and symbolic value—newcomers are learning not only how to live in the U.S., but also how to become "proper" citizens (Ong 2003). Citizenship in the contemporary U.S. is markedly shaped by neo-liberalist capitalism, individualism, rationalism and healthism (Crawford 1994; Mamo 2010; Nettleton 2005; Ong 2003). U.S. cultural norms "provide codes and social scripts for the domestication of the individual body in conformity to the needs of the social and political order" (Scheper-Hughes and Lock 1987: 26). Historically, the assimilation of migrant bodies into the "normal" U.S. body politic has been an explicit government goal (Markel and Stern 1999; Ong 2003; Porter 1999). To the extent that migrants seek to develop human, social and cultural capital as well as access to resources in their new country of residence, when possible they adapt by adopting their interpretations of prevailing social norms.

U.S.-Caribbean Migration

While the populations of Caribbean nations are relatively small, given their intertwined history with the U.S. and the multiple migration and development relationships shared within the Americas, growing concern about non-communicable disease among Caribbean populations is relevant to current and future population health in the U.S. First, for several large metropolitan areas, Caribbean populations represent a significant proportion of the foreign-born populations e.g. New York City, Boston, Miami (Acosta and De la Cruz 2011; McCabe 2011). Second, as with other immigrant groups to the U.S., data are mixed on the health status of Caribbean immigrants living in the U.S. (CAREC 2007; CDC/CAREC 2011; Mahoney 2012; Smith 2012). Data vary by national origin, gender and perceived race/ethnic background. Today's Caribbean immigrants and their descendants will help comprise those immigrants whose health deteriorates in the U.S. Moreover, given the large proportions of Caribbeans of African, Asian and mixed race descent among the U.S. immigrant population, Caribbeans may experience racialization or ethnicization processes which may be quite different from those of some European, Latino and Asian American subpopulations based on historical race relations and quasi-imperial political

relationships with the U.S. Racialization and other institutional or structural forms of discrimination and/or violence may cause undue stress and/or emotional health challenges--both risk factors for the development of chronic diseases (Krieger et al. 2011).

The Caribbean region possesses one of the largest disease burdens attributable to NCDs due to rapid social and family change, urbanization, globalization and migration (PAHO/CARICOM, 2006). Moreover, the global labor migrations within which Caribbean workers figure prominently, have led to unbalanced formal and informal care arrangements since generations of workers have left their aging parents behind with children while they work in the U.S. or other high income countries such as the U.K and Canada (Benería 2008; Ho 1993; Stilwell 2004). While the financial burden may be subsidized by those working abroad--former Pan American Health Organization (PAHO) Director, George Alleyne, and others have expressed great concerned about the practical and professional care burden weighing down evolving health care systems and economies of the largely middle income Caribbean nations (BCUN, 2011). Caribbean exports of nurses and health care professional is world renown; yet their shortage of health care workers with experience and expertise and non-communicable diseases and aging is less well known and understood (BCUN, 2011). By 2025, Trinidad and Tobago, in particular, is expected to have a notably high aging index. The aging index, defined as the ratio of the number of persons aged 60 and over to the number of youths under age 15, is a number used by demographers and government planners to estimate increasing demand for social, economic and political resources from older people (Pan American Health Organization and the National Institute on Aging 1997). Outside of Europe and North America, the Caribbean is the "oldest" region of the world, with 10 percent of its aggregate population aged 60 years and over (Pan American Health Organization and the National Institute on Aging 1997).

Table 1 presents sample demographic and social characteristics for some Caribbean immigrants to the U.S. as measured by the U.S. Census Bureau (2013). Caribbean populations may be found in many U.S. states, but are concentrated in the NY tri-state area (NY-NJ-CT), Florida and the Washington, D.C. metropolitan area.

Table 1: Selected Census Statistics on Caribbean Populations Living in the U.S.

Characteristic	Jamaican	Trinidadian & Tobagonian	Dominican	Total U.S.
Estimated population[1]	1.0 million	196,000	1.6 million	308 million
Women	55.2%	56.7%	55.5%	50.8%
Foreign-born, entered before 2000	79.6%	81.2%	74.3%	65.4%
Foreign-born, not a U.S. citizen	40.2%	44.9%	53.1%	55.5%
English language use	92.9%	95.0%	8.1%[2]	79.5%
High school completion	83.2%	87.9%	64.6%	85.7%
Bachelor's degree	23.9%	24.2%	15.2%	28.5%
Labor force participation	73.0%	72.5%	67.0%	64.7%
Female labor force participation	72.3%	70.1%	62.6%	58.5%
Educational services and health care employment	35.2%	31.9%	22.4%	22.9%
Median household income	$49,634	$51,057	$34,925	53,046
Adults, 65 years and older	15.8%	12.9%	31.7%	13.0%
Life expectancy, at birth (home country)[3]	Female: 80 Male: 75	Female: 74 Male: 70	Female: 77 Male: 69	Female: 79 Male: 76

[1] Census estimates for immigrant populations are often thought to be undercounts. These statistics are largely from 2006-2010 estimates from the American Community Survey (ACS).
[2] The Dominican Republic is part of the Spanish-speaking Caribbean along with Puerto Rico and Cuba. 91.5% of Dominicans reported using Spanish at home.
[3] Source: U.S. Bureau of the Census, International Programs Center, International Data Base, March 1997.

Purpose

The purpose of this research is to explore migration, acculturation and globalization as factors relevant to the establishment of dietary and physical activity norms among immigrants to the U.S. This project seeks to contribute to emerging scholarship on immigrant health and improve understanding of contextual, social and emotional factors that contribute to practices and routines when one's geographic and/or political environment changes. U.S. immigrants represent an increasing share of the U.S. population, have influence over growing numbers of U.S. citizens (as parents, grandparents and partners), and embody an unknown portion of the future's health related risks and burdens associated with chronic diseases.

This project sought to thoroughly investigate social and structural factors that contribute to immigrant routine adoption around meals/eating and physical activity in order to identify less considered elements of health practices. Improved understanding of such practices may improve the resonance and

effectiveness of health promotion interventions. The research will combine general research among immigrants (including my previous research and published literature) with in-depth inquiry into the practices and beliefs of immigrants from one specific region—the Caribbean. Findings should contribute to public health and social science knowledge about factors beyond food choice and physical environment that contribute to quotidian decisions and lifestyles among everyday people including immigrants. Knowledge about diet and physical activity adaptation and health-seeking amidst significant dynamism may contribute to improved access to care and health information for other immigrant groups and populations managing simultaneous cultural, economic and social changes. This research also attempts to advance health and migration inquiry beyond the immigrant health paradoxes.

This study represents a novel effort to bring together lessons from diverse disciplines (epidemiology, communications, social sciences, behavioral sciences) into more cohesive theorizing about how immigrant populations experience health, diet and physical activity. More specifically, findings from this research may be used to better understand immigrant health processes, to better describe processes associated with living transnationally as well as potentially inform future interventions and communications about diet and physical activity as important risk factors for non-communicable diseases. Ultimately, this research theorizes about how transnational immigrant populations develop everyday practices and incorporate or overlook health promotion ideals about diet and physical activity.

Research Questions

Uncertain about the processes and ideas that this research would identify, I anchored my investigation with four broad research questions:

1. What is the range of social, structural and emotional factors that contribute to transnationals' understandings and actions related to food, eating and dietary routines?
2. What is the range of social, structural and emotional factors that contribute to transnationals' understandings and actions related to physical activity and everyday routines?

3. How do transnationals' ideas about health relate to their beliefs and practices around diet and physical activity?

4. What features of transnationals' quotidian life facilitate health promotion, health maintenance or health degradation while adjusting to life in the United States?

By attempting to answer these questions, this research aims:

- To describe transnationals' health beliefs and behaviors related to diet and physical activity including stressors.
- To describe relationships between transnational identity (identity related to maintaining ties/activities in two different nations) and health beliefs and behaviors related to diet, physical activity and chronic disease prevention.
- To understand influential factors and messages in participants' development of ideas about food/diets, physical activity, health and U.S. belonging.
- To develop a health-promotion specific theory of acculturation and adaptation based on the responses and observations of Caribbean immigrants to the U.S.; and
- To propose health-specific acculturation measures or items that pay particular attention to social, structural, and emotional factors.

I suspected that inside the black box of acculturation were a variety of influences that shaped individual and group assemblages that become the stories that we tell about the relationships between migration and health. This hypothesis was informed by ecological frameworks, multiple literatures (reviewed briefly herein) and my previous experience with both diverse immigrant groups and social determinants of health and health disparities.

Assumptions

Migration makes one's world topsy-turvy and introduces immigrants into new social games and social worlds where the rules may be unknown, surprisingly similar or incredibly different. As one

attempts to settle the unsettled life and restore some sense of order and ontological safety, one modifies, creates, and performs different ways of being and belonging. The primary assumptions undergirding this work are that there is something unique and special about migration processes and that recognizable changes in context allow those concerned with society and social production to see how things come to be. Rather than a singular event, migration spans numerous processes, spaces and times until it is no longer visible—these processes of unknown but likely long duration chart ones journey from Jamaican to Jamaican-American to African American. Revealing more than what happens when one encounters dynamic change, narratives and practices of migration comprise much about human social experiences including resilience, adaptation, norm recognition and conformity, skill and resource enhancement, generational tension and transfer, resistance and ostracism.

Second, it is of note that this research explores experiences among ordinary Caribbean immigrants living in the US. The individuals and collectivities sampled and represented do not necessarily have a specific diagnosis, illness, or disability. In contrast with its labeling, much of the theorizing within the Sociology of Health and Illness or Medical Sociology examines illness; this paper attempts to deepen sociological understandings of health or, perhaps, pre-illness. Going back to Parsons "sick role" and early 20th century conceptualizations of deviance and abnormality in health, bodily expressions and psycho-social characterizations, the discipline has been most interested in elaborating relationships between social circumstances and unhealthy bodies and unhealthy societies (Nettleton 2005). However, as health and illness might best be understood as relational (but not always oppositional) and fluid, the study of how material and social circumstances are inscribed on bodies (individual and social) may benefit from considerations beyond those already experiencing illness. Like illness, health or states of health, are also likely to be structured, inscribed and recreated through social processes.

This research examines how transnational communities interpret messages and take action in domains of life where health professionals suggest that everyone is increasingly at risk. Diet and activity are important epidemiological risk factors associated with increased rates of non-communicable or chronic diseases worldwide; and both influence the pathways of other illnesses and conditions including

aging. While these associations are documented and noteworthy, risk factors alone do not cause disease. The study of risk factors presents probabilistic pathways toward illness. Risk factors are central to regimes of truth backed by the authority of epidemiology and preventive medicine, but also signify both Foucauldian "government at a distance" and the biomedicalization of everyday life which extend beyond the borders of illness to implore the healthy or those at risk of becoming ill to engage in self-surveillance and health-attainment projects (Clarke et al. 2003; Lupton 1999). Given the salience of the psychosocial elements of eating and being physically active, this research brings to light some of the implicit assumptions about the relationships between risk factors and health as experienced by lay individuals.

Implications of the Research for Sociology

Grounded by the stories and experiences of transnationals themselves, this research endeavors to bring together lessons from diverse disciplines (epidemiology, social sciences, and behavioral sciences) into more cohesive theorizing about how transnational immigrant populations experience food, activity, and health, and establish new habits and routines related to common health risk factors of diet and physical activity. This research hopes to meaningfully contextualize the everyday practices and decisions that culminate in health "lifestyles," as well as contribute to global, NCD prevention and wellness efforts. Findings from this research may be used to better understand immigrant health processes, to better describe processes associated with living transnationally as well as potentially inform interventions and communications about diet and physical activity as important risk factors for non-communicable diseases (World Health Organization 2009). Moreover, by using the stories and experiences of transnationals themselves, this research asserts the importance of lay knowledges and interpretations, while contributing to ongoing dialogues among experts and laity about the causal pathways of illnesses and factors that place one at risk (Popay and Williams 1996; Shim 2005).

Organization of the Manuscript

This dissertation consists of nine chapters. After the introduction, our journey begins in Chapter 2 with a presentation of my conceptual approach to the research questions as well as brief introductions to

the theories that have shaped the overall project. Historical and discursive overviews of migration as a type of global flow and citizenship are also presented here. Chapter 3 situates the research in relation to epidemiological research by reviewing recent empirical research on migration and health. Much of this research describes immigrant health paradoxes; many topics and questions remain unexamined in this field. Chapter 4 outlines the study's research methods and aspirations including the procedures and data sources. Next, Chapter 5 introduces the participants, sample characteristics drawn from their interviews, survey responses and researcher interpretation, as well as, their understandings of health, the pursuit of health and the various factors that coalesce in ephemeral and dynamic presentations of health and/or illness. Chapters 6 through 8, respectively, elaborate interpretive findings about the emotional, sociocultural, and structural factors described as shaping new practices of eating and physical activity among the Caribbean immigrants interviewed. Finally, Chapter 9 highlights connections between the research findings and existing theories and perspectives, while also introducing a framework of immigrant health acculturation to be used in future research. Finally, future research directions are described after a review of this project's contributions to the sociology of health and illness and public health.

If the researcher succeeds in describing the narratives, relations, absences/silences and insights gleaned conducting this work, readers should be able to co-create a field of understanding that: situates transnational immigrants' everyday decisions and lifestyles into broader contextual frames; draws out undertheorized stages and processes of adaptation, incorporation, assimilation or enculturation (steps between migration and re-settlement) around two types of practices—diet and activity; provides additional contextual information about risk factors which can be used to modify measurement of risk factors or inform interventions and future research; contributes to discourse on adaptation processes, psychosocial pathways to health inequalities and social determinants of health; and counsels against methodological nationalism in research related to migration and health.

Finally, unlike in quantitative research, the highest number of endorsements is not always the most interesting or informative data. Unanimity, a range of perspectives, as well as exceptional and outlying case experiences may all be used to elaborate ideas under discussion.

Chapter 2: Conceptual Approach and Theoretical Considerations

Building upon sociological theories of practice and embodiment and public health concepts related to social determinants of health, the study procedures were designed to explore processes of lifestyle and practice re-development among transnational immigrants living in the U.S. These literatures helped inform the design of the study as well as the selection of data collection strategies and instruments. This chapter presents important theoretical and conceptual frameworks considered as the researcher attempted to address the proposed research questions. Consistent with grounded theory approaches to qualitative research, additional theoretical perspectives were considered post hoc to analyze connections between findings and the broader research context. Post hoc theoretical considerations are discussed in the concluding paragraphs of each of the finding chapters.

Theories of Practice

Concepts from theories of practice espoused by Giddens, Bourdieu and other social scientists have contributed to the framing of the research questions, study design and instrument development. Sociological theories of practice favor neither subjectivism nor objectivism, but instead work to understand interrelationships, at the meso-level, among structures and actions (O'Reilly 2012: 5). Practices are not only valuable because they demonstrate connections between social and conceptual levels, but also because the seeds of change lie within practices. According to Warde (2005), "the principal implication of a theory of practice is that the sources of changed behavior lie in the development of practices themselves. The concept of practice inherently combines a capacity to account for both reproduction and innovation" (140). Production and innovation are social processes about which social scientists and interventionists care a great deal. Warde uses the term practices trajectories to draw attention to the history, surrounding institutional arrangements and identifiable stages of practices (Warde 2005). Practices are dynamic; they evolve alongside people and situations; "immersion in a practice has the features of a 'career,'" with ups and downs, learning periods and mastery (Warde 2005). Sociological

perspectives on practices help illuminate the taken-for-granted fibers that enrobe specific behaviors; behaviors are frequently the target of health-related interventions and policies.

Furthermore, even when culture (or the visible vestiges of culture) almost disappears, the visible "doing" of habits remains. This perspective is critical for understanding the influence of migration on second and third generation immigrants. Swidler's work on culture highlights the openings available when people's lives become unsettled (Swidler 1986). When lives are settled, people move along fairly continuous rhythms: there is no major activity; behaviors rely on norms and implicit assumptions that have been built up over time. Being settled creates continuities of style and ethos that are enacted as common sense or habitus. Unsettled lives, similar to Giddens' critical situations, demand more intense connections to action. When people experience unsettlement, they question and revise norms, try new models and develop new "common sense" based on situated knowledge, interpretations, and strategic considerations of ideologies (Giddens 1991).

Extending this theorizing, I believed that the unsettled lives of immigrants, specifically, could accentuate processes and phenomena from which we may all learn important lessons about practice development, habit formation and habit context. Theories of practice draw attention to social rules, resources, sources of social power and sanctions, innovation, disjunctures between thoughts and actions, and embodiment. Through narratives about migration, adaptation and everyday action, I seek to cull representations and understandings of immigrant practice trajectories including their enmeshments in history, sociocultural rules and power relations, and macro-level structures.

Embodied Health

Second, the sociology of embodiment draws attention to the fact that human action often manifests through human bodies. Embodiment research attempts to restore awareness of the body in physical and social action as well as complicate assumptions about bodies, their functioning, and ideas of "normal" bodies that implicitly pervade social research (James and Hockey 2007; Nettleton 2005). James and Hockey (2007) describe embodied health identities as one feature of social identity that is part of the

ongoing organization of interaction and everyday life that draws attention to processes and the circumstances of embodiment.

This project is about identities as much as it is about practices and context. Identity, a practical accomplishment of "the dialectical interplay between processes of internal and external definition," is critical to transnationals view of their lives (Jenkins, 1996 as quoted in James and Hockey 2007; Levitt and Lamba-Nieves 2011) . Moreover, the social recognition of similarities and differences among individuals and notions about individual rights, privileges and deservingness of resources occur within layered identity games where individuals consider themselves in relation to other individuals and collectivities. While much has been written about the importance of identity, far less is known about the processes "within individuals" that lend a sense of fixity to ever-under construction identities (Craib 1998). Relying on concepts like embodied health identities, social scientists can recognize the structural frameworks behind action, yet also investigate *how* broader social and structural factors play a part in everyday experiences (Craib 1998). By exploring practice reformation and identity change as it relates to diet and physical activity behaviors, I hope to illuminate some of the interplay between the micro (individual) and macro (structural) levels while also describing participants' approaches to agency, choice and innovation (Craib 1998). This approach further allows one to examine the risk factors of diet and physical activity in relation to both routinized sources of stress and general life difficulties (Craib 1998). Participant narratives presented here explore embodied experience and physical, know-how so that we may glimpse the presence of bodies and knowledges within new or adapted practices.

Similarly, psychosocial perspectives on health allow for connections to be considered among social structures, individual agency, the body, health manifestations, and embodied emotions. Psychosocial perspectives of health inequalities suggest that elements of social life: "a sense of control; perceived social status; strength of affiliations; self-esteem; feelings of ontological insecurity, and so on, lead to variation in health outcomes" (Nettleton 2005). Social inequalities become inscribed on individual bodies or "get under the skin;" and people who experience greater senses of autonomy, social cohesion and social support are better able to respond to stresses, problems and uncertainties (Nettleton 2005).

Research into stress responses, acculturative stress, psychological distress, and weathering among immigrants suggest that this might be an important area for ongoing research (Arcia et al. 2001; Doamekpor 2013; Krieger et al. 2011)

Moreover, since migration, changes in social circumstances (status, control, cohesion, norms), changes in diet, and changes in routine may each induce stress, challenges and uncertainty; medical sociologists should empirically explore "biographical disruption as a cause of chronic illness:" a potential reversal in Bury's canonical causal chain between illness and disruption (Williams 2000). Bury posited that chronic illnesses, changes in one's physical or biological body, led to crises among those experiencing them such that their sense of identity and life story were meaningfully altered or transformed. Psychosocial factors shaping health inequalities suggest that disruptions in one's biography or life story may cause or prevent chronic illnesses or ill bodies. Similarly, theorizing about emotion management and emotion work around acculturation and the adoption of new norms including healthiness and individualism represent other manifestations of material-psychosocial relationships. Intense levels of emotion work may be similar to stress precursors of disease and illness within the bodies of individuals. Considerations of emotions as embodied sensations nudge researchers to ask questions about lay experiences; that is, rather than studying "unhealthy acts" in isolation, we should attempt to elucidate connections between unhealthy diet and health outcomes via psychosocial pathways and underdeveloped senses of social cohesion and autonomy after migration-related disruptions. The topics explored in the interviews and observations consider possible psychosocial pathways to health and illness.

Migration and Social Determinants of Health Approaches

More recently, immigrant health concerns have been presented under social determinants of health (SDH) frameworks. SDH approaches examine contextual and structural determinants and socioeconomic position as social determinants of health inequalities. Per the WHO framework for Social Determinants of Health (SDH), context includes social, political and economic conditions that produce, configure and replicate social hierarchies like the educational system, the labor market, the welfare state,

etc. (Solar and Irwin 2010). Structural mechanisms generate stratification and class divisions that position individuals and families within hierarchies of power, status and resources (ibid). The most examined social stratifiers in health research include: income, education, occupation, social class, gender, and race/ethnicity. Taking migration and acculturation as social processes that manifest through multiple levels of action, migration status might also be a critical stratifying factor; whereas migration and incorporation processes help configure and are also shaped by: social contexts, health-affirming or health-damaging social conditions, and cumulative or long-term consequences of differential health outcomes. Previous research on immigrant health disparities has revealed barriers to access and utilization of health care and services (including prevention efforts) among some immigrant groups (Gordon-Larsen et al. 2003).

Beyond WHO, other researchers (Acevedo-Garcia et al. 2012b; Horevitz and Organista 2013; Hunt, Schneider and Comer 2004; Vega, Rodriguez and Gruskin 2009) propose using a SDH approach to immigrant health in order to emphasize the contributions of social and structural factors to health risks and health outcomes among immigrant and minority populations. SDH approaches seek to balance representations of individual level factors as the primary culprits in risky health behaviors and poor health outcomes. These researchers also theorize against the cultural essentialism that they believe seeps into epidemiologic research that cites culture, a frequently inadequately defined variable or factor, as an explanation for various findings (Horevitz and Organista 2013; Hunt, Schneider and Comer 2004).

One example of public health efforts to use SDH approaches includes Vega et al's (2009) exploration of mortality trends among Latino immigrants. Their research produced trend data for causes of mortality where Latinos experience disparate outcomes—diabetes, homicide among younger men, work-related injuries, human immunodeficiency virus (HIV), liver disease (including liver cirrhosis), and specific types of digestive system cancers, including cervical, stomach, and liver cancer. One of the only attempts to look at Latino immigrant health status over time, the study highlights the importance of immigrant health disparities (or excess mortality) despite generally superior health outcomes relative to U.S. born individuals (Vega, Rodriguez and Gruskin 2009). As lower socioeconomic status among Latino

immigrants defined by lower income and educational attainment persists, the authors suggests that more immigrant health research must include variables about health care access, preventive health care, and epidemiologic life-course factors *for both sending and receiving nations* (Vega, Rodriguez and Gruskin 2009). Latino immigrants achieve better health despite worse health care access (Vega, Rodriguez and Gruskin 2009). This SDH research demonstrates how, in part, due to limited access, health care has a marginal impact on population level health and mortality—other factors seem more important. Vega et al. (2009) call for better understandings of housing, and neighborhood composition (ethnic enclaves), residential segregation, and generational transfer of cultural capital on immigrant health outcomes. The researchers specifically advocate for trans-disciplinary research "to investigate mechanisms that increase risk behaviors among Latino youth in US environments"(Vega, Rodriguez and Gruskin 2009). This subgroup of US youth, comprised of both children arriving in early childhood and children born in the United States to foreign-born parents, constitutes the heart of an ongoing demographic transition. They represent "the tip of the iceberg" of emergent health disparities in the Latino and immigrant populations that may largely be determined by differential environmental exposures and intergenerational social stratification patterns (Acevedo-Garcia and Bates 2008; Vega, Rodriguez and Gruskin 2009). Canonical knowledge about other immigrant groups is minimal and/or equivocal.

SDH approaches also allow for considerations of history. For immigrants to the U.S, historical constructions of acculturation are profoundly intertwined and dependent upon views of "spoiled," damaged, or devalued minority social groups that already treat them as cultural Others (Goffman 1963; Horevitz and Organista 2013; Rudmin 2003). Care should be taken to minimize the scientific use of "cultural" risk factors to pathologize behaviors of minority or marginalized collectivities, when risk behaviors are significantly shaped by structural factors like resources, time, labor, etc. (Shim 2005). Health is complex; migration and incorporation involve complex interactions. Denouncing attribution of health disparities or paradoxes to poorly-conceived, static cultural norms, the aforementioned SDH researchers would like to ensure that individuals and families are not blamed for problems in our collective social and structural systems (Acevedo-Garcia et al. 2012b). Further, to the extent that histories

and health influences are intertwined, more attention must be placed on historical understandings of both immigrant sending and receiving contexts.

SDH researchers pursue considerations of context when examining health disparities or vulnerabilities that might make one susceptible to present or future health problems. Given mixed findings on the presence or absence of health disparities among immigrants, interest in describing or understanding potential vulnerabilities that make immigrants susceptible to excess morbidity and mortality has been controversial and overlooked in terms of resources and research.

This project is an opportunity to advance theorizing about how and why health changes as individuals and families move through different geographic spaces, as well as about processes of health maintenance among those confronted by dynamic change. We all encounter dynamic change, but immigration provides a sensitive or "unsettled" period when logics and practices may be questioned, reformulated and/or reinforced in order to make quotidian living possible (Swidler 1986). SDH approaches seek to make more visible some of the conventional analytics of sociology--stratifications, conflict, institutions, social order, social control, alienation, power, identity and social capital—in order to better understand lived experiences of health and illness (Acevedo-Garcia et al. 2012b; Castles 2007; Solar and Irwin 2010).

These theoretical ideas along with those more specific to the study of migration and health should be thought of an aperture through which qualitative data and research experience can be viewed and analyzed. Emergent themes and narratives required deeper consideration of these theories as well as exploration of other social sciences theories that help shape the discursive milieu surrounding Caribbean, transnational immigrants living in the United States.

Chapter Interlude

"There is something strange about the way we study migration. We know, often from personal experience, but also from family talk, that moving from one place to another is nearly always a major event. It is one of those events around which an individual's biography is built. The feelings associated with migration are usually complicated, the decision to migrate is typically difficult to make, and the outcome usually involves mixed emotions. . .Migration tends to expose one's personality, it expresses one's loyalties and reveals one's values and attachments

(often previously hidden). It is a statement of an individual's world-view, and is, therefore, an extremely cultural event. And yet, when we study migration scientifically, we seem to forget all this. Migration is customarily conceptualised as a product of the material forces at work in our society. . .the migrant is seen either as a "rational economic man" choosing individual advancement by responding to the economic signals of the job and housing markets, or as a virtual prisoner of his or her class position, and thereby subject to powerful structural economic forces set in motion by the logic of capitalist accumulation." (Fielding 1992: 201)

Migration, Global Flows & Citizenship: A Historical and Discursive Review

This section describes some of the dominant theories used to represent immigrant experiences with migration, social incorporation or acculturation. Present research appears to be intimately connected to prior theoretical, ideological and discursive representations of migration. In order to derive more meaningful and insightful research questions, future researchers should understand the limitations and blind spots of conventional conceptualizations, as well as theoretical and structural openings presented by overlooked understandings of migration and incorporation process. To this end, four brief theoretical overviews follow exploring: 1) a chronology of migration and incorporation studies, 2) consideration of the ways in which migration studies may be contextualized by broader trends of global flows or globalization, 3) how studies of migration are connected with notions of citizenship, and 4) trends in migration and health research. These reviews are critical for understanding the contemporary migration studies landscape as they introduce and reproduce assumptions evident in obvious and surreptitious ways in today's research, but they also demonstrate the disciplinary and political limits to exploring the wholeness of migration and incorporation phenomena.

While this section reviews multidisciplinary understandings and treatment of migration at a conceptual level, the theoretical engagements presented frequently involve empirical evidence. Attempts to isolate the theoretical from the empirical help limit the scope of this review, but my perspective is consistent with Castles and Miller (2003) who view the empirical and theoretical divide in studies of migration as artificial and detrimental to thorough understandings of how migration is socially produced and affects multiple societies. Much migration theory has been derived based on extensive observations or considerations of demographic and census data. Moreover, the scholars involved, historically, have

engaged in both kinds of work. Therefore, while scholarly cycles of theorizing and (empirically) testing may be distinct in some areas of study, within studies of migration studies, this distinction is not always obvious or desired. My review of the theories and theorists herein attempts to distill critical understandings of the topics being considered, broadly reproduced or replicated ideas, and potential rays of innovation or insight which remain overlooked and underexplored. Notwithstanding migration crises throughout the world, the U.S. receives approximately 20% of all migrants and U.S. migration research continues to dominate English-language literature; therefore, this examination will principally draw on findings from the U.S. The final paragraphs on migration and health focuses on empirical research published since 2000.

Migration and Assimilation

Within U.S. social science traditions, studies of migration began in earnest upon arrival of unprecedented numbers of Southern and Central/Eastern Europeans throughout the US and Asian/Pacific migrations on the West Coast. These migrations were perceived as qualitatively different from previous waves of migration based on the dominance of national origin groups previously underrepresented in state-sponsored or recognized migrations from Western and Northern European countries. These migrations occurred alongside periods of tremendous change in social and political relations among "white" landholders and citizenry and other populations with whom they lived and worked since the founding of the U.S.—indigenous American groups, free and enslaved people of African descent, indentured servants, and others whose social, economic and/or political status were deemed subordinate. The period of 1880-1930 became known as the period of "new immigration" when U.S. politicians and citizens across the country expressed concerns about the social incorporation and integration of immigrants who were "different" than those who had come before them (Archdeacon 1983). This period was also a time of great study of migration within the social sciences. Social scientists were interested in two major arenas related to human migration: 1) why did people migrate and 2) how did people fit into their new societies. Migration studies have changed little since this time.

In order to understand the underlying assumptions and present-day operationalization of migration understandings, this chapter explores a selective scholarly history of migration studies. More specifically, this section describes three intellectual traditions within migration studies: 1) theories of migration focused on immigrants as problems and migration's impact on host/ receiving countries, 2) series of dichotomous frameworks used to characterize migration narratives (push-pull, sending-receiving, alien-citizen, etc.), and 3) theories of assimilation and acculturation. These intellectual traditions claim numerous canonical developments in the study of migration. Ideas embedded within these conceptualizations have historically shaped inquiry related to migration and continue to exert tremendous methodological and ideational power over those seeking to complicate or re-theorize assemblages of all things migration-related. Moreover, while certain concepts have been broadly adopted and advanced empirically and theoretically; other concepts remain poorly conceptualized, undertheorized, or untested. These ideas seem both representative and constitutive of the field that contributes to current and future inquiry related to migration, immigrants, globalization and their complex relationships with health and illness.

Migration as a Social Problem of Host Societies

While human migrations have occurred throughout history, geographical boundaries as well as notions of citizen and foreigner/outsider intensified during the post-Enlightenment period characterized by the rise of nation-states as a dominant political organizing form. Moreover, enduring multiple imperial, colonial and military projects, organizing populations as vital resources of nation-states persists despite problematic boundary delineation, adherence to other sociopolitical groupings, and local resistance. Foucault presciently described how this period of nation-state building became intricately intertwined with ideas of health and salubrity (Foucault 1974/1994). As nation-states emerged and competed for resources, power, and symbolic capital, the health and fitness of their citizens (almost exclusively defined as asset-owning men) was a critical sign of the nation's health and strength. First, bodies were used as indicators of a nation's ability to physically defend its boundaries by fighting. Second, the biological

reproduction of bodies signified national fertility and fecundity and the ability of nations to proliferate. Likewise amidst significantly lower life expectancies and poorly understood infectious diseases and illnesses, the visible presence of health and wellness were increasingly associated with better constitutions and etched into social memories in particular physical forms. Bodies were another means of policing geopolitical boundaries—sorting the pure from the polluted, the fit from the unfit, the citizen from the serf, slave, and/or foreigner (Douglas 1966/1967; Foucault 1974/1994; Rose 2007).

As the reign of nation-states became rationalized and more bureaucratic, monitoring flows of the population, particularly those who appeared to be foreign (bodies) became more important. Nations maintained sovereign power by controlling the physical entry of migrants as well as guiding the distribution of rights, claims and responsibilities to migrants (Massey et al. 1993; Rose 2007). For example, official U.S. immigration policies set the number of migrants who can enter the country legally by national origin and guide the provision of material and social resources e.g. temporary health care, access to education, nutrition supplements, job training, etc. to help migrants settle and adapt to life in the US.[1] As nation-building, nation-defining and nation-preserving activities have always represented normative visions of what societies sought to project and reproduce, US immigration policies have historically favored Northern and Western European migration and limited legal access to migration and citizenship for immigrants from other regions of the world, particularly those easily distinguishable by national origin, phenotype, language, religious practices or styles of dress (Castells 2000; Ong 2003; Portes and Zhou 1993).

Waves of migration between nation-states in the nineteenth and twentieth centuries were often compelled by war, hunger, quests for employment or land and categorical expulsions (Castells 2000; Massey et al. 1993; Petersen 1958). Moreover, migrations were frequently facilitated by changes in technologies like transportation and communication. People who migrated often possessed some characteristics that allowed more stationary populations to identify and classify them as different, whether

[1] For a comprehensive listing of U.S. immigration laws please see:
http://library.uwb.edu/guides/usimmigration/USimmigrationlegislation.html

language, appearance, rituals or practices. When more homogenous populations encountered people who were different, elites and scholars of society grew increasingly interested in the ramifications of immigration on existing social relations, norms, and cohesion, as well as the unknown resource and genetic burdens presented by immigrants and their families against geopolitical aspirations of progress (Rose 2007; Rose and Novas 2003). Alongside the dominance of nation-states as an geopolitical, organizing frame and the rise of global human rights movements in the 1970s and 1980's, nation-states and, later, quasi-state and supranational agencies like the United Nations and the International Organization of Migration more closely monitored movements of migrants as well as initiated efforts to rationalize the movements and rights of migrants and reduce some forms of migrant exploitation (International Organization for International Organization for Migration (IOM) 2012).

Today, migration involves complex networks of actors: nation-states, multinational corporations, non-governmental organizations, communities and individuals. Despite the elaboration of more complicated and contested relations between individuals, societies and states in the latter part of the twentieth century, the nation-state perspective on migration as a potential threat to sovereignty persists in manifestations of methodological nationalism and the privileging of host/receiving society perspectives in migration research. Studies of migration often use political or territorial lines to bound inquiry about the movements of individual people through geographic and social spaces (Gray 2008; Halfacree 2004; Khagram and Levitt 2008). Similarly, studies of immigrant incorporation are frequently framed around discussions of how, when and why foreigners may become more like native citizens (Alba and Nee 2003; Bloemraad 2006; Le Espiritu 2009; Massey et al. 1993; Portes and Zhou 1993). In the US, recognition that both indigenous and slave populations were forcefully relocated or incorporated into the U.S. body politic based on land annexations, colonization and chattel slavery complicates the dominance of a national myth of the U.S. as a "country of immigrants," as well as ideas about social incorporation. Moreover, with scrutiny directed towards immigrants who arrive in new nations, U.S. involvement or instigation of global migrations disappears from the frames of social analysis and critique. Based on this perspective of migrants as social problems; "native," "U.S.-born," and "mainstream" society, attempting

to classify relatively homogenous groups, are terms that have come to represent the unmarked category of migration studies (Keogan 2002). Data presented here attempt to recognize changes in everyday lives of people, rather than, simply, how immigrants become more like United Staters/Americans.[2] The conventional categorizations of U.S. and foreign emerge, but are problematized by their context and fluidity. Some new habits described by participants were already burgeoning in spite of, or, perhaps, enmeshed within histories upon histories of migration.

World systems theory and some postcolonial theorizing about migration, position migration as the result of neoliberal, capitalist systems which have helped sort the world into economically and politically developed (core) and less developed (periphery) nations based on dehistorized accumulations of capital and resources (Massey et al. 1993; Wallerstein 1974). Similar to dependency theory in international relations, world systems theory identifies three ideal types of countries: core, semi-periphery and periphery. Core countries are economically and, frequently, politically, developed, and exploit peripheral countries for resources and labor (human capital). Periphery countries depend on core countries for capital, investment and are often possess underdeveloped industries and political systems. Semi-peripheral countries possess a mix of characteristics associated with core and peripheral countries (Massey et al. 1993; Wallerstein 1974).

While the colonial-post-colonial migration affinities inherent in world systems theory contributed to an increase in post-colonial research on migration, post-industrial and postmodern concerns with pluralism and difference have also increased investigations of migration from the perspective of migrants themselves or their sending societies (Bhatia and Ram 2001; Itzigsohn 1995; Lawson 2000; Massey et al. 1993; Portes, Fernández-Kelly and Haller 2005). Despite evidence of mixed effects on receiving communities, popular rhetoric and media discourse on migration emphasize the economic and social *burdens* of immigrant reception and incorporation symbolized by narratives of border enforcement,

[2] There is no commonly used English word to represent people who were born in and culturally identify with the United States. Although the term American is frequently used colloquially and academically, people from other parts of the Americas don't always comprehend or agree with the terms use. Given the presence of words such as British, French, Jamaican, New Yorker, etc.; the absence is notable. American will be used here; the researcher's use of the word approximates that of "United Stateser," but participant or discursive usage of the word may vary.

immigrant social service costs, criminal justice impacts, etc. (Dave 2014; Tavernise 2013). Moreover, due, in part, to the perceived reducibility, measurability and quantifiability of migration “products” like economic capital and remittances, travel patterns, and political participation; studies of migration have predominately focused on economic and political features most salient to sovereign nations: from motivations for migration to migration pathways and immigrant incorporation and adaptation (de Haas 2007a; de Haas 2007b; Levitt and Lamba-Nieves 2011; Massey et al. 1993). Ironically, social and cultural features of migration and immigrant populations have frequently drawn the greatest disdain e.g. smells, sounds and customs—leading to existential threats and minor moral panics throughout modern times (Hall 2001; Horton and Barker 2009; Portes and Rumbaut 1999; Thomas and Znaniecki 1919; Welch 2003). Not confined to history, current political rhetoric posits a nation-state threatened by the potential differentness of immigrants who are Muslim or from Mexico.

Taken collectively, social theorizing about migration as concerns of nation-states oscillates among depictions of immigrants as objects of study, embodiments of social problems in need of solutions; and agents of incremental, intentional or unintentional social change. Early extensions of migration theory broadened and deepened descriptions of migration phenomena; whereas, more recent conceptualizations demonstrate the richly layered reach and effects of human migration and mobility, as well as the complex lives of immigrants as embedded economic and political, and, occasional, sociocultural subjects and agents (For example, see moorings by Moon, 1995; life cycle approaches by Plane & Rogerson, 1991; and transnationalism by Schiller, 2005 and 2006 discussed more below). As processes that delineate political and social boundaries as well as reconfigure material and cultural goods, migration processes are worthy of continued monitoring, surveillance, and intervention by states seeking to assert particular types of sovereignty and domination.

Migration and Competing Dualisms

Building upon characterizations of the foreign and Other, the second type of migration scholarship delineates migration as the study of competing dualisms (Bendelow and Williams 2002;

Douglas 1966/1967; Fanon 1952/1968; Giddens 1984; Hall 2001). Most notably, the push and pull factors that purportedly drive migration, sending versus receiving societies, as well as the categorical classifications of citizens and non-citizens or aliens. Ravenstein's (1885) original laws of migration as well as work by later scholars reinforced the notion of immigrants as individuals forced or lured out of their home societies by "bigger" social, political and economic forces (Gardner 1981; Moon 1995; Petersen 1958). Early reasons for migration were theorized as factors that impelled or forced people to search for livelihood and lives elsewhere (push factors) like wars, famines, political unrest, instability and corruption; oppression, poverty, unemployment and exclusion. On the contrary, pull factors—economic opportunity bundles, industrialized labor and lifestyles, aspirations and imagined life improvements—compelled people to assume the costs and risks of building lives outside of the contexts that were most familiar to them. In both cases, immigrants decided to move or migrate, but were presumed to make such decisions for purely economic and political reasons—agency is exercised as a response to overwhelming life circumstances. While the identified push and pull factors are more varied and nuanced in today's research, migrants continue to be depicted as relatively passive or reactive actors within migration studies, with little analysis devoted to the power relations and dynamics which may or may not influence their movement. Even today, most migration research conceives of sending and receiving societies as distinct and independent entities with isolable relationships and concerns relative to migrants. This conception justifies examination of migration factors and impacts within national boundaries and minimizes the dynamism, interaction, and recursiveness that characterize migration experiences (de Haas 2007b; Levitt and Lamba-Nieves 2011; Levitt and Schiller 2004).

Theorizing Immigrant Assimilation and Incorporation

This section describes theorizing about immigrant assimilation and incorporation; straight-line assimilation, segmented assimilation and alternative, pluralist views of immigrant social incorporation are described. Influenced by the publication of Park's "Human Migration and the Marginal Man" (1928), in particular and by the Chicago School, in general, US social scientists were interested in identifying and

correcting deviant characteristics among immigrants and ensuring a type of assimilation that promoted dominant/pervasive ideologies including asceticism, abstinence and the ascendancy of individual property rights. Park defined assimilation as “a process of interpenetration and fusion in which persons and groups acquire the memories, sentiments, and attitudes of other persons and groups and, by sharing their experience and history, are incorporated with them in a common cultural life”(Park 1928). Despite Park’s more nuanced definition of assimilation, many studies of migration and assimilation after 1928 explored unidirectional assimilation where immigrants were expected to conform to and adopt the norms of their receiving society.

This idea of straight line assimilation was often represented by the “melting pot,” a pot where many cultures melted together, flavored most by those in dominant socio-historically determined positions. Immigrants arrived in a new country and would shed their old ways, values, cultures and lifestyles in order to blend into to the receiving country. Envisioned as a rational exchange that became more morally-tinged over time, immigrants who intended to contribute to their new societies and pursue available pathways to full citizenship were expected to give up one set of ways of being and belonging for another. Although the melting pot metaphor evolved into stews, salad bowls and collages over time, most early scholars of migration ignored Park’s intimation that social relations and norms were reproduced in slightly different ways based on the presence of immigrants so that a new common cultural life emerged incrementally. In 1992, Gans introduced “bumpy line assimilation” in order to complicate the linear trajectory implied by straight line assimilation. His approach also included notions of ethnicity and perceived ethnicity (via skin color) as potential obstacles to taken-for-granted assimilation for the second generation or children of immigrants (Gans 1992; Gans 1994).

Few social scientists of the early and mid-twentieth century problematized the directional flow of assimilation: immigrants were to become less like their imagined, homogenous and less progressive home societies and more like the idealized American to which all citizens aspired. Social scientists and social workers familiar with the efforts of the Chicago School and similar researchers engaged in programs of civic training and development in order to assist immigrants in their transition to the U.S. Education

programs and socioeconomic incentives sought to inculcate mainstream US values and ideals into immigrant workers and families (Gordon 1964; Park 1928; Thomas and Znaniecki 1919). This process of injecting desirable cultural attributes into newcomers represented early visions of acculturation. Acculturation and assimilation have been used in tandem since these early social programs, but are operationalized within empirical research in myriad ways.

After the 1965 Immigration Act, migration to the U.S., shifted so that immigrant populations were less European, more Asian and largely from other countries within the Americans (North, Central and South). While some concerns expressed by U.S.-born populations were similar to those expressed in earlier decades, newer waves of immigrants experienced increasingly racialized moral panics about how immigrant culture and influence would lead to the decline of the U.S (Hall 1996; Hier 2002; Omi and Winant 2014). While the specters of racial infiltration and genetic annihilation were raised during the migrations of the early twentieth century, immigrants after the mid-twentieth century often experienced greater visibility due to phenotypic variation, social and residential segregation and more segmented labor markets (Massey et al. 1993; Portes and Zhou 1993). Social scientists made efforts to distinguish newer waves from previous waves of migration, yet without much change in basic theories about migration.

Based on observations of more diverse immigrants and second generation residents (children of immigrants), Portes and Zhou (1993) developed a theory segmented assimilation. Segmented assimilation argues that the social stratification and resources that configure society also help bound the life chances and life choices available to immigrants. Some immigrants strive for "the American dream" and achieve upward mobility or social stability through increasing acculturation or social integration, while other immigrants achieve downward mobility. A third group of immigrants, under the theory of segmented assimilation, achieves economic advancement while remaining relatively socially insulated and deliberately preserving the immigrant community's values.

While many contemporary scholars are critical of straight line assimilation theories, such theories continue to influence research in migration. In fact, straight-line assimilation and segmented assimilation represent the two dominant theories of migration and immigrant incorporation. Moreover, Alba & Nee

have introduced a modern version of this theory embracing Park's nearly forgotten ideas about mutual change (2003). More specifically, Alba & Nee theorize that assimilation processes take time and given the greater heterogeneity of the U.S. population, and the rapidity with which newer waves of immigrants have arrived, more time is needed for the U.S. "common culture" to absorb these waves of immigrants. They believe that results from the second and third generation may prove that contemporary immigration patterns are not so different from past waves of European-dominant migration despite US racial and social stratification. In their estimation more time and empirical evidence are needed to establish new "laws" of migration and resettlement, yet they believe contemporary immigrants encounter more favorable social and economic circumstances than their elder counterparts, due, in part, to gains attributable to civil rights movements and formal re-affirmations of merit-based, social mobility (Alba and Nee 2003). Critics of Alba and Nee as well as many older theories of assimilation suggest that such theories underestimate the extent to which race, and whiteness and blackness, in particular, structure the social fields encountered by immigrants (Barker-Ruchti et al. 2013; Jung 2015; Richards 2014; Romero 2008; Treitler 2015).

Other Health and Migration Frameworks

Two other theoretical frameworks which may be relevant to explorations of health and migration include multiculturalist and transnational studies approaches to migration/immigration. Though different in their emergence and conceptualization, both of these theories may be described as resting on pluralist assertions about society (Bloemraad, Korteweg and Yurdakul 2008; Vertovec 2007; Zhou 1997). First, multiculturalist approaches to migration suggest that the US has always been a multicultural society and newcomers, from diverse background, extend and expand the multicultural nature of US society. Individuals and groups reference multiple cultures and traditions in living their everyday lives. Multiculturalist ideas about pluralism pushed those thinking about assimilation and acculturation pathways to begin considering bidirectional or other directional paths for changes in norms and culture. Critics of the most orthodox pluralist theories believe that such theories undervalue or ignore ideas about

social cohesion, normativity and power relations since not all multicultural perspectives are granted equivalent social honor or given equal social space (Zhou 1997). Within health care, multiculturalist approaches seemed to undergird the “multicultural health” and “cultural competence” efforts of the late 1990s to early 2000s enlisted to help medical and health professionals recognize that patients they served relied on diverse and complex bundles of resources and sociocultural histories when making everyday decisions about health and lifestyles. However, acknowledgement of diversity, alone, offers few solutions for addressing differential access to care, services and socioeconomic resources and the hegemonic position of allopathic medicine in any societal considerations of health, health care and illness—critical considerations when examining relationships between migration and health.

Starting from the multiple and overlapping social fields present in the lives of immigrants who maintained ties to their home country as well as post-modernist discussions about the decline of the nation-state as a social category, Levitt and other social scientists postulated a transnational approach to understanding migration which calls for a relational, cross-border, more fluid approach to understanding immigrant cultures, values and lives (Khagram and Levitt 2008; Schiller 2005). Transnational perspectives seek to embrace and better operationalize concepts like social field, simultaneity and social production/reproduction within empirical examinations of immigrants and their relationships with a variety of contextual factors (Schiller 2005). Levitt and Schiller (2004) and others have attempted to describe and refine methodologies that ensue from more transnational perspectives (Boccagni and Decimo 2013; Goldring and Landolt 2014; Levitt and Lamba-Nieves 2011; Levitt and Schiller 2004; Mata-Codesal 2012).

It is of note that many theories describe factors that shape immigrant decisions to migrate, how and why immigrants move, but once immigrants move the theorizing become less clear. Immigrants are presumed different upon arrival; perhaps, inherently so, with expectations advanced so that time, individual effort and selective social guidance will result in assimilation. The literature is shockingly silent about the things that happen in between new arrival and becoming *fully* assimilated or acculturated (if this is even possible.). Empirical observations seek to fill in gaps about where migrants live, near

whom they live, to what extent they participate in education and criminal justice systems, in what jobs and sectors they become employed, whether and to what extent they rely on public services, when and if their habits seem more like the predefined mainstream. Though scales have been developed and efforts have been made to quantify and measure acculturation, the multidimensional processes that comprise acculturation remain largely undertheorized (Berry 1986; Birman 2011; Gordon 1964; Lara et al. 2005; Lopez-Class, Castro and Ramirez 2011; Stuart and Ward 2011; Viruell-Fuentes 2007; Viruell-Fuentes, Miranda and Abdulrahim 2012). The proliferation of scales and measures highlight affinities and preferences, rather than activities and actions, enveloping societal incorporation or adaptation processes within mysteries of social interactions or individual psychologies (Abraído-Lanza et al. 2006; Arcia et al. 2001; Berry 1986; Birman 2011; Perkins, Palmer and García-Ramírez 2011). After some amount of time and some experiences, immigrants are categorized as assimilated/acculturated or not. Some theorizing picks up after this point such that degradation in various social, economic and health outcomes are attributed to acculturative stress among first, second and third generation residents, segmented assimilation or resistances to "mainstream" assimilation/acculturation (Arcia et al. 2001; Berry 1986; Perkins, Palmer and García-Ramírez 2011; Portes and Zhou 1993).

Acculturation

As a construct, acculturation is quite controversial and bears different meanings and nuances across disciplines. Rather than focus on the multiple constructions of this term, one commonly referenced definition will provide a conceptual starting point for thinking about the term. Largely focused on psychological dimensions of group interactions, Berry's (1986) conceptualization of acculturation is often cited and modified; it describes three phases of acculturation as well as different levels on which acculturation operates. His work defines acculturation as a process that results from contact between different groups where the group with most social power requires accommodations of the group with less social power—assimilation (minimizing social distance and "disappearing" into the mainstream) may or may not be part of the accommodation (Berry 1986). The three phases of contact, conflict and adaptation help break down acculturation into identifiable parts. Moreover, his outline of the group and individual

levels and domains (language, personality, identity, cognitive styles and attitudes) assert a set of predominately internal and responsive changes associated with acculturation (Berry 1986). In coining acculturative stress, Berry notes that such stress is most severe when the cultural distance between groups is the greatest, when contact is involuntary, and when the host society insists that one path to acculturation be followed (Berry 1986). While silent on the embodied and physical manifestations of acculturation, Berry's conceptualization demarcates areas of potential tension (and innovation?) for immigrants while allowing for several (he counts four) possible pathways of social incorporation (Berry 1986; Celenk and Van de Vijver 2011). The review of empirical evidence will present some of the ways that acculturation has been operationalized in research as well as problems with the term's translation from concept to measurement. Both acculturation and incorporation will be used throughout this document.

Collectively, social science conceptualization of migration, assimilation and acculturation offer useful heuristic principles when thinking about the relationships between health, migration and immigrant social incorporation processes. First, the history of this body of work suggests that keeping both sending and receiving societies, whether conceived of as national, ethnic or other groupings, within view seems important. Immigrants are affected by and responsive to contextual factors in both their home societies as well as the communities that receive them. Neither society alone seems capable of shaping complex outcomes with lagged effects like health or illness. This work also encourages researchers to seek empirical evidence rather than rely exclusively on stereotypes of either home country norms or the U.S. mainstream.[3] Migration processes are likely determined by some combination of home-country context, migration decision-making processes, receiving-country context, agency-structure relations as well as other global or transnational relations; which factors are most important remains a question for empirical investigation, rather than disciplinary or ethnocentric exclusion.

[3] For example, recent efforts to validate a psychometric scale of assimilation that included a measure of individualism, has found that "mainstream" Americans are not quite as individualistic as stereotyped. Since the measure sought to distinguish individualist from collectivist ethnic origin groups hypothesizing differences in assimilation/acculturation. This finding has complicated results related to the measure (Schwartz et al., 2012).

Second, immigrant incorporation processes are social and involve relationships between individuals, families, immigrant groups, majority others, and minority others; although most contemporary research fails to account for relational social forces. Moreover, in recent theorizing across disciplines of political science, sociology and psychology; discrimination, a highly social process, has figured prominently as a factor influencing multiple aspects of migration processes (Birman 2011; Das Gupta 2010; Krieger et al. 2011; Nazroo 2003; Ong et al. 1996; Read, Emerson and Tarlov 2005; Viruell-Fuentes 2007). Third, researchers should work with immigrant populations to characterize the directional flow and magnitude of the specific values, concepts or habits under investigation. Most manifestations of discursive or practical reproduction emerge after contestation and contradiction, rather than tidy either-or choices. Fourth, efforts should be made to acknowledge and recognize social structures including stratifications which predate migration experience both in the sending and receiving environs. Migration accounts of gender, race, ethnic and religious difference support the ways that pre-existing social conditions interact with immigrant visibility, incorporation and treatment (Bailey 2001; Nazroo 2003; Ong 2003; Peek et al. 2010; Portes, Fernández-Kelly and Haller 2005; Shah, Dwyer and Modood 2010; Zhou and Lin 2004).

While psychological and emotional aspects of migration and acculturation have been taken up quite extensively in psychology, other researchers have borrowed psychological definitions and psychometric scales without fully appreciating or recognizing the ways in which psychological acculturation may be intertwined with physical and social acculturation processes. As the empirical review in the next chapter will demonstrate empirical research on migration and health frequently relies on blunt, proxy measures to describe multi-level, layered, perhaps rhizomatic, processes associated with migration and immigrant incorporation. Table 2 describes the range of factors that migration theories raise with regard to everyday living and/or health. These perspectives should be regarded as coexisting ideal types; for example, segmented assimilation theories draws from both the perspectives of straight-line assimilation and pluralism. Conditions throughout a migration experience may be influenced by more than one of these perspectives over time.

Table 2: Table of Migration Perspectives

Perspective	Actors/Social Relations	Assumptions	Guidance/Implications
Migration as Social Problem of Receiving Nation	• Nation-state (sovereign) interests dominate • Featured actors include state, immigrants, and receiving community • State structures are central	• Distinctions between sovereign states and their populations • Nation-states have right to control borders and populations • Migration viewed as problem to control • Immigrants may not fit in, so efforts should be made to encourage blending irrespective of historical or contextual factors	• Immigrant practices need to change; norms must be adapted • Undesirable immigrants and those having difficulty should return to their home country or may not gain citizenship • Immigrants should be screened for health problems upon entry so as not to endanger U.S. population • Efforts should be made to minimize public charge including achieving health norms of healthy diet, physical fitness, and moderate alcohol use
Migration as Reflection of Hierarchical, Global Dualisms	• Terms of dichotomies defined by state (rhetoric and policy) and socially through collective and discursive formations • Power and exceptionalism of wealthy receiving states reified • Ignores or minimizes structures and institutions • Essentializes • Featured actors include state, immigrants, and non-immigrant counterparts •	• Hierarchical, moral and ethical opposites which must be balanced with • Numerous social and cultural representations of eternal battles between good and evil, right and wrong, purity and danger • Moral high ground belongs to the U.S. over them (immigrants) from largely deficient countries of backgrounds	• Social incorporation possible, but status dominance must be maintained by "mainstream" • Kernel of old (genes, practices, norms) may remain, but immigrants should be vigilant about making "right" choices • Good over bad health choices may be harder for defective "thems" to make
Straight-Line Assimilation	• Privatization of state concerns • Nonprofits and service agencies assume greater role in socialization • State devolution alongside increased economic industrialization and globalization • Increased presence of risk framing • Hegemonic presence of this perspective in immigrant health and migration discourse	• Cultures are essentialized: common core U.S. culture and tangible immigrant culture that • Immigrants shift from home culture to mainstream US culture • Universalisms espoused • Possible and desired migrants change with the ease of change attributed to the	• Adopt pro-assimilation and acculturation standards and programs • Incentivize acculturation through material resources, jobs, housing, etc. • Risk monitoring & aspirational ideal that include illness prevention and health promotion • Treat migration as an one-time event

Perspective	Actors/Social Relations	Assumptions	Guidance/Implications
	• Featured actors include immigrants, receiving community members, service agencies, diaspora members, immigrant networks	quality of the person, family, or group • Some national and social groups more desirable than others • Linear and chronological unfolding of adaptation and incorporation	
Pluralist Perspectives on Migration and Acculturation	• States have complex and disjointed interests • State devolution alongside increased economic, political and cultural globalization • Discourse/media more widespread and contested based on democratization of some communications and low cost transportation • Featured actors include immigrants, receiving community members, service agencies, diaspora members, immigrant networks, sending community interests and representatives • Stratified mobilities	• Less stable "core" cultures recognized • Multiple assimilation pathways • Acculturation as a bi-directional or multi-directional process where both immigrants and sending and receiving communities change • Ease of acculturation related to many social, historical factors and the context of the move • Groups contribute differently to milieu • Stratification affects immigrants; immigrants affect, reify, accept or resist terms of stratification	• Promote integration and incorporation as well as maintenance of sending community ties • Support self-sufficiency through social and structural support for more even access to opportunities • Rhetorically value multiple cultural contributions • Encourage and support multicultural and multilingual schools, housing, and workplaces

Before exploring the empirical literature on migration, social incorporation and health, this chapter will briefly consider two additional themes that help situate migration and health within a discursive universe relevant to contemporary understandings and practice of social science: globalization and citizenship.

Migration as One Type of Global Flow

The flows of people—migrations—occur simultaneously with other global flows: capital, ideas, material culture, etc. Theoretical and empirical studies of migration have primarily focused on the movement of people, money, labor and practices described as cultural. Flows of material culture have

focused on art forms, crafts and foods, sometimes fetishized. Few scholarly works have addressed the flow of ideas (beyond macro-ideologies like capitalism or neoliberalism) across national borders and boundaries, despite new theorizing about the role of information and information technology in late modernity (Castells 2000). Several theorists who have made claims about the interrelationships between global flows of people and global flows of other things are briefly considered below.

In his 1990 essay, Appadurai (1996) asserts that conventional studies of globalization, relying on economics, politics, ideology or geography to explain social and cultural phenomena, may understate relationships of fluidity and discontinuity. Beyond discourses of homogenization and nationalism, he believed that these incongruities where economics, culture and politics no longer follow the expectations of social science should be the new subject of social theory. In order to begin assessing these "disjunctures" Appadurai proposed an analytic framework that explores five domains of global flows. His proposal introduces *ethnoscapes*, *mediascapes*, *technoscapes*, *financescapes*, and *ideoscapes* as the building blocks of imagined worlds, "the multiple worlds that are constituted by the historically situated imaginations of persons and groups spread around the globe" (Appadurai 1996:33-36; See Table 3 here). Taken together, these –*scapes* are said to reveal social relations that account for dynamic multiplicities of actors, histories, politics and situatedness that connect macro-level global flows and micro-level interpersonal interactions. The five scapes allow for people, media, finance/economics, technology and ideologies to collectively remain in view, whereas conventional analysis about globalization might privilege analyses of finance and people.

Table 3: Appadurai's Global Flows Framework (The Five -Scapes)

Description of Five -Scapes
Ethnoscape: the landscape of persons who constitute the shifting world in which we live: tourists, immigrants, refugees, exiles, guest workers, and other moving groups and individuals constitute an essential feature of the world and appear to affect the politics of (and between) nations to a hitherto unprecedented degree.
Technoscape: the global configuration, also ever fluid, of technology and the fact that technology, both high and low, both mechanical and informational, now moves at high speeds across various kinds of previously impervious boundaries.
Financescapes: the disposition of global capital flows that is now more mysterious, rapid and difficult landscape to follow than ever before, as currency markets, national stock exchanges, and commodity speculations move megamonies through national turnstiles at blinding speed, with vast, absolute implications for small differences in percentage points and time units.

Description of Five -Scapes
Mediascapes: refer to both the distribution of the electronic capabilities to produce and disseminate information (newspapers, magazines, television stations, and film-production studios), which are now available to a growing number of private and public interests throughout the world, and to the images of the world created by these media.
Ideoscapes: a concatenation of images, but they are often directly political and frequently have to do with the ideologies of states and the counter ideologies of movements explicitly oriented to capturing state power or a piece of it.

Building on Benedict Anderson's imagined communities (1991), Appadurai then describes how the imagined and the act of imagining have become a larger part of contemporary social relations. Anderson's thesis suggests that modern nations and nationalism are the products of social interactions rather than "naturally" occurring structures or ideologies. Among the factors that help shape national definitions and national identities, Anderson accounts for Others, colonialism, imperialism, print capitalism, racism, language and quantifying practices. Appadurai builds upon the invented and constructed nature of these nations to assert that now, more than ever, nations are not only products of imagination, but also products with porous or less homologous geopolitical borders/boundaries. Appadurai builds an analogy between the social and cultural dialogues/affinities fostered by print capitalism and the ability of contemporary individuals to form new communities that cross geographic boundaries, while also experiencing, reading about and reflecting on life together as collectivities. He suggests that the social and cultural ramifications of the intensifications in migration and communication ("electronic capitalism," in particular) are much more complex than simplistic notions of global convergence or capitalist domination and are just beginning to be grasped by scholars of globalization (Appadurai 1996). Electronic capitalism, here, refers to the production and distribution of electronic media and the insinuation of that media and related desires and fantasies into our lives. Global flows combined with contemporary acts of displacement, deterritorialization, appropriation and indigenization allow for the emergence or acceleration of imagining as social practice.

Appadurai asserts, "The imagination has now acquired a singular new power in social life. . . More persons in more parts of the world consider a wider set of possible lives than they ever did before"(Appadurai 1996:53). Mass media, the internet and mobile communications (channels of

electronic capitalism) and the news that travels along transnational social networks deliver "a rich, ever-changing store of possible lives" to people in vastly different social, cultural, moral and geographic spaces (ibid). People use this information to not only construct new ideas about what is possible for their lives, but also as a means to negotiate changes in their own daily lives to move closer to their imagined lives.

Imagination is neither art, nor mere fantasy. Imagination has become a shaper of lived experience; imagination has power. Moreover, the dynamic interplay between media, migrations and everyday life "create communities with no sense of place" (Appadurai 1996:29). The processes of deterritorialization (removing/uprooting an idea/concept/person from its "native" locale) and reterritorialization (using something uprooted in a new or different set of circumstances) of ideas and concepts elevate the mutability and precariousness of conventional social forms like culture, society, family, and indigeneity; while both allowing for and incubating heretofore unimagined innovation in the construction and manipulation of lives and selves.

For example, Caribbean women venturing to the United States to work in positions as nurses or home health care aides construct a narrative of the living standard and enhanced opportunities for their families that the improved material conditions of U.S. employment will provide. These women also simultaneously join communities of transnational workers with whom they are familiar through social encounters or connections through their social networks. These immigrant health workers incorporate "foreign" strategies and "distant" tools to reimagine and refashion their lives. While the ability to envision and pursue something which one has never seen can be life-changing for the lives of individuals, Appadurai points out the more powerful social elements of these acts lie in between the unfolding of lives and their imagined counterparts; in these crevices new communities are formed. "Communities that generate new kinds of politics, new kinds of collective expression; and new needs for social discipline and surveillance on the part of elites"(Appadurai 1996:54).

These contemporary imagined communities and *scapes* comprise part of Appadurai's rationale for the decline of the nation-state; these communities consist of collectivities and individuals and new

types of institutions and representations that transcend geopolitical borders, while simultaneously undermining or rewriting "glocal" traditions (local traditions informed by global knowledges and accesses even if uneven).The notion of imagined or created communities and collectivities is crucial for understanding aspects of the Caribbean, a syncretic and imaginary region, created through a series of global flows dating back centuries and premised on ideas of mixing, cosmopolitanism, and unities in diversities despite the persistence of hierarchical societies.

While, definitionally, the *scapes* seem unwieldy and almost unimaginable; Appadurai's contribution expands the horizons for those theorizing about and writing about globalization. This work has been inspirational to other theorists. Healthscapes, developscapes, emoscapes—other panoramic sketches that reflect some sense of structure and fluidity as interactions between humans and non-humans co-create social situations—have since been developed (Clarke 2010; Idvall 2008; Loftsdóttir 2009). Healthscapes, devised by Clarke, are most relevant to the current inquiry.

Defined as "ways of grasping, through words, images, and material cultural objects, patterned changes that have occurred in the many and varied sites where health and medicine are performed, who is involved, sciences and technologies in use, media coverage, political and economic elements, and changing ideological and cultural framings of health, illness, healthcare and medicine; healthscapes are assemblages, infrastructures of assumptions as well as people, things, places and images that undergird health and medicine and which are nonseverable from, yet exist in relation to other sociological institutions like family, religion, economy, polity and media" (Clarke 2010:105). Beyond supporting the simultaneous appraisal and analysis of diverse concepts, Clarke convincingly argues that healthscapes also perform cultural work (Clarke 2010). Healthscapes sensitize researchers to the temporal and ethical dimensions of specific practices and "regimes of living" while also providing the milieu within which health/medicine becomes a cultural good and gains cultural authority over certain types of gazes and knowledge (Clarke 2010; Collier and Lakoff 2005; Foucault 1974/1984; Foucault 1974/1994; Star and Griesemer 1989/1999). Healthscapes are the intersections of the economic, cultural, material, symbolic, institutional, collective and individual which must be represented by more than texts or scholarly

frameworks. Clarke uses healthscapes to describe diverse contextual elements of widespread social shifts in the use of conceptual scaffoldings beginning with the rise of biomedicine (1890-1945), moving to medicalization (1940-1985), and then biomedicalization (1980-present). Her healthscapes include infrastructure, basic social processes, foci of the clinical gaze, main modes of clinical action, main foci of biomedical sciences, main foci of biomedical technology, medical constructions of patients and identities, main media constructions of biomedicine, key rhetorics, major alternatives, and health social movements (Clarke 2010). Considered alongside Appadurai's five *scapes*, these elements create the circumstances for certain types of health interpretations, practices and actions to emerge.

Healthscapes render health as a cultural good which can contribute to or detract from immigrant efforts to acquire cultural capital. Healthscapes further demonstrate the multifaceted production and reproduction of aspirational and practical subjectivities available to immigrants who move to the U.S. from elsewhere. Today, immigrants are bombarded by governmental, commercial and personalized messages about what and when to eat and drink, how to optimize energy; as well as messages about expediency, individualism, postponing pregnancies and the potential for technomedicine to overcome age and some ailments so that people may approximate living forever. Healthscapes could help account for the overlapping and manifold nature of these contextual factors alongside health institutions and health outcomes. As Clarke (2010) asserts, visual iconography, media messages and informal social norms all contribute to specific framings of health and illness. Often missing from these frames are alternatives; structural, social or economic barriers to achieving set forth ideals of health citizenship and new biomedical normalcy (Clarke 2010). By analyzing healthscapes as situated and infused with power relations, Clarke attempts to address one of the major limitations of Appadurai's theorizing. Though more lives and imagined ways of being and belonging are possible—individuals living in *all* social locations cannot access or take advantage of these possibilities.

Responding to similar concerns as Appadurai and Clarke, other social researchers have turned to Bourdieusian notions about how structure, habitus and various forms of capital interact to produce and reproduce action (Bauder 2008; Erel 2010; Kelly and Lusis 2006; Oliver and O'Reilly 2010). Their efforts

highlight the importance of keeping macro- and micro-level processes “in the frame” when studying social phenomena, but also attempt to explicate the relationships and processes involved in immigrant efforts at distinction and capital exchange.

Like the other theoretical frameworks considered in this section, Tsing’s (2005) theory of friction keeps both macro and micro, collective and individual, global and local concepts within view, but focuses on the qualities and character of the interactions among these facets of social problems that allow them advance or be reproduced over time. She uses an analogy of tires meeting the road in order to propel a car forward; friction is the small universal or recognizable elements of diverse concepts which allow for them to be misrecognized, appropriated and simultaneously perpetuated through a series of mini-alignments. Friction draws attention to the “sticky engagements” of connection that bind people, spaces and things across encounters. In Tsing’s words: “friction is the grip and slip of the worldly encounter” where differences are disruptive and “heterogeneous and unequal encounters can lead to new arrangements of culture and power” (Tsing 2005:1-7). Friction does not tidy our conceptual frame, but makes space for the messiness of contested negotiations, inequality, multi-level interaction and global-local entanglements.

Where migration is concerned, friction characterizes conditions of migration, incorporation and everyday life in both sending and receiving societies. Through an amalgamation of agency, will, opportunity, convenience, and “close enough”-ness, migrants are able to imagine, create and navigate new social situations. Moreover, new frictions emerge as immigrants engage in long term processes of adjustment, adaptation and incorporation. Friction is a relational or network fluidity where old ideas and new ideas meet and mingle resulting in slightly altered configurations; a recognizable core remains lending some sense of stability to dynamic encounters (Tsing 2005; Tsing 2009). By studying those things made universal and the work embedded within the efforts to create shared meaning, friction allows for interpretative, yet practical understandings of the recursive and interdependent nature of relationships between the global and the local or between contextually enmeshed immigrants and their native-born counterparts. Friction provides a conceptual tool that describes complex relationships and continuities while being mindful of contradictions and contestations at symbolic and practical levels.

The heuristic devices of scapes, capital, and friction provide qualitatively different, yet potentially productive, means of modeling and demonstrating relationships among immigrants and the various social and physical spaces they inhabit. Despite their limited uptake within empirical migration and health research, these theories and concepts suggest complexities of migration and geographical contexts beyond the dominant dualisms of here and there, sending and receiving, developed and developing nations. Although, some literature describes the flow of material, cultural and discursive objects like equipment, pharmaceuticals, and body types, few scholars have attempted to trace theoretical constructions central to migration and health (e.g. medical technologies, ideas, texts, visual images) as objects in their own right which travel through space and time and are constantly remade (Casper and Clarke 1998; Clarke 2010; Rivoli 2009). More attention should be paid to the construction and flow of migration and health related objects and their meanings.

Finally, while considering global flows and broad mobilities is important, DasGupta (2010) and Le Espiritu (2009) caution against global research that obscures lived experiences including tendencies to ignore global, ethno-racial hierarchies and other forms of stratification (e.g. gender, class, etc.). Das Gupta (2010) further demonstrates that rather than existing alongside globalization, these social institutions co-constitute the various projects (e.g. nation-state or diaspora-building), theories and practices related to migration. These less formal, more naturalized, ideological formations should not be overlooked in studies of migration. Shiller describes it this way:

> In the current historical conjuncture, the structures of production and capital accumulation are global in ways that no longer necessitate internally homogeneous national labor forces. Consequently, in the United States a sector of corporations, foundations, and universities now promotes multiculturalism as a nation-state-building project. It has set aside the task of acculturating immigrants to a single language, history, and culture. It persists in hegemonic projects that obscure exploitation, the domination of capital, and vast inequalities in wealth and power by instilling in citizens a sense of shared U.S. national destiny. At the same time, the various "multicultural" U.S. immigrant populations with their transnational ties to home societies become means of connecting and representing U.S.-based capital within the global economy. (Ong et al., 1996, commentary)

Despite turns away from orthodox beliefs in homogeneity, some sense of US and other nationalisms persist. Whatever circumstances or contextual factors immigrants encounter across their migration journeys, new conceptualizations of state, nation, citizen cannot escape the past—the past, present and future meet in aspirational imaginaries of social cohesion, belonging and cultural uniqueness.

Perhaps revealing an overwhelming range of factors for those interested in definitive answers to social challenges; the theoretical innovations discussed in this chapter have largely been ignored by those focused on migration and social incorporation[4]. The majority of migration research continues to draw from paradigms presented in the previous section i.e. straight-line assimilation, with few theoretical innovations in mobility and global flows having been tested empirically.

While most texts on globalization include technological advances in transportation and communication as two developments which accelerated global flows, and some have investigated the global journey of specific goods (t-shirts, medical devices, scientific techniques) around the globe, far fewer have examined what make things ready and acceptable for global mobility and the mixed arena of formal and informal flows that comprise what is referred to as globalization (Appadurai 1996; Casper and Clarke 1998; Castells 2000; Clarke 2010; Held and McGrew 2003; Horton and Barker 2009; Rivoli 2009; Robins 2009). While technological advances conjure images of videoconferencing, far simpler advances like fewer barriers to international telecommunications and travel helped greater numbers of people move across nation-state boundaries and even greater numbers of people have or sustain contact with people outside of their immediate geography. Breaking barriers of time and space, even before economic integration of the late 1990's, distant items could be conjured, described, discussed and, in some cases, experienced within one's remote home, village or community call center. Moreover, goods brought back as tokens or as part of new habits by those who had ventured abroad could be incorporated in incongruous or unexpected ways into traditional practices and rituals so that the interpretive meaning of objects

[4] While it is true that most of these authors might not be defined as those focused on migration or related studies. These authors exclusion from attempts to advance theorizing on migration and acculturation reinforce concerns about disciplinary boundaries and institutional silos which may obscure or obfuscate scholarly understanding of these important processes.

changes (Horton and Barker 2009; Robins 2009; Tsing 2005). Thorough understanding of *how* ideas travel and are reproduced remains a gap in the health and migration literatures.

When I conducted a review of the literature, I was unable to find any articles focused on how immigrants learn about or incorporate U.S. imperatives of health and individual responsibility into their lives. Preferences along a continuum from individualism to collectivism have been included in some empirical assessments of immigrant health, yet practical or psychological indicators of increasing individualism are not included (Chun and Akutsu 2003; Schwartz et al. 2012). As part of broader migration and incorporation processes, processes and practices for learning about and adopting new ideas about health and illness remains a gap in the literature.

Citizenship and Health

Like many of the words (nation, assimilation, acculturation) explored in this chapter, citizenship is frequently used with myriad meanings and interpretations. Most conceptualizations of citizenship build on Marshall's (1963) definition of citizenship as a bundle of rights and obligations. Marshall described an evolution of citizenship from emphasis on civil rights of the eighteenth century, to political rights in the nineteenth century and social citizenship of the twentieth century (Marshall 1963). Marshall described citizenship as an ideal and category of equality, yet also anticipated potential conflict between full citizenship and capitalism. Lay and discursive conceptualizations of citizenship often draw from legal, political or economic perspectives similar to Marshall's conceptualization. While the differences across disciplines is an important site for theoretical bridging and explication, the final section of this chapter is primarily concerned with variations of citizenship derived from sociology and anthropology.

For immigrants moving to the U.S., recognizing, understanding, adopting and/or modifying U.S. norms have practical and symbolic value—newcomers are learning not only how to live in the U.S., but also how to become "proper" citizens (Ong 2003). Citizenship in the contemporary U.S. is markedly shaped by specific brands of capitalism, individualism, rationalism and healthism (Crawford 1994; Mamo 2010; Nettleton 2005; Ong 2003). U.S. cultural norms "provide codes and social scripts for the

domestication of the individual body in conformity to the needs of the social and political order" (Scheper-Hughes and Lock 1987:26). Historically, the assimilation of migrant bodies into the "normal" U.S. body politic has been an explicit government goal (Markel and Stern 1999; Ong 2003; Porter 1999). To the extent that migrants seek to develop human, social and cultural capital as well as access to resources in their new country of residence, when possible they adapt by adopting approximate interpretations of prevailing social norms.

While discursive constructions of migration and citizenship focus on claims about rights and responsibilities within nation-state formations or formal categories of entitlement to such claims, citizenship as a concept is more complicated. Citizenship is not simply concerned with the relinquishment of voting or civic rights in one country for a new assemblage of rights in another country; citizenship is about more than changes in boundaries, classification or identities. Citizenship often entails some mix of rights, claims, privileges, obligations, recognitions, and responsibilities; and is comprised of both public and private commitments. Citizenship becomes a moral and habitual practice that interpellates deserving and undeserving people as subjects, casting doubt on the belonging, being and claims of those deemed undeserving. Like other categories, citizenship is ever-changing in its demands and requirements—rights conferred may be denied; resources and privileges gained may be lost. Moreover, in the realm of migration and national belonging, citizenship evokes entrenched dichotomies of insiders and outsiders represented by citizens and non-citizens/aliens; and legal and illegal residents. Citizenship is often expressed in reference to territorial borders and/or some common sense of national identity (McKinley 2009).

For immigrants, notions of citizenship operate at different levels (Bloemraad, Korteweg and Yurdakul 2008; Marshall 1963; McKinley 2009; Ong 2003). Citizenship conventionally describes legal, political, civil, social, and cultural rights and responsibilities. Legal and civil rights outline basic access to judicial process and legal claims. Political citizenship focuses on voting, political participation and civic engagement. Social and cultural citizenship control access to social recognition, opportunities to fulfill social and cultural expectations as well as use of social services and resources like education and health.

The emergence of citizenships linked to one's existence as a human being, assemblage of genetic material, or nexus of exposomal expressions[5] complicates citizenship. Biopolitical forms of citizenship provide an additional arena in which one can be judged, while also deepening representations of citizenship beyond internalized messages about one's genetic composition (Rose 2007). Where health is concerned, resources and privileges are often distributed based on health status which, in turn, contributes to future health status. It is under this gaze of biomedicine and technology that mothers are disciplined for the conditions of their wombs—sites which may optimally or suboptimally prepare future children for lives of health or illness (Barker 2004; Clarke 2010; Foucault 1974/1984; Foucault 1978/2007; Petersen and Lupton 1996).

This chapter will conclude by exploring two health-related conceptualizations of citizenship: biological citizenship (Rose 2007) and flexible citizenship (Ong 1999). Both of the originating authors rely heavily on Foucault and his concept of governmentality. Governmentality is an "approach to social regulation and control" that connects regimes of individual, self-regulation with the management, ordering and disciplining of spatially-defined, aggregate populations (Lupton 1999:85). In late modernity, governmentality is intimately bound with perceptions of risk and risk calculus. Discourses, knowledges, practices and institutions inform and shape individuals' ideas and actions related to social behavior including risk, and help to create normalized subjects who: 1) know how to recognize risk, 2) change their behaviors to avoid risks and 3) incorporate or honor (in diverse ways) societal values/norms. Neoliberal expressions of governmentality rely on direct-coercive and indirect-voluntary strategies to control populations (Lupton 1999).

First, rather than proposing a specific definition of citizenship, Rose (2007) proposes conceiving of historically situated ideas about citizens as dynamic "citizenship projects." Similar in derivation to Foucault's (1982/1997) body projects and Omi and Winant's (1994) racial projects, Rose's citizenship

[5] The exposome refers to the totality of exposures that a person experiences over a lifetime and the impacts those exposures have on the body. Studies of exposomes were proposed by cancer researchers who wanted more thorough understanding of environmental exposures to accompany genomic research (Human Exposome Project, 2017).

projects are defined as the ways that authorities thought about (some) individuals as potential citizens and the ways they tried to act upon them in that context." (Rose 2007:131). Citizenship projects have historically been central to the construction of nation-states practically, technically, and symbolically (Rose 2007). Citing the rise of the discursive importance of "multiculturalism" and "globalization," as well as changes in relationships between citizenship and science, Rose (2007) coins the term biological citizenship. Biological citizenship describes citizenship projects that have linked their conceptions of citizenship to beliefs about the biological existence of human beings, as individuals, as men and women (Rose 2007). Making up citizens from above (places of privilege) as well as below where individuals are made through ideas of somatic individuality and "regimes of the self," biological citizenship is both individualizing and collectivizing (Rose 2007; Rose and Novas 2003).

As individuals, active citizens are expected to shape their life course by taking corporeal and genetic responsibility in the present through rational actions based on probabilistic knowledge of future outcomes (Rose 2007). Expectations around somatic individuality and reflexivity construct new distinctions between moral (good) and amoral (bad) citizens/subjects (ibid). Educating citizens to be active participants: 1) shifts responsibility for day-to day risk management from the state or authorities to individuals; 2) is intended to promote public trust in science, government, and the value of risk calculation; and 3) performs democracy during periods of low citizen attention and involvement in civic and political spheres (Rose 2007).

In terms of the collectivizing character of biological citizenship, Rose describes biosociality as "forms of collectivization organized around the commonality of a shared somatic or genetic status." (Rabinow, Gibbon and Novas 2007; Rose 2007:143). Biosociality draws people together, but also generates new categories "of corporeal vulnerability, somatic suffering, and genetic risk and susceptibility" and new technologies to address them. In a different way, community-based interventions that rely on community health workers, participatory research or empowerment with intentions to inform, direct or change behavior or develop support for health-affirming and illness management behaviors represent another form of collectivizing inspired by biological citizenship (Rose 2007). New forms of

biological citizenship demand responsibility and activism that also help create new types of problematic persons—those who refuse to identify themselves with the responsible community of biological citizens or who refuse to perform normative acts of responsibility and active engagement (Rose 2007). Rose's differentiation between biological citizens and problematic persons reinforces the essential nature of classification or categorization schemes to practices of government (Rose 2007). Rose's biological citizenship is similar to others' conceptualizations of genetic citizenship (Heath, Rapp and Taussig 2008) and sanitary citizenship (Briggs and Hallin 2007). Sanitary citizenship as discussed in Briggs and Hallin's work on biocommunicability will be briefly discussed.

Briggs and Hallin (2007) build on Foucault and Rose to present a version of citizenship that interpellates subjects, but that also that produces the social context within which citizenship is performed. Biopolitical constructions of citizenship and how individuals and populations get interpellated by them shape access to health; while health status and classifications, in turn, shape constructions of biopolitics and citizenship (Briggs and Hallin 2007). Their extension of biological citizenship generates an analysis of "biocommunicability: the ways in which the constitution of social subjects is embedded in ideologies about the "flow" of information and of discourse, about who constitutes biomedical knowledge, who is authorized to evaluate it and to speak about it, and through what channels it is assumed to flow." (Briggs and Hallin 2007:45-46). Their analysis identifies media as a critical agent in the production and distribution of discourses, practices, and social relations (Briggs and Hallin 2007). They further suggest that public discourse plays a critical role in naturalizing ideas (Briggs and Hallin 2007). "Like contemporary forms of biopolitics, biocommunicability produces a sense of freedom for some subjects, the right to acquire any knowledge that might pertain to one's self and to receive it in whatever fashion one chooses, and for others the feeling of exclusion, subordination, and constraint—the sense that "information" is not directed at or accessible to them." (Briggs and Hallin 2007:46).

Discourse help accounts for the missing link between the internalization of ideologies and the freedoms of choice available through increased flows of communication. Freedoms are eroded by normative prescriptions and disciplinary forms of social control. Furthermore, amidst societal shifts from

models of dominant medical authority towards a greater sense of patient-consumer knowledge and autonomy, biocommunicability, like the postmodern concepts of biopolitics and biomedicalization, moves beyond communication about avoiding illness to consider the range of discourses involved in instructing contemporary patients about how to maximize freedom, well-being, quality of life and the future of one's children (Briggs and Hallin 2007). "Rather than imagining passive receivers of authoritative information, the patient-consumer model casts laypeople as individuals who make choices in the absence of their physicians and the presence of the media." (Briggs and Hallin 2007:52). Media delivers messages, but also reinforces ideologies of consumer choice and individual responsibility—norms under a new social contract for consumer-citizens. Media also reinforces notions of time, perpetual motion, and goal-driven progress potentially recasting ideals or norms around how to spend time, how to be in the world, and how to belong (Briggs and Hallin 2007). The portrayal of Spanish-speaking immigrant parents on television news illustrates the potential role of media in constructing discourses of "problematic, immigrant parents"--

> "The story projected a situation in which services were available, but parents failed to exercise their options because they did not have proper information; the state and media would remedy the situation by bringing them that information. Immigrant parents were thus projected as doubly failing in their governmental duties, seemingly not self-motivated to seek out relevant information on health and to secure their children's well-being." (Briggs and Hallin 2007:60).

These parents were unfit to be regarded as citizens.

In parallel pursuits, others have identified media as a critical agent in acculturation processes (Dalisay 2012; Davis et al. 2002; George and Geneviève 2005; Lara et al. 2005; Lopez-Class, Castro and Ramirez 2011; Nutbeam 2000); therefore, ideas about biocommunicability and biocitizenship may be doubly important for immigrants. Media plays an important role in conveying ideals of citizenship, but also in casting "the undeserving" for all to recognize and elude. Moreover, by intertwining health and market principles, media reifies rationalist ideologies (e.g. self-interest maximization) and conflates patient-consumer consumption with citizenship and healthism (Briggs and Hallin 2007).

Briggs and Hallin's (2007) work helps outline the connections between discourse and citizen-making, but also demonstrates how shifts in power in the technoscientific health arena contributes to new responsibilities of citizenship. The knowledge of health professionals is exercised as a power to define and normalize, but also monitor and measure far flung populations through governmental strategies like public health (Lupton 1999). Expertise renders multiple "social fields governable through detailed documentation, classification, evaluation and calculation" (Petersen and Lupton 1996:14). However, professionals are no longer the only self-regulating agents of social control; the lay public also enacts regimes of self-surveillance and disciplinary control. "New prudentialism" replaces the provision of practical medical solutions and the examination of root causes of social problems with discourses about personal choice and personal responsibility (Lupton 1999:99). Lay people once responsible for only consulting a professional are now responsible for attaining and maintaining their individual health as well as the well-being of the environment, distant lands and future generations—a broadened definition of social citizenship (Petersen and Lupton 1996).

Finally, in quite a different construction, Ong's considerations of citizenship explore: a) what and who exists transnationally, b) how constructions of citizenship respond to myriad social forces and globalization, and c) connections between citizenship and forms of capital (Ong 1999; Ong 2003). Through her observation and analysis of Chinese transnational immigrants and Cambodian refugees living in the U.S. and several Pacific metropolises, Ong highlights determinants of citizenship that are slightly different than other authors. First, building upon a transnational perspective, Ong's earlier work recasts transnational inquiry into a project concerned with bringing economic rationalities of globalization into the same frame as the cultural and practical dynamics that shape human and political responses to globalizing forces (Ong 1999:5). Moreover, she asserts that the logics of culture and practice that make transnational actions thinkable, practical and desirable are embedded in processes of capital accumulation (Ong 1999). Ong's work reminds us that individuals are only one type of actor and that many more transnational acts are practiced and maintained by corporations, militaries, as well as colonizing and non-

colonizing nation-states that help create and shape circumstances for individual migration from one area of the world to another.

Then, seeming to accept the economism that dominates studies of migration and mobility, Ong describes migration decisions as well as subsequent decisions about citizenship, transnationalism and cultural identity that are made in response to social circumstances and openings that allow for capital accumulation. She describes well-educated, affluent managers from Hong Kong, Taiwan and China who accumulate capital through investment and nimble transversals of sociocultural spaces created by easy transportation, rapid communication and nearly universal recognition of economic capital. Taking economic and social capital accumulated in their home countries, these individuals and families travel the Pacific region seeking to convert capital into new opportunities for capital accumulation. As business people with a foot in at least two (sometimes more) worlds, Ong's subjects are able to convert economic and social capital into locally-specific cultural capital which leads to increased social standing across national boundaries, which, in turn, leads to even greater capital resources. Interestingly, this strategy for capital accumulation works best for those willing to exist in-between categories of citizenship whether as part-time citizens, dual citizens, legal residents or stateless cosmopolitans.[6] After describing such flows of capital, Ong believes that two modifications of Bourdieu's conceptualizations of capital are necessary.

First, despite Bourdieu's ideas about convertibility, Ong stresses that under pressures of globalization and late capitalism, only economic capital seems convertible or exchangeable for other forms of capital. Consistent with Foucauldian notions of stratified or graduated sovereignty, this assertion suggests that citizenship is constructed differentially for different people based upon the economic capital that they are able to wield and control. Ong embraces this perspective and extends its relevance to consider the differential ways that nation-states and authorities respond to shifting relations between

[6] Horton (2004) describes a similar ability to convert social and cultural capital into economic capital and capital accumulation among Cuban American refugees in the Southwest whose citizenship is constructed differently than that of their Mexican American counterparts. Arriving after enduring political hardship and extreme ocean journeys, Cubans are granted start-up capital as refugees or asylees that discursive constructions of their acceptability, pluck and entrepreneurship help convert into economic opportunities, economic capital and over time cultural capital as a group deserving of US citizenship.

states, societies and markets by distinguishing strategies and technologies of governing segments of the population based on their relationship to the market (Ong 2000). Different opportunities, obligations and responsibilities are distributed to those migrating to the US based on their economic capital and class positions, as well as judgments about their market-worthiness or social productivity.

Second, Ong questions the naiveté of Bourdieu's stipulations about the structural limits to cultural capital accumulation. Bourdieu suggests that the only limits to cultural capital accumulation are the "shifting criteria of what constitutes cultural capital in time and place" (Ong 1999:91). Ong problematizes this view by introducing embodied characteristics—skin color, foreign accent, phenotypic variation, tastes—that may count as symbolic deficits in a new society, imposing a social structural constraint on one's ability to have cultural capital recognized (Ong 1999). Money or economic capital only goes so far.

In her later analysis of Cambodian refugees' social incorporation, Ong (2003) flushes out the role of the state and institutions that extend the governing powers of the state and society. Ong begins by describing the changes in social relations that Cambodian refugees likely experience when transitioning (sometimes in multiple stages via refugee camps in other countries) from a totalitarian state that wields absolute power over the social body and individual bodies to a democratic society whose order is, in part, maintained through internalized disciplinary regimes and institutional/structural apparatuses concerned with bodies and "cleanliness," a purity discourse (Ong 2003). Rather than a coercive or malign disciplinary knowledge/power, Ong describes a benign disciplinary knowledge/power that is constitutive of an U.S. democracy that maintains social order and control through "administration, surveillance (at the level of individuals and the social body), normalizing values and hierarchies" (Ong 2003:91). Drawing upon Foucault's discussion of the clinical (or medical) gaze, Ong presents medicine as authoritative knowledge/power assemblages that define and advance notions of illness, wellness, hygiene, health, life and death (Ong 2003). While medicine surveys bodies and investigates anatomy and clinical symptoms using new techniques, medicine also makes authoritative judgments about normalcy while instilling concern about future anatomical/biological developments which may be eliminated or reduced through risk reduction activities (Ong 2003).

Foucault generally spoke of states or interests as creating "docile bodies" appropriate for living in late capitalist societies. Ong extends this idea to describe the subject-making processes that newcomer refugees encountered: “becoming the modern biopolitical subject entails a two-part process of acquiring a specific set of practices and a specific philosophy of life" (Ong 2003:92). Bodily and medical regimes were central to the citizen, subject-making process. “Daily encounters between refugees and health workers were lessons in new “bodily regimes” The refugees’ bodily regimes, survival logics, and adoption of certain biomedical principles and practices were co-constitutive of their constructions as passive, obedient, yet untrainable subjects. For Cambodians in this study, the lessons of citizenship were not just the normative “oughts” that providers sought to inculcate, but also a politics of subordination and manipulation that “entailed figuring out how to obtain resources controlled by experts” (Ong 2003:109). Ong’s reflections on citizenship seem to mirror Portes and Zhou’s (1993) ideas of segmented assimilation, though it is unclear that the two theories have been linked either genealogically or empirically.

This chapter described various ways that the larger context of migration may be incorporated into theoretical inquiry. Theoretical and empirical, migration research also demonstrate the hegemonic frames and ideas that constrain conceptualizations of migration and incorporation. Some of these frames include: nation-state, foreign, non-Western, assimilation, and citizen. Since “the ‘deserving’ citizen of the neoliberal state must actively take on their responsibilities for self-improvement,” immigrants and scholars must rise above narrow interpretations of these terms to advance more widespread understanding of migration trajectories and processes, as well as support for transitions (Rose 2007). Migration touches every dimension of human and social existence. Understandings of broader contextual factors are imperative to embracing more processual approaches to migration. Process approaches “acknowledge ambiguous and multiple perspectives situated in the everyday, and ‘focus on the processes of everyday life, in the form of daily activities, as a frame of reference’ (Gonzáles, 1995: 237).” (Halfacree 2004:242). Reducing the "event" focus in migration studies would help restore ideas about not only processes, but also "non-event" (quotidian) aspects of migration stories (Halfacree 2004). Given the dynamism of

external forces as well as geopolitical and environmental situations that compel migrations, scholars, service providers and immigrants may benefit from perspectives that consider complicated causes of migrations, non-linear adaptation processes, and multiple sites for incorporation and social support. As most theoretical engagements lack innovation and are characterized by undertheorizing, individual and collective experiences of migration and incorporation should remain open to empirical testing. Further, identification of commonalities and differences can be addressed through well designed empirical studies without prematurely personalizing or ethnicizing perceived challenges along migration careers.

Chapter 3: Empirical Research on Migration and Health: Beyond the Immigrant Health Paradox

Chapter Overview

Within a life course perspective on health and aging, migration represents a critical period during which individual behaviors, everyday practices and social circumstances are established anew. As immigration to the US diversifies creating multiple migration and social incorporation experiences, there is much to learn about the strategies used by individuals to build lives and health amidst dynamic social, economic and cultural conditions. Moreover, given growing consensus that for many immigrant groups, time in the US increases their health risks, a particular urgency drives research interest in understanding the mechanisms and processes that shape health-related acculturation and other processes that may influence immigrant health and social status.

While an "immigrant health advantage" has been described for some groups in the U.S., the heterogeneity of immigrant experiences as well as limited access to resources lead some groups to experience health disparities (Abraído-Lanza et al. 2006; Acevedo-Garcia et al. 2012b). For immigrants, the complexity of the U.S. health arena is further complicated by acculturation and assimilation processes, contextual change, and challenges accessing health care and services. Empirical research has made strides to reveal relationships between migration, incorporation processes and health, but many questions remain. Having previously considered some of the theoretical and conceptual issues affecting studies of migration, particularly as related to health, this chapter seeks to summarize empirical findings on migration and health over the last two decades. While some examples have been selected to demonstrate the application of theories discussed previously, the focus here is on how investigations of migration and health have evolved as well as promising and necessary directions for future research based on the status of the empirical literature.

Migration and Health Research

Within the U.S., studies of migration and health have largely consisted of cataloguing health outcomes, disease etiology and risk factors (including social factors) among those who have migrated to the U.S. and/or comparing disease incidence, prevalence or severity among U.S.-born and immigrant populations (Acevedo-Garcia and Bates 2008; Acevedo-Garcia et al. 2012a; Singh and Siahpush 2001). Acculturation processes and preventing morbidity and mortality associated with perceived risks for specific immigrant subgroups have figured prominently (Goel et al. 2004; Patil, Hadley and Nahayo 2009). More recently, immigrant and refugee health has been studied under the auspices of broader concerns about health disparities, health inequities or interests in the social determinants of health. Concerns with immigrant health disparities have revealed barriers to access and utilization of health care and services (including prevention efforts) among some immigrant groups (Gordon-Larsen et al. 2003). Typical articles in immigrant health discuss the effects of a cross-sectional measurement of acculturation or acculturation processes on specific health outcomes or health-affirming or degrading socioeconomic conditions like occupational mobility, residential segregation, or household income. Consistent with the hegemonic grip of U.S. nation-state perspectives on migration research, far fewer articles have explored connections between immigrants' health and their home country contexts, migration event experiences, or their experiences under globalization (Castles 2007; Viruell-Fuentes, Miranda and Abdulrahim 2012).

Research on acculturation and health have revealed poor understandings of U.S health systems and health care processes among many immigrants, but relatively better health status and outcomes among those who have had *less* contact with the U.S. health care system (Goel et al. 2004). Representing 63% of the U.S. Latino population and close to 30% of the foreign-born population, Mexican-origin individuals have been the dominant subject within immigrant health research (Acevedo-Garcia and Bates 2008; Vega, Rodriguez and Gruskin 2009) and their proportionate size and youth affect findings about health among U.S. foreign-born or immigrant populations nationally. However, many immigrant groups, Latino and non-Latino, experience lower risks of mortality, detrimental health behaviors like smoking, alcohol use and low fruit and vegetable intake; obesity and cardiovascular disease when compared to

native born populations (Abraído-Lanza, Chao and Florez 2005; Acevedo-Garcia and Bates 2008; Bates et al. 2008; Singh and Siahpush 2001). More positively, immigrant groups experience superior perinatal and mental health outcomes when compared to U.S.-born populations (Acevedo-Garcia and Bates 2008). Initially labeled the "healthy immigrant effect" based on studies among Mexican immigrants, epidemiologic paradoxes account for a significant proportion of the published immigrant health literature (Acevedo-Garcia and Bates 2008; Singh and Siahpush 2001; Stephen et al. 1994). Today, research on diverse groups of immigrants contribute to scholarly discourse on the topic both within and outside of the U.S. (Bennett et al. 2007; Hamilton and Hummer 2011; John et al. 2012; Sam et al. 2008; Speciale and Regidor 2011).

One example of recent epidemiologic research by Cunningham, Ruben and Narayan (2008) synthesized findings from immigrant health research between 1980 and 2007 based on their analysis of 71 primary research studies focused on ten health outcomes. Overall, foreign-born individuals were found to be healthier: with longer life expectancies, less likely to be diagnosed with heart disease and mental disorders, less likely to be overweight or obese, less likely to have a low birth weight baby and less likely to suffer or die from breast, prostate or colon cancers (Cunningham, Ruben and Narayan 2008). For these health outcomes, the gap between foreign-born and native born individuals increased when compared in subgroups matched by race-ethnicity. For example, foreign-born blacks fared better than U.S. born blacks for all health outcomes (Cunningham, Ruben and Narayan 2008). This review supported findings by Goel et al. (2004) and Gordon-Larsen et al. (2003) suggesting that increased duration in the U.S. leads to immigrant health convergence so that immigrant health profiles resemble those of U.S. born individuals and U.S. born individuals typically have worse health profiles (Cunningham, Ruben and Narayan 2008). Moreover, using a regional classification scheme, the authors also highlight the overrepresentation of Americans and Europeans and underrepresentation of Africans and Asians in national samples of immigrants in research relative to their presence in the U.S. foreign-born population (Cunningham, Ruben and Narayan 2008). The nativity and race findings also remind scholars that immigrants' experiences of migration and the US vary even if some elements of adaptation and

incorporation may be similar. Future studies and surveys should be designed so that analyses can attempt to disentangle nativity, race/ethnicity and country of origin (Cunningham, Ruben and Narayan 2008).

The Dominance of the Immigrant Health Paradox

Often referred to as the immigrant health paradox (IHP) or the Latino health paradox (LHP), this paradox, conceptually, represents empirically-based observations that immigrants experience "better-than-expected" health outcomes given their presumed lower social status and potential challenges with social integration (Acevedo-Garcia and Bates 2008; Bennett et al. 2007). Some versions of the concept also suggest that the longer one is exposed to life in the U.S., the less protective one's immigrant status becomes as a risk factor (Acevedo-Garcia et al. 2010; Antecol and Bedard 2006; Goel et al. 2004). Most of the IHP research discusses three explanatory models: 1) cultural: where protective social and/or cultural factors among immigrants are implicated, 2) selectivity: where selection prior to migration favors healthier would-be immigrants, and c) artefactual: where evidence for paradoxes is due to data and measurement limitations (Acevedo-Garcia and Bates 2008; Cunningham, Ruben and Narayan 2008; Vega, Rodriguez and Gruskin 2009).

As persistent gradients between health and social position have been noted over centuries and nations in demographic and epidemiological literature, immigrant health amidst sometimes poor or unstable economic and social conditions harbors lessons to be learned about optimizing health with limited resources (Acevedo-Garcia and Bates 2008; Kawachi 2000; Lynch and Kaplan 2000). By uncovering health amidst unexpected conditions e.g. among low socioeconomic status immigrant groups, contemporary health disparities and social determinants of health research further stimulated interest in relationships between migration and health (Acevedo-Garcia and Bates 2008; Vega, Rodriguez and Gruskin 2009). Although numerous articles have highlighted inconsistent findings in support of the IHP by both health outcomes of interest and immigrant populations, the concept pervades understandings of immigrant health within epidemiologic and other health research (Abraído-Lanza et al. 2006; Horevitz and Organista 2013).

In *Latinas/os in the United States: Changing the face of America,* Acevedo-Garcia et al. (2008) provide a thorough review of IHP as researched among Latino populations. Before discussing recent developments and recommendations for improving this body of research, findings from this review will be discussed. Since most of the findings are consistent with other empirical evidence, the article provides convenient scaffolding around which to organize.

First, there is no consensus on the existence, relevance and importance of IHP. Empirical research may best be described as contested, muddled and inconclusive. Among Latinos, health advantages have been documented in: mortality, irrespective of nativity, though the foreign-born have more advantage; with respect to infant mortality; low birth weight (by nativity), substance use/abuse; smoking; and psychiatric disorders (Abraído-Lanza et al. 2006; Acevedo-Garcia and Bates 2008; Singh and Siahpush 2001; Viruell-Fuentes, Miranda and Abdulrahim 2012). Conversely, health disadvantages described in the literature include: diabetes, obesity, HIV/AIDS, asthma (by nativity), being uninsured, occupational and environmental exposures such as musculoskeletal disorders, infectious diseases, injuries and limited physical activity (Abraído-Lanza, Chao and Florez 2005; Acevedo-Garcia and Bates 2008; Singh and Siahpush 2001; Viruell-Fuentes, Miranda and Abdulrahim 2012). Health selection among immigrants has been associated with lower mortality rates, higher life expectancy, relatively better birth outcomes and lower risk of illness (Lassetter and Callister 2009). Yet migration can have a variety of impacts on immigrant health; "researchers have associated these health changes with stress, climate differences, racism, separation from family members, and modifications in the physical environment, lifestyle, and cultural milieu." (Lassetter and Callister 2009). Potentially influential factors on immigrant health include: length of residence, stress of acculturation, disease exposure, lifestyle, living conditions, risky behaviors, healthy habits, social support networks, cultural and language barriers, racism and discrimination, and awareness of US cultural health beliefs and practices (Abraído-Lanza, Chao and Florez 2005; Acevedo-Garcia and Bates 2008; Arcia et al. 2001; Lassetter and Callister 2009; Viruell-Fuentes, Miranda and Abdulrahim 2012). Demonstrating the sort of geopolitical, hierarchically-based Americentrism present in some of the literature, it is of note that much of the literature assumes that

healthy habits are learned and cultivated upon moving to the US (Misra et al. 2000; Rudmin 2003). This assumption bears connections to historically simplistic arguments about the value of core (read almost always as more advanced, receiving countries) over periphery (read as less advanced, sending countries) nations that fail to examine the role of core-periphery relations in developing core countries' strategic advantages.

Second, in order to address cross-disciplinary incoherence, the authors call for multidisciplinary research that includes public health practitioners and social scientists and that embraces complex understandings of context (Acevedo-Garcia and Bates 2008). Latino immigrants should be considered embedded in and shaped by multiple contextual factors including their sending countries, multiple adaptation processes, and the receiving community. This call echoes those of social scientists focused on migration and acculturation. The critical role of disciplinary boundaries, assumptions and interpretations have risen to prominence during this review due to high levels of theoretical and conceptual redundancy, a proliferation of mediocre measures and common critiques of poor cross-disciplinary literature and theory reviews guiding empirical research (Chun and Akutsu 2003; Horevitz and Organista 2013; Hunt, Schneider and Comer 2004; Lara et al. 2005; Rudmin 2003). While "research on acculturation and health has not kept pace with acculturation theory," the recalcitrance of untested assumptions and undertheorized concepts and the replication of poorly validated measures is glaring and must be overcome to meaningfully advance the field (Abraído-Lanza et al. 2006; Barnard et al. 2014; Celenk and Van de Vijver 2011; Chun and Akutsu 2003; Hunt, Schneider and Comer 2004; Rudmin 2003). Acevedo-Garcia and Bates (2008) also sound a demographic alarm for researchers to improve their understandings of the connections between migration and health since the size of the second generation is expected to surpass the first generation by 2020. "Given that foreign-born Latinos appear to have a health advantage over U.S.-born Latinos, the increase in the second generation might have implications for the health status of Latinos" as well as the health status of the country overall (Acevedo-Garcia and Bates 2008).

Third, research on epidemiological and demographic associations between numerous variables used to represent health status, morbidity and mortality has flourished with few improvements in metrics

or methodological considerations e.g. appropriate reference populations. Research on mechanisms and pathways involved in migration and adaptation experiences producing situated kinds of health and illness remains lacking. Several scholars have called for more qualitative and cross-national research and longitudinal studies in order to help break this research impasse (Acevedo-Garcia and Bates 2008; Horevitz and Organista 2013; Lassetter and Callister 2009; Viruell-Fuentes, Miranda and Abdulrahim 2012).

Explorations of IHP related hypotheses in quantitative studies within health and social science have often relied on inadequate measures of immigrant socioeconomic status, acculturation and critical exposures (including potential confounders) along implicit, rather than explicitly articulated, pathways to disease. More specifically, the literature has relied on proxies to "measure" acculturation. Language (skill, use, comfort and preference) is the most commonly used measure of acculturation (Acevedo-Garcia and Bates 2008; Horevitz and Organista 2013; Viruell-Fuentes, Miranda and Abdulrahim 2012). Nativity, length of residence, generation status, proportion of life lived in receiving society, and age at arrival are other variables commonly used as measures of acculturation (Abraído-Lanza et al. 2006; Acevedo-Garcia and Bates 2008; Arcia et al. 2001; Horevitz and Organista 2013; Lassetter and Callister 2009; Viruell-Fuentes, Miranda and Abdulrahim 2012). Proxies and other reductive measures fail to explain why acculturation processes result in poorer or better health. Existing research efforts have neither described nor clarified the relationships between acculturation and health. Furthermore, researchers rarely compare multiple measures of acculturation in order to distinguish explanations of variance (Arcia et al. 2001; Viruell-Fuentes, Miranda and Abdulrahim 2012) or use multiple comparison groups in order to differentiate other social phenomena like globalization or economic development (Acevedo-Garcia and Bates 2008; Horevitz and Organista 2013; Madrigal et al. 2011; Viruell-Fuentes, Miranda and Abdulrahim 2012). In addition to being narrowly defined, empirical conceptualizations and measures of acculturation processes rarely consider: diversity within groups, macro and institutional level factors that influence family/collective and individual actions, the changing and context-dependent salience of identities; or practices and lived experiences (Birman 2011; Portes and Rumbaut 1999). Few articles have

attempted to identify the mechanisms through which IHP or acculturation influence or produce health or illness; findings from such attempts will help improve theorizing and conceptual utility in the promotion of improved health outcomes (Abraído-Lanza et al. 2006; Acevedo-Garcia and Bates 2008).

Beyond the Immigrant Health Paradox

More recently immigrant health concerns have been explored through social determinants of health framings. Concerns with immigrant health disparities have revealed barriers to access and utilization of health care and services (including prevention efforts) among some immigrant groups (Gordon-Larsen et al. 2003). The WHO Commission on Social Determinants of Health (SDH) put forth a new framework for addressing SDH in 2010 (Solar and Irwin 2010). The report distinguishes two types of social determinants—social causes of health and illness (social determinants of health) and the *social factors determining the distribution of these causes* between more and less advantaged groups (social determinants of health inequalities)—that are related to three potential mechanisms or pathways:

- Social contexts, which include the structure of society or the social relations in society, create social stratification and assign individuals to different social positions.
- Social stratification in turn engenders differential exposure to health-damaging conditions and differential vulnerability, in terms of health conditions and material resource availability.
- Social stratification likewise determines differential consequences of ill health for more and less advantaged groups (including economic and social consequences, as well differential health outcomes per se). (Didierichsen as quoted in Solar and Irwin (2010))

SDH approaches examine contextual and structural determinants and socioeconomic position as social determinants of health inequalities. In this framework, context includes social, political and economic conditions that produce, configure and replicate social hierarchies like the educational system, the labor market, the welfare state, etc. (Solar and Irwin 2010). Structural mechanisms generate stratification and class divisions that position individuals and families within hierarchies of power, status and resources

(Solar and Irwin 2010). The most important social stratifiers considered in health research include: income, education, occupation, social class, gender, race/ethnicity, and sexuality. Taking migration and acculturation as social processes that manifest through multiple levels of action, migration status might be a critical stratifier; whereas migration and incorporation processes help configure and are also shaped by social contexts, health-affirming or health-damaging social conditions, and cumulative or long-term consequences of differential health outcomes.

Acevedo-Garcia et al. (2012b) propose using a SDH approach to immigrant health in order to emphasize the contributions of social and structural factors to health risks and health outcomes among immigrant and minority populations. These researchers are also theorizing against the cultural essentialism that they believe seeps into epidemiologic research that cites culture as an explanation for various findings (Horevitz and Organista 2013; Hunt, Schneider and Comer 2004).

Using data from the National Center for Health Statistics and the National Program of Cancer Registries, Vega, Rodriguez and Gruskin (2009) produced trend data for causes of mortality where Latinos experience disparate outcomes—diabetes, homicide among younger men, work-related injuries, human immunodeficiency virus (HIV), liver disease (including liver cirrhosis), and specific types of digestive system cancers, including cervical, stomach, and liver cancer. This is one of the only attempts to look at Latino immigrant health status over time. The study highlights the importance of Latino immigrant health disparities (or excess mortality) despite generally superior health outcomes relative to U.S. born individuals (Vega, Rodriguez and Gruskin 2009). As lower socioeconomic status among Latino immigrants defined by lower income and educational attainment persists, the authors suggests that more immigrant health research include variables about health care access, preventive health care, and epidemiologic life-course factors for both sending and receiving nations (Vega, Rodriguez and Gruskin 2009). Latino immigrants achieve better health despite worse health care access (Vega, Rodriguez and Gruskin 2009). Nonetheless, this study underscores the marginal impact of health care access on population level health and mortality—non-health care factors seem more important. Vega, Rodriguez and Gruskin (2009) call for better understandings of the role of housing and neighborhood composition

(ethnic enclaves) on Latino health outcomes since residential segregation is widespread in the U.S. and benefits accrued to immigrant parents may erode over time resulting in negative relationships between ethnic enclaves and children's (or future generations') health outcomes. The article advocates for trans-disciplinary research "to investigate mechanisms that increase risk behaviors among Latino youth in US environments. This subgroup of US youth, formed partly by children arriving in early childhood and partly by children born in the United States to foreign-born parents, constitutes the heart of the demographic transition. They represent "the tip of the iceberg" of emergent health disparities in the Latino population that may largely be determined by differential environmental exposures and intergenerational social stratification patterns (Acevedo-Garcia and Bates 2008; Vega, Rodriguez and Gruskin 2009).

Historical constructions of acculturation are profoundly intertwined and dependent upon views of "spoiled," damaged, or devalued minority social groups that already treat them as cultural Others (Goffman 1963; Horevitz and Organista 2013; Rudmin 2003). A sense of stigma may, in part, be conveyed by scientific use of "cultural" risk factors to pathologize behaviors of minority or marginalized collectivities, particularly those of racialized groups, even when risk behaviors are significantly shaped by structural factors like resources, time, labor, etc. (Shim 2005). Health is complex; migration and incorporation involve complex interactions. Denouncing attribution of health disparities or paradoxes to poorly-conceived, static cultural norms, these researchers would like to ensure that individuals and families are not blamed for problems in our collective social and structural systems (Acevedo-Garcia et al, 2012). This call from social epidemiologists is similar to recent calls from community and cross-cultural psychologists to incorporate ecological and social factors into research with immigrant communities in order to reduce individualistic bias in that discipline (Birman 2011; Perkins, Palmer and García-Ramírez 2011).

Migration studies has an opportunity to advance theorizing about how and why health changes as individuals and families move through different geographic spaces, as well as about processes of health maintenance among those confronted by dynamic change. We all encounter dynamic change, but

immigration provides a sensitive or "unsettled" period when logics and practices may be questioned, reformulated and/or reinforced in order to make quotidian living possible (Swidler 1986). These authors also propose cross-national investigations in order to enhance understanding of population health patterns in sending and receiving societies (Swidler 1986). SDH perspectives elevate conventional analytics of sociology--stratifications, conflict, institutions, social order, social control, alienation, power, identity and social capital—in order to elaborate understandings of health and illness that more closely reflect lived experiences (Acevedo-Garcia et al. 2012b; Castles 2007; Solar and Irwin 2010).

Based on this limited review, several recommendations for a future research agenda in migration and health are of note. First, given the emphasis on culture in migration studies, there is an abundance of qualitative literature on migration and health although much of it either explores "folk traditions" and cultural conceptions of illness/disease attributed to a specific immigrant population or adopts explanatory frameworks that focus on the cultural (Betancourt and López 1993; Giuliano et al. 2000; Guarnaccia and Rodriguez 1996; Howlett, Ahmad and Murray 1992; Lewis-Fernandez and Kleinman 1995; Lopez and Guarnaccia 2000; Patil, Hadley and Nahayo 2009; Venters and Gany 2011). In this research, culture is black box where everything happens out of sight and cultural characterizations obscure within group diversity and negotiations between "Western" and "non-Western" that may take place within individual decisions and habits (Horevitz and Organista 2013; Hunt, Schneider and Comer 2004). This research has shed light on many important potential barriers to health and conceptual disjunctures experienced by immigrants e.g. female genital cutting, and simultaneous use of indigenous medicines and cures; however, there is room for additional research. Beyond cataloguing differences, qualitative research may be extremely valuable in identifying and describing contextual, structural, individual and household/familial factors that shape immigrant knowledge, attitudes, practices and perceptions about health and illness or mechanisms and pathways of health achievement and health degradation over the short and long-term among immigrants and their descendants.

Second, examinations of embodiment and bodily capital among immigrants have drawn recent attention along with the rise of theorizing about the psychosocial perspective on health inequalities

(Lenette, Brough and Cox 2012; Sternberg and Barry 2011). The psychosocial perspective of health inequalities suggests that elements of social life: “a sense of control; perceived social status; strength of affiliations; self-esteem; feelings of ontological insecurity, and so on, lead to variation in health outcomes” (Nettleton 2005). Under this perspective, social inequalities become inscribed on individual bodies or “get under the skin.” Moreover, people who experience greater senses of autonomy, social cohesion and social support are better able to respond to stresses, problems and uncertainties (Nettleton 2005). Research into stress responses, acculturative stress, psychological distress, and weathering among immigrants suggest that this might be an important area for ongoing research (Arcia et al. 2001; Doamekpor 2013; Krieger et al. 2011).

Third, features of the physical environment as well as discrimination and racialization have begun to be incorporated into studies of migration and health (Krieger et al. 2011; Oza-Frank and Cunningham 2010; Viruell-Fuentes 2007). These researchers assert that neighborhood, community and environmental variables should be included in future studies since urban physical spaces, norms, expectations and resources may impact have complex influences, positive and negative, on health behaviors and health-seeking (Oza-Frank and Cunningham 2010). “[T]here is a growing appreciation that environmental influences contribute to adult health disparities by influencing biological processes and responses across the life cycle, with certain ages or developmental stages particularly sensitive to environmental and social influence (Barker, 1994)” (Kuzawa and Sweet 2009). Whereas discrimination and racialization were often underestimated or ignored in earlier studies of immigrant experiences, current research shows these social processes to be critical to the migration and incorporation experiences of visibly and audibly different immigrants in receiving societies characterized by racialized and/or colonial histories (Gee et al. 2006; George and Geneviève 2005; Horevitz and Organista 2013; Kelly and Lusis 2006; Krieger et al. 2011; Nazroo 2003; Viruell-Fuentes 2007).

Finally, previous reviews have suggested focusing research attention on: a) better defining the epidemiologic paradoxes under investigation and their compositional variables, b) proposing mechanisms and processes through which health may be realized by immigrants, c) distinguishing ethnicity-related

effects from general immigration effects or SES effects, d) recognizing dynamic contextual interactions between home countries and U.S. immigrant populations, and e) selecting appropriate reference groups (Abraído-Lanza et al. 2006; Acevedo-Garcia and Bates 2008; Horevitz and Organista 2013). Additional conceptual and theoretical advances like the problematization of Euclidean place (Cummins et al. 2007), identification of multiple health paradoxes and potential explanatory factors, recognition of dynamic home country and U.S. contexts, and structural/institutional factors (Zambrana and Carter-Pokras 2010) should also be considered when developing future research. Much remains unknown.

Caribbean Immigrant Health

Caribbean immigrants have garnered little attention within migration and health research. This fact is probably due to a variety of factors including presumed cultural proximity, geographic proximity, small populations outside of specific metropolitan areas, and the collapsing of Caribbean immigrants into other racial and ethnic categories for research purposes. However, a review of existing literature reveals research similar to the types of migration and health research featured in this chapter i.e. Caribbean immigrant dietary knowledge as well as literature on the prevalence of psychological well-being, chronic illnesses, and mental health conditions. A brief review of what is known about Caribbean immigrant health concludes this chapter.

Research into specific health burdens of Caribbean populations corroborates demographic aging and disease transitions from acute/communicable to chronic/non-communicable conditions across geographies. Moreover, crises related to HIV/AIDS, diabetes and other conditions have been heralded since the early 2000's (Caceres 2002; Camara 2001; Fraser 2001; Reddy and Yusuf 1998; Voelker 2001). Within the overall Latin American and Caribbean region monitored by the Pan American Health Organization, a regional arm of the World Health organization focused on health throughout the nations and territories of the Americas, approximately half (50%) of all people aged 60 years and older have hypertension (Bidulescu et al. 2015; Pan American Health Organization (PAHO) and the Caribbean Community Secretariat (CARICOM) 2006). Socioeconomic status and historical differences in

population movement have also been associated with differences in rates of hypertension. For example, in the United Kingdom and the United States, ethnicity gradients have been observed such that Caribbean-born Blacks have higher hypertension rates than West African-born Blacks and Caribbean-born Blacks have lower rates of hypertension than African-Americans, respectively (Bidulescu et al. 2015; Cooper and Rotimi 1997; Fang, Madhavan and Alderman 1996). Fang, Madhavan and Alderman (1996) also found similar patterns for cardiovascular disease.

Within the U.S., Caribbean immigrant women have been identified as being two to four times more likely to be diagnosed with Type 2 diabetes mellitus than non-Hispanic whites (Smith 2012). And in more recent island-based work, Sobers-Grannum et al. (2015) identified gender as an independent risk factor for diabetes among Caribbean populations such that women are more likely to develop Type 2 diabetes mellitus than men, controlling for multiple factors. In terms of cancer screening rates, Caribbean nationals and Caribbean immigrants to the U.S. and U.K., have reported lower rates of diagnostic screening for prostate and cervical cancer than their U.S. or British counterparts; yet no disparity was found for breast cancer screening rates (Consedine et al. 2015).

Comparing trends in causes of mortality and life expectancy among African-descendant, Caribbean and U.S. populations, Hambleton observed a reversal in the Caribbean's protective effect against mortality. For five of six major causes of death and overall life expectancy, Afro-Caribbean populations lost their advantage to African American populations. That is, in 1990, the life expectancy gap favored Afro-Caribbeans over African Americans by 1.5 years. By 2009, African Americans could expect to live 0.6 more years than their Afro-Caribbean counterparts (still 4.1 fewer years than American Whites). Despite the gap between African-descendant and American White populations, these data present a smaller life expectancy gap than in 1990 which researchers find promising.

As with other markers of one's time in the U.S., researchers have found that exposure to the U.S. social and economic context increases Caribbeans' chances of experiencing psychiatric disorders and higher allostatic loads, a physiological measure of cumulative stress (Doamekpor 2013; Williams et al. 2007). In terms of psychiatric disorders, conditions that are rarely found among foreign born, first

generation populations became more prevalent than among their U.S. counterparts in evaluations of third generation adults (Williams et al. 2007). Likewise, cumulative stress differences begin to emerge once immigrants have lived in the U.S. for five years (Doamekpor 2013). Although cohort and other timing effects cannot be excluded, both of these phenomena have been theoretically linked to social experiences of racism and discrimination. Similarly, goal striving stress has been associated with more physical health problems among Caribbean immigrants than among African Americans or U.S. whites (Sellers et al. 2012). Furthermore, examining interactions between occupation and race/ethnicity, Ertel, Berkman and Buxton (2011); and Hurtado et al. (2012) found that lower amounts of sleep, higher stress levels and increased job strain were associated with one's categorization. Across national origin groups, language and immigration status, Blacks and lower level health care workers e.g. CNAs fared worse than their non-Hispanic White and more skilled e.g. RN counterparts (Ertel, Berkman and Buxton 2011; Hurtado et al. 2012). These social determinants of health approaches to research highlight relationships between socioeconomic conditions and health outcomes, while also posing questions about racial sorting processes in the U.S.

Beyond health statistics, research has identified societal factors and health beliefs which may also characterize some Caribbean individuals and populations. First, health policy research has identified seven factors which may increase immigrants health-related vulnerabilities: political marginalization, social marginalization, lack of socioeconomic/societal resource, socioeconomic status, limited English proficiency, regulations and insurance coverage (Derose, Escarce and Lurie 2007). All, but limited English proficiency seem relevant for this study population; though it is important to note that approximately 14% of Black Caribbean immigrant children identified living in linguistically isolated households (Hernandez 2012). Derose, Escarce and Lurie (2007) define vulnerable populations as those who are at increased risk for poor physical, psychological and social health outcomes and limitations in access to health care and services. Due to interactions between individual and collective characteristics and one's environment (broadly defined), immigrants endowed with education, skills, and visions of productivity become more vulnerable social actors.

Finally, health beliefs recognized among both U.S.-resident and other Caribbean populations include: relationships between health and spirituality, belief in traditional, herbal remedies for healing and skepticism of preventive health, risk factors and allopathic medical knowledge (Archibald 2011; King et al. 2005; Scott 2001; Smith 2012). In sum, Caribbeans tend to intertwine notions of religion or spirituality with health status and outcomes, individual locus of control and therapeutic alliances with health providers. Based on research conducted in multiple locations, researchers have suggested consideration of the following when tailoring health education and interventions for Caribbean populations: regional history, notions of respect, employment/work as an everyday meditation in gratitude for one's ability to earn a living, potential belief in and reliance on traditional foods or herbal remedies for their healing powers, and comfort with contradictions(Archibald 2011; King et al. 2005; Scott 2001; Smith 2012; Williams and Sternthal 2010).

Caribbean immigrant health and illness emerge from complex social and geopolitical arrangements which also produce intermittent and recurring periods of moral panic and fear when immigrant populations, including Caribbeans, are presented as carriers of diseases and drugs or those "resistant" to norms of their U.S. environs (Portes, Kyle and Eaton 1992; Takeuchi 2016). These representations, evident in news coverage of the most recent vector-born virus outbreaks i.e. Zika and Chikungunya, can be alarmist and rely on deep-seated notions of Other in the U.S. imaginary (Koutsky and Carey 2017; Sachs 2015; Schuster 2016; Vora 2016).

Chapter 4: Research Methodology

In order to address the research questions described above, multiple methods were employed. This section describes research methodology for the dissertation including discussions of: a) rationale for mixed methods research design, b) sampling, c) research design, d) data collection and management, e) data analysis and synthesis, f) methods to ensure research quality, and g) methodological adjustments during project implementation.

Rationale for Qualitative-Led, Mixed-Method Research Design

Qualitative research is most instructive when it can reveal the *hows* and *whys* behind academic subjects of inquiry. Creswell describes the need for focusing on research questions that call for real-life contextual understandings, multi-level perspectives, and cultural influences as well as an interest in exploring the philosophical and theoretical underpinnings of disciplines or paradigms as representing "best practices" in mixed methods research (Creswell et al. 2011; Plano Clark and Schumacher 2011). This project sought to develop rigorous analysis of contextual understandings, multi-level perspectives and taken-for-granted underpinnings around issues of migration and the conventional health risk factors of diet and physical activity. Qualitative methodology will allow the researcher to describe and untangle the complex factors that contribute to practices in the realm of diet and physical activity, elaborate processes and conditions for decision-making, provide multiple perspectives on practical interpretations of migration and transnational belonging, and develop new ideas about critical factors influencing immigrant health behaviors related to chronic diseases, health maintenance and/or health degradation. Qualitative data are central to this investigation. However, in an effort to produce scholarship of relevance to the field and improve public health practices, three validated, quantitative measures/instruments were also administered to help me better discuss reliability, generalizability and transferability while theorizing about specific factors and pathways to particular diet and physical activity practices. This study was implemented based on a multi-stage, convergent parallel mixed methods design as depicted by the diagram below (Plano Clark and Schumacher 2011). Qualitative and quantitative data were collected,

analyzed, compared and interpreted. Subsequently, interpretative findings will be used to devise new or revised quantitative survey items or research hypotheses.

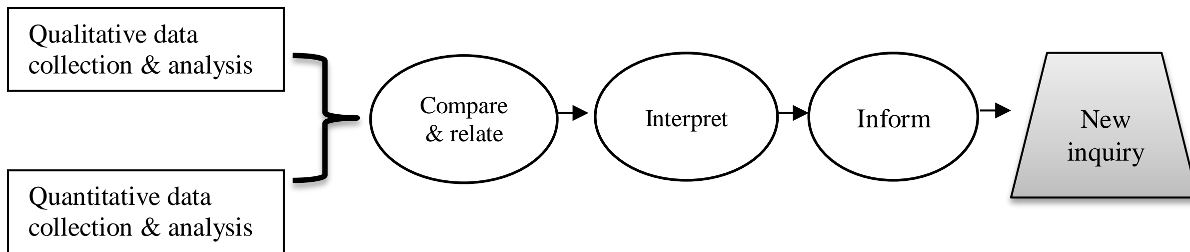

Figure 1: Planned research process

Research Methods

This research builds upon constructionist grounded theory approaches in order to excavate and analyze the proposed research questions. Grounded theory is based on the premise that researchers should develop theory through rigorous analysis of empirical data (Glaser and Strauss 1967). Grounded theory seeks to reduce investigator bias and develop substantive theory through empirically validated concepts (Glaser and Strauss 1967). Given the lack of knowledge about the relationships between the factors of interest as well as researcher interest in the social construction of everyday practices that guides this work, a constructionist approach to grounded theory seems most fitting (Charmaz 2006). Social constructionism is concerned with differences and complexity, making modest rather than grand theoretical contributions, interactions between "knowing subjects" and extant discourses, and pluralities of (partial) perspectives and social processes (Clarke 2005: 294). Moreover, building on Clarke's situational analysis, a postmodernist resituating of grounded theory, this project seeks to make visible the co-constitutive nature of "the situation" and its conditions by answering the question: "How do these conditions appear—make themselves felt as consequential—*inside* the empirical situation under examination?" (Clarke 2005: 71-2). Iterative processes of data collection and analysis were used to provide explanations of transnational, immigrant behavior grounded in data collected from interviews and observations. Grounded theory acknowledges that data are functions of the location of the researcher and participants in specific times and spaces, together we co-create interviews and moments observed

(Creswell 2012). Consistent with Creswell's definition of qualitative research, this project attempted to: use an emerging approach to inquiry; collect data in natural settings, sensitive to both the people and places under study; and analyze data using both inductive and deductive strategies that help establish patterns and/or themes (Creswell 2012).

In addition to constructivist grounded theory, multi-site ethnography, life history and institutional analyses paradigms were considered in the development of this study. A layered and complex approach is needed to explore the research questions under investigation since diasporas and transnational networks represent under-theorized, meso-level collectivities that may have influential salience for some individuals and groups. By drawing on a combination of social science methods, I have attempted to design a feasible, quality research project. Ultimately, data were obtained from individual life stories, demographic and risk factor data, observations, interviews with experts, and extant texts ranging from public service announcements to policy briefs. This research does not attempt to discern one knowable truth about the phenomena of interest, but rather situate specific actions under public and professional scrutiny within broader social and political contexts. This small-scale project seeks to draw attention to overlooked phenomena and processes in order to improve interdisciplinary knowledge which may garner additional inquiry and funding in the future

Madden (2010) defines ethnography as a social science practice where researchers seek to understand human groups, societies or institutions by spending time in the same social spaces as study participants. Multi-site ethnography moves conventional ethnographic concerns with the intimate, local and everyday/quotidian beyond singular sites or social spaces (Madden 2010; Marcus 1995). The nature of social spaces, once regarded as singular and embedded within existing, dominant geopolitical structures, has been complicated and re-examined across social science disciplines such that the multiplicity, complexity and co-constitution of sites are frequently considered (Marcus 1995). Sites do not refer to one place or community, but the recognition of multiple sites also draws relations between subjects and the composition of sites into the view of inquiry and analysis. Multi-sited ethnography interrogates multiple sites, but aims to present deeply contextual knowledge about related social

phenomena. Multi-sited ethnography cannot create holistic representations of social systems, but can provide knowledge about how the overall system works from a particular perspective (Marcus 1995: 99).

Multi-site ethnography speaks to the interconnected nature of transnational practices and seems most fitting to explore the topics of interest. This study may be limited in terms of conventional ethnography since the observations will be in-depth, yet relatively short in duration; however, the implemented methods intend to provide a nuanced description of the social phenomena of interest in relationship to other social factors while also theorizing about social processes, mechanisms and consequences based on empirical data and interpretations. Sites explored during this research include individual accounts, observations in community settings, public media and discursive texts.

Life stories were selected as a means of eliciting participant stories since migration narratives frequently unfold in tandem with one's life story. The life story or life history method provides a means of referencing specific time frames and critical moments in relationship to the phenomena of interest potentially uncovering unrecognized coincidence, antecedents and consequences of various actions (Adriansen 2012; McKeown, Clarke and Repper 2006; Thompson 2004). This method also enables the researcher to relate personal events to larger social and political, time-bound events e.g. changes in governmental policy. Examples of this method's implementation include lay participants being asked to share their migration stories beginning with their birth and initial memories about migrating to the U.S. or attaching timeframes or global events e.g. economic recession of 2008 to remembrances about observations back home in Trinidad.

Finally, institutional analyses paradigms draw researchers' attention to the social power of institutions and discourses on everyday lives and experiences (Smith 1987). Many ideas and images are produced and reproduced by social and class interests content with the status quo. Researchers interested in lay experiences and representations should be sensitive to "social forms of consciousness that originate outside of experience, coming from an external source and becoming a forced set of categories into which we must stuff the awkward and resistant actualities of our worlds"(Smith 1987: 54-57). Institutional ethnography further draws one's attention to the textual, archival and mediated forms of discourse which

help comprise the tacit knowledge undergirding the complex social spaces in which everyday activity unfolds (McCoy and Devault 2006). As health, in general, and diet and activity as risk factors, in particular have become highly mediated and discussed in public and expert for a; inclusion of these forms of discourse seemed essential to analysis. Examples of discursive material analyzed throughout the research process included policy documents, health promotion materials sponsored by Caribbean governments and international organizations like the World Health Organization, event programs, menus, email correspondence, conference discussions, and articles from media channels and academic journals.

As this research is expected to place discourses of social sciences and public health in conversation, some conventional public health concepts and methods have also been considered in order to triangulate data and increase the validity and cross-disciplinary acceptance of findings.

Sampling

The primary research sample consisted of transnational immigrants, living in the U.S., who were born in nations of the Caribbean basin region (Editorial Research Reports 1985).

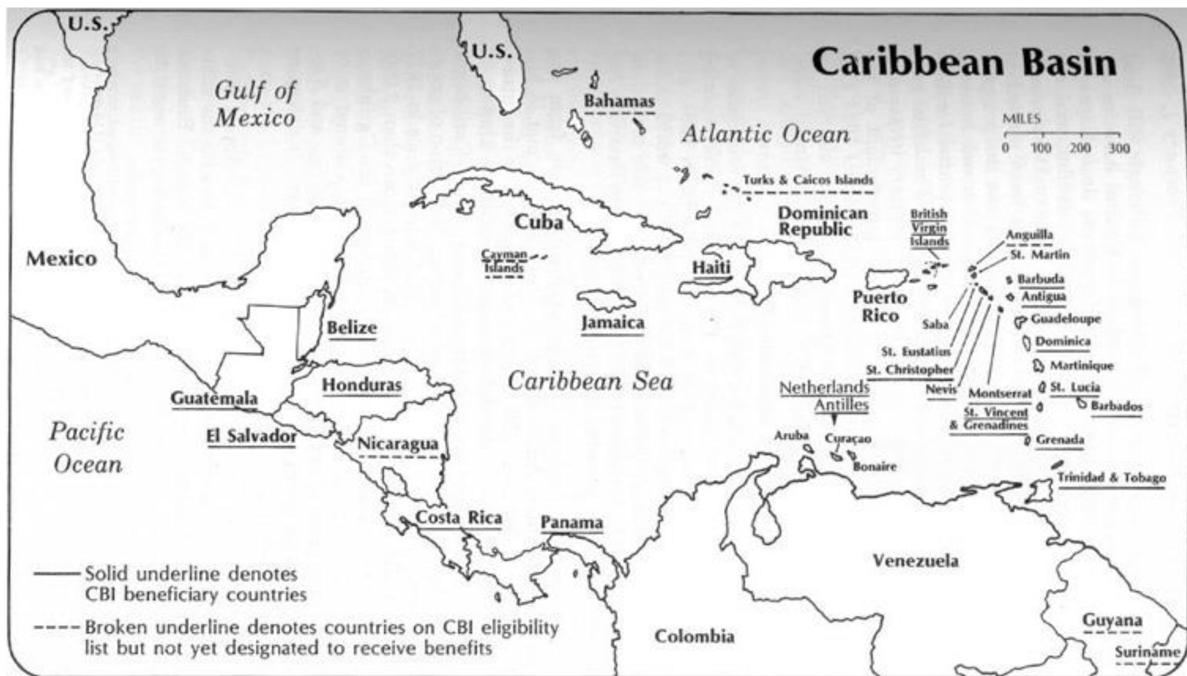

Figure 2: Map of the Caribbean Basin

Given burgeoning changes in the health status of Caribbean nations as well as the unique patterns of migration between the Caribbean and the U.S. (discussed earlier), transnational populations from this region were selected as a study population. Moreover, access to the desired populations were improved due to significant residential or labor concentrations in certain towns of the U.S. Participants were identified and enrolled using purposive, criterion sampling, followed by snowball sampling referrals. Inclusion criteria included: adult, ages 18-65 years; identify as transnational; living in the U.S. at least part time; interested in sharing their experiences about diet, activity, health and migration; and comfortable completing an interview in English. Exclusion criteria included: current hospitalization or institutionalization, those under 18 years of age and those uncomfortable or unable to complete an interview in English. Participants were recruited from the general population using print and electronic advertisements, in-person appeals, and participant referrals of non-family members living in the U.S. Eighteen individual interviews were completed among this primary research population. Interviews were also conducted with three key informants working with or near Caribbean immigrant communities. These domestic key informants as well as two international key informants, working in the Caribbean, were asked questions about health, diet, activity and non-communicable diseases. Key informant interviews included public health and health care personnel, non-governmental organization staffers, other researchers and neighborhood market managers. Key informants were identified and interviewed based on referrals from study participants and experts in the U.S. and Caribbean. The entire research protocol was reviewed and approved by the Committee on Human Subjects Research at the University of California, San Francisco.

During research implementation, theoretical sampling was used to collect data about specific concepts and processes emerging from data analyses. Theoretical sampling means relying on data collection "driven by concepts derived from the evolving theory and based on the concept of 'making comparisons';" and adapting data collection strategies in order to maximize opportunities to discover variations among concepts and to thoroughly explore categories (Strauss and Corbin 1998). Theoretical sampling was used to modify and/or deepen interview questions and probes for topics deemed critical and

that emerged early in interviews. Depending on the range of variation reported by participants in the sample, additional participants with specific types of experiences or profiles were sought. For example, when two participants mentioned differential use of alcohol before and after migration to the U.S., interview questions were rephrased to capture more experiences with food *and drink.* One probe, specifically about alcohol use, was also added.

Data Collection Methods and Instruments

Data collection for the study relied on multiple methods and strategies. In-depth interviews, surveys, observations, and extant media/documents comprised most of the data analyzed. Where useful and/or available, secondary health and social statistics are also used to describe participants' context and background. Data collection was designed to allow for substantive description of the processes involved in transnational living (maintaining activities in the U.S. and another country), the negotiation of diet and physical activity beliefs and practices across national and cultural boundaries; social, structural and emotional factors influencing diet and physical activity practices, and lay consideration of diet and physical activity as risk factors for poor health outcomes.

In-depth interviews

In-depth interviews allow for qualitative researchers to collect data about topics that are understudied or not well understood and provide an opening for the terms and relations familiar to lay individuals to enter academic and research discourses. As this research was interested in uncovering basic and taken-for-granted processes and relationships, in-depth interviews represent the primary data collection strategy for the project.

During a pilot study that began in October 2012, an interview guide was developed and refined based on the field performance of the questions and participants reactions to the questions. Modifications to the interview instrument included adding a complementary section on physical activity to questions that focused on diet and addressing topics raised by participants in their interviews or questions for the interviewer. Beyond diet, physical activity and health, the revised interview guide allowed for greater

explorations of emotions, social norms and aspirations and racialization/ethnicization processes. Interview guides used for lay participants and key informants are included in Appendix A. While one never intends to ask all of the questions listed in an interview guide, the guide was designed to help study participants recount: a) how diet and physical activity happened in their "home" country, b) how eating and activity happen for them in the U.S., c) what processes are used to negotiate the various factors that help them decide what to eat or how physically active to be as a transnational in the U.S. and when they return home, d) how eating and activity practices may influence and/or be intertwined with their identities and e) how diet and physical activity are connected to health and other social institutions in their lives.

Interviews were conducted with transnational immigrants living in the US and key informants in the U.S and Caribbean in 2015 and 2016. Interviews were audio recorded and transcribed. Interview notes were also taken during or immediately after each participant interaction. Participant interviews ranged from 28 to 97 minutes, totaling more than 16 hours of interviews with a mean interview length of 65.2 minutes. Four participants provided additional materials that were related to stories they shared or answered follow up questions by email. These documents were uploaded into the electronic data file for analysis alongside their interviews. The participant with the shortest interview provided emailed responses to four additional questions, a brief personal biography, as well as referrals to multiple pieces of writing to which she contributed. Some, but not all of her professional work has covered topics similar to those discussed in the interview. Though this interview was shorter than others, an abundance of data were obtained from this participant.

Demographic survey and validated quantitative scales/instruments

In addition to interviews, participants were asked to complete a brief demographic survey and three validated instruments related to the topics to be explored by the study. These quantitative measures will allow the researcher to situate participant responses discursively with other immigrant health literature. Normative data for validated instruments can also help one understand how similar the study sample is to other immigrant samples as one of the future objectives of the researcher is to create new quantitative survey items. A copy of the survey items is included in Appendix A. Survey instruments

consist of demographic, health status and social capital items as well as validated stress and emotional well-being scales. More specifically, the validated instruments administered included: the World Health Organization Five Well-Being Index (WHO-5), the Perceived Stress Scale (PSS-4), and the New Immigrant Survey (NIS) Skin Color Scale. Participants were able to complete the questionnaires in writing or orally with the assistance of an interviewer.

The World Health Organization Five Well-Being Scale (WHO-5) is an internationally validated questionnaire designed to measure subjective well-being from a psychological perspective. WHO-5 was published in 1998 and has been translated into more than 30 languages. A 2015 review of 213 PubMed and PsycINFO studies that used the WHO-5 found the index to be effective in clinical trials, a sensitive and specific screening tool for depression, and deployed across a variety of fields and disciplines (Topp et al. 2015). The brevity and simplicity of administering and scoring the scale are likely responsible for its widespread use. Respondents are asked to describe how each of the five statements corresponds to their well-being over the last 14 days. Answers range from 0 (at no time) to 5 (all of the time); raw item scores are summed and multiplied by 4 to obtain a percentage score where 0 indicates the absence of well-being and 100 indicates maximal well-being. Most relevant for this study WHO-5 scores have been validated as predictive factors of both depression, stress and low social capital (Topp et al. 2015).

The Perceived Stress Scale (PSS-4) was designed to assess levels of perceived stress in community samples using simple wording and general questions. The four items ask respondents to answer based on their thoughts or feelings for the last month. Though initially developed among a population that was younger, more educated and more White than the general U.S. population, the scale has been used extensively in the U.S. and abroad. Scores are obtained by reverse coding two positively coded items and summing responses for all four items. The PSS-4 is useful as a brief measure of stress when respondent time is limited and has been found to be predictive of chronic and event-based stress and health status (Cohen, Kamarck and Mermelstein 1983; Cohen and Williamson 1988).

The New Immigrant Survey (NIS) Skin Color Scale was designed to assess the role of skin color in immigrant experiences by social scientists working on the National Longitudinal Study of

Freshman(Massey et al. 2003). The scale, constructed with the assistance of a graphic designer and meant to be printed for use, ranges from 0 to 10 where 10 represents very dark skin. The scale was intended to be used by interviewers to evaluate participants' skin color (Massey and Martin 2003). Though widely used, the NIS Skin Color Scale has been controversial due to concerns about inter-coder reliability and bias in perceptions of non-Whites' skin color by White interviewers (Hannon and DeFina 2014). For this study, skin color using the scale will be assessed by the interviewer and respondents. Where different scale scores were selected—interviewer and respondent selections were combined using an arithmetic mean. Different scores were selected by respondents and interviewers in two cases.

Anthropometric measures

In order to consider the research findings alongside some physical measures of health status, efforts were made to obtain height and weight for participants. Height was acquired through self-report. Weight was measured using an Ozeri Precision Pro II 440 lb., digital bathroom scale or by self-report for those who declined being weighed. As half of participants completing in person interviews, declined to use the scale in public, self-reported weight measures recorded in survey documents will be used for all participants.

Observations

To gather a broader understanding of how dietary and physical activity practices fit within participants' lives and communities, I conducted observations in frequented locales, Caribbean neighborhoods and markets as well as during Caribbean events and celebrations. Neighborhood and frequented locales observations were conducted in selected neighborhoods of Brooklyn, Queens and Westchester County (New York); and New Haven and Hartford (Connecticut). Specific places e.g. restaurants or stores mentioned by multiple participants were also visited. Neighborhood and community observation locations were refined based on census statistics, field notes, and observation checklists. Observation data includes menus, novels, photographs of health-related message observed on billboards, transportation shelters, train stations, etc. Additional observations were made during four, regional parades and street festivals. Observation time in each location ranged from 20 minutes to seven hours for

an approximate total of 37 hours. Notes from these "community" observations were recorded in a study journal and incorporated into routine memos as part of ongoing data analysis. Professional meetings or conferences on topics ranging from Caribbean health to immigration were also attended in order to immerse myself in relevant discourses of the day. Professional meetings and conferences ranged from 2 hours to 2 days in length.

Extant texts

In order to describe relationships between discussed macro-level and institutional factors and participants' transnational experiences, extant documents and objects were analyzed as texts in order to provide additional context. A pilot study identified media messages; food packaging, grocery stores, markets, restaurants and other food purchase points; information technology, health care systems and providers, food preparation equipment and skills, foods, gardens, neighborhood physical environment and/or economic resources as items that could potentially influence participant practices. Important discourses included those concerning migration, culture, transnationalism, health/healthiness, risk, epidemiology, obesity, physical activity, responsibility, care, taste, pleasure, socialization, acculturation, globalization, sustenance and identity. Determined after initial interviews, thematically relevant material culture and discourses were analyzed for this project. Analyses of extant text were facilitated by completion of an Information/Discourse Analysis Fieldwork Form. Content discussed and presented during professional conferences on non-communicable diseases, migration or acculturation also contribute to this source of data.

Secondary Health and Social Statistics

Finally, in order to situate the research framing and findings within broader public, political and professional concerns about migration and health, secondary data in the form of quantitative health and social statistics may also be sought and referenced throughout the study. Population-based health measures and trends, documented home country social norms and data on migration trajectories are examples of this type of data. Published and grey literatures may be considered given the small and specific population of interest.

Table 4 summarizes the various data sources considered while investigating the research questions of interest. The diverse data collected undergird findings interpreted from participant narratives, the project's primary data source.

Table 4: Summary of Study Data Sources

Selected Data Sources	**Number Completed**
In-depth interviews with Caribbean immigrants	18
Key informant interviews	
U.S. based	3
International	2
Demographic surveys	15
Other Sources	
Neighborhood observations	20
Community events	4
Relevant conferences/professional meetings attended	12

The study culminated with a final sample of eighteen primary participants. Primary participants consisted of Caribbean immigrants living, at least part-time, in the U.S. Three participants met study eligibility criteria, but also presently or previously worked with Caribbean immigrant populations and also served as key informants.

Researcher Embeddedness and Positioning

My training as a researcher interested in qualitative and interpretive methodologies asks that I explore and, where relevant, discuss my own position and experiences as a researcher in relationship to the topics under inquiry. Likewise, Bourdieu's work, in particular, asks researchers to examine the social relations thrust into the frame of inquiry by the presence and actions of the researcher herself (Bourdieu 1980/1990). Reflexive practice helps surface taken for granted social relations that undergird interactions between interviewers/researchers and research participants and allows researchers to place the situated nature of research within the analysis frame (Finlay and Gough 2008). Although some reflections on reflexivity will be presented alongside data findings and interpretations, my relationships with perspective and actual participants and subject-matter experts may impact the implementation of this study.

I am a person of African and other ancestry who is regularly perceived as both U.S. born and foreign-born for a variety of factors including educational privilege, comportment, skin color, accent and languages spoken. Though I possess no Caribbean ancestry, I may be perceived as Caribbean in both the U.S. and abroad; I have lived in the Dominican Republic and on the Caribbean coast of Guatemala. I may also be perceived as being from other regions of the world. My professional career spans public health research, non-governmental organization and program design, evaluation and implementation work in and amongst diverse racial, ethnic and national origin groups from the U.S., Caribbean, Latin America and parts of Africa and Asia. Due to topic of this research project and a demonstrated knowledge of certain customs, phrases and practices; many participants assumed that I was foreign–born or the children of immigrants. These assumptions led to easy rapport in most cases and led some people to share information that they reported never having shared before. One Afro-Trinidadian participant, asked me three times if I was of Indian descent—it is difficult to know if her uncertainty about my heritage influenced her responses. She seemed more comfortable in her responses near the end of the interview and actually continued talking once we stopped recording and walked to a nearby subway station together. As a listener, I sometimes felt like I was learning too much about participants' given the less invasive nature of most of the study questions. Some more intense narratives were emotionally challenging to manage during the course of the interviews without offering physical (hugs) or verbal (words) comfort and silences.

Beyond my individual characteristics, I have been a participant and observer in an academic research center dedicated to studies of health equity (Equity Research and Innovation Center at Yale University) including specific projects focused on Caribbean health status (e.g. the Eastern Caribbean Health Outcomes Research Network (ECHORN)). I have observed center coordinating and administrative meetings since February 2015 and participated in cross-site meetings and conference calls. Participation with ERIC has allowed me to "live and breathe" current conceptualization and challenges related to Caribbean and immigrant health. Several formal and informal key informant discussions and interviews took place around research center staff or meetings.

Finally, in terms of the situation of the research, the areas of inquiry pursued in this research involve important, routine and mundane aspects of people's daily lives. Remembrances offered by participants are necessarily incomplete, but often raised statements of values and beliefs that were related to the more simple actions being described. Research about food has frequently tapped into intimate cultural and emotive meanings (Alkon and Agyeman 2011; Avakian and Haber 2005; Belasco 2008; Biltekoff 2013; Counihan 1999; Cramer, Greene and Walters 2011; Julier 2013). This research has as well; and extended those discursive notions to cover ideas about life, death, belonging, worth, and physical manifestation of social problems by also exploring activity and health.

Research Implementation

Recruitment

For the primary sample, Caribbean immigrants to the U.S. were recruited using community-based outreach, email and internet-based advertisements and referrals from individuals and/or organizations familiar with the target population. Recruitment efforts initially focused on candidates who emigrated from any country in the Caribbean basin region, but later focused on countries represented by multiple respondents. Potential candidates expressing interest in participation were most frequently from Brazil, the Dominican Republic, Jamaica and Trinidad and Tobago. Contact information was taken for Brazilians in case of future expansion of this research program; however only participants from Caribbean islands were included in the sample. Interested parties were screened for eligibility using a screening script in person, by telephone or through email communications. Once eligibility and interest were established, interviews were scheduled for mutually agreed upon times and locations. Interviews were primarily conducted in person in public places such as coffee shops and restaurants; some interviews were conducted by telephone or by Skype. Those who participated remotely were asked to provide a recent photograph for skin color evaluation—photos were immediately deleted after completing the NIS Skin scale.

Key informants were recruited by the researcher based on reviews of the literature and areas in which Caribbean immigrants live; informants were selected due to their familiarity with Caribbean immigrant populations, practices and locales. Key informant interviews were conducted in non-governmental organizations, ethnic retail locations and by telephone. Demographic characteristics of participants are provided in the next chapter.

Although dissertation resources did not allow for foreign travel, additional research in sending countries of the Caribbean would help to differentiate understudied elements of globalization and dynamic change in receiving locations from migration effects. Future Caribbean-based data collection will include interviews with lay individuals, professionals working in health care, in general, and chronic disease care and prevention, in particular and extant documents e.g. health promotion materials.

Consent & Research Participation

Once screened for eligibility and informed about details of the consent and participation processes, consent was obtained, verbally, by the researcher. Participants received a Research Information Sheet describing participation activities and providing contact information for the researcher and ethics committee of the university.

Participants were asked to spend approximately 1.5 hours with the researcher during their initial meeting. These interview appointments included administration of an in-depth interview, demographic survey, validated scales, and anthropometric measurement. The researcher conducted all of the semi-structured interviews based on the interview guide attached as an appendix. Most initial interviews were conducted in person; four interviews were conducted by telephone or Skype. Follow up or clarification interviews were conducted by telephone. When collected, paper forms were placed in an envelope for participant privacy until responses could be entered into electronic databases. Anthropometric measures were recorded on a field collection data sheet, but are not reported here due to incomplete administration. During the initial interview meeting, participants were also invited to refer others to participate.

Interview data were recorded and, later, transcribed and coded. Once transcribed and verified using the audio recording, interviews stored on a computer or university server were deleted. Survey data were linked to interview data using a unique study identification number. Participant contact information (telephone, email, and address, if applicable), interest in shopping observation, and contact information for home country referrals were stored in data files separate from consent forms and the study ID key.

Participants received $20 (gift card or cash) for their participation, as well as entry into a drawing to win an electronic tablet. One person received an electronic tablet. Incentives were provided at the end of the corresponding interview or observation session. For telephonic or web-based interviews, gift cards were mailed (in envelopes or electronically) to participants no later than two days after research participation.

Data Analysis and Synthesis

Qualitative data were managed and analyzed with the assistance of Version 11.2 of NVivo software (2015). As described above, data analyses procedures were largely informed by constructivist grounded theory (Charmaz 2006; Clarke 2005) Analysis of extant data and key informant interviews was continuous and ongoing throughout the research project and began before the first interview. Early qualitative data analysis included memoing, concept mapping, comparative analysis, and content analysis. Early memos addressed anticipated and emergent themes and connections to the literature as well as reflections on the researcher's position relative to the research questions and participants. Coding and other analyses began after the third interview. As initial themes emerged, they were analyzed alongside data from participant observation, extant texts, and/or key informant interviews. Memoing and situational mapping occurred throughout the analysis process in order to provide "contextual" (situational) reference and relational diagrams (Clarke 2005). Summative analysis consisted of: coding, categorization, theoretical sampling, relational mapping, and peer review. Coding procedures drawn from the grounded theory approach included open coding, in vivo coding, focused coding, axial coding and theoretical coding (Charmaz 2006: 45-70). Brief descriptions of these qualitative, analytic tools follow:

- Coding refers to the conceptual naming and categorizing of qualitative data text. For a segment of text, a code should answer the question "what is this about?"
- Categorization refers to the process where qualitative data codes with similarities will be categorized into concepts or themes, and these will be the basis for the construction of a conceptual framework for the study. Categories may be hierarchical, axial, oppositional or otherwise connected.
- Constant comparison means to be engaged in an iterative process of analysis and data collection such that later interviews build on ideas developed in earlier interviews, as well as ongoing monitoring of the overall research process.
- Theoretical sampling and development refers to relying on data collection "driven by concepts derived from the evolving theory and based on concept of 'making comparisons'". This means that sampling and data collection strategies were adapted in order to maximize opportunities to discover variations among concepts and to thoroughly explore categories (Strauss and Corbin 1998).
- Relational mapping refers to organizing themes or topics which have emerged from analyses in ways that describe and explain how those themes connect to each other. I used various visual mapping techniques to test schematic representations of emerging findings at points throughout the analysis process.

In addition to triangulation across data sources, peer review and proxy member checking was used to validate researcher interpretations and theorizing. Peer review methods, in particular, were used to obtain peer input on researcher interpretations, emergent analysis and theory. Per the study aims, analysis focused on social, structural and emotional elements found in the data. The analysis framework developed during the study seeks to advance theorizing about the processes of eating and being active, living transnationally and negotiating diverse health beliefs and health messages.

For the quantitative data obtained from the demographic survey and packet of validated scales, simple descriptive analyses and summary scores were derived before conducting additional quantitative analysis. Analytical variables e.g. categories or typologies for quantitative analysis were generated from qualitative data analyses. Correlations were examined between newly derived variables e.g. migration trajectory that emerged as critical or meaningful based on overall study analysis and existing measures. The small sample size limits the power of any quantitative analysis, so such analyses should simply be considered exploratory. New survey items, proposed for future research, are based on research interpretations of both qualitative and quantitative findings. Quantitative analysis and data explorations were conducted using SPSS and Microsoft Excel software.

Ensuring Research Quality

Qualitative research relies on different measures of quality, validity and reliability. Guba and Lincoln (1994) suggest that qualitative researchers consider the credibility, dependability, confirmability and transferability of their research in order to ensure quality. High research standards may be maintained by considering quality throughout the research process from research design to reporting. Credibility refers to whether or not research findings seem accurate (credible) from the standpoints of the researcher, participants and the research's audience (Bloomberg and Volpe 2012; Creswell 2012). Credibility stems from methodological validity and interpretative validity (Bloomberg and Volpe 2012). The research design intends to efficiently pose and address the research questions; the multi-method and multi-sited design correspond with the current state of related research as well as the types of data needed for the inquiry. Qualitative research training and practice attempt to instill rigor into data collection, analysis and interpretation processes. Guidance from faculty mentors and peers will aid in assuring standards of credibility, authenticity, empirical rigor and integrity.

Primary data were triangulated across data sources as well as alongside relevant secondary data. Two interview transcripts were reviewed by a colleague and proxy member in order to validate codes and themes. Data triangulation and inter-rater reliability checks support rigor, interpretative validity,

dependability and trustworthiness (Bloomberg and Volpe 2012). An audit trail of memos, journal entries, field notes and transcripts will be available to confirm research findings, reduce concerns about researcher bias, and describe the relationships entered into between participants and researcher. Member checks were used recursively (to describe phenomena) and reflexively (to learn from or recast interpretations) throughout the analysis and writing processes (Cho and Trent 2006). In terms of transferability, the next steps of a larger research program would be to test survey or interview items developed from this research on different immigrant populations. The researcher's ability to obtain thick, rich description of the participants and their context contribute to claims of potential transferability or relevance in a similar or extrapolated context (Bloomberg and Volpe 2012).

Chapter 5: Participant Characteristics and Health Conceptions

Demographic Characteristics of the Sample

Life experiences as reported by eighteen study participants comprise the primary source of data discussed in this document. Table 5 summarizes demographic characteristics for participants as well as data captured using written survey forms. Participants hailed from five Caribbean basin nations: the Dominican Republic, Guyana, Jamaica, St. Lucia and Trinidad and Tobago—and the United States. Two participants were born in the U.S., but spent their early years of life living transnationally between the U.S. and another country. As described by several participants, it is fairly common for participants with connections to the U.S. to try to give birth in the U.S., ensuring legal citizenship for the child; and then raise a child in the Caribbean (fulltime or part-time) in order to ensure that they are steeped in Caribbean culture and norms prior to returning to the U.S. to live. The interviewer believes that inclusion of the two U.S. born participants is appropriate given both the complexity of empirically observed transnational living among Caribbean and other immigrant populations and the participants' demonstrated knowledge about the topics under investigation.

Table 5: Participant Demographic Characteristics

Participant Characteristic	n (Percentage) or Mean (S.D.)
General Demographics (N=18)	**n (Percentage)**
National origin	
Dominican Republic	2 (11.1%)
Guyana	1 (5.6%)†
Jamaica	5 (33.3%)
St. Lucia	1 (5.6%)
Trinidad & Tobago	7 (38.9%)§
United States	2 (11.1%)±
	18 (100.0%)
Gender	
Female	12 (66.7%)
Male	5 (26.7%)
Other gender	1 (6.7%)
Instrument-Based Demographics (N=15)	**n (Percentage) or Mean (S.D.)**
Age, range=26-64 years	38.3 years (11.3)
Time since first arrival in U.S., range=6-41 years	23.1 years (10.6)
Most recent trip to home country, range=1month-12 years	3.9 years (4.1)

Participant Characteristic	n (Percentage) or Mean (S.D.)
Self-identified ethnicity (some identified more than one)	(*% mentions*)
African American	1 (5.9%)
African descendant	1 (5.9%)
Afro-Caribbean	2 (11.8%)
Afro-Caribbean/Indo-Caribbean	1 (5.9%)
Asian American and/or Pacific Islander	1 (5.9%)
Black	2 (11.8%)
Black Caribbean	1 (5.9%)
Caribbean	1 (5.9%)
Dominican	1 (5.9%)
Hispanic	1 (5.9%)
Indo-Caribbean or Indo-Caribbean mix (one parent not Caribbean)	2 (11.8%)
Jamaican	3 (17.7%)
US race category typically used	
Do not choose one/leave blank	6 (40.0%)
Black/African American	5 (33.3%)
Other	2 (13.3%)
Asian: Indo-Caribbean	1 (6.7%)
Asian American and Pacific Islander	1 (6.7%)
Black, but not if same as African American	1 (6.7%)
Caucasian	1. (6.7%)
Hispanic/Latino	1 (6.7%)
English as primary language	15 (100.0%)
Second language spoken regularly	6 (33.3%)
Employment at time of survey	
Fulltime	8 (53.3%)
Part-time	3 (20.0%)
Fulltime graduate/ professional student	2 (13.3%)
Unemployed or retired	2 (13.3%)
Frequency of communication to home island	
Once per day or more often	7 (46.7%)
Less than daily to weekly	3 (20.0%)
Less than weekly to monthly	2 (13.3%)
Varies or other time frame	3 (20.0%)
Material remittances	
Send things	6 (40.0%)
Send money	3 (20.0%)
General health status	
Very good	9 (64.3%)
Good	4 (28.6%)
Neither good nor poor	-
Poor	1 (7.1%)
Very poor	-
Educational attainment	
Some college courses beyond high school	2 (13.3%)
Associate's degree or completed two year college/trade program	2 (13.3%)
Bachelor's degree or equivalent	4 (26.7%)
Post-bachelor's courses	1 (6.7%)
Graduate level degree (completed or in progress)	6 (40.0%)

Participant Characteristic	n (Percentage) or Mean (S.D.)
Household income category	
$0-$20,000 per year	2 (14.3%)
$20,001-$40,000 per year	4 (28.6%)
$60,001-$80,000 per year	5 (35.7%)
$80,001-$100,000 per year	2 (14.3%)
$200,001+ per year	1 (7.1%)
Household size	
One	7 (46.7%)
Two	4 (26.7%)
Four or more	4 (26.7%)
Relationship status	
Single or no committed relationship	8 (53.3%)
Married	5 (33.3%)
Partnered/committed relationship	1 (6.7%)
Divorced	1 (6.7%)
Migration category	
Child migrant	7 (46.7%)
Education migrant	5 (33.3%)
Economic migrant	3 (20.0%)
Food insecurity	
Worried household's food would run out before money to buy more	3 (20.0%)
Food ran out and did not have money to get more	2 (13.3%)
Scale Scores	**Mean (S.D.)**
WHO Five Well Being Index, Range: 24%-100%	68.0% (22.3)
Poor psychological well-being (score ≤ 50%)	14.3%
Perceived Stress Scale-4, Range: 1-10	5.0 (3.2)
New Immigrant Survey Skin, Range: 1-9	5.0 (2.7)

[†]This lay participant was born in Guyana of parents from Guyana & Trinidad and raised in Trinidad & Tobago.
[§]This lay participant was born and raised in Trinidad & Tobago though one parent is from Haiti.
[±]These participants were born in the U.S., yet spent time transnationally as children and adults in Jamaica and/or Trinidad & Tobago.

Two-thirds of the participants identified as female, one person identified as both male and female and the remaining participants identified as male (26.7%). National origin and gender were known for all participants; data for other demographic characteristics were captured via survey forms that were not completed by three people interviewed by telephone or on site at a festival or event. As described in the table, survey-based data were obtained for fourteen or fifteen people depending on the item.

Participants ranged in age from 26 to 64 years, with a mean age of 38.3 years. They have spent an average of 23 years in the U.S., as represented by the date of their first arrival in the U.S., and have visited their "home" nation at least once, on average, in the last 3.9 years. Two-thirds of participants return home once or twice per year with participants' most recent trips home ranging from the month prior to the interview to twelve years ago. As participants' relationships in their home country change,

participants' patterns of travel also change. For example, familial deaths, familial migration to the U.S. or Canada and selling of family-owned property resulted in fewer trips home for some participants.

Demonstrating their levels of transnationalism, 66.7 % of participants communicate with their home island weekly or more frequently, with two participants using mobile technology to text or chat with relatives several times per day and 60% send material remittances (money or things) back home. Consistent with study eligibility requirements, all participants used English as a primary language, yet one-third reported routinely using a language other than English, generally Spanish, French, or Creole.

The majority of participants were single (53.3%), worked fulltime (53.3%), and reported household incomes of $60,000 or more (53.3%) which is higher than the U.S. median income of $56,516 in 2015 (Proctor, Semega and Kollar 2016). Although the median income for the Northeast region, where most participants live, was $62,812 for 2015, participants reported income by categories such that the majority (57.1%) reported income corresponding with categories for $60,0001-80,000 per year, $80,001-$100,000 per year or more than $200,000 per year indicating that they are probably earning more than the median income for the region (Proctor, Semega and Kollar 2016). Consonant with these reported income levels, 73.3% of participants had attained a bachelor's degree or higher levels of education including two participants who were currently enrolled in doctoral programs. All participants had completed some education beyond the high school diploma. Nationally, only 32.5% of U.S. residents complete a bachelor's degree or higher; participants are better educated than the general population of Americans and subpopulations such as the foreign-born (Ryan and Bauman 2016).

Participants' relationship with racial identification and U.S. racial categories was a hallmark experience of their transition to living in the U.S (discussed later). The majority of participants also reported having a difficult time choosing and using U.S. categories of race and/or ethnicity, something which was rarely requested or recorded in their home countries. Though the names used by participants varied and a few participants defied using U.S. racial terms, the majority of participants could be described as being of African and/or Asian descent. Participants of Asian descent reported either Indian or Chinese heritage. The two Dominican participants identified as Hispanic/Latino with one describing

himself as "not a black Dominican." Forty percent of participants reported not choosing a racial category on many U.S forms or preferring to indicate Other. One participant who reported indicating "Caucasian" on U.S. forms in order to avoid potential discrimination, described herself as a "Jamaican of African descent, descendant from the Ashanti peoples of Ghana."

Finally, in terms of the specific areas of inquiry in this project, 92.9% of participants reported their general health status as very good or good; only one participant described their health status as poor. A similar proportion (92.8%) of participants reported a relative health status of much better (57.1%) or slightly better (35.7%) than other adults their age. Regarding food practices, 86.7% of participants reported relying on home-cooked meals prepared and eaten at home for the majority their meals, with 73.3% reporting eating traditional foods weekly or more frequently. Twenty percent of participants responded affirmatively to food security screenings indicating that their household may not always have access to sufficient food which is similar to a national, normative sample of caregivers across seven U.S. metropolitan areas (Hager et al. 2010). Similarly, participant well-being scores were not statistically different from normative populations of people completing the WHO-5; thirteen percent of participants demonstrated poor psychological well-being and the sample mean was 17 or 68% (Newnham, Hooke and Page 2010; Topp et al. 2015). Yet, perceived stress scores were higher than normative U.S. population scores (mean: 4.5) and lower than normative U.K. population scores (mean: 6.1) (Cohen and Williamson 1988; Warttig et al. 2013). Thirty-six percent of participants reported moderate to high levels of perceived stress (scores ≥ seven) with scores similar to smokers in other U.S. study populations (Cohen and Lichtenstein 1990; Cohen and Williamson 1988).

In terms of skin color, participants in this study ranged from the lightest scale score (1) to the second darkest scale position (9); the mean skin color recorded was five which is darker than skin color measurements of U.S. immigrant populations, national samples of workers, and Hispanics, but lighter than skin color measurements recorded among U.S. black immigrant groups such as Jamaicans and Haitians in the 2003 New Immigrant Survey (Hersch 2008). Even removing the respondents who identify as Hispanic/Latino and of Asian descent, the remaining study sample (mean: 6.2) is slightly lighter than

black immigrant groups (means: 6.6 female, 7.4 male) previously measured in the U.S. using the NIS Skin Color Scale (Hersch 2008; Hersch 2011). The skin color profile of the sample is of note due to previous findings that lighter skin color may be associated with improved employment prospects and earnings, higher income, higher home ownership and better personal health in the U.S. among immigrant populations (Hersch 2008; Hutchings et al. 2016).

Though the small sample size and lack of variation in some categories prevents appropriate comparisons across variable categories, Table 6 presents select participant characteristics grouped by both migration trajectory and income.

Table 6: Comparisons of Sample by Migration Category & Income Group

Selected Participant Characteristics	**Comparison Groups**			**Total**
	Migration Category (n)			
	Child(ren)	**Education**	**Economic**	
Income group				
Up to $60,00	2	2	2	6
More than $60,000	4	3	1	8
Self-reported health				
Poor-Less than Good	1	0	0	1
Good-Very Good	5	5	3	13
Illnesses reported				
None	2	2	1	5
One or more	4	3	2	9
Time in U.S.				
Less than 10 years	0	2	1	3
10 years and more	6	3	2	11
Traditional food consumption				
Less than weekly	3	1	0	4
Weekly or more often	4	4	3	11
Scale score	**Mean (Standard Deviation)**			**n**
WHO-5	17.7 (5.1)	14.6 (5.8)	21.5 (4.9)	11
Perceived Stress Scale	5.0 (2.9)	6.2 (3.6)	2.0 (1.4)	11
NIS Skin Color Scale	4.6 (2.8)	4.6 (3.2)	6.8 (1.3)	15

	Income Group		
	Up to $60,000	**More than $60,000**	**Total**
Self-reported health			
Poor-Less than Good	1	5	6
Good-Very Good	0	7	7
Illnesses reported			
None	0	5	5
One or more	1	8	9
Time in U.S.			
Less than 10 years	0	3	3
10 years and more	1	10	11
Traditional food consumption			

Selected Participant Characteristics	Comparison Groups		Total
Less than weekly	1	2	3
Weekly or more often	0	11	11
Scale score	**Mean (Standard Deviation)**		**n**
WHO-5	18.8 (5.4)	14.8 (5.4)	11
Perceived Stress Scale	4.2 (3.1)	6.0 (3.4)	11
NIS Skin Color Scale	6.3 (2.4)	4.3 (2.8)	15

Perceived stress scores and educational attainment are negatively correlated with self-reported health. (Statistically significant at p=0.03 in Spearman rho (nonparametric) due to small sample size.) Number of illnesses is also negatively correlated with SRH at the p=0.003 level.

Participant Conceptions of Health

Defining Health

Since the study sought to record quotidian practices related to food/diet, physical activity and health, it is not surprising that health encompassed different meanings for participants and evoked multiple understandings of the relationships between health and expert-validated, risk factors of diet and physical activity. Definitions of health were not readily at hand for most participants, once pondered and articulated, health was frequently related to the concept of lifestyle, but not all participants directly connected health with food, eating, diet, or activity the primary foci of our interviews. Even though activity was not mentioned by all participants as being related to health, participants' ideas about health were very much concerned with bodies and embodied experiences. The next section presents both specific definitions of health as well as the researcher's interpretative understandings of the multiple components that help participants grasp whether or not health exists in their lives. Table 7 presents nine definitions of health expressed in participants' own words. Though there is overlap in these working definitions, each definition emphasizes a slightly different attribute of health and health status as experienced by this sample of transnational Caribbean immigrants

Table 7: Participant Articulated Definitions of Health and their Interpretive Significance

Health Definition	Interpretative Significance
I feel like [health] encompasses a lot of different realms, obviously some totally outside of food. Not necessarily exercise but having an active lifestyle. Also just health care would fall into that in terms of consistently being in a position where you're able to go to the doctor's often, where you're able to get checked out for things. I think it involves all these many different pieces of the puzzle that have to come together and it's a matter of maintaining each one sort of almost individually. You try to stay active and then you also try to plan your meals appropriately and you also try to go to the doctor's and you just try to, like, not push your body any further than you should. So I guess maybe it will all come back to tailoring your body to like what your life is like. Whether that is, if you're working in a corporate environment making sure you're staying extra active because you're probably sitting or standing all day. Things like that." –Marco	Health as individual and effortful juggling of activities in various life domains.
"Being able to withstand like pressure is one way of thinking about it. So if you're physically fit, you feel strong, you can withstand anything that comes. Umm if you're physically fit you are also generally mentally fit, because I feel like you have that direct health and that mind-body connection. If you feel healthy, then your mind is/rests better, I think. And this could be any kind of life stress. [pause] So being healthy is [pause] being able to withstand the pressure of life physically and mentally. Let's put it that way." –Lameshia	Physical and mental ability to endure, manage, and survive various life pressures. Physical resilience bolsters mental resilience.
"Health, I think, just means being conscious that you are probably not well. Being conscious of your body, I'll say. And most people should come to the conclusion that, wow, our bodies are in shambles, even like the relatively healthier ones of us. You get checked up and do artery stuff. It's probably like just the food we consume, you should tell yourself, is killing you, and then you should just automatically be like, "Hey, I'm going to live a better lifestyle, better—eat a cleaner lifestyle. And that's what I think health is, being conscious that you're probably doing it wrong, really researching it and really, really listening to your body and trying to do it better. Yeah. Health is consciously working to make your body better every day. I don't think there's a goal. Health isn't like somewhere you achieve. It's like a lifestyle" –Ramon.	A fatalistic, yet hopeful understanding that our health may be doomed by societal norms and ills like bad food, but we can choose to live with awareness and vigilance to improve things. An end goal of health is illusive.
"Health to me means maintaining a stable weight, um, you know, eating balanced portions, exercising, um, loving yourself, taking care of yourself. All that is health to me. Because if you love yourself, you're going to want to take care of yourself, you know. And also, um, my religious belief also plays a role. Because, you know, your body is the temple of God and you should take care of your body, you know, your temple. So I don't smoke. I never smoked. I drink occasional wine, but I'm not an alcoholic. I don't drink strong, vodka, gin. I don't drink those strong drinks. But, um, I do drink, you know, a glass of wine occasionally. Um, so health to me means doing everything in moderation, you know, um, living an active life as much as you can tolerate." –Happy	Loving oneself and fulfilling one's religious or moral obligations.
"To me, health means everything. Because, um, without your health, you can't enjoy the other stuff that comes for you. Like, um, without health, you can't get wealth." –Paul	Connects health and wealth by establishing health as a basic requirement for being able to pursue or receive other things in life.
"Health means being able to do what we want. The body working, functioning properly without having aches and pains. Eating properly,	Connects health to aging and having bodies that can do what we want without pain.

Health Definition	Interpretative Significance
moderately. And—health? Just being able to, like I said, do things we want to do without the aches and pain, especially as we grow older. You know, everything just seems to break down. I think that should be stopped (laughs).” –Alice	
“Yeah. I want to pass on the importance of like healthy eating and just balance, just, you know, being physically active, eating healthy. I also want to pass on like a love of our traditional foods. What I consider traditional foods—that's huge to me. I try my best to pass those things on by like demonstrating that Mommy exercises, ‘Look, Mommy eats vegetables; we're all going to eat vegetables.’ And not just—I think sometimes too like adults say, "Oh, you need this. You're a kid," but then don't do it. So I try to demonstrate for them so that, you know, it'll be the norm for them.”	Healthy living is part of cultural capital that can be passed down to or cultivated in one’s children.
“I think, you know, some of the basic primary care education we get here, it shouldn't just be for medical professionals. I mean, I think it should be like integrated in high schools. Med school changes your perspective on what you should be eating, and I feel like everybody should know that. Like it shouldn't just be doctors who know these things.” –Denine	Health pursuits may be shaped by and/or limited by knowledge. There may be learned aspects (cultural capital) of health and healthiness that are not always available to everyone.
“So health to me means a life that is, mostly, free of pain or discomfort. It means being active, being able to, um, you know, experience the world. . .taking walks, being in the sun, um, hiking, stuff like that. And also, um, you know, being like conscious of what you eat, but also just taking joy in the things you prepare and sharing them with other people, which is something that's also been really positive about like the change that my family has made over the past few years. You know, when they come to visit, we all cook together. And we talk about what we're making and experiment with different things. So, um, yeah.[health], it's an individual endeavor, but it—I think it's made a lot more positive when you can share it with people.” –Karima	Health is described in very embodied terms i.e. free of pain, walking, etc. The individual pursuit of health may be made more meaningful when shared with others.

As depicted by Marco’s quote in the table above, health was experienced as something to be accomplished in the U.S. In his quote, Marco describes some of the tasks he has embraced in his pursuit of health. Other participants also provide an extensive list of surveilling, pre-emptive, taken-for-granted and reparative actions taken in their considerations of health. Health is presented as effortful achievement rather than a general state of being to which everyone is entitled. Within global health frameworks, health is frequently presented as a basic human right. Moreover, not all participants experienced the effortful pursuit of health as a life-enriching quest; in fact, several participants reluctantly or begrudgingly think about health. As conceptualized in contemporary U.S. society, the pursuit of health seems obsessive and unnecessarily life-degrading—paraphrasing a quote used in the next chapter, vigilance initiated to maintain one’s health sucks vitality out of living. Marco also identifies the variety of potential messages,

sources and domains that one would have to understand and navigate in order to achieve ideal health. Other quotes in the table highlight physical, physiological, psychological and spiritual domains of individual health pursuits. It is of note that many of these personal interpretations of health involve pursuit of an ideal alongside balancing the damage caused by structural/societal ills and one's ability to keep moving forward. Many of the immigrants in this sample hope to create healthy lives, while implicitly conceding something that some won't say out loud—the playing field may not be level. Hope and resilience are the silent lessons that accompany healthy lifestyle practices that most of the parents and grandparents intend to pass on to future generations in their families. Health is recognized in one's ability to withstand life's challenges, propel one's body and mind forward through time and space, enjoy the people and environment one encounters and live in moderation even if one encounters obstacles. Health is much bigger than the potential risk factors of diet and physical activity.

Component Characteristics of Health Pursuits

Based on participants' definitions of health as well as their beliefs about what fosters and/or hinders health in their lives, Table 8 details the variety of attributes of health described by participants. Health, its maintenance and pursuit were viewed as having multifaceted influences as well as resulting from a lot of individual effort and some luck.

Table 8: Component Factors of Participants' Health Understandings

Type of Characteristic	Analytic themes from data
Bodily/physiological	• Weight • Genetic/familial inheritances • Appearance • Bodily integrity and ability • Activity/movement • Energy/energy balance • Age/youthfulness • Stress/pressure/worry • Pain • Beauty/attraction • Sleep

Type of Characteristic	Analytic themes from data
Mind/mental	• Stress levels • Stress elimination or management • Gender relations relief • Adaptability • Spiritual well-being • Mind-body resilience (being able to “get over,” recover, bounce back from life’s ills) • Living life to fullest • Self-sufficiency • Against being labeled unhealthy
Social/relational/interactional	• Comradery/fellowship • Sharing with others/not alone • Familial/multigenerational • Stratified opportunities • Work-life balance • Social and self-surveillance • Image Perceiving the self as healthy; having others perceive you as healthy) • Humor • Survivors • Validated by medical checkups/exams • Tailoring the body to what your life is like
Material	• Simply having any food and other basics of life • Numbers to indicate normal functioning/lab results • Costs associated with health maintenance • Pharmaceutical assistance • Exercise equipment
Behavioral	• Smoking/tobacco use • Alcohol use • Effort • Planning • Choice • Healthy lifestyles • Moderation • Gyms as gatekeepers
Oppositional	• Not sick • No symptoms or episodic illnesses • No problems • Not smoking • No drugs • No hospital • No depression • No discrimination • No allergies • No white rice • No meat • No vaccines
Illness management	• Symptom management of chronic illnesses e.g. asthma, diabetes • Limitation • Government monitoring and intervention • Understanding causes of illness or what worsens illness

Type of Characteristic	Analytic themes from data
Global changes/globalization	• Power of multinational corporations • Changes in diet • Changes in time • Changes in transportation • Changes in diseases • Changes in consumption • Results of having more choices • Changes from old to new ways • Changes in health costs • Global pressure to keep nations healthy • Convergences
Media	• Heuristic devices such as the food pyramid • Diets and food restrictions • Social norms/rules about food and activity • Normal bodies • Dishonest commercials/advertising
Physical activity	• Exercise • Sports • Sitting/sedentary culture • Dance • Soccer • Running • Walking • Martial arts • Being in the sun • Being outside • Being near water
Food	• Good foods = fresh, fruits, vegetables, organic, healthy • Bad foods = fast food, processed, packaged, junk, fried • Nutrition/nutrient risk • Home cooking • Farms/gardens • Dietary restrictions • Limiting salt, oil, sugar, carbs • Balanced diet • Portion sizes • Salads • Over-indulgence • Abundance • Critical lens on some traditional foods • Meal planning
Threats to health	• Time pressures • Stress • Work/employment demands • Everyday life activities to maintain lifestyle • Untrustworthy food industry & colluding governments • Safety and spatial constraints • Internet/electronic devices • Environment • Prejudices/stigma • Fear

Type of Characteristic	Analytic themes from data
Opportunities for health	• Choices • Diverse activities • Online/internet resources • Religions • Stress relief

For most participants, health was experienced as embodied and quite physical; four people explicitly mentioned mental health without prompting. Body weight, body shape and other physical elements of lifestyle were described as elements of health. However, health was most salient in two circumstances: 1) as a physical or physiological resource that allowed participants to work or 2) when illness or sickness emerged. The absence of health increased the salience or visibility of health in one's life, yet only illness which prevented work was taken seriously by most participants across genders. That is, the presence of chronic illnesses or conditions whose symptoms could be managed without much discomfort, that could be treated with pharmaceuticals (for some), and or that could be ignored until conditions or their symptoms became more serious were not really considered illnesses. Given the close relationship between health and physical capability or ability, one wonders about how Caribbean immigrant populations manage the presence of disabling or physically debilitating conditions. Moreover, emphasis on work as a means of fulfilling one's American dream is accompanied by lower levels of concern about or little room to prioritize health. Lower levels of concern are observed in this sample both through their narrative representations and through optimistic reports of health status in spite of the presence of common chronic illnesses like heart disease and asthma.

Food and eating were somewhat related to health through participants conceptions of lifestyles or healthy living; yet, food/eating were not a dominant theme in most considerations of health. The most salient elements of food/eating related to maintaining healthy lifestyles were specific restrictions of salt, cholesterol, fat and/or sugar. Foods or meals themselves were less frequently described as part of healthy lifestyles. To the contrary, "American food" was sometimes described as a threat to health. Describing immigrant food as potentially protective, Lakshmi recounts common ideas from past decades: "The universal feeling was that there was no such thing as American food. The things that Americans ate were

substandard, they were not cooked from scratch, nobody knew what they were doing. And so you had—you know, you really needed to stick to your own food ways for your own health and for, you know, a sense of well-being and so on." Further, through experience with new institutions and norms, participants acquired new thoughts about familiar food objects which recast those objects as risky. For example, packaged or processed foods once eaten in their home country were suddenly regarded with suspicion by many after encountering adulterated ingredient lists not found "at home." Risk and risky objects are critical features of late capitalist societies described by social science theorists such as Beck (1986/1992); Foucault (1978/2007); and Lupton (1999).

When listening to participants talk about both what they believed was expected of them by society as "good people" or "good immigrants" and what they attempted to do, I wondered whether or not this awesome list of possible responsibilities was overwhelming and contributed to occasional expressions of dismissiveness, fatalism or shoulder shrugging. While some participants seemed to share this burden for health with their God, most participants seemed to exist in a place and time where they recognized that the demands of health could never be met, yet some efforts towards health might provide an additional resource upon which one could draw when facing life's challenges. This conceptualization aligns well with arguments about health as savable and exchangeable cultural capital that individuals, in this case, immigrants, can use to help navigate social positions. Adequate physical and mental health are used to acquire material and financial gains which may be exchanged for improved symbolic and social status.

In addition to the complexity of factors comprising health, the majority of participants reported experiencing the demands and requirements of healthy citizenship as new during their adaptation journeys. If the pursuit of health was an important demand of citizens in their home countries, their experiences in the U.S. felt qualitatively different and more burdensome. In particular, participants described new expectations that individuals should use data rather than intuition or experience to direct decisions, and dedicate effort to an aspirational notion of health. A few participants hypothesized that what they were experiencing may be part of the globalization of personal responsibility such that

individuals seemed to bear more responsibility for their life successes and failures than in the past, even though multiple domains influence outcomes such as health including domains which feel outside of individual control. These participants believed that these new expectations were spreading back home as well such that future immigrants from the Caribbean might not experience the same level of culture shock as Denine noted based on a recent trip home: "I think even though I kind of knew the trend, I [thought] there was a difference between Caribbean lifestyles [and their relationship] to health. But I think right now, the world is becoming so one way, whether it's Western or whatever way, I think it's not going to make a difference. . .I think the kids are going to come up for college now are not going to get a lot of culture shock in terms of food, anything. Like I think they're going to do a great transition." Denine reported experiencing quite a bit of culture shock when she arrived, but she now believes that globalization may diminish many of the differences that surprised her. Not only have cultural similarities and exposures increased worldwide, but also Denine continues, "the health problems you see up here and outside [of the Caribbean] have trickled their way home" such that most chronic conditions and cancers are common. A similar shift in burden and responsibility from states and societal institutions including one's designed to protect society such as safety nets to individuals has been ascribed to contemporary capitalist regimes where social investment languishes under economizing schemes that value private return on investment and stratified wealth distribution that preserve the status quo. Participants' observations reveal, in part, what contemporary, global capitalism feels like to ordinary citizens.

Chapter Summary

Taken together, participants' notions of health corresponded with postmodern or poststructuralist views of health as something to be achieved or accomplished through effort and work by the individual. This explication of health meanings reveals the complex juggling act perceived by participants in their pursuit of health. Health was regarded as multifaceted and described as interacting with many systems including: medicine, media, economic, labor, social, political, housing and transportation. While

participants were generally knowledgeable about the ways in which food and physical activity are considered risks across the health professions, participant identified risks to health were more complex.

Figure 3 depicts my general framework for describing the varied actions, practices and levels that collectively comprise immigrant health acculturation or immigrant health adaptation. Elements of this framework will unfold through analyses over the following chapters, yet this basic figure allows one to glimpse how sociological analyses may help advance broader theorizing about the conditions, contingencies and possibilities of immigrant adaptation, particularly as it relates to constructions of health and illness among contemporary citizens/residents living in the U.S. Moreover, as migration and health research has historically privileged economic and legal/political elements of citizenship and immigrant incorporation, my analyses will highlight the role of emotional, sociocultural and structural/societal factors in shaping everyday practices.

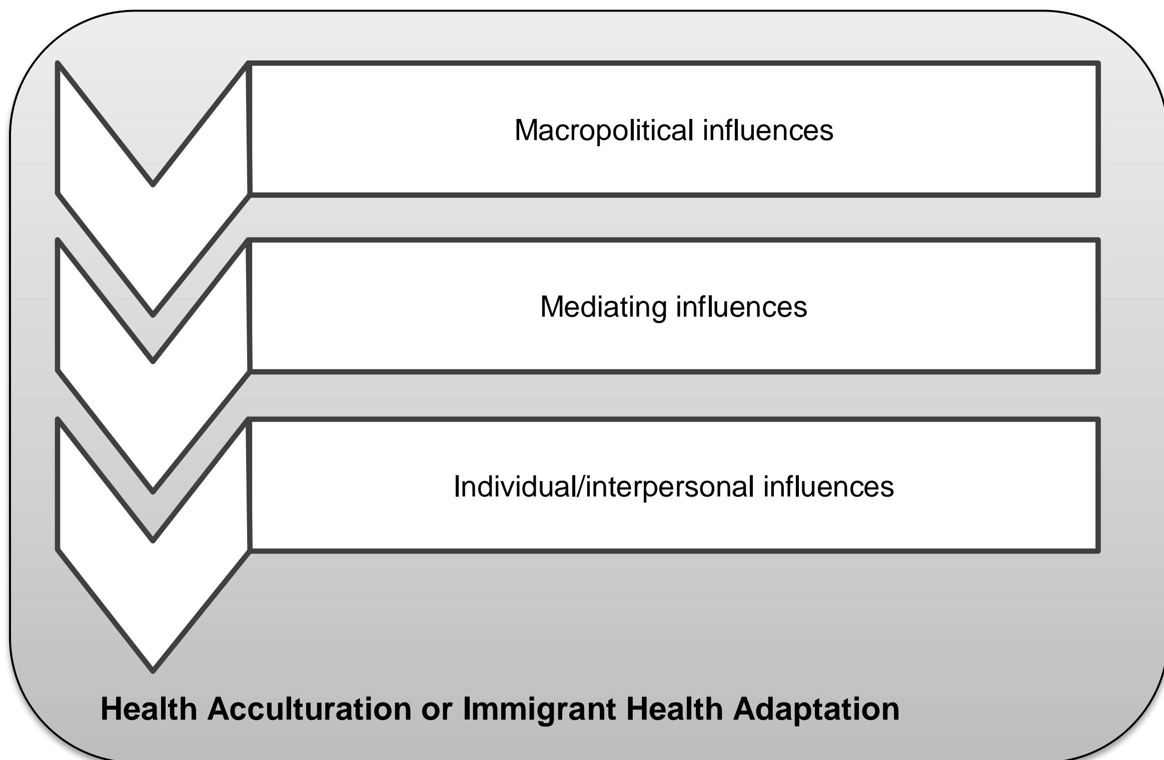

Figure 3: General Health Acculturation Framework

Chapter 6: Emotional Factors Influencing Immigrant Diet, Activity and Health-Related Adaptations

> *"We live somewhere: in a country, in a town in that country, in a neighbourhood in that town, in a building in that street, in an apartment in that building. We have difficulty changing, even if it's only the position of our furniture. Moving house is quite a business. We stay in the same neighbourhood, we miss it if we change. Something extremely serious needs to happen for us to agree to move . . ." (Perec, 1997:71–2). (As quoted in Halfacree, 2004:240)*

Overview of Social Theorizing on Embodied Emotions

Recounting migration and adaptation experiences generated a range of emotions and emotional intensity of varied duration, difficulty and salience. Emotional factors influencing re-establishment of diet, activity and health-related habits are discussed first because emotions are experienced most immediately in the encounter of the interview. Emotions arise from and shape experiences of the body and mind including experiences with illness and wellness. Moreover, the structuring of emotions and "feeling rules" by discourse, power/knowledge, and norms means that people learn to feel in ways specific to their situations with many feeling while simultaneously considering what they should be feeling (Hochschild 1979). Within sociology, emotions have been explored as a means of connecting micro-level practices or acts with macro-level institutions or structures (Hochschild 1998). Within the sociology of health and illness, emotions have been explored most with regard to health care organizations, health care professional, caregivers and chronic illnesses (Bolton 2000; Bondi, Davidson and Smith 2005; Consedine and Moskowitz 2007; Exley and Letherby 2001; Freund 1990; Gale and Sultan 2013; Mark and Mark 2005; Olesen and Bone 1998; Phillips 1996). There is little discussion of emotions in the health promotion literature. A priori, the current research questions and interpretive analysis sought to understand two areas within the sociology of emotions deemed potentially relevant: a) emotion work and emotion management and b) relationships between emotions, embodiment and psychosocial factors associated with various health outcomes in previous research (Bauer 2014; Bendelow and Williams 2002; Consedine and Moskowitz 2007; Freund 1990; Gale and Sultan 2013;

Hochschild 1979; James and Hockey 2007; Williams and Bendelow 1996). These concepts will be reviewed briefly before presentation of the analysis of emotional factors influencing transnational immigrants' health-related practices.

The concept of emotion work, generated by Hochschild, fits well with the identity work and acculturative performances of transnationals. Most influential in this subdiscipline and building on Goffman's dramaturgical approach, Hochschild elaborated concepts of emotion work and emotion management that demonstrate both how emotions, behaviors and cognition are related and how social situations are constantly being remade and re-performed (1979). Emotion management involves manipulation of cognitive and behavioral practices in order to adapt one's relationship to "feeling rules" shaped by social and cultural scripts (Hochschild, 1979). When there is a discrepancy between one's actual emotions and the emotions one is expected to display based on pervasive social norms, one can either seek to align their emotions with feeling rules or change their behaviors in order to better align the emotions experienced with those expected of them. One participant's efforts "to adapt and get used to" eating alone led to emotional and physical discomfort. Lameshia described new "migrant meal buddies" who she believed she developed relationships with based on the sense that they "each miss having people to connect with, especially over food". Drawing parallels between the buddies' social expectations and feeling rules around food/eating, Lameshia further explained their connections by drawing parallels among the climates and social "warmth" of their home countries. She engaged in both cognitive and behavioral practices of emotion management. Like others, she sought to recreate a more familiar social situation so that she could re-experience familiar emotions including comfort, connection and tension relief.

Next, the psychosocial perspective of health inequalities suggests that elements of social life: "a sense of control; perceived social status; strength of affiliations; self-esteem; feelings of ontological insecurity, and so on, lead to variation in health outcomes" (Nettleton, 2005: 59). Moreover, people who experience greater senses of autonomy, social cohesion and social support are better able to respond to stresses, problems and uncertainties (Nettleton, 2005: 59). Since migration, changes in social

circumstances (status, control, cohesion, norms), and changes in diet each induce stress, challenges and uncertainty; medical sociologists could further explore "biographical disruption as a cause of chronic illness" or a potential reversal in Bury's causal chain between illness and disruption (Williams, 2000). While not explored in depth in these interviews, at least one participant indicated the emergence of chronic health problems of unknown etiology which seemed inexplicably linked to her migration experience. Moreover, considerations of emotions as embodied nudge researchers to ask questions articulated by lay experiences: rather than simply studying "unhealthy acts," we may consider indirect connections between unhealthy acts and health outcomes via psychosocial pathways and underdeveloped senses of social cohesion and autonomy after migration-related disruptions.

Participant Emotions

Methodologically, notes on overall and specific emotional expressions during interviews were coded in transcripts, with ten emotion-specific codes and other emotion-related themes emerging during analysis. The ten emotional expressions coded during analysis included: depression or sadness, desire, dislike, distrust, guilt, happiness or joy, comfort, loss, passion, and anger/upset. Table 9 presents some of the relationships between emotions and the core areas of interest: diet, activity and health.

Table 9: Emotions as related to topics under inquiry

Emotions	Relationships to eating	Relationships to health	Relationships to exercise	Other important relationships
• Happiness • Joy • Comfort	• Stems from social gatherings around food • Suitable substitutions • Abundant food • Establishing similar social gatherings • Home cooking • Food	• Gatherings as source of social connection • Gatherings as stress-reducing and problem airing • Humor as part of gatherings • Focus on food present, not what one might eat in the future	• Cultural expression esp. dance • Soccer	• Depends on receiving area • Caribbean social support helpful • Pride
• Fun	• Social gatherings • Establishing similar social gatherings		• Dance • Softball, cricket	
• Dislike, • Displeasure	• Terrible food in institutions	• Emphasis on work over living		• Grow accustomed to eating alone in

Emotions	Relationships to eating	Relationships to health	Relationships to exercise	Other important relationships
• Disgust	(schools) • Dislike of typical US foods • Eating alone • Food experimentation • Health consciousness disrupts enjoyment of food • Food/health vigilance	• Racial profiling by police (potential for violence) • Stress associated with work, racial formation, adaptation, etc.		spite of hate • Discrimination/stereotyping • Employment mistreatment • Wastefulness
• Isolation • Anomie	• Eating alone	• Social networks • Social isolation • Social retreat		• Depends on receiving area • Fear of others/U.S. • Misrecognition (as other groups) • Moral superiority
• Sadness • Depression	• Eating alone • Change in/lack of social gatherings and social ties	• Social isolation • Fear • Mistrust		• Homesick • Miscommunication • Fit • Alcohol use
• Uncertainty • Unknown	• Cooking • Lack of familiar ingredients, supplies and equipment • Food experimentation/substitution	• Science of nutrition • Good food vs. bad food		• Excitement • Fear • Shock/surprise
• Distrust • Mistrust	• Corporate foodstuffs (profits over people) • Health consciousness disrupts enjoyment of food	• Health consciousness disrupts enjoyment of food • Frustration with information/misinformation		• Label reading as type of vigilance • Fear of others/U.S. • Discrimination • Employment mistreatment
• Loss • Nostalgia	• Social gatherings and social ties • Spice • Values & norms			• Bond with other immigrants over absence of type of gatherings • Climate • Consumer culture
• Politeness • Professional courtesy • Sanitization	• Market transactions more smooth	• People don't address weight/fat		• Customer service • Indirect communication favored over direct • Miscommunication • Lack of communication—nodding and smiling)

Emotions	Relationships to eating	Relationships to health	Relationships to exercise	Other important relationships
• Resilience	• Adapting habits	• Value on living for some • Value on accumulation for some • Moral high ground		• Discrimination/stereotyping • Judgement • Tough love • Prioritizing example-setting
• Tough love (emotional reticence of parents)	• Food as proxy for love not expressed in other ways?	• Emotional repression		• Displays of having it together • Resilience?

Emotions related to migration and health exist alongside ordinary, everyday emotions related to work, relationships, etc. Participants appeared most emotional when talking about ritualized aspects of their lives in their home country. Stories of migration and adjustment, generally; and food-related rituals and social gatherings, specifically, generated the largest quantity of and most intense emotional responses. This finding affirms wide ranging academic studies asserting deep and complex ties between emotions and food/eating (Avakian and Haber 2005; Biltekoff 2013; Counihan 1999; Cramer, Greene and Walters 2011; Delormier, Frohlich and Potvin 2009; Dyck and Dossa 2007; Guendelman, Cheryan and Monin 2011; Julier 2013).

Participants' narratives surfaced numerous emotions around food and eating—joy, passion, happiness, frustration, confusion, disgust, resignation, disgust, disapproval, apprehension (see Figure 4)—yet the emotions expressed most intensely and that seemed to invoke the most behavioral and cognitive commitments were those associated with things participants lost in their migrations and were not able to convincingly replace.

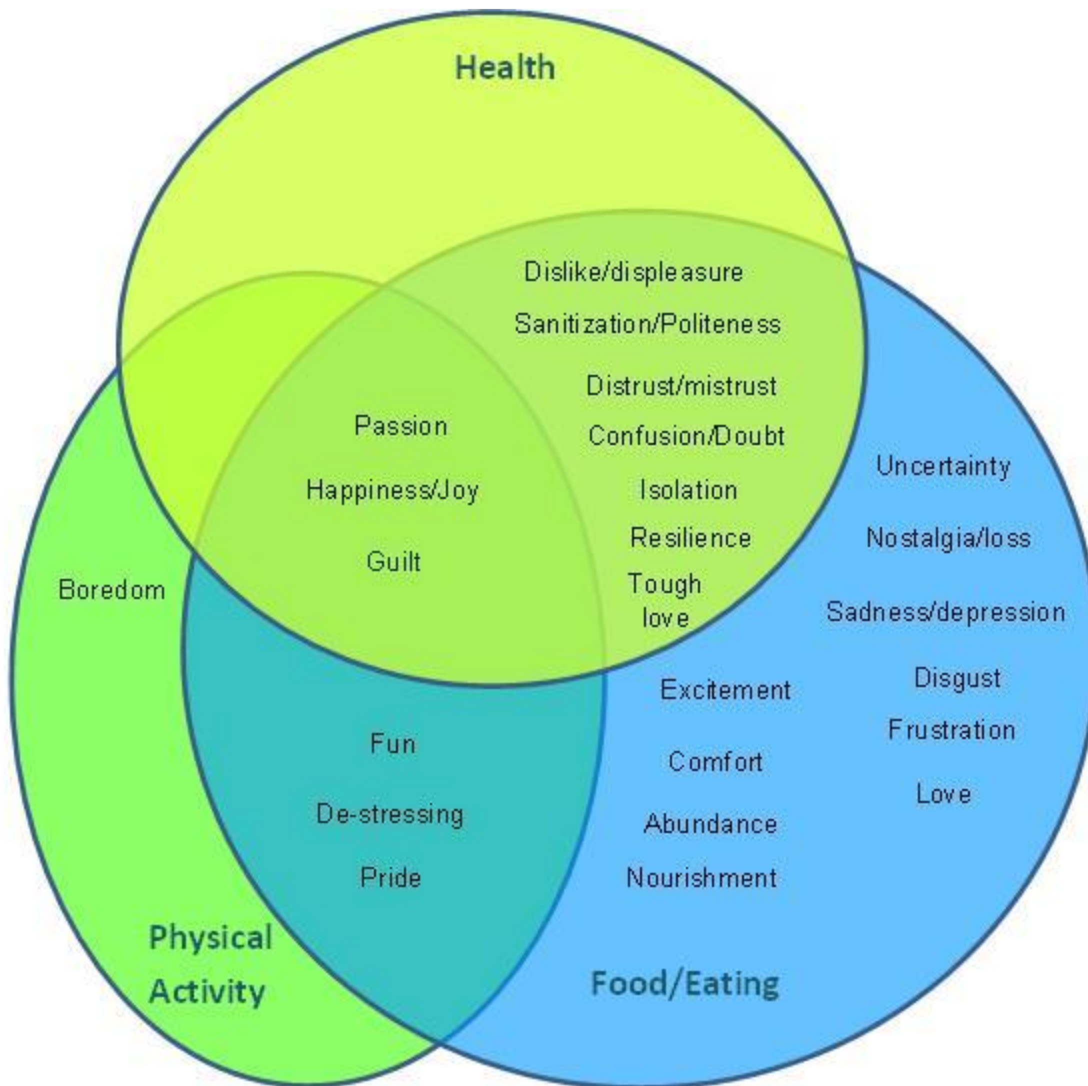

Figure 4: Emotions raised in participant narratives by thematic area

One of many people who told stories about the loss of food-related rituals, Lameshia said, " I feel like, you get so accustomed to being so alone, so I've gotten accustomed to being alone, so it's nothing to eat alone. I just eat alone, but I really hate eating alone because it's like one of the few things that I hate doing alone. I like doing other stuff alone, but it's such a difference when I'm eating with somebody versus not. [Laughs and sighs]. I actually enjoy eating with people." The shift to eating alone or in less social ways was described quite passionately by the majority of participants. It is of note that for this particular participant, the loss she felt was not simply loneliness or isolation; she was engaged in many activities and had many friends in her town. The feelings she expressed were about missing a specific

style of socializing over food and meals and mirrored others' stories. Her narrative continues so that she finds other immigrants from "socially warm" climates with whom to form a supper club.

The loss of food-related rituals and the accompanying social isolation experienced, for some, was frequently discussed. Though the described social isolation was attributed to various factors, it was a common experience that sometimes led to resigned or depressed decision-making when making health-related choices, particularly when participants felt they had limited cooking skills:

> "The very first time [I had to learn to cook], I was probably [resentful]. But after that, it was nice—I realized it was nice to be able to like make stuff on my own and not have to wait for [my roommate] to cook or to say, "Hey, what are we eating for dinner today?" So, yeah, it was a—I don't know, it gave me a sense of like independence as far as like food and like eating." Charlotte

> "I had to learn out of necessity—I couldn't find the things that tasted good to me, so I had to cook or else I don't know what I would have eaten." LizEtta

Learning to cook was largely something that occurred in the U.S. for most participants, augmenting the list of skills that they needed to develop amidst circumstances of change and compressed time.

After loss, the happiness, joy and comfort provided by food, meals and eating was discussed by the majority of participants. Positive emotions were associated with both the embodied feelings of comfort foods helping to physically and psychologically nourish bodies as well as the social connections and warmth situated around and within mealtimes. Here, two participants describe the positive way food connects with their emotions in their home country and current city.

> "It's all happy. [Laughing] I can't think of anything not happy. Yeah, I [laughing] I honestly think it's happiness . . .and there's. We have comfort foods as well. Lentils is something that's a type of comfort food, it's really comforting to have like you. . .it's almost like a staple. Callaloo is another. Doubles is a comfort food. Yeah, it's all happy. You are involved with people most times; you hardly ever eat alone and. . . it's (pause) it's usually, it's usually a happy time. Eating is a very happy thing. Like you have to eat and when you eat you talk to people and you share, you make jokes and then you talk about stress or someone jokes and you laugh to get rid of the stress. Or you come up with really good ideas and stuff over food. . .food and drinks, it's—it's an important part of the society and it's happy. I can't think of a non-happy time with food. Even if it's something you don't like, it doesn't have a bad ending the meal by the time you're done. The meal is good and you eat it." Lameshia

> "If I wake up with enough time I'll go to a coffee shop near my house and get iced coffee. And they make their chocolate croissants fresh in the morning so you can get them when the chocolate is still melty and that's when I know I'm going to have a great day when I get one of those. Yes, this is going to be the best day ever. And I think, If I have this every day this isn't going to go well...But it's so good I can't help it." Marco

On the negative end of the emotion spectrum, participants also expressed frustration with their perceptions of degraded food quality once they moved to the U.S. This degradation was perceived across a variety of geographical settings. Other frequently expressed emotions such as excitement and wonder, referred to abundance, variety and growth of both food and social circumstances. Part of the immigrant, emotional context seemed to be shaped by ideas and elation related to new possibilities, openness and newness that are constitutive of migrating—most participants predicted that their journeys to the U.S. would involve some element of autobiographical recreation and greater freedoms. Participants were impassioned about their stories and experiences and many recounted them with vigor; however, beyond storytelling, passion was reserved for few concepts under inquiry.

For most, passion was directed towards food, social gatherings, and generational transfers of material assets and possessions, and moral/religious beliefs. A few participants were passionate about not assimilating or becoming American. Three participants expressed passion for two different aspects of health: one for the study of medicine and helping others as a doctor; the other two focused on the development of their (male) physical bodies. Overall, concepts related to general health and exercise did not generate the same types of emotional responses as food and eating. Health was rarely discussed in emotional terms. Even discussions of weight, weight gain and weight fluctuation raised minimal emotion expression. In terms of physical activity, dance was most associated with passion—dance was viewed as part of one's Caribbean heritage as noted by Daymond:

> "Growing up in Trinidad, you know, dance was—you know, Trinidad is a party island. . . .You're always dancing, so dancing is in my blood. But I also grew up in Indian dance and Indian culture. And dancing in the Indian culture is very big, the girls dancing. So I want to see the girls and I want to see the girls dancing. And in Trinidad we have this big annual national competition held by a national Indian organization, right? And, uh, more than 100 dance schools enter that competition because the prizes are big. But of course it comes out to one winner. But short of preliminaries and the finals, you get to see a lot, a lot of dance, you know? And even you go to a temple after service on a Sunday, there's

> dance classes going on after service. So I've been exposed to dance my whole life. I love it. So it's my favorite art form."

This participant was unique in that he explicitly connected his passions for cultural food and dance:

> "Just that I love doing it. And you know, for me it's like a dance. When I cook, I have a process I follow. Following the process is like a dance. Right? It makes me happy. It makes me feel better. The endorphins get flowing. So scientifically I am better, you know? So, no, I've never stopped for any reason. You know, I cook for people all the time, too. Recently I cooked for, uh, this volunteer group from my church. A bunch of young people volunteer. And when I see young people volunteering, it makes me happy. And for the most part—as a matter of fact, I don't remember having any negative experiences with regard to food."

Daymond's last sentence well summarizes participants' experiences with food; many narratives included a near verbatim reflection that food experiences were almost always positive. Participants feelings about meals and food became more complicated in the U.S., often due to reductions in social connection and enjoyment, yet opportunities to share food were always described positively even when the food tasted terribly.

Emotion Work among Participants

The emotion work most evident in participant narratives included management of emotions related to being displaced or unsettled, personal and collective emotional work around the construction of family and emotional expressiveness (discussed further below), and ambivalence about discursive, social norms of healthiness, consumerism and a sanitization or formalization of social interactions. First, migration led to multiple emotional shocks and adjustments to living in the U.S. Getting settled into new routines and practices in the U.S. took time and energy. Unanticipated changes related to migration were most difficult to manage emotionally and pragmatically as described by Denine:

> "I think just anything different—I think unexpected cultural changes I think would be always my shock. Like a lot of things I didn't expect to be different. Where like the communication thing [not being understood by fellow English speakers], that was a huge stress for me my first few years because I love to talk. [Laughter] And, um, things like food, like not finding seasoning here was a huge stress—it made every meal miserable."

Disappointments due to institutional or societal gaps between rhetoric and actions required critical adjustments of emotions and emotional responses. For example, participants' understandings of their Caribbean cultures described an expectation that the successful among them appear "together."

Having one's life together is a colloquial concept that bundles many practices enacted through routines and everyday activities: aspiring to a better life, working hard, worshipping God, providing for one's family materially, limiting complaints, and exemplifying a "quick to recover" style of resilience. Many participants struggled to reconcile aspects of their life that were potentially out of balance or that felt emotionally draining with their desire to perform "having *it* together." Participants wanted to have their lives together for their families, loved ones and friends. Those who did not meet expectations could encounter sharp or cruel censures from family members as quotes from Paul and Kim demonstrate:

> "[My parents] see my life as kind of like secure. It's like I've got a job and, um, I'm ambitious. They're like, 'That's what we wanted for you.' Like, you know, they've come to the realization, they're like, 'Look, um, even though you're not doing exactly what you want, but you didn't turn out too bad. Like we don't see you like, um, taking drugs, going crazy, like losing your mind. So you have like a goal, so we're not too mad at you.' It's like, 'We're not too mad.' That's what they tell me, 'We're not too mad at you. So you're not that horrible.' That's what they tell me. They said, "You could have been worse, but you're not that horrible.' That's how they talk to me. It's like tough love. Even though they're strict, but they, they do care." Paul

> "I don't really like talking to people [in my family]—It's okay. If I have nothing to talk about, I'm not—I don't like the chat chat, chit chat. I'm just not—if I have something to talk about, I'll talk to who—but I'm not very—my mind is a little bit, um, beyond the scope of my family members. So I have different views and, you know, so I'm not really considered someone to talk to. So it's all right. Because, because I spoke my mind. I—I'm not supposed to do that. . . My mom was like, at home, she was a bitch at home. Outside, "Woo, Miss.". You know, she was a principal and all this stuff and, you know, went to church and all this. But she was, she was a tyrant. And so when we weren't getting along or I didn't do what she liked I was the problem." Kim

People who were together were considered successful; they also escaped some scrutiny and parental/familial surveillance. Not coincidentally, the value placed on having one's life together fuses well with rhetorical and discursive ideas about what it means to be a "good immigrant". A similar internal pep talk was described when people felt out of sorts—to paraphrase the common narrative: "OK, breathe, now let's get it together, [Insert name here]." The importance of having one's life together resulted in constant surveillance by self and others, adaptation and management of emotions so that one appeared

"together" and frequent dampening of emotions for some. Importantly, ensuring that one's life was together also detracted from other possible expenditures of time and energy for immigrants in this sample e.g. proactively considering one's health. Further, though this may change in time, being or living healthy was rarely perceived as being essential to having one's life together.

Emotional Ambivalence about U.S. Norms around Health

Participants were ambivalent about social norms around healthiness and consumption and reported changes in these norms as being quite stark. First, participants believed that U.S. society places more emphasis on being healthy, feeling healthy and preventing illnesses; yet, many believed that rhetoric, anthropometric measurements and health statistics belie Americans healthful practices and/or expert knowledge about how health might be achieved and maintained. One participant asked if nutrition was a "real" science and several participants referenced changing guidance about health promoting diet and activity habits. Given these reactions, it is of note, that a large proportion of participants and/or their families were exposed to health professions. Caribbean-born nurses and paraprofessionals comprise a significant proportion of the U.S. health care workforce (Aiken 2007; Brush, Sochalski and Berger 2004; Ertel, Berkman and Buxton 2011; Kingma 2007; Pittman, Aiken and Buchan 2007; Stilwell 2004). Many participants attributed disparities between the claimed value of health and health outcomes to American hypocrisy or "trickery"—"liars, liars, liars" one woman exclaimed; many things about the U.S. felt deceitful to her. Similarly, others recalled having similar reactions to revelations about gaps between rhetoric and reality with U.S. beliefs about discrimination, equality, fairness and transparency. Related to food and eating, one third of participants recalled feeling aghast when they realized that the foods and drinks they purchased contained varied and odd ingredients with which they were unfamiliar—

> Lameshia: I think, generally, we were conscious on some level of what we/you put in your body or how much you eat of what, but that never. . .consciousness never really interrupts enjoying food. [Laughing] . . .so, if there's a lot of food around, you eat! You eat everything possible that you can eat. And you enjoy it.
>
> Interviewer: Do you feel like that's different here versus there? That somehow consciousness interrupts enjoying food?

> Lameshia: [Finishing sentence with interviewer] interrupts enjoying food? Yeah. Yes. I feel like it does. And I feel like it does personally though too because. . .I became this label reader. . .so I read every single thing on the label. I never did at home. And why? So what. . .So one of the things that I noticed. Well, one of the first things we all noticed, this was in Miami at school, we noticed how much stuff goes in the food. When you buy. . .I think the first thing we noticed this with was juice, so you buy juice. We would buy the cheap juice. We buy juice and it has all of this stuff inside of it—OK, where's the fruit? [laughing] Which is really different from home because you buy juice. There are all kinds of different ways to get juice. There are juice vendors, you can get juice on the street—it's juiced fruit. Even at the stores you get fruit juice and that's what you expect to get. You can buy these same Minute Maid or whatever juice you get from the U.S. or we have a local or you have Kool-Aid, I think everybody probably has Kool-Aid in their society. Or you have the what do you call the fruit juice in the packs. . the umm. . .the umm. . .concentrate. So, you can buy those too, but they are usually locally produced. So they are juice. Juice you would think it is really simple. There was this eye-opening thing about "Wow! If you can have juice with all of these things, then what are you eating?" So then, we started really paying attention. Sorry, this is when I was in Miami in college. But we really started paying attention to to what's available in the U.S., you know for food. So when you start eating, I feel like when you start thinking about it a lot it always interrupts the enjoyment that you get out of food because, you know, I just started not trusting a lot of stuff in the supermarket, period

Beyond realizing a need for vigilance around reading food labels in the U.S., this quote demonstrates how the joy the used to characterize food and eating has been replaced, at least in part, by vigilance and mistrust due to unfamiliar food production practices and previously unknown dangers lurking in corporate food and drink products. As most participants had family members with farms or were much more aware of their food sources in the Caribbean, the idea that substances other than foods would be added to foods was remarkable. One participant described being shocked by the seven ingredients in her orange juice; back home juice was juice from the fruit, period. Emotionally, some felt misled and more felt disappointed when even "the most basic things" could not be trusted. The quote above represents one of the emerging themes around emotions, dietary context and health vigilance. While related to vigilance and stress concepts common in the social determinants of health literature; these data are interesting because the reasons for the vigilance are often related to both a desire to be healthy, but also mistrust of government and/or corporations.

Feelings about consumer and corporate food perversity and potential duplicity and U.S. exaltation of health combine with other feelings of mistrust from other spheres of life to create wariness,

cautiousness and a sense of social retreat among some participants. In fact, several participants described what sounded like a dampening of their emotional responses due to pervasive dissonance between the words and actions around them. Rather than expect better, the most disappointed participants associated with insular (Caribbean or Asian), social groups and focused on economic and family building tasks. Despite feelings of mistrust and disappointment, participants still ascribed to some ideas about achieving and maintaining one's health (discussed later).

Ambivalence was also expressed about emotional responses to the centrality of consumption in U.S. life and the sanitization of social interactions in the U.S. Although the majority of participants sought some version of an American dream that involved material consumption and accumulation, many were disturbed by excessive materialism in the U.S. when compared to the nations they left. Different terms: materialism, consumption, buying, commercialism—were used to describe a similar perception that consumption of material goods was more highly valued in the U.S. than in their home country. Charlotte pointed out how this difference was particularly stark around Christmas: "I don't know if this is from like growing up or like now as an adult, but the holidays being so sort of commercial here and less family-oriented . . .it just seems a lot more commercial. Definitely less religious, way more commercial. I think even people like in Jamaica who like aren't particularly religious still have a—still sort of value Christmas a little differently, and it just feels a little different when you're there." Yet Ramon viewed contemporary Caribbean consumption as more like the U.S. and this style of consumption as related to worldwide changes of globalization and technological change:

> "Culturally, I think it's all dead. It's all fallen by the wayside, and we're all a consumer culture. And people think, 'If that looks nice, buy it. How much—it's $100? Damn. Put it on layaway. Forget it. I'll just put it on my credit card.' That's the culture that we live in now, and it makes me sick. Nobody even cares about where they come from anymore. People represent because it divides them, not unifies them. Like you're supposed to represent where you're from and do all that stuff, but I think the culture in the Dominican Republic is pretty much the culture from the rest of the Western world. Buy, buy, buy. I mean purchase, purchase, purchase."

While these perspectives may seem quite different, the majority of participants noted transnational differences that have converged over the last decade such that their home countries are less

distinguishable from the U.S. Furthermore, materialism was connected to social isolation for some—people in the U.S. were selfish in ways that valued individual consumption over community building and communal accomplishments. Among more religious participants, this perceived materialism provided another reason to seek similar (Caribbean or immigrant) acquaintances, rather than native ones.

Conversational norms and expectations provided ancillary rationales for seeking Caribbean acquaintances and developing Caribbean social networks. The majority of participants reported Caribbean conversations being more direct and intimate than American ones. Some also described Caribbean comfort with bodies and movement as being "less repressed" than in the U.S. Interestingly, though presented as negative characterizations of U.S. social norms, people who noted these differences between the U.S. and the Caribbean also reported coming to appreciate and enjoy a greater predictability and ease about more indirect U.S. interactions. American interactions, perhaps fittingly for other aspects of US life, were terse, less involved (even if cryptic at times), efficient and required lower levels of emotional and social commitment. Americans were described as being overly polite and having sanitized social interactions. Issues of weight and overweight were identified as health-related examples about which participants found it difficult to have frank and direct conversations in the U.S. Whereas, bluntness about weight, slim to fat, was more common "back home;" across groups, offerings of food to help one "fill out" or "put some meat on their bones" was a gesture of love and familiarity. These food offerings further demonstrate the ineffectual resonance of food when it comes to thoughts about either health or weight.

Although all of the participants expressed some feelings about less group-centered meals and expectations in the U.S and several participants had great difficulty trying to manage their emotions, it is of note that the women interviewed seemed more impacted by the loss/longing than the men. One's age at migration and migration expectation also seemed to result in different processes of adapting to the U.S. emotional culture e.g. people who migrated to the U.S. as very young children (<=5 years of age) had less difficulty identifying and practicing U.S. emotional norms. The intensity with which women expressed their loss and their evocation of "stress" suggests a need for future research consideration of gendered processes of stress-making beyond conventional causes of economics and discrimination. Participant

experiences of and concern about stress aligns with the aforementioned psychosocial approach to social inequalities (Nettleton, 2005: 59). Interestingly, participants who reported more episodes of stress and/or depression reported more physical illnesses; two people with reported illnesses reported stress caused by illness. Participants mostly described stress as related to societal factors, but a few experienced food related stress. Two people described having worse eating habits when stressed like Koko:

> "I'm going to confess I'm a stress eater. When I am stressed, I eat a lot of carbs, I eat a lot of sweets and stuff like that. Especially during the month from December to March. It's a stressful time for me. . .I hate winter and it's very depressing for me, so I tend to eat a lot during that time. I tend to gain a lot of weight during December and March. But I am mindful, you know, once spring hits, it's just like my body just calibrates itself and I just start dropping weight again because it's like the sun is out, I can feel the sun on my skin, I feel better. I go to the gym and I work out two hours a day. I try to do two hours a day."

Whereas a few others described a low level of environmental stress caused by their reactions to corporate food and widespread misinformation about what foods one should eat. Figure 5 highlights two possible indirect pathways between feelings and health conditions as narrated by participants. Rather than simply being an epidemiologic risk factor, these paths demonstrate that diet and eating practices are integrated into actions and reactions embedded within specific social circumstances.

For example, in the case of several participants the loss of meals as arenas for socializing and stress reduction led to less interest in food choice and eating which were followed by to inconsistent dietary selections and less social and physical activity. With fewer familiar and acceptable ways to reduce stress, stress accumulated and was chronologically followed by different illnesses or physical conditions. In their cases, diet and activity existed along their pathways to illness, but did were not necessarily viewed as the cause of illness.

In another example, Kim's divorce and subsequent job loss led to her living under different circumstances. Her poor physical environment fueled social frustration and left her few choices when it came to food and cooking. Decisions about Kim's food were made by government and nonprofit agencies since she felt dependent upon whatever food stuffs she was able to procure with her limited resources. Kim's agency, previously enacted in an organic,

middle-class lifestyle was constrained by present circumstances of poverty. Kim took whatever food she could get for her family and could not count on that food being healthy except for during the summer when farmers' markets honored her food stamps. Kim walks a lot, but she feels like her sons' physical activity is limited by both health conditions such as asthma attributed to their public housing and the range of safe options available in their neighborhood and schools. Her health has deteriorated and she expected that it would continue to do so unless she could change her circumstances. Kim's narrative provides a good illustration of how social and structural vulnerability may be intertwined with health vulnerability. In her case, a decline in social status precipitated health and employment changes that lead to poverty and increasing health challenges for herself and her children.

Finally, though not represented in this figure, remembrances of Caribbean meals (discussed earlier) suggest that food practices can have both positive and negative effects on health even though health surveillance activities disproportionately focus on negative aspects of food consumption. Might future health intervention efforts bolster positive aspects of Caribbean meals in lieu of simplistic "too many carbohydrates" messages?

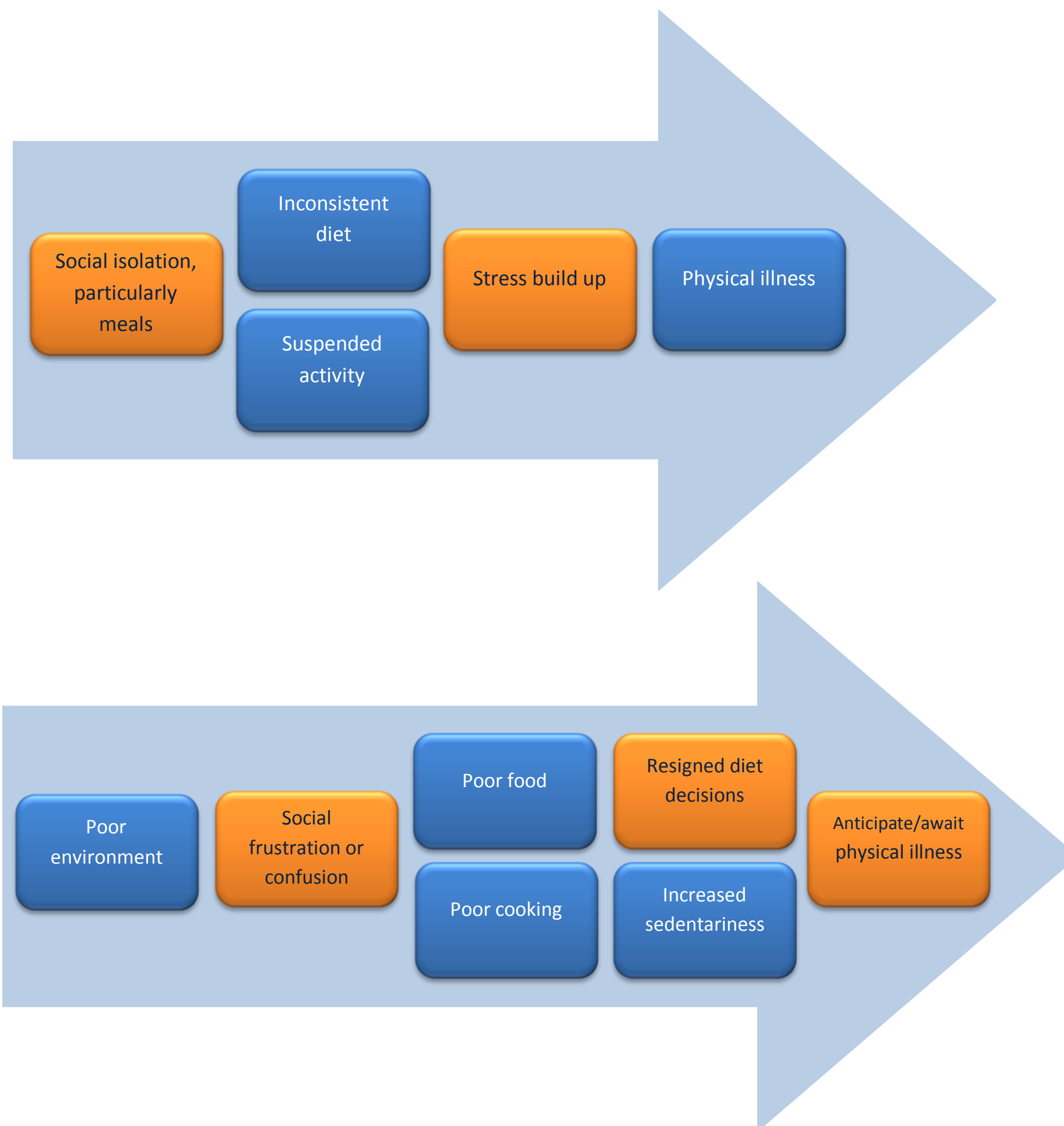

Figure 5: Two potential pathways connecting emotions and illness per participant narratives

Embodied Emotions

Examining participants' emotions through the lens of embodiment reveals different experiences for women and the one "other" gendered person. When speaking of bodies, weight was the most common invocation. Weight was discussed in terms of post-migration weight change, efforts to maintain, lose and

gain weight as well as fluctuations in weight with seasons, pregnancies, and diets. Beyond weight, explicit and implied discussions about bodies were limited to discussions of health and exercise or movement. When defining health and healthiness, participants indirectly described expectations about the capacity of one's physical body and mind to withstand life's demands. When discussing both health and exercise, bodies engaging in dance movements were most frequently discussed.

Highlighting a different facet of embodiment, living in women's bodies seemed to result in different emotional responses to migration and adaptation. Many women—particularly those who migrated for educational purposes—experienced frustration or resentment when having to learn to cook. Most of them did not learn to cook in their youth, when others learned, because their parents set them on an educational path which made studying their priority. Once they arrived in the U.S., often in college, they did not have the skills or know how to prepare the foods that previously nourished them nor transferable cooking skills to easily learn to prepare U.S. meals. Most of these participants eventually learned to cook, but described a period of frustration that stemmed from this role change and their inability to prepare food for themselves. Relatedly, for women who changed social roles from single to married, there may have been more pressure to learn how to cook since cooking was still viewed by most participants as primarily a woman's responsibility within households. In addition to feeling dissatisfied with the initial quality of their cooking, many women reported feeling sad about the lack of social interaction around meals. The reported sadness varied in duration and intensity with social isolation, intermittent melancholy and months-long depression all being reported related to loss of Caribbean family and meal rituals.

Reports by both men and women suggested that alongside conventional gender role expectations, women benefitted from migration in the form of greater social freedoms related to labor and independence. Daymond observed: "on an individual basis, I think women, when they come here and they work, they're more confident than men. And that confidence might give them a little more sense of freedom. . ." New experiences related to greater independence also entailed experiencing new stresses and sources of both contentment and fear. The independence and strength historically expected of Caribbean

women, and immigrant Caribbean women, in particular, when it came to expectations of establishing family foundations may have conditioned specific emotional responses including the eventual emotional blunting mentioned earlier. Overall, women seemed more affected by changes in social habits and routines after migration to the U.S.

Other Emotion-Related Themes

Two other emotional themes emerged in data analysis. First, though not directly related to migration and the reestablishment of routines, many participants addressed dissonance between intrafamilial expressions of emotions and ideas about the prioritization of family even when partial or sequential migration occurs. Many participants talked about being taught and understanding when they were growing up that family was primary—no matter how far away, the people you can trust and the ones you strive for are family. However, as they aged, most expressed some confusion about the subdued emotions expressed by their parents or family members. People defended their parents' love for them, but realized that they had not really learned how to express emotions from their families. As part of their adaptation to the U.S., participants learned more about emotional norms and expectations. Karima described her parents as rare, emotive Caribbean parents:

> "My dad is actually a pretty emotive person. He always told us, you know, "I love you" growing up, and he gave us pet names and stuff. Very affectionate. My mom wasn't quite so affectionate. She was when I was young, and then for a number of years she wasn't, which I think had to do with a lot of stress she was experiencing in her life. And, um, she's kind of opened up again now and our relationship is closer. But, um, some of my friends will say that they have very stoic parents, especially fathers and they don't say 'I love you,' even, you know, to their daughters. . . My close friend here is Jamaican-American. She has this joke, um, that her father will call her, um, under the guise of like asking her where something is in the house to ask her, you know, how she is. Then he'll be like, 'Oh, well, you know, how're you doing?' And then he'll close by saying, 'Oh, you know, your mother and I love all three of our children very much.' And that's the closest he gets to saying "I love you."

Several others mentioned how this brand of "tough love" was sometimes difficult, but the importance of family bonds was understood as important. The importance of family was, in part, demonstrated by: gatherings, food offerings, migration, providing for them materially and multiple sacrifices. Sacrifices consisted of a wide range of actions including living apart from family due to migration, working jobs

beneath one’s education, dealing with workplace and/or housing discrimination, not “rocking the boat,” and social isolation that were all endured in order to improve the material life of oneself or one’s family. In addition to these articulated sacrifices, migration affected families in other ways. Happy noted:

> “So, you know, the family is not as close as—close knit as we were and that's the thing with coming—that's one of the things here. Um, moved—family moved away to different states and then you don't have that bond, that family bond anymore. For example, when I came here, back home in Jamaica, you know, you have children and it really took a village to raise a child and the village really did raise a child because, you know, our parents didn't have to worry about babysitter for us. The neighbors were there and they automatically watched out for us or looked out for us. But here, you don't know your neighbors. You know, I hardly see my neighbors at all. You know, everybody just—you know, occasionally when you're outside, they may wave to you, but you really don't know who your neighbors are so, you know, you really can't ask the neighbors to look out for your child or, "Could I leave my child here for a minute? I've got to go to work or I've got to go." No. And then, you know, the culture and things have changed here in terms of child abuse, you know, so you really can't trust, you know, a lot of people with your children, you know?”

Happy’s quote addresses both changes in familial relations as well as lack of social ties and trust within one’s neighborhood—a change from pre-migration circumstances for most. Emotionally, children felt isolated by their parents’ lack of emotional expressiveness and limited social networks, but also felt supported and motivated to succeed at independence. Participants’ emotional investments focused on dissonance and disappointment which led to resignation and social retreat for some. In lieu of intense, familial, emotional investments, participants reported personal capital investments in material accumulation as a means of providing for family, but also a means of limiting control by governments and other entities through independence. In light of initial experiences of disappointment and dissonance, mistrust of governments and institutions was easily incorporated into participants’ quotidian paradigms; however, most participants believed there was some level of material success that could make one less susceptible to intervention from governments or other institutions. Part of the sacrifice associated with “Western striving” was comprised of expectations and acceptance of family disruption, disappointment and disbelief in institutions, as well as beliefs in oneself/one’s close circle and self-realization. Connecting back to participants’ experiences of losing the social elements of meals and eating, the role of family gatherings may have been amplified in the shadow of limited emotionality such that the loss of the

gatherings after migration was experienced more saliently; perhaps, more so, because food remains a means of expressing both love and cultural pride for many Caribbean families.

Finally, potential, relational connections between disappointment, resignation, emotion management, and the reproduction of status quo social relations are interesting. Since emotions and social relations were not the focus of this inquiry, these connections are speculative, but certainly interesting given sociological evidence about the co-constitutive nature of acts and society. Disappointments about encounters in the U.S., led many people to adjust their emotional expectations so that they would not expect the ideals espoused in the U.S. and they lived with resignation as a more important emotion. Resignation and emotion management, to shift their actual emotions to emotions that were expected of them in the U.S., were accompanied by limiting social interactions and relationships for some participants, as well as abstention from or eschewal of political/civic participation for many. Retreat from non-Caribbean or non-immigrant social life performs social work of reinforcing ideas about stoic and hardworking immigrants who “don’t rock the boat” while also contributing to a reportedly unwanted isolation among those living in non-immigrant or racially diverse neighborhoods.

Among participants of African descent, in particular, their immigrant differentiation sometimes isolated them from African Americans with whom they shared phenotypes, some experiences and history of discrimination and syncretism and, sometimes, neighborhoods.[7] Ambivalence around African Americans led to expressions of both yearning for solidarity and support, but also acceptance of U.S. stereotypes about African Americans as occupying the least desirable social position—social positions unlikely to change without some rocking of boats. The stereotypical social foil of the low African American is recreated through multiple social and emotional processes that contradict the racial equity explicitly valued by most participants. Misrecognition of participants as African Americans was also experienced ambivalently. The misrecognition indicates successful adaptation so that participants don’t stand out, but also potentially classifies one, socially, underneath one’s immigrant aspirations.

[7] It is of note that Caribbeans of non-African descent may also feel comfortable with and seeking solidarity and support from Americans of African descent due to their own countries histories and affinities. This paragraph focuses on the unique tension raised by Afro-Caribbeans themselves about their challenging relationships with African Americans.

Cognitively, most participants said they didn't believe in stereotypes or stereotyping and recalled the pains they experienced from others' stereotyping; yet, their emotional adaptation, social retreat and isolation may help maintain status quo racialization. Status quo racialization processes (to be discussed in Chapter 8) were deemed harmful and challenging by participants of all racial and ethnic backgrounds with participants who described themselves as Black recalling more experiences of discrimination. These relationships warrant further inquiry within sociology given their potential implications for social interactions, social movements and invisible social structures influence on health outcomes. Emotional responses may, symbiotically, be shaped by and serve as building blocks of invisible and intractable social structures that contribute to both health and illness.

Chapter Summary

Participant narratives implicitly portray people who are resilient and adaptive. Individual and familial focus on aspirations and exposure to multinational migration experiences seems to allow participants and their families to embrace and take advantage of the social friction that allows for making a life in various international locales. This facility with adaptation may also engender isolation or truncated social ties and engagement due to the partial similarities that lie under frictious discourse and limited emotional investments. Since friction, previously defined as the grip of awkward connection across difference, is about persistence (or stickiness) in light of potential social clashes, it is of note that most participants view their U.S. belonging with an awkwardness or unsettledness (Tsing 2005). Only a few participants felt comfortable describing themselves as "assimilated;" most viewed themselves as neither assimilated, nor acculturated nor home country nativist, but living between cultures with legal (in most cases) citizenship in the U.S.

Moreover, the mistrust and reticence associated with health promotion and health messaging seems to indicate a partial rejection or at least resistance to the need to achieve or accomplish health in contemporary society. Health is taken for granted with many chronic illnesses and conditions ignored or minimized as long as people can "keep going" or "keep moving." This sentiment about illness raises

questions about how disabling conditions or conditions that limit mobility affect Caribbean immigrants' perceptions of themselves and their health.

Within this sample of Caribbean immigrants, the emotional factors influencing re-establishment of diet, activity and health-related habits included the emotions associated with various actions, emotional reactions to aspects of adaptation, emotion work and management undertaken to both adopt and shield oneself from U.S. social norms, and potential relationships between individual and familial emotions and sociopolitical engagement in immigrants' neighborhoods and communities. Emotions as discussed here are both social actions as well as structures which help set up the field for practices. Emotions are constellations of feelings and experiences that prime individuals' social actions and reactions to the one's environment. Food, rather than activity or general health, generated the most emotion-based content for analysis. This chapter presents the gamut of emotions expressed and described by participants when narrating their migration experiences as well as implicit understandings of the U.S. emotional landscape and researcher interpretation of relationships between emotional and other data.

Loss of the comforting and restorative aspects of mealtimes and eating with others represent a critical forfeiture for most participants. Some participants sought to recreate the emotional and social elements of meals even when there was no expectation that the foods they also missed could be recreated. While participants eventually replaced the foods that were eaten and some of the pleasure associated with sharing meals over time, many felt unable to replace the feeling and sense of stress relief that was formerly associated with meals. Moreover, despite mistrust of various U.S. institutions, values and messages, participants seemed to be quite aware of health promotion efforts to direct people towards healthy foods. Though almost all had made health-related adjustments to their dietary habits e.g. reducing carbohydrate consumption, many were resentful or ambivalent about the potential risk lurking in their conventional foods. One expert's observations corroborate the researcher's perceptions of this ambivalence:

> "I think that there's a tension between how can we give up our food and still maintain health. And the argument that, "We've eaten this way for centuries, for generations. This is not what's making us ill." But of course, you know, just like with African-American

> culture, the foods also were accompanied by very rigorous and strenuous long-term labor, right? So, yeah, you always ate that way and the food didn't make you ill. The food fueled you, but now you're sedentary. Even the translation—even the difference of coming from the Caribbean to here, you're still talking about a more sedentary lifestyle. Because, as you know, the Caribbean people walk around a lot. You know, they take public transportation. You know, it's just different. So I think there's an awareness, but I think there's also a resentment when it comes to a discussion of adapting the way they cook."

And a research conference focused on Caribbean, non-communicable diseases provided a similar story about tensions between food and health, when food is a primary expression of love:

> "One of our delegations from the project, the Puerto Rico delegation, actually is looking at childhood obesity. And one of the things that became very clear through that project is that one of the emotions is love, right? We tend to show love through food. So we don't say, "I love you," necessarily. I mean this is now paraphrasing their findings. You don't say love. You show love, right? So I know that my niece is coming. I know she loves curry goat. So I will make sure I make curry goat for her when she comes, and that is my expression in a very sort of physical way of how I think of you and how I feel about you. We also express that love through sort of overeating, right? Like, "Eat more," or not chastising around it. "Oh, it's all right. Let them eat," right?

Caribbean immigrants are struggling with tensions between rational messages that tell them to give up traditional foods e.g. rice and plantains and eat less, while also *feeling* a need for more support, comfort and love traditionally provided over meals with family and friends. In addition to deep, historical, emotional and cultural ties with food, early experiences of distrust with the representation of foods and drinks in the U.S. stoke immigrant doubt about the trustworthiness of ever-evolving, pronouncements about things that are healthy or unhealthy. When U.S. food seems disgusting or flavorless, immigrants are uncertain about what to eat and how much changing their habits really matters. Being able to innovate by building upon some of the now missing positive elements of Caribbean foodways might go a long ways to restoring emotional balance, improving intrafamilial relations, reducing social isolation and attenuating some of the risk ascribed to everyday dietary practices.

The findings presented here affirm potential theoretical and empirical contributions of research focused on potential psychosocial pathways to health inequalities as well as further research on emotions, embodiment and emotion work among immigrant populations, generally,

and related to processes of norm negotiation and social retreat or engagement within receiving communities stratified by racial and class formations. Diet and activity are more than unhealthy acts under study, but represent complex bundles of emotions, understandings, and embodiment which contribute to both health-affirming and health degrading pathways or processes of aging.

Chapter 7: Sociocultural Influences on Immigrant Diet, Activity and Health

Sociocultural Influences on Health-Related Adaptations

While the social determinants of health framework used by WHO and other health researchers draws attention to the social, contextual factors that shape and predate health, analysis of the influences affecting adaptation practices of the immigrant participants seeks to parse various elements of social life including social stratification and use narrative experiences to interpretatively consider relationships between such factors. While sociocultural and structural factors might both be described as social factors within the SDH framework, the following analyses draws on sociological discrimination of social factors into meso-level, family and group factors (identified as sociocultural factors in this paper) and broader, societal factors (identified as structural factors in this paper and discussed in the following chapter) in order to discuss the relevance of social layers and potentially diverse spheres of action culminating in everyday practices. This chapter presents analyses of interactional, familial and group level factors which appear salient to participants' reconstructions of everyday routines and practices as part of their adaption to U.S. life. After introducing the importance of food and eating to participants' lives, the chapter considers three types of sociocultural factors which influence diet, physical activity, and health maintenance practices.

Food as Central to Life

Food was identified as central to Caribbean life by almost all participants. Both historically and discursively, it has long been established that food serves critical practical and symbolic functions in human life (Avakian and Haber 2005; Counihan 1999; Cramer, Greene and Walters 2011; Delormier, Frohlich and Potvin 2009; Julier 2013). Although participants have spent different amounts of time in the U.S. and expressed varying levels of comfort and familiarity with U.S. life, they unanimously believed that food was more important and more central to life in the Caribbean when compared to the U.S. Participants identified food as a major part of national and ancestral cultures, everyday nourishment and

practice, and the social infrastructure for connecting the past, present and future through people, crops (products of the earth) and recipes (know-how with ingredients). Even among people with difficult familial relationships, food and eating are also very intertwined with notions of family and home.

> "It's always been a much deeper connection to eating meals when we've been over there then when we moved over here. . . But me and my whole family, we're all really into food and it's a huge joining factor between all of us. And especially when we're down there we'll make a trip to go out together and buy everything together and cook it together and it becomes this huge family thing rather than just one person being the person cooking everything and putting it out for everyone." (Marco)

The narratives of other participants were similar: "Meal time was definitely like sharing more, joking, you know, catching up on like what other family members were doing back in Jamaica or elsewhere." (Charlotte); "Cooking is such a way of life for us; I have like family secret recipes for cakes and hot sauce and sweet breads and pies." (Koko) Simply echoing the social nature of food and eating practices, Lameshia's words well summarize what was heard across participants, "food is like joy; food is shared and meant to be shared."

Food and eating were described as central to social life and related to one's emotional life (discussed in the previous chapter). Most, but not all participants, fervently rejected a more utilitarian characterization of foods and eating practices. In fact, the imbrication of food into multiple aspects of one's life as well as various practices and habits that typically call for eating at least once daily suggests that food, eating practices and, over time, diet and eating routines are intricately intertwined with participants notions of sustenance, health and adaptation. These entanglements are well represented by one participant's use of cooking and eating practices to reflect the evolving nature of her Caribbean-American identity where changes were sometimes realized outside of her consciousness.

> So when people start to say to you in the United States, 'Oh, well, you don't sound Jamaican,' it causes this dissonance of, 'Wait a minute. Like, I still very much identify with this place, but now I'm losing it [the place].' And it's a very scary thing. And I don't know if immigrants have different almost like crises points, right? So it's almost like a midlife crisis where you realize, 'Oh my gosh, I've been here 15 years now, and that wasn't the original plan,' right? 'That wasn't the original plan, and now I'm morphing into this other thing with or without my intention, right? Like, I'm morphing into this other thing.'

This thing that LizEtta feared becoming, at least surreptitiously, was American. She also went on to describe how any cooking skills she learned, proactively, since her undergraduate arrival in the U.S. were eroding due to her status as a single woman without children. Further reflecting the shared and social nature of Caribbean cooking and eating, she believes that most Jamaican dishes are "not suitable" to be made for one person.

In spite of voluminous ideas about the importance and centrality of food to their lives and their cultures, participant narratives revealed numerous contextual factors that helped shaped their overall eating and activity practices as well as their ideas about how these practices were related to their health. In general, participant narratives described several domains which seemed relevant for the shaping of quotidian practices related to diet and activity: family life, migration trajectory including time in the country and anticipation skill (both prior to migration, but also post migration in terms of aspirations), belonging and citizenship, logistics/pragmatics and know-how. These domains depart from, but overlap with conventional migration metrics of language, intermarriage and time in country; briefly discussed in turn.

As most participants spoke English prior to their migration, language was not perceived as a barrier to migration or reception despite accent discrimination being mentioned. One's time in the country is a measure of time which simplifies the more complicated migration trajectories conceptualized here. Migration trajectory (explored later) includes one's reasons for migrating and expectations, one's anticipated path once one moved to the U.S., and one's temporal experiences of migration and adaptation. Most participants had clear ideas about what should be accomplished in their migration stories whether their aims were obtaining a college degree and work experience in the U.S. before returning home or making a new life in the U.S. Lastly, findings suggest that marriage is only one of the important relationships which may shape one's health-related practices and measures. While partners were important in several narratives related to the re-establishment of eating and activity practices; the presence of children seemed more relevant for this population. This finding raises the need for empirical testing of the importance of a marital partner over children as an indicator of acculturative practices and behaviors.

In most cases, adults yielded to children's desire to fit in with their peers and adjusted the entire family's diet based on the preferences of their children. Children learned what was desirable, acceptable or normal through school lunch and other social interactions. Stories conveyed by Koko and Lakshmi discuss this phenomenon from different vantage points. Koko described how she tried a product that her toddler son was drawn to based on advertising: "And my son—he was getting into the whole how they were marketing the food and advertising of the food. And my son was like, 'I want to try it. I want that.' So I tried." Her experiment with boxed macaroni and cheese was unsuccessful and resulted in her having food thrown at her. Her son, a toddler, didn't like the product once he tasted it and preferred her home-cooked, Caribbean style macaroni and cheese. Lakshmi described the role of children in influencing family diets based on her understanding of common immigrant youth experiences:

> "[B]elieve it or not, the most influential factor in this tends to be children. So you have school children, they go to school. It's kind of like my—my—a good friend's son is on—I don't know if you've ever seen the show *Fresh Off the Boat*. So the child that plays Eddie—Hudson—his father is a friend of mine. And even before that show, we used to joke about that famous line from that show, 'I need white people's lunch.' *[Laughter]* Because that is essentially the—you know, obviously they're Chinese. I'm, you know, Trinidadian and Iranian. But, nonetheless, that was the experience that we had as the children of immigrants. 'I need white people food,' because you can't roll up in here with curried goat and roti and not have every other kid in the—on the—at the table thinking, 'What the hell is that?' So I think that is the main influencing factor of what's acceptable and appropriate is, you know, for immigrants who have children and the children come back and say you know, 'Other people don't eat this. I can't eat this.'"

She further described how children are delivering these messages of U.S. health acculturation bidirectionally "saying things like that you can't eat this grease-laden food, and the children coming back and saying, you know, 'You shouldn't be putting so much coconut oil,' and, 'you know, you can't eat so much starch' and, you know, white carbohydrates. . .them coming back and saying, 'We eat too much white rice.'" Representative of many participant stories where people came to the U.S. as children or raised children in the U.S. (irrespective of their birth location), these stories highlight the importance of children and children's observations and social relationships in reshaping familial practices and norms around food, eating and health. These stories also highlight U.S. refiguring of Caribbean foods through the lens of health. The potential tension or conflict created by this family dynamic is less obvious, but of

great interest given descriptions of Caribbean norms that leave limited space for children's ideas and perspectives. In the words of Kim, "You don't listen to your children in the Jamaican culture. You, um—it doesn't matter what age you are. You are seen and not heard." The practice of using children's food preferences to guide familial choices may operate counter to other intergenerational norms.

The following analyses of sociocultural factors illuminate the complexity of adaptation processes while also identifying sub-processes which have been obscured by opaque discourses of acculturation. Individuals are part of families and communities; they develop specific ways of being based on pragmatism, their personal skills/know-how, perceptions of what is expected in the U.S. and dynamic health consciousness shaped by observations in the U.S. and back home. One element of participants' perceptions of what is expected in the U.S. had to do with coming to grips with a different racial formation structure in the U.S. than encountered elsewhere. Racial formation, to be discussed more in Chapter 8, complicated the relationships, affinities, physical and social proximity of many participants; while establishing invisible, yet knowable aversions for others e.g. not wanting to be like African Americans. The desire for social distance from African Americans was further complicated by youth, young adult, and second generation, hip hop affinities among both Afro-Caribbean and Indo-Caribbean participants' families and networks.

Specifically, immigrant eating and activity practices appear to have been shaped by three types of sociocultural factors with processual steps or stages identified across four adaptation processes. Figure 6 graphically depicts the researcher's interpretation of the collective experiences of study participants as they described their lives and adaptations to living in the United States, particularly as it relates to practices around eating and physical activity.

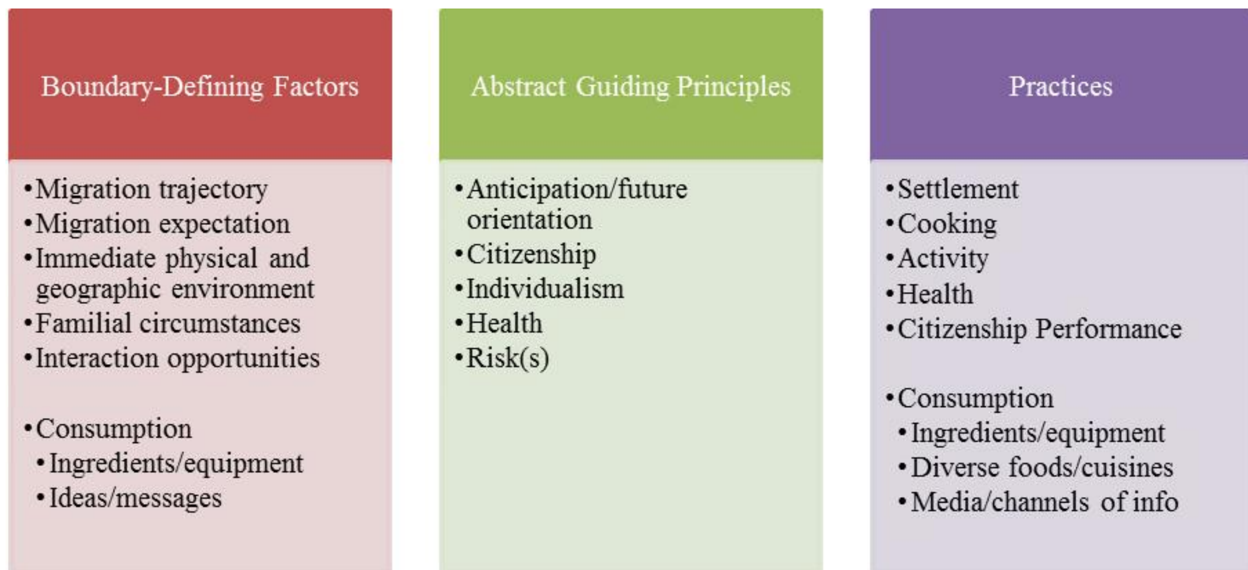

Figure 6: Sociocultural factors influencing health, diet and physical activity

Sociocultural factors identified included limiting or boundary-setting factors, abstract guiding principles and practices. The four adaptation processes most salient at the sociocultural level are related to settlement, cooking, social citizenship, and health realization. Most of the processes describe relationships between mediating and individual factors as organized by my Immigrant Health Acculturation Framework (see Figures 3 & 11).

Limiting or Boundary-Setting Factors

First, participant narratives revealed several factors which helped define the boundaries within which they perceived their opportunity set for migrating and adapting to life in the U.S. including their practices related to health acculturation. While the existence of these boundaries may be debated in other sociological projects, most participants presented salient outlines for how understood their lives to be once they decided to migrate to the U.S. The specific bounding factors varied across participants; yet similarities were observed in both the types of factors described as well as the function of the factors in establishing initial parameters for one's life in a new country. These boundary-setting factors comprised the symbolic limits within which immigrants' new lives would be made. The permeability of these boundaries varies, but each of these factors drew a line beyond where social movement would be

challenging or undesirable. For example, participants less interested in returning to their home country more deliberately shed old eating habits in favor of diets more reflective of U.S. abundance and diverse cuisines as a means of breaking with their past:

> "Where else could I get Thai, sushi, Italian or Chinese any night?" (Lameshia)

> "I intended to make a life here. I did not want to go back to Trinidad—I didn't know what I was coming to, but I knew it would be better than what I had over there. But, again, that was just a fleeting thought as I came through. Didn't know how I was going to make that happen, you know? Not—it wasn't a goal, but it's just that, "I didn't want to come back there." (Alice)

Rather than immigrant agency being constrained by factors encountered in the U.S., attitudes about their adaptation were also shaped by the knowledge that returning home was either undesirable or impossible depending on the circumstances under which they left. Participants' adaptations were shaped by migration trajectories, migration expectations, familial circumstances, interpersonal interaction opportunities and consumption. While some of these factors were pre-determined prior to one's moving to the U.S., other factors emerged based on one's environment, experiences and resources once living in the U.S. Among the factors shaping one's adaptations to living in the U.S, phases of physical or geographical settlement or residency were also discussed.

Physical and geographical settlement conditions included whether or not one was moving to join relatives, moving to an enclave or area with identifiable Caribbean populations, geographic proximity to both the Caribbean and cities where many people of Caribbean descent reside, type of neighborhood and housing type. Many participants also expressed an interest in being able to eventually move to a home that they owned and that was on land where they could have a small garden and that was more suburban, than urban in character. Land, gardens and lower density housing reminded most participants of their home country and agricultural heritage. These elements were not discussed in detail, yet described as instrumental in helping to outline immigrants' adaptation journeys. Physical and geographic factors are also discussed in the chapter on structural factors influencing immigrant health adaptations since spatial considerations can be experienced as both immediate/intimate and grand in scale.

Migration trajectories, a term generated during this research, draws upon Warde's (2005) descriptions of practice trajectories. Migration trajectories refer to specific pathways of migration based on one's reasons for migrating as well as patterns of living related to one's anticipated social position. Within the current sample, specific migration trajectories have been theorized for migrations related to education, economics and successful progeny. Beyond merely describing one's reasons for migrating, a trajectory describes a migration career that begins with one's reasons for migrating, includes pathways for learning and adapting and ends with one's perspective on their migration and citizenship. One's migration trajectory seems to help shape or structure practices related to adaptation in both collective and individual ways. For example, immigrants on an education trajectory socialize with other immigrants on a similar trajectory, reinforcing one another's views about the social world and how one may navigate her new environs. In my data, participants on education trajectories differed from those on economic or successful progeny trajectories; and one's trajectory informed ideas and practices related to eating, activity and health. In Charlotte's case, her mother moved to the U.S. in order to improve her children's life chances:

> "it was more like more of a push to be well-educated. Like, school is everything. You need to do well in school. You need to excel. So that was always the message. So, you know, when it came time to apply to college, it's funny because my mom—my mom and my dad aren't college educated. My mom is a diploma-trained nurse. And so but she—I definitely—there was no question. And even though she hadn't gone through that process herself, it was like, okay, that is the logical—that's the next step. Yeah, it was never a question. But, yeah, definitely the expectation was that you would like, you know, go for—"Do more than I did."

Table 10 describes some of the similarities found among people sharing migration trajectories. It is of note that the presence of children in a household seemed influential across trajectories.

Table 10: Exemplar adaptation patterns observed based on migration trajectory ideal types

Trajectory Type	Education Trajectory	Economic Trajectory	Successful Progeny Trajectory
Description	Migration to the U.S. driven, primarily, by individual interest in obtaining a college or advanced degree or better educational opportunities than found in one's home country.	Migration to the U.S. driven by economic or financial gains for oneself or one's family.	Migration to the U.S. driven by parental or familial interest in better educational and employment opportunities for one's children than found in one's home country.
Home Country Class Origins	Typically from middle class or better class backgrounds as defined in their home country.	From working and middle class backgrounds as defined in their home country.	From working and middle class backgrounds as defined in their home country.
Journey to the U.S.	Moved to U.S. alone and typically knowing where they would be taking classes	May have moved to the U.S. alone or with other family members.	Parents accompanied by children who move at critical stages of development or learning for their children; or so that children have time to establish themselves in the U.S. in order to do better than their parents.
Characteristics of initial immigration period	Initial periods governed by school-sponsored visas.	Initial periods may be marked by working as many jobs as possible and saving money for improved housing in the U.S. and back home.	Initial period may be marked by family separations and instability
Aspirations and interests upon arrival in the U.S.	More interest in returning to home country.	Material accumulation emphasized within home. Interest in achieving financial and familial goals. May return to home country under proper circumstances. Interest in outward expressions of U.S. success e.g. building home in home country.	Education and material accumulation emphasized within home. Interest in becoming as American as possible without losing Caribbean identity. Only expect to make temporary visits to home country.

Important institutional arrangements related to Caribbean immigrants' migration trajectories include high numbers of relatives in the U.S. or in other developed nations e.g. Canada; significant labor histories in certain categories of employment and home country selection processes which favor the international mobility of skilled, working class and middle class individuals over the poor. Fitting with global migration patterns, the wealthiest Caribbeans rarely give up their home country status and exist among a class of global elites who may spend time in multiple countries.

Migration trajectories help shape and bound adaptation periods and may merit further exploration in future migration and health research. While this effort was not focused on elaborating migrant trajectories, plausible trajectories have been created based on my interpretation of available data. If trajectories are influential on immigrant health and practices adaptation, future research might focus on better characterizing the trajectories.

In a similar manner, migration expectations, limit one's ideas about how and whether one should adapt or acculturate. Migration expectations describe one's perspectives on what they believed the U.S. to be like before migrating as well as one's understanding of how they might be incorporated into society once they migrated. Migration expectations ranged from those expecting to live in the U.S. for a short time to those who migrated with no expectation of returning to their home country. Moreover, some of the stress described in participants stories of migration and adaptation is caused by their efforts to reconcile gaps between their expectations and the realities of living in the U.S. As described earlier in the text, Denine struggled with the taste of foods and building relationships when she realized that many people could not understand her variety of English. Furthermore, demonstrating the potential physical ramifications of adaptation-related stress, Koko's described disdain for U.S. emphasis on work as exemplified by her quote comparing three countries she has lived in—Trinidad, the U.S. and Italy—and describing a stress-related health scare:

> "West Indians, West Caribbean folks is like, 'Everything irie, man. Just laid back and smooth sailing,' you know? But in America, as you wake up in the morning, meetings, phones, you got to get this done, work, work, work, work, work, work, work. You know, back home, they shut things down. You have half an hour for lunch here? You getting an hour for lunch, two hours for lunch. In Italy, shut it down three whole hours. You come back, you have your siesta, sleep, go home, come back, and you work from 5:00 till 11:00. . .You can imagine they shutting down work for three hours in the day over here? No. You know, they relax and they take time off. And work is—it's—you need work so you can survive, but they're about living. We need to live here!. . .I got a scare a couple months ago when I was working in the school system. I would work from 7:30 to 2:00 and then come here [to a business she started] from 3:00 to 11:00, 12:00, 1:00. And I did that for two years and I almost passed out at a job one day. And I had to go to the doctor and they were like, "What's going on?" how much hours are you working?" And I was like, "I'm working six hours—six days a week." And they're like, "Okay, you got to quit your job." I was like, "Well, I'm not quitting [my organization]." So I realized that I needed to slow down."

Another source of stress in adapting to living in the U.S. is related to immigrants' family circumstances. Meals are central to Caribbean life; analogously meals are central to family life and are described as important times for family gathering and relationship building. While family as an influencing factor may seem obvious, the role and structure of family in shaping one's migration and adaptation has been less studied than other factors and is generally reduced to variables of marriage or intermarriage in survey research. In this research, families were transnational and lived transnationally for short or long periods of time based on their circumstances. Family life is critical in determining one's everyday practices and routines including those related to diet and physical activity. While participants' partnerships or partnership aspirations seemed relevant in their descriptions of their adaptation processes, the presence of children in the home seemed critically important. For example, Koko described how her husband nudged along her cooking and eating adaptation under U.S. circumstances: "my husband said, 'Listen, you got to, you know, get with the program. You have to learn to cook, you know, for two days.' And I didn't know how to do that." Her husband's ideas about familial cooking factored in new demands on their time and resources as parents in the U.S. where cooking was no longer simply for joy and sharing. Yet, as Koko's earlier account with her toddler demonstrated, she viewed her children's as an even more influential factor in her changing dietary habits. Koko journeyed from housewife to chef to community leader emphasizing the importance of both quality foods and easy family nutrition for children who may grow up in single-parent households; she started a nonprofit that teaches youth to cook (and cater) with an interest in relieving some stress for working moms in a working class town of Connecticut. Participants, like Koko, noted changing the household diet, practices and activity modeling based on the presence of children. It is of note that the presence of children in households has rarely been included in studies of health and migration. Beyond partners and children, tensions with family members remaining in the Caribbean were also described as factors related to social interactions, eating and stress.

Similar to family circumstances, one's opportunities for interpersonal or social interactions seemed to outline additional contours for one's adaptation processes. As food and eating were almost unanimously connected to social dimensions of life among participants and food was overwhelmingly

viewed as something that was “meant to be shared,” specific adaptation processes and practices including emotional reactions were frequently described as being dependent upon one’s set of social opportunities. These social opportunities included the types of people available for participants to interact with, time available to socialize and affective or emotional responses to misalignments between one’s desires or expectations and lived realities of eating and engaging in physical activity in the U.S. Many of the participants described efforts to recreate social, rather than material, elements of Caribbean eating and activity with varying degrees of success—

> I have found that when I eat with friends it’s more fun. And I have found some friends to eat with. Ironically, they are all from different umm [laughing] a different part of the world. I mean—other countries, (voice saddens a bit) but it’s not regular. Only recently, and I mean really recently (speaking more enthusiastically), I started eating regularly with one of my friends from Brazil. She’s from a part of Brazil which is very similar to Trinidad in climate. So it’s similar and it’s like we’re sisters, so it’s nice. It’s like when we first met, it was that kind of feeling, like ‘Oh my God, I’m so happy I met you.’ So, we both, we’ve been spending a lot more time together, and we eat together. So, we meet for lunch. . .And we’ve been trying to do this weekly meeting to eat together thing and it’s been really comforting. We talk about all of stress in school, ‘cause we’re all in PhD and you know, all the stresses with doing research, life, dealing with the advisor, dealing with this. . .It’s nice; it’s really, really nice. Even last night, she came over for dinner. That was fun. I hardly ever have people home. [Laugh.] Well, I have a really small studio, so that’s one of the reasons that I can’t invite people, but it was so, it was such a difference. And I didn’t eat lunch, so dinner was sort of like the lunch. So it was nice to have somebody. . .to have somebody to hang out with. . .Yeah, since I’ve been to Utah, I feel like and overall I spend more time alone. There are a few people, I would go and eat with apart from these new people but it wasn’t consistent. These new friends have been really consistent since we’ve met. And a lot of it is because we miss. . .we each miss having people to connect with [pause] especially over food. [Giggle].” (Lameshia)

> She was like a big sister. So, yeah, we would eat [together]. Sometimes we'd have friends over and like eat together. growing up, she cooked—she was the eldest, and so she cooked for—and her mom like was a LPN or something like that. But she would have—she had the responsibility of cooking for her siblings, so she was used to like cooking. I just started cooking and wasn't used to cooking large amounts of food. She was, so I'd say often enough—probably at least once a week we had friends over and we'd just kind of sit and eat together. (Charlotte describing eating with another Caribbean-born person she befriended in college)

Effort placed on ameliorating the social aspects of eating and being active seemed critical, in part, due to the unexpected nature of the life change. Most participants expected that the actual foods, spices, equipment, etc. used in cooking and eating in the Caribbean would change in the U.S., but did not

anticipate such drastic differences in normative behaviors that surround things like pre-packaged foods, eating collectively, making sacred time for eating and family, eating on the go/in the car and eating alone. Eating alone was mentioned by many participants as a big change and seems well described by Lameshia.

> "Eating on a regular basis is very much alone. I spend a lot of time eating alone. Umm. I feel like. . .But, I have found some spaces. Ok let me think about this, what's different? The main difference is that I eat alone and I sometime eat while I'm working, but I generally try to keep that separate. So I maintained that. Umm. Well, I spend a lot of time eating along. [pause] I. . .The first time I ever went out alone to eat was when I came to Utah. I mean like I actually went out to eat at a restaurant and I was alone. I was like, 'Whoa this is different, this is really different.' [Laughter] Like I didn't know what to do. I was actually thinking, 'Well, maybe I should have brought a book to read.' [Laughs.] I was confused. I didn't know what to do. I was looking at my phone. I was playing around with my phone. I talked to my parents on the phone like umm. Like I was like I'm attached to my phone. It was really weird. [Laughing, then pause.] But I got accustomed to doing it. I do it, but I don't [pause]. . .umm. . .it's really interesting. I was talking to one of my friends about this like for the full time that I've been here. Apart from being in grad school which is a kind of like a lonely, very much a lonely process, lone endeavor or pursuit, apart from being in Utah, OK, there's no Caribbean people, [Both Lameshia and I laugh.]. . .there's no "family" I have alone meals. Umm. But I feel like, you get so accustomed to being so alone, so I've gotten accustomed to being alone, so it's nothing to eat alone. I just eat alone, but I really hate eating alone because it's like one of the few things that I hate doing alone." (Lameshia)

In order to counter some of these changes, re-establishment of Sunday dinners, also routinely observed by some U.S.-born families and individuals, served as a place and time of cultural respite and rejuvenation for many. Caribbean Sunday dinners also simultaneously served as a venue to collectively test and evolve strategies and hybridized rituals for living and eating in the U.S. Koko describes her Trinidadian-born and Brooklyn-raised, husband's Sunday dinner:

> He has 11 brothers and sisters but, you know, he grew up with seven of them, and that was something important. Every Sunday, they sat down at the dinner table for breakfast and they would stay there till late hours of the day. So when I came—you know, I came from a small family. It's just me and my brother, my mom and dad, and my dad always used to be working and my mom worked a lot. So we would be home and then on the weekends or in the evening times we would have dinner. But he had this huge family and they all stayed together—basically at one point forced me to sit at a table and eat, because I would go and sit away from the table. He said, "No, you got to sit down and eat." And I used to cry because it was just like so constricting to me, until I realize how important it was to—for our kids to have that family time. So I really appreciate him doing that, because it was difficult. . .After a while, it was difficult to sit down at the table all day. Because you ate, you get up and go do your work, you know? And he's sitting down and talking and chatting. I was like, 'I got to go wash the clothes. I got to go clean the house. I got to go wash the dishes.'

Koko had no interest in the leisurely Sunday dinner described by many other participants, but came to appreciate the value such dinners held for her children as well as how the dinners helped keep a large family together. Despite similar national origin backgrounds, Koko and her husband brought different familial traditions to the U.S. Koko's family lived more agriculturally and operated a food business, so she thought there was always too much work to have leisurely meals, but believed in being fully present and enjoying food at meals. LizEtta also described Sundays as being a symbolic means of celebrating the abundance that has befallen many Caribbean immigrants to the U.S. by returning to pleasures of multiple island dishes and the specialness of social time for one afternoon each week. She described all Sunday dinners and social events like baby showers as having "far too much" food prepared in traditional ways e.g. grating carrots by hand for carrot juice.

Consumption appears to be the final boundary-defining factor evoked in participant narratives. Sociologically, consumption refers to processes where social actors agents engage in appropriation and appreciation, whether for utilitarian, expressive or contemplative purposes, of goods, services, performances, information or ambience, whether purchased or not, over which the agent has some degree of discretion. Therefore, consumption is not simply a practice but, rather, processes present in moments across every practice" (Warde 2005). Under contemporary capitalist regimes, we are ever consuming or contemplating objects for consumption. This analysis includes material, ideological and discursive forms of consumption—consumption is much larger than buying products in social spaces.

While each of the limiting factors identified contributes to the structure of one's adaptation processes, consumption serves both demarcation and practical functions for participants. Consumption is both generative in that marketing and consuming objects generates new wants; and responsive since consuming some types of objects fills agents' desires, wants and voids. Figure 7 depicts relationships between some of the more commonly described items consumed by participants noting whether concepts are involved in adaptation practices as boundary-setting factors, practices or some combination of the two; since the theme re-emerges in findings related to practices used to achieve or maintain health.

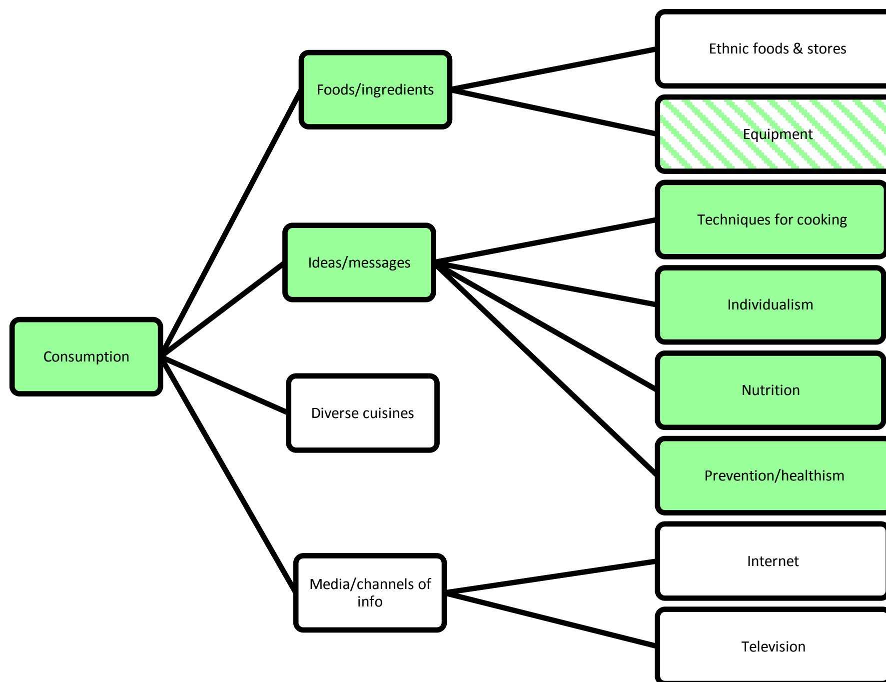

Figure 7: Excerpt of analysis schematic on consumption, related ideas and practices.
In this figure, green indicates boundary-setting factors and white indicates practices.

Consumption related to foods, ingredients, equipment and information are prominent among diet and activity related practices. Furthermore, ideological and discursive consumption operate like boundary-setting factors describing or scripting possibilities for adjustment and adaptation. The most important ideas and messages related to eating and activity adaptation include highly mediated notions of cooking techniques/know-how and individualism as well as more global notions of nutrition and healthism. Consumption of cooking techniques and know-how parallel the rise of the Food Network, competitive and instructional cooking shows and blogs and the expansion of culinary retail outlets. However, imperatives to use "tools of the trade" to prepare one's meal (which may have been previously prepared without such tools) are aspirational marketing appeals to enhance cooking pleasure. The aspirational messages that accompany many of these items as well as some ethnic food products convey "the good life." This good life is part of the American dream that many participants sought when they began their migration journeys.

Findings from this research support my hypothesis that core-periphery ideas about health and disease are not necessarily easily distinguishable. Many participants talked about changes within their home countries over the last five to ten years that have been marked by the global convergence of population-level, disease transitions; diffusion of diet and activity practices as well as greater public awareness of health, risk reduction, and prevention.

> "I don't remember anything. I can't recall growing up. Since I've been home [in the last few years] though, I'm not sure if it's my consciousness about food or health overall since I've been in the states or if it's the government making a more concerted effort to make a connection between food and health because we have this growing incidence of chronic diseases [in Trinidad] and there's been major food campaigns. No, not food, but health and food campaigns to get children in schools to eat healthier and umm and a lot of that is recent to me. Because I don't remember having that exposure or having that much exposure to that when I was in school or even when I was working at home [before graduate school]. . . I've been home on two different occasions within those five years. And since I've been home, I feel like there are a lot more. Oh you know, what the main health message is that's been standard, smoking. 'Don't smoke!'. But that's that's that's everywhere, but I feel like there's been more, more campaigns about eating fruits and vegetables. Literally. I am not joking. I found it so strange that there are these campaigns, I was like OK because Trinidadians eat a lot of fruit and vegetables. [Laughing]. . . that's what we eat fruits and vegetables. There are fruits every. There is a new fruit season nearly every or every I don't know, every quarter few weeks. There's always a new season. People eat a lot of fruits and veggies. People go to markets every Saturday; that's like a given. So, I didn't really understand the context of that message, but from what my friends are telling me, our diets have changed significantly. . .because we have a lot more multinational places, food places." (Lameshia)

> "You actually see a lot of NCD ads now. Like this ad about, um, chronic inflammation and heart disease that comes on every morning, which surprises me. I was shocked the first time I saw it." (Denine)

More importantly, for the aims of this research, some participants described possessing specific ideas about health maintenance or health attainment that were acquired prior to their moving to the U.S. This finding provides evidence of dynamic and more universal, global ideologies about health and risk, departing from models of migration that suggest that immigrants are 'injected' with U.S. ideas about nutrition, diet, health and activity upon migration. Although knowledge and recitation of nutrition and prevention ideas were common; health and its connection to risk factors of diet and activity were minimally salient in the everyday lives of immigrants in the study. Health, despite being described in terms of accomplishment or achievement, remained fairly abstract in its relationship to eating and

activity (or lack thereof), although risk reduction and tradition were both identified as part of one’s calculus in adapting one’s everyday practices and lifestyle for U.S living.

Abstract Guiding Principles

Health is one of five abstract guiding principles considered when immigrants made decisions related to diet and physical activity. Unlike the boundary-defining factors, the abstract guiding principles identified in the narratives functioned as less rigid compasses of one’s social perceptions, behaviors and activities. Rather than defining parameters, these principles provide loose frameworks for guiding one’s actions and symbolic resources to which immigrants may turn while redefining practices and re-establishing routines. Some of these factors were aspirational. The abstract guiding principles identified were: anticipation/future orientation, social dimensions of citizenship, individualism, basic health and risks to U.S living and establishment.

Although only a few participants explicitly described their ability to plan for the future as a strength resulting from their Caribbean experience, their words were corroborated by others’ descriptions of the importance of being able to anticipate and plan as critical for successful transitions to U.S. society. In fact, several participants believed that this learned skill provided them with an advantage over both U.S.-born individuals and children of immigrants:

> Well, the Trinis in particular and some of the Guyanese saying that Americans are stupid and don't have common sense. And for the most part—They're right. I don't know what happens with the education system here, that a person can become an adult and not have certain basic knowledge. You know what I mean? Or not act based on that knowledge, if they have it. You know? So, in that sense, I say yes, a lack of common sense. And common sense for me is general knowledge and habits everybody should have. Right? Because everybody has it, it's common. But for some reason that's lacking. in the youth—and I'm talking about Indo-Caribbean youth who grew up here. Whether they were born here or born in the Caribbean, when they grow up here, they lack that. And I'm talking specifically about the Indo-Caribbean community. But I've seen it applied to all communities where the youth grow up here in America. White, black, everybody, there's a general lack of common sense. . . And forward thinking is another thing I don't see a lot of. You know, if I'm heading out to here, I'm looking to see which do I have to use or which hand I have the use. So by the time I get to the door, I know what I'm doing. A lot of people you see they'll walk up to the door and they push one door or the other and they don't know what they're doing because there's no forward thinking. I'm always forward thinking. And the folks who grew up in the community, they learn that.

> In the Caribbean, sorry, they learn that forward thinking from their parents and everybody because the parents do it. I don't see that here. (Daymond)

Being able to think one or two steps ahead helped people improvise and adapt, improving their social mobility and eventual attainment of legal citizenship status if desired. Further, embracing discourses about U.S. rule of law and bureaucracy concerning political citizenship, participants perceived clear pathways to legal citizenship; many had family members who were already U.S. citizens. Only one person expressed uncertainty about her prospect for legal citizenship.

Highlighting distinctions between political and social citizenship, many participants rejected the perceived individualism of U.S. society. However, this U.S. norm was strategically valued and employed when participants wanted to pursue more individualistic pursuits for themselves:

> "I think that Americans are much freer. You know, they're more liberal. I don't know how you would put it. . .I came here on the advice of a girlfriend and entered cosmetology school because they sponsored my visa. I quit after two days and found a business school to go to and back my visa. That cosmetology school was not for me—it seemed like a good plan when I told my Dad I was moving to the States." (Alice)

U.S. individualism provides a creative opening for many immigrants to explore facets of themselves and life that they may have felt uncertain about pursuing on their home island. Like Alice, many participants looked forward to being able to step away from their families a little bit in order to become more their own person. Individualism was viewed as non-Caribbean and affirmatively American, but as a value that might bolster adaptation and immigrant success, particularly for women: "On an individual basis, I think women, when they come here and they work, they're more confident than men. And that confidence might give them a little more sense of freedom and less pressure than men. But, uh, for the most part, I think it's the same pressure." (Daymond)

Existing as a powerful and salient archetype among participants, successful immigrant or good immigrant discourses guided many participant actions. When re-establishing everyday routines related to diet and physical activity, concerns with the realization or accomplishment of health were only salient when health and risks potentially endangered participant pursuits of their American dream. Among participants, achieving success once in the U.S. was critical for day-to-day and long term survival in the

U.S. as well as preservation or enhancement of social standing in one's home country. In Charlotte's words "I think folks look back—at like family or friends back home and they're like—of course you're expected to come here and like do really well, you know, at whatever cost. Like, you need to succeed. You need to—you know. . .you need to." Daymond believed that the desire to succeed was brought with immigrants from their home country, especially in the case of the Indo-Caribbean communities from which he believed many Caribbean entrepreneurs emerged: "Like it is in the Caribbean, you know, you live in the neighborhood with nice concrete houses and yours is a wood house. At some point, you want to rebuild it. It's similar. You see a neighbor putting up a nice fancy fence. You want a nice fancy fence. It's similar here. You know, that underlying competitiveness. What do they call it here? Be like Joe or Johnson or something?" The expression Daymond was looking for was "keeping up with the Joneses." This competitive drive was deemed an important value by many with numerous social and "start-up" costs being worth the effort to succeed and accumulate wealth in the U.S.

> I think, you know, you migrate here for like opportunity, so I think the natural thing to do is like—and because you're afforded more opportunities, you take advantage—I think sometimes we take advantage of too many opportunities. And so, you know, you have some people working two jobs because they're like, "Oh, yeah, you can make great money doing this and then nighttime you can do this, too." So I know a lot of families that did that. And I don't know if it's necessarily because they needed it to put food on the table. I think it was just like, "Oh yeah, we can—you know—it's more. We can have more." And less attention to I think quality of life. Because I don't know that many people are doing that in Jamaica. But then the opportunities really aren't there. If you have one job, you're lucky. So I think, yeah, they definitely take advantage of like every opportunity that comes their way, or more than one opportunity at a time." (Charlotte)

Though not experienced much among this sample of participants, staggered or step migration where parents leave children behind and bring them to U.S. later was discussed and considered relatively common among participants' social networks and Caribbean populations, more broadly (Smith, Lalonde and Johnson 2004; Suårez-Orozco, Todorova and Louie 2002; Zentgraf and Chinchilla 2012). Suårez-Orozco, Todorova and Louie (2002) found that 85% of immigrant adolescents in their random sample of Boston and San Francisco school youth had been separated from both of their parents for an extended period of time during migration. Participants characterized this type of migration as parents sacrificing their time and relationships with their children in order to provide a better material life.

Finally, despite mention of excessive discursive connections made between diet, physical activity and health in media and popular culture, many participants reluctantly admitted that they rarely considered health when making decisions about eating or being sedentary. Physical activity, however, was inspired by historical activity, focused efforts on weight loss or maintenance, or periodic health kicks—so health was frequently considered when making activity decisions. Health, as narrated by participants, was well characterized by one carnival-goers words when she asked what I was researching: "Well there's the health that helps us work, work hard, and the health that we lose when something bad happens like cancer—I don't really think about it most of the time" (Caribbean Festival Caribbean Festival Attendee 2015). From this perspective, health is a general resource which allows one to take advantage of opportunities for labor and investment—a baseline that helps one fulfill their migration mission. The only other time health becomes truly salient for many is when health is lost—the absence or decline of health raises health to the level of everyday consideration. Participants' routines were largely constructed based on time, financial and food resources, and cooking know-how. Moreover, as discussed in Chapter 6, many participants were most interested in restoring social and emotional elements of diet and activity habits, so less attention may have been paid to the potential health ramifications of specific diet and activity choices. "Even when the [American] food was bad," Lameshia said, "we enjoyed it together." Her simple sentence demonstrates the salience of togetherness over the specific nature of the food. The low quotidian salience of health was anticipated based on previous work and research among immigrant populations; however, this disconnect of consciousness between expert-defined health behaviors and health should be concerning to those attempting to better understand factors influencing health or improve population health. Health promotion or risk reduction interventions frequently target diet and activity practices as distal causes of poor health.

Risk, in general, and risks to one's health, in particular, were also discussed in abstract and somewhat dismissive ways. Many participants were most troubled by potential threats to their immigrant success story or American dream rather than risks to their health. The described risks to immigrant success were largely structural or societal in nature e.g. employment and political trends or

discrimination; however, awareness about potential threats to success was something that remained on many participants' minds. Several participants were mistrustful of food producers and government regulations around food and mentioned potential risks to their health caused by poor food quality. Many were surprised and disheartened by corporate practices that were allowed in food production, but typically dismissed problems at corporate or government levels as problems "beyond their control." For example, people did not like the misinformation conveyed in food marketing efforts; yet believed that producers and government regulators would continue to allow it. This sentiment is fueled in part due to ideas about political and civic participation and nonparticipation brought from the Caribbean (as discussed more in the next chapter). Further, while many participants worried about the potential long term consequences of poor quality or unsafe food, only two participants described relying on this perspective when making decisions about their own dietary practices. This pattern supports public health research distinctions between knowledge and acts of decision-making. Alongside common acceptance of U.S. exceptionalism in the region, a handful of participants highlighted emerging equivalencies of risk between developed and developing economies such that non-communicable diseases and packaged foods were becoming ubiquitous in their home countries.

Many sociologists characterize contemporary societies by the presence and advancement of risks on multiple levels (Bickerstaff, Simmons and Pidgeon 2008; Giddens 1999; Lupton 1999; Walklate and Mythen 2010). Participant discussions of risk support these characterizations, while also demonstrating the difficulty of connecting rational understandings of risks with actions, performances or representations crafted in order to address or confront identified risks.

Practices

The third type of sociocultural factor identified was practices. Practices were one of the main areas of inquiry in the study. Several practice trajectories per Warde's (2005) description could be identified in the data. Practice trajectories arise from history, are conditioned by institutional arrangements and practices paths look much like those of "careers," with starts, stops, ebbs, flows,

maturity and decline (Warde 2005). Data on practices helped identify specific, sometimes chronologically ordered, actions that immigrants took in their journeys to adapt to new environments. Practices discussed were primarily related to cooking and eating, but practices related to valuing, maintaining and achieving health; establishing or not establishing activity habits, consumption and material accumulation also arose. Though some steps were described more thoroughly than others, the steps elaborated upon here should be considered ideal type patterns—they sensitize researchers as to what matters as well as where potential opportunities for intervention exist. Understanding these steps is a forward stride in unraveling the manifold social actions happening inside the black box of immigrant acculturation and adaptation.

First, descriptions of cooking practices covered motivations and roles filled by cooking and eating practices and multiple consumption-related practices. Table 11 provides ordinal steps in the identified practice trajectories. However, as mentioned, these steps could occur in different orders or exist simultaneously within one person's life. Moreover, a different person might move between two steps for an extended period of time, before moving to a different step in the trajectory. Although the trajectories described moved forward in time, they were not necessarily linear.

Table 11: Practice Trajectories Embedded With Health Acculturation

Settlement Practices	Cooking Practices	Activity Practices	Health Practices	Citizenship Practices
1. Move to Caribbean enclave or not 2. Follow friend, partner, or relative 3. Move to areas with more land 4. Follow social group e.g. church 5. Own home	1. Learn to cook or not 2. Learn to cook with U.S. schedule & resources 3. Pleasing family with meals 4. Raising level of cooking so that it returns to level of celebration/gratitude 5. Establishing or reclaiming rituals e.g. Sunday dinner	1. Movement of moving 2. Less activity 3. Discomfort with U.S. exercise patterns 4. Recognition of need for more activity 5. Increase activity or remain	1. Greater eating; less enjoyment of most foods 2. Weight gain 3. Movement towards self-discipline intertwined with successful immigrant narratives	1. Immigrant status and intentions 2. Dual persona 3. Accidental American 4. American [People may live in varying degrees of transnationalism within steps 1-4.]

6. Own additional properties if feasible	6. Equilibrium after abundance crisis = confident cooking 7. Passionate cooking 8. Turning food into business/livelihood	sedentary		

Cooking was interpreted as serving as a means for comforting and nurturing self and loved ones, providing biophysical sustenance, and displaying acquired and nascent skills. Over time, cooking also served positioning functions helping to not only locate individuals within social networks, but also to distinguish class and immigration status positions. The quotes in Table 12 further illustrate the multiple roles filled by cooking practices.

Table 12: Multiple roles of Cooking in Immigrant Adaptation

Figurative Role	Quotation
Cooking as distinction	"My whole family loves to cook and we love food. And one of my closest cousins she would always have dinner parties like once a year and she would always go through *Gourmet* or *Saveur* or one of these magazines to always prepare something high end and fancy that we would almost never have in any other kind of scenario ever or never even heard of. And I remember when I was 21/22 we would always go over to her house and watch *Top Chef* together. And it would always start super late in the evening. And one day we thought 'Hey, we should pick out random recipes that we find on *Epicurious* and start making them.' And the first thing we made was this wild mushroom risotto, some kind of beet with mushrooms encrusted something... And that was the first really complex involved thing I had ever cooked in my whole life and it was like, before that the only thing I would ever make was mashed potatoes or plantains or scrambled eggs. It was just, I only knew how to make 3 or 4 things. And they were all super easy. And afterwards it was just, it became this thing where we just started cooking things we found online. And it became even more involved when my family would be like, 'You should make a dinner for so-n-so's birthday!' And we'd go all four course dinner, we'd get very fancy about it and stuff." (Marco) "But what I've seen very anecdotally so far is that there's this sensibility, even among immigrant communities, that to try new things and to try all the different foods that are now available in the United States, of other cultures, of American farm-to-table movements, of higher-end chefs, the people they see on TV, says something about them as a sophisticated new world person." (Lakshmi)

Figurative Role	**Quotation**
Cooking as identity	"I was shocked that people here didn't know how to cook. . . Because on the islands, at age 12, you should already know how to cook, clean, wash, iron. You know, if your mom gets sick, you should know how to take care of your brothers and sisters and everything. So that's how we were raised, to be more housewives and to take care of the children and whatever." (Koko) "[E]ven today when I think up until they [my younger siblings] became adults, they ate very differently than my [older] sibling and I. I think as adults they ate—yeah, plus and also they live in areas where there are still a lot of Caribbean influence. So they now cook Caribbean foods, but differently too than, like I would. . .You know what, it's funny. I think I was with my sister in [another state] a couple of years ago and I forget how she cooked the curry goat, but I was like "What are you doing? That's not like, our style." But, yeah she's found—I don't know. . .her technique is a little different, but she's found her way back with a sort of different technique or approach to making it. They also eat a lot more, I think, American foods, more often than, like, I would." (Charlotte)
Cooking as Americanizing	"Um, so, you know, they ate a lot of whole foods, and then they came to the United States. My mom said she really hated food here at first. I think she found it bland in comparison to Jamaican food. Um, and then after a while, you get used to things. . . in the '90s, it seemed like everybody was eating out of cans. So we had a lot of canned foods or we used a lot of canned ingredients to make foods. Um, we ate a lot of cereal. Just a lot like a lot of processed stuff, which, I mean, you know, I'll still eat on occasion. [Laughter]. Um, but I don't think it occurred to any of us that, you know, eating stuff out of boxes or out of cans all the time wasn't the best thing." (Karima)
Cooking as globalizing	"If you don't have the means, then, you know, you're going to—basically you're not going to be as adventurous. You're not going to say, you know, I'm here from whatever country, and how amazing that you can get Eritrean food in America when I would never get that anywhere else. So I'm going to try it, and that says something about me." You know, it depends on education and means certainly." (Lakshmi)

Accompanying these ideas about cooking were participant understandings of whether or not specific practices helped maintain or degrade their health practices. For example, the comforting, fortifying and nurturing aspects of cooking were experienced as practices that might bolster one's health and well-being. Whereas, experiences of cooking and eating practices becoming more functional were described alongside losses of enjoyment of food and eating; such loss, connected to feelings of depression and sadness, was experienced as detrimental to one's health. These experiences and affective responses align with beliefs about the centrality of food to Caribbean social life as well as ideas about food being "meant to be shared" and "adding goodness" to life. Connections between re-establishing practices of

cooking and eating and one's social context were similarly discussed. Cooking and eating identifiably Caribbean foods could both create social comraderie and stratify based on the community within which one was living. When living in communities with other Caribbean people, food was a way to share, reconnect to some overarching Caribbean norms, and blunt experiences of culture shock or cultural dissonance. In other circumstances, food choices could label one as low class e.g. fast foods, cosmopolitan e.g. diverse cuisines, or aspirationally American e.g. cooking "fancy" meals and hosting dinner parties. In some communities, people who did not eat enough vegetables or "green foods" were looked down up for being unhealthy or unaware about optimal nutrition. One participant who had lived on both the East and West Coasts found this discourse to be increasingly common, present in both regions and extremely classist: "So like I'm always involved and right now there's the huge push for local agriculture and all that jazz. Much more strongly in some states more than others. Obviously here, especially in [California] it's huge. To a slightly more obnoxious extent than others. Especially coming from New York... It comes across much more--people will at times look down on you for not following that here" (Marco). Kim's experiences with poverty and her desire to eat organic foods corroborated this sentiment: "The food that I eat are certified organic, so I have to go—I'm on food stamps, so I have to go to [town in CT] where there is a cooperative and they have my sort of food there. That's where I buy my food. And then I do the farm vegetables when they have—um, you know, in the summertime, but that's where I get my fruits. . .it's hard to eat the way I want with no money and I have my three sons."

When asked about connections between their cooking and eating practices and government or public health messages, most participants described being aware of multiplying representations of health imperatives in many sites, geographic and media, throughout the U.S. and Caribbean; but viewed guidance offered by such messages as confusing, vague, dated or too removed from health outcomes to worry about. Even among health professionals with more knowledge about nutrition and health promotion, evidence about connections between diet, activity and health was viewed as specious and ever-evolving—

> And they have to eat organic and they have—I mean, if I get the organic cheap enough, I will buy it, I will use it. But, yes, I think they stress too much on eating, you know, too much of this and too much—I say you can eat anything you want. They can't eat beef. I said, "Are you kidding? Beef is my middle name." You know? I said, but again, the word is moderation. You don't eat a big one like this. You eat a little piece like this. (Alice)

> "The most stressful food thing, the thing that causes me the most stress as far as food goes, is the fact that people don't know, the fact that my mom will go—oh my God, so many examples. But the saddest part is that they think they're doing the right thing because the label says 'natural'. The label says '100 percent pure', or the label says 'no artificial coloring'. You know, there's—there's no label for 'this thing is loaded with chemicals and you shouldn't be eating it. But it's the misrepresentation of what really is and what is not good for you that is the saddest thing, because there's no way I can convince my dad that Coors Light is better for him—I mean is not good for him. You know, he's like, "It's beer and it's light. Come on." That's just one example, because he loves Coors Light. My dad never drank or smoked a day in his life. He discovered Coors Light a couple of years ago, and I'm like, "It's the worst decision of your life." (Ramon)

> "One of the key things for me is the way food is marketed to people and children. It's very misleading. And all of—even some of the organic stuff, I wonder about that because is it really organic? You don't get oranges in the winter. And in order to get oranges from another country and to have it in the winter, you're going to have to do something to it, so it's not organic. I know what an organic orange is. It's not really that color, you know? I had to do a lot of picking of oranges to make juice for the family, and it doesn't look like that. So that to me is very misleading, and the way the food is being produced is—even though they say it's organic, it's still a lot of pesticides and different things. Let's not even get into that conversation with the food industry and the seeds and how they get the seeds to make the food and grow the food. It's—that's a totally—I don't want to call company names, but that's another issue. But I think, you know, there's a major problem because I don't think any food in the US is actually organic, to be quite honest. You know, you just have to use the best that you can have and that's available to you. You know, try to eat as healthy as you can. Stick with the green herbs, fresh fruits and vegetables, you know, limit your carbohydrates and your sugars and things." (Koko)

Participants' beliefs in nutrition, prevention and health varied, yet frequently accompanied ideas about "becoming American." Reminiscent of LizEtta's fear of slipping into American-ness unexpectedly, most participants hoped to actively manage their transitions into "Americans" with some never wanting to be perceived as such and with others feeling like there is no nationality they would rather be.

Different from cooking and eating practices, activity practices were more difficult to describe with three participants simply stating that sedentary habits from home were simply transferred to their lives in the U.S. These participants also described themselves as coming from a "sedentary culture."

Narratives about activity practices were far more wide ranging than those for diet covering participants who have always been very active within active families to those who described themselves as unchangingly sedentary. In between, many participants described a more lengthy process of trying to figure out the need for “exercise” in the U.S. as opposed to using energy consumed as food by simply going about one’s day. As Karima described, her parents’ paying attention to their health took decades after they realized their jobs and lives were more inactive than when they were young Jamaicans:

> “reincorporating all these habits from Jamaica to their life here. Um, so I think, you know, if I had to summarize the trajectory, it's like, you know, kind of healthy, whole foods, lots of activity, coming to the United States, working, usually in these sedentary jobs, eating lots of—um, eating out a lot for lunch, like eating like canned, like processed foods a lot. And then maybe returning to those, um, whole foods that were like the foundation of their lives, um, in Jamaica.”

Lameshia described being very active in Trinidad, but has found it more challenging to find the right mix of diet and exercise in the U.S.:

> “And my family, my parents, we’re all pretty active, so we’re always doing something physical. My dad and brother were in football [soccer], I was in dance, and mommy and I used to go running a lot. I think, generally, we were conscious on some level of what we you put in your body or how much you eat of what, but that never. . .consciousness never really interrupts enjoying food.”

Charlotte discussed her desire to model appropriate diet and activity for her children:

> “So early, before I had kids, when I was pregnant, I thought, "I'm going to introduce vegetables at an early age." I did. Yeah. Yeah. I mean it—you know, a lot of other parents say, ‘Why do your kids eat’—my kids love salmon. Like, my four-year-old. Yeah. I want to pass on the importance of like healthy eating and just balance, just, you know, being physically active, eating healthy. . .I also want to pass on like a love of our traditional foods. What I consider traditional foods. So, yeah, that's—that's huge to me, and I—yeah, I try my best to pass those things on by like demonstrating that Mommy exercises. ‘Look, Mommy eats vegetables. We're all going to eat vegetables.’ And not just—I think sometimes too like, ‘Oh, you need this. You're a kid,’ but then you don't do it yourself. Or you should do—so I try to demonstrate that for them so that, you know, it'll be the norm for them.”

Kim described targeted walking time and sex as her only forms of exercise, but contrasted her approach to living i.e. eating organically and forcing herself to walk each day to her friend:

> “So I have to exercise. I do a regimen. And sex is a great exercise. . .It's true. This is why my stomach is down. But, yeah, but I do, you know, calves, legs, hands, and I walk at least for a half an hour. It doesn't matter in what direction. If I have to go the store, I

> walk. But I mainly—I walk to [area] Park and back. As long as I'm sweating, I feel better. I feel better when I'm working out. And I'm a very lazy person, so work—I have to put in the effort to do that. It's the best thing for us, but a lot of us don't do it. Like my friend who is waiting for me, she's like 300 pounds. But because of her age, she will never listen to me about nutrition, so it doesn't make any sense for me to say anything to her. So, I mean, she's busy praising Jehovah, but. . ."

Kim's efforts to achieve healthiness are of note for several reasons: she was one of the participants least satisfied with the life she has found in the U.S.; at the time of the interview she was struggling with food security and unemployment and her reported health problems are more serious than other participants. As she presently aspires to move to Canada or move back to Jamaica, her interest in health is less tied to achieving and performing U.S. immigrant success than many of those interviewed. She was also suspicious of many U.S. institutions and seemed to believe in health as a universal right, unfortunately, denied many people around the globe by powerful interests. Kim's health and well-being had been neither maintained nor protected, and, possibly, degraded during her time in the U.S.

Reverberating from the abstract guidance of ideas about social citizenship partially defined by mythologized versions of the American dream and successful immigrant discourses, many new or emergent consumption practices were identified in relationship to diet and physical activity. The most common consumption practices identified were those relevant to: a) food and ingredients, b) ideas and messages, c) diverse cuisines and d) media and channels of information. Some of the items described within processes were also identified as factors defining boundaries for one's new diet and activity practices such as possession of specific cooking equipment or symbolic ideas about how successful immigrants should behave in order to be net contributors to society (discussed earlier). New consumption imperatives that accompanied participants' migration and adaptation included use of ethnic foods and markets, global/diverse cuisines representing various aspects of globalization, recipes consumed in books and the internet, food media programming, internationally shipped or carried spices and products from home and home cooking equipment and techniques. These consumption imperatives helped many of those interviewed express their knowledge of what being American *should* look like, demonstrate their acculturation to life in the U.S., as well as equip their American dream stories with material accoutrement

fitting of their social standing and/or aspirations: “I like going to the farmer’s market or a nice supermarket like Whole Foods or Trader Joes and just kind of picking out whatever stands out to me. I think, ‘I haven’t had spinach in a while, or leeks or mushrooms.’”(Marco).

Interestingly, consuming in “just right” ways signaled one’s Americanness as well as one’s success (or aspirations) as an immigrant—most frequently an immigrant who was not dependent upon or beholden to a government. Consumption considerations included the adoption of self-surveillance behaviors based on participants’ specific interpretations of the social rules in the U.S. In most cases, they acknowledged the privileging of individuals (individualism) in the U.S. and understood that individual responsibility was a “normal” expectation of those aspiring to “ordinary, middle class” lifestyles.

Possessing a more critical stance of the status quo than her immigrant mother, Kim described her disgust with her mother’s reaction to her shopping at Whole Foods: “She said, ‘Why are. . .why are you being so white?’ ‘Whoa. So being a vegetarian, being white and shopping? Because I can't go anyplace else. I come here because this where my certain kind of food is. And we—yeah, my son is healthy. I'm healthy. That's the whole point, right?’” Kim’s analysis of her mother’s reaction was embedded within a story about how “white people’s approval” was more important than what was “right” for her mother. Her mother chided Kim’s food choices until the mother was diagnosed with cancer; then white people and authorities began telling her to change her diet and eat more like Kim. Kim’s mother viewed her choices as alternative and different from the U.S. norms common in her imagined aspirational and conservative social community.

Participants’ consumption practices represent forms of social citizenship, independent of legal/political citizenship, yet which may draw rewards and sanctions in social, professional and local circumstances while also helping to shape one’s sense of belonging. Koko described how learning to cook and being able to cook American, Caribbean and European foods well gave her cache in social circles and among professional peers. Further her personification of the American dream was one of many factors which led to sponsorship opportunities and advanced culinary training in Europe.

Among this sample of participants, gender and age appear to interact so that males, who came to the U.S. as child immigrants expressed the least ambiguous desire to "assimilate" or simply be American, across racial categories. Among the women interviewed, only an Asian-identified, immigrant expressed a belief in total assimilation even though she recognized that others may not view her as "fully American" based on her accent—"I don't care what no one thinks, I'm American" (Alice). Most other people interviewed expressed more complicated relationships to the notion of assimilation and sought a hyphenated Caribbean-American identity equilibrium.

For participants in this study, new patterns of consumption also aligned with broader aspirations to accumulate material wealth and possessions that many carried with them from their home countries. For most, but not all, participants, their U.S. narratives were to be fueled by stories of aspiration, achievement, hard work and sacrifice; followed by more flexibility and choices when older. Many people wanted to take advantage of the abundant opportunities perceived in the U.S. Several people described how the stereotype of Caribbeans with multiple jobs derives from an interest in accumulating as much as possible as quickly as possible. Accumulation of money, property and material things would help one define one's lifestyle and ensure future security. The interest in doing so quickly derives from both historical experiences of society changing quickly, as well as uncertainty about one's ability to stay in the U.S. indefinitely, for either legal reasons or preference. One third of participants believed they would return to their home country at some point; presently, most do so for only short stints i.e. a few weeks to a few months at a time. Anything accumulated while in the U.S. would bolster their lifestyle and future financial security in their home country. Some people worked hard in order to accumulate so that they might provide an idyllic life for their children; others worked hard expecting to retire to the Caribbean, yet expecting to make medical or leisure trips to North America or Europe—any material wealth accumulated would help fulfill these visions.

Within the U.S. context, consumption and accumulation are intimately connected with ideologies of capitalism and individualism. Individualism is one of the ideas that participants felt compelled to buy

into once moving to U.S. Koko describes despair at realizing the isolating nature of U.S. individualism even when living with a family group:

> "[U]p here, it was like a jungle. You know, everybody's for themselves. Nobody really cared about their neighbors really. If you were in need, you got to figure out how to do it or else nobody really helped. And it was like—and I came, I realized, you know, I'm on my own, you know, and you had to fend for yourself. And it was very depressing for like a good two years. You know, and then the wintertime was a different story."

Even when collectivism or familism prevailed as personal values, social circumstances reinforced notions of individual success or failure and individual responsibility for many aspects of one's life. Most agreed that adaptation to atomizing processes in the U.S. took time to learn to navigate, but also described an emotionally and physiologically uplifting return to social cooking and eating over time, sometimes even decades later as in the case of Karima's parents:

> "And also, um, you know, being like conscious of what you eat, but also just taking joy in the things you prepare and sharing them with other people, which is something that's also been really positive about like the change that my family has made over the past few years. You know, when they come to visit, we all cook together. And we talk about what we're making and experiment with different things. So, um, yeah. It's, it's an individual endeavor, but it—I think it's made a lot more positive when you can share it with people. (Karima)

In terms of overall health experiences as immigrants, the majority of participants described adaptation processes where they: a) experienced less joy when eating, b) gained weight upon moving to the U.S., and c) adopted self-disciplining strategies in order to regain health, lose weight and fulfill their roles as successful immigrants. Some people established exercise practices and/or modeled exercising to other family members as a disciplinary measure.

Chapter Summary

Food is central to Caribbean-American life and related to many Caribbeans' perceptions of themselves and/or their adaptation processes. While some aspects of food-related acculturation appear easier to manage than others, the process of becoming content with one's hybridized diet takes many years during which one's dietary practices may range from health-affirming to potentially health-

damaging. Analyses of sociocultural practices surfaced three types of interpersonal and meso-level factors influencing immigrant adaptation: limiting or boundary-setting factors, abstract guiding principles and practices. Limiting factors helped define boundaries within which actions related to diet and physical activity could be taken. Abstract guiding principles provide loose, horizon-like frameworks for assistance navigating longer-term challenges. Practices, primary foci of the study, were enacted within a context shaped by the aforementioned limiting factors and guiding principles. Elements of potential practice trajectories for settlement, cooking, activity, health achievement and citizenship performance were outlined.

The sociocultural factors discussed in this chapter alert researchers to potential vulnerabilities for mental and physical illness that may arise as stress, self-disciplinary practices and evolving and contingent approaches to health attainment and maintenance emerge. First, gaps between immigrant expectations and U.S. realities were experienced as stress by many participants. Stress shares epidemiological risk factors status with diet and physical activity as a precursor or predictor of many illnesses and can accelerate and exacerbate existing health conditions. Stress is currently under intense investigation, scientifically, as providing psychological-physiological mechanisms that channel feelings of stress into illnesses in bodies (Geronimus 2000; Geronimus et al. 2006; Lewis et al. 2006; Sullivan et al. 2017; Van Dyke et al. 2016).

Based on participants interpretations of the successful immigrant discourse, a variant of several sociological discourses concerned with forging productive bodies for states or governments (Foucault 1974/1994; Foucault 1978/2007; Lupton 1999), practices that comprised the re-establishment of diet and activity routines included self-disciplinary, domestication of one's bodies and habits in order to assume new roles in the U.S. social and political order. Like the refugees in Ong's *Buddha Is Hiding: Refugees, Citizenship, the New America*, the transnationals I interviewed are *becoming* modern biopolitical subjects which "entails a two-part process of acquiring a specific set of practices and a specific philosophy of life" (Ong 2003). Widespread participant embrace of successful immigrant and American dream discourses are accompanied by sets of practices that: 1) link immigrant changes to governing social ideologies, 2) accept

the positioning of health and population fitness in relationship to expressions of successful citizenship and 3) surfaces irreconcilable quandaries about the structural or non-individual factors of U.S. life which may contribute to individual success and failure. As the following quote from Kim demonstrates, non-critical acceptance of these social discourses situate Caribbean immigrants in potentially precarious social positions between contested social norms and some of the race/ethnic groups with which they may find affinities, figurative shelter and shared residential spaces, particularly African Americans and other racialized immigrant groups. “I asked my mom and dad, I said, "For the richest country in the world, why are there so many poor people?" "Well, they're not doing what they're supposed to." "Oh, what do you mean they're not doing what they're supposed to do? Really? That's your concept?". . .My parents act stupid and closed-minded” (Kim). Kim’s critique of her parents was of their unquestioning and ahistorical acceptance of individualism, self-sufficiency and merit discourses. We know from other comments that Kim’s parents also looked down upon poor people for “not doing what they’re supposed to do.” Though they might agree with Kim’s perception of her parents’ views, several participants of Afro-Caribbean and Indo-Caribbean descent discussed the tension between one’s immigrant status and the racialized social positions of those deemed racially similar. Many Afro-Caribbeans did not feel like they were African American. Indo-Caribbeans felt their communities were ignored or made invisible by dominant, U.S. beliefs about or ignorance of South Asian diasporas. This last point reminds us that U.S. social stratifications (to be discussed more in the next chapter) are funneled through lenses of resources and experience shaped by social stratifications in one’s home country, one’s migration process (frequently stratified along lines of employment, wealth and country of origin) and immigrants’ reproduction of status quo social arrangements in the U.S.

The sociocultural factors identified are meso-level factors which link macro-level factors with interpersonal and individual factors through both actions and ideas. At the crossroads where many influences meet prior to being operationalized as conscious actions, sociocultural factors were the most varied factors influencing one’s adaptation processes with several candidates for critical concepts that

could be included in quantitative modeling of health acculturation such as longing, the presence of children and belonging to a “sedentary culture.”

Chapter 8: Structural Influences on Immigrant Diet, Activity and Health

One of the hallmark dualisms within social sciences is the debate between the role of structure and agency in shaping human action. There are various definitions of these terms, but for the purposes of this paper, simple definitions suffice. Structure refers to the ordered arrangements of society and social institutions; whereas agency refers to one's acting by exercising free choice and independence. Action refers to almost every act imaginable whether physical, visible or imaginary. Various social science theorists have posited different roles and primacy for structure and agency in theories of social action, social movements and social change. As described earlier, examinations of health ideologies, practices and outcomes often implicate contributions of both social structures and agency, with more contemporary social scientists favoring arguments against dichotomous understandings of structure and agency for more complex or relational ones. Giddens (1991) posited that social structures and agents were co-constitutive—structures shaped agents and were also reproduced by the acts of agents. Social norms, self-reflection and changes in time-space relations including globalization were engaged in both processes of social system reproduction and innovation. In a related fashion, Smith (1997) argued that power in social interactions could often be found within the institutional and organizational arrangements of society. Common structures of interest within sociology include: family, socioeconomic position, the state, religion, media, science, systems of education and racialization, and normalized social institutions such as gender relations or marriage.

Though originally borrowed from social scientists working on communicable diseases such as HIV/AIDS, the role of structure in shaping public health environments has been discussed for decades. Despite similar roots and various publications about structural factors (primarily focused on interventions) in public health research and interventions, significant friction exists between use of the terms structure and structural across the disciplines of sociology and public health. Within epidemiology and public health structures usually refer to systems level objects that shape, promote or hinder specific health behaviors of interest. A Google Scholar search for recent public health articles on structural factors

identified the following structures within public health research: environmental exposures, housing and neighborhoods, employment patterns, incarceration, poverty, health care systems, access to health care or social services, information asymmetries, supply chains, and organizing mechanisms (Blankenship et al. 2006; Bowleg and Raj 2012; Geronimus 2000; Jones 2000; Sommer and Mmari 2015). Outside of HIV/AIDS, however, structural ideas have gained limited traction in public health research and researchers have been slow to identify and address structural factors influencing health or structural approaches to public health solutions. Some of this resistance is probably related to ideas of complexity that contradict siloed funding and expertise, as well as challenges of perceived scope and ontology. Where do health problems begin? How should health experts respond to health problems if they involve geography, economics, and social policies? Based on my previous professional efforts to use structural interventions to impact chronic disease risk factors, I believe that policy, workplace, and environmental policies may lack nuanced understandings of how structures are experienced which may help account for the difference between recommendations to add public bikes and low income-accessible farmers' markets and recommendations about interventions and enforcement among realtors. Participants frequently wondered "why does it remain so difficult for me to buy a house or live where I want without interference from stereotyping by brokers and realtors?" This chapter hopes to bridge some of the disciplinary differences in the meaning and use of societal structures by demonstrating individual, lay perceptions of and responses to structures that may be less tangible and more distant from health outcomes than those identified by public health professionals as possible sites for interventions.

As experienced by participants, the factors that seemed to shape their lives on a societal level were often about competing freedoms such as one's freedom to work, an ability cherished about the U.S. economy, or one's freedom to self-define, a privileged derived from different social freedoms in the U.S. How might immigrants best satisfy their souls and their roles? Which freedoms, rights and privileges were worth fighting for and which should be taken advantage of in the present? Participants' everyday practices were also influenced by their attempts to balance individuals' perceptions and desires of independence and autonomy with sociopolitical interest in immigrant performances of the good

immigrant/citizen. Performing the good immigrant helps one fit in better in privileged parts of society, but is also defined by a social obedience and acquiescence that helps reify and reproduce the status quo. Similar to thematic explorations in the two previous chapters, I was uncertain about what I would find, but wanted to understand the extent to which structural factors figured into participants' own understandings of their adaptation to U.S. living as Caribbean immigrants. Though words like "societal," "pervasive" or all-around" were used rather than structural, structural factors were quite salient in participants' discussions of adaptation, daily decision-making and liminal aspects of their routines. Six broad categories of structural factors emerged: 1) citizenship, political/civic representations and engagements, 2) one's physical and geographic environment, 3) socioeconomic class and status, 4) normative ideological and discursive structures, 5) reterritorialized Caribbean norms and 6) effects of globalization. The remainder of the chapter presents discussion of these categories of structural factors as well as empirically grounded examples depicting how the factors influence practice development or health-related actions. The chapter concludes with an interpretive assessment as to how structural factors may shape health-related beliefs and routines.

Citizenship Influences on Immigrant Adaptation

Citizenship is intimately entangled with migration and international mobility, so it seems natural that ideas about political and/or civic representations and engagements would surface as being relevant to participants' adaptation to living in the U.S. Political citizenship is the dominant form of citizenship in scholarly discussion of migration and is defined by rights and responsibilities associated with participation in institutional systems of law and governance, usually attached to a specific nation-state. Political citizenship is typically represented by voting, office-holding and participating in other activities related to elections and state decision-making (Janoski and Gran 2002; Ramirez, Soysal and Shanahan 1997). As discussed in the earlier review of the literature, other facets of citizenship are also relevant; in fact, the literature led to my sensitization to consider elements of economic and social citizenship. Economic citizenship refers to rights and responsibilities conferred upon individuals to participate in the

economy through labor, earnings and retirement security; while social citizenship is concerned with access to social recognition, opportunities to fulfill social and cultural expectations as well as use of social services and resources like education and health (Bloemraad, Korteweg and Yurdakul 2008; Marshall 1963; McKinley 2009; Ong 2003). While there was much discussion about what constitutes one's fitting or belonging both within U.S. society, generally, as well as within one's local or immediate neighborhood or community, more specifically; participants described four ways in which political and civic citizenship factors shaped their adaptions.

First, participants described the legal documents and government-sanctioned, formal positions that allowed them to travel to, live and work in, and/or bear passports of the U.S. Legal citizenship is critical in establishing how one begins to live in the U.S. Although many Caribbean participants, arrive in the U.S using educational, travel or work visas; many participants traveled to the U.S. through federal, family reunification and sponsorship programs. Although current citizenship status was not asked of participants, the topic was frequently discussed as part of the process of immigrant adaptation; I suspect that citizenship and naturalization rates within this sample are higher than they are for Caribbean immigrants in the U.S. or in the northeast region (Duncan and Waldorf 2009). The path from filing paperwork for residency or citizenship was reported to take many years, with various status changes between foreign and U.S. citizenship. Among those who obtained formal citizenship, the swearing in ceremony and receipt of a U.S. passport were symbols that allowed participants to breathe sighs of relief and feel like they technically belonged in the U.S. and were "really American."

Only a few participants mentioned overstaying their 90-day, travel visas or living in the U.S. "illegally." All participants who described a period of time when they were in the U.S. "without papers" or "illegally" could be categorized as economic migrants. Living illegally presented specific challenges related to employment, financial accumulation, and health insurance according to participants. Without health insurance, participants abstained from utilizing health care and services and experienced significant stress associated with fears of being discovered, fined, and/or expelled. Legal recognition as a U.S. resident or citizen was denoted as a minimum threshold for broader feelings of citizenship and belonging,

as well as extremely influential on one's ability to obtain employment, housing and other resources deemed important for establishing life in a new country. Those who traveled between the U.S. and their home countries most often were necessarily those who could easily travel outside of the U.S. and return, establishing very different parameters for their style of transnationalism when compared to those who did not have such freedom of movement.

Explicating multiple facets of citizenship is important given different meanings and interpretations of what one could and should expect about living in the U.S. beyond one's official designation by a bureaucratic agency. Economic and social citizenship are intertwined with political citizenship, yet interpreted as distinct guidance about living in the U.S. Most participants accepted implicit rules indicating that citizenship was comprised of situated practices that asserted one's independence, productivity, assimilation and contributions to the moment-by-moment and day-by-day social reproduction/recreation of society. Empirically, economic citizenship was comprised of feeling like one had the ability to seek and obtain employment for which one was qualified and the ability to benefit from monetary and material resources that would be obtained through employment opportunities. For jobs requiring lower to middling levels of education and skills, participants noted voluminous opportunities and chances to work beyond the 35-40 hours that conventionally constitute "fulltime" employment. In Charlotte's words:

> you know, you migrate here for like opportunity, so I think the natural thing to do is like—and because you're afforded more opportunities, you take advantage—I think sometimes we take advantage of too many opportunities. And so, you know, you have some people working two jobs because they're like, 'Oh, yeah, you can make great money doing this and then nighttime you can do this, too.' So I know a lot of families that did that. And I don't know if it's necessarily because they needed it to put food on the table."

However, disappointment was noted as participants with tenure and experience noted "invisible" limitations placed on their ability to be promoted or obtain higher level positions. Reluctant to ascribe U.S. glass ceilings to discrimination and prejudice, many participants mentioned that these ingrained, societal factors may be to blame for the feeling like they are "running in place." Reflecting on her mother's experiences in the U.S., Karima said: "my mom's particularly frustrated. She works as a civil

servant. Um, she has kind of hit the, the glass ceiling, which is quite low in fact. So she's been working at the same job for about 10 years. [Her supervisors] always tell me how indispensable she is to the department, and nonetheless she can't get advanced, and she's taken initiative. . .she's leaning in, as they say, and it's not working."

Moreover, social citizenship was described as feeling like one fit in one's neighborhood or community (or somewhere), developing an understanding of and ability to navigate U.S. norms, and contributing to society. Part of understanding U.S. norms included learning about and aspiring to fulfill archetypal roles of good, hard-working immigrants. Almost all participants expressed highly favorable affinities for these mediated social identities, with half of the participants cultivating critiques of these ideas over time. Where legal/political citizenship influences one's movement within the nation and across national boundaries, and one's livelihood, participants' understandings of economic and social forms of citizenship helped outline the types of lives they could create in the U.S. For example, when Happy moved from New York City to Atlanta, she was surprised by the lack of friendliness and neighborliness found in the South (Southern hospitality is a common U.S. discourse with which she had been familiarized). Her solution was to limit her social interactions with others:

> "Well, honestly, for myself, I never try to fit in somewhere that I don't feel comfortable and I try to stay within my, um, realm or with my—where I am—my comfort level. I am not afraid of venturing out or, um, going certain places or feeling that I cannot become or I'm not good enough. But if going to like an office party makes me uncomfortable, I will not go. I choose not to go. And I have done that several times. I mean there are times I don't go to my, you know, office party because of the quote/unquote majority that's going to be there, you know? But, um, I tend to stay within my, um, friends and family group."

Similarly, Koko found companionship in her church which "had lots of Trinidadians." U.S. experiences with callousness, ignorance and/or differential social expectations, led to these (and other) participants' narrowing and homogenizing of their social circles. This response was reported more by women than men such that even men who were disappointed by attempts to broaden their social horizons continued to look outward. For example, Daymond described a period of trying to only date European American or white women, but later realized that his temporary idealization of white women as potential partners in the U.S. didn't really fit his beliefs and interest in many cultural expressions. "Now," he said "if there's any kind

of cultural event—Puerto Rican, Uzbek, Ethiopian—I'm there mingling and socializing. I even bring our Indo-Caribbean delicacies to help share our culture."

Time spent living in the U.S. revealed perceived inconsistencies between values idealized by common U.S. rhetoric and participants lived realities. In Charlotte's case, as a grade school student she recognized signs of exclusion or differential treatment: "Despite being [a nation of immigrants,] I don't know that everyone was so welcoming to immigrants. When I first moved, [people around us would say], I don't know. 'These people are coming in.' I mean, I don't know, but I definitely was treated differently from both whites and the African-American students. . . Even in like elementary school. You know, it's like fifth grade, sixth grade and how some kids maybe got more praise." Daymond described how social systems and not just individual interactions can also be stacked against ethnic communities and immigrants (institutionalized racism):

> For instance, let's look at the MTA. It's the biggest transportation company in the United States, probably in the world; and 93 percent of their revenues come from the subway system. Right? But the white people use Long Island Railroad, so they get a third of the monies because they're the ones with a voice. Right? But 93 percent of the revenue's coming from the subway system, 93 percent should go back in. Whenever there's a decision about which project to fund, Long Island Railroad gets first priority—monies are not coming back to the people who pay for the system. . . The subway system gets second or third priority."

Although most believe that their circumstances in the U.S. are better than their lives would have been in their home country, most also harbored various levels of mistrust for governments, bureaucracies, corporations including those representing the food industry and other types of authoritative entities. When describing the reasons that they lost trust in these groups and institutions, participants cited experiences with government mistrust in their home country, personal experiences with unfair treatment, and observations of patterns of unfair resource allocation, societal investment and indifference towards certain groups or neighborhoods in the U.S. Though my investigation of citizenship is cursory, participant narratives easily demonstrate the blurred lines between here (U.S.) and there (home countries); past and present. Ideas from one geography bleed into ideas from another; ideas mix, fuse and bolster one another

irrespective of national origin. One's experiences and identities prior to migration cannot be extricated from their lived experiences in the U.S. as is customary in conventional migration research.

The final arena of political or civic interaction mentioned frequently by participants was schools. Schools were identified as a primary site of socialization for both children and parents—expectations of parents were often conveyed through formal and informal school policies as well as teacher/administrator communication or judgement. Moreover, as indicated in the previous chapter schools were also where children frequently learned about U.S. norms, values and lifestyle representations. Rather than simply serving as a site to educate and inform immigrants, many participants reported being surprised and stressed out by what schools expected of parents. Most of the respondents who raised this concern were familiar with Caribbean education systems that assumed educational responsibilities with far less parental involvement than demanded in the U.S. A few participants also commented on their belief that U.S. education systems led to inferior results when compared to education in the former Commonwealth (English-speaking) Caribbean; these participants partially attributed their success as immigrants to differences in education quality. Recontextualizing the higher educational levels and economic success of Caribbean immigrants when compared to many native-born populations, a few participants also pointed out an often made, apples-oranges comparison of Caribbean immigrants, who were frequently starting from a different educational status despite national poverty, and their U.S.-born counterparts, who appeared less able to pull themselves out of poverty. LizEtta described the judgement that U.S.-born people were lazy and incapable as a type of "selective, historical amnesia" that aligns well with aspirational ideas about access to the American dream and immigrant desires to be "good immigrants." Reproduction of the myth about U.S. lower class and/or African American laziness ignores differences in access to resources available to immigrants in both their home country and the U.S. and discounts the role that such myths have played in generating contemporary U.S. society.

Perceived patterns of dissonance, unfairness and hypocrisy contributed to participant reluctance to engage in civic activities including parents' associations. Participants used caution when deciding how much to get involved in local politics or activities both due to uncertainty about the outcomes of such

efforts, but also due to potential fear of reprisal for "rocking the boat." Most believed it was sometimes necessary to rock the boat, but reserved such actions for times when their life or livelihood seemed in peril. Participants were largely confident that they could direct their family through challenges presented by schools and neighbors without broader civic engagement. It is of note that participants describe experiences with legal, political/civic, economic and social citizenship, yet many attempt to limit visible or identifiable acts of citizenship i.e. voting or petitioning due to feelings of legal and economic insecurity or home country experiences with political suppression. Discomfort experienced due to limited civic and social engagement is deemed part of the costs of migrating and adapting to life in the U.S. Ironically, engagement rather than retreat are most often associated with expansion of democratic rights and entitlements within the U.S. Tentative or liminal engagement by Caribbean immigrants may contribute to their marginalization or invisibility in certain realms of society. Only two participants were actively involved in efforts to improve Caribbean voting, political engagement and/or political representation.

Ong and Rose's conceptualization of citizenship and citizenship projects reinforce how dimensions of physiology and biology are also imbricated into ideas about civil, political, social and cultural rights and responsibilities. Rather than simply being a legal status to which immigrants can aspire, citizenship involves learning new ways of being and belonging that demand interpreting complex, contradictory and contested forms of knowledge and practice, as well as traversing social and cultural terrains with porous, sometimes invisible, but consequential boundaries. Citizenship understandings and practices may be one of many processes that comprise what social scientists mean when they say acculturation. Further, assessments of citizenship complement measures of migration and social incorporation by better characterizing immigrants' relations with authorities, nation-states, and institutions fostering national aims of social cohesion through reduced public responsibility and greater individual responsibility. Among this population, citizenship understandings also connect participants' life experiences with collective identities and abundant micro-opportunities to perform values and beliefs related to public and individual responsibility.

Physical Environment & Geographical Influences on Adaptation

After the multiple facets of citizenship, participants described the influences of their physical and geographical environment on their adaptation. Unlike citizenship and societal norms which were described as complex and difficult to reduce to simple terms, aspects of the physical environment were described more simplistically. Participants presented the following as factors influencing overall and health-related adaptation to life in the U.S.: the identity and location of one's receiving community e.g. New York City or Miami; urbanicity, scale and population density of the community in which they lived; the presence of immigrants from similar home countries, the presence of a general immigrant population, proximity and accessibility of familiar foods, intensity of residential segregation; as well as the organizing logics and expectations espoused by schools and workplaces. Although there were various narratives associated with these factors, Figure 8 presents how these factors were typically described in relationship to diet, physical activity and health.

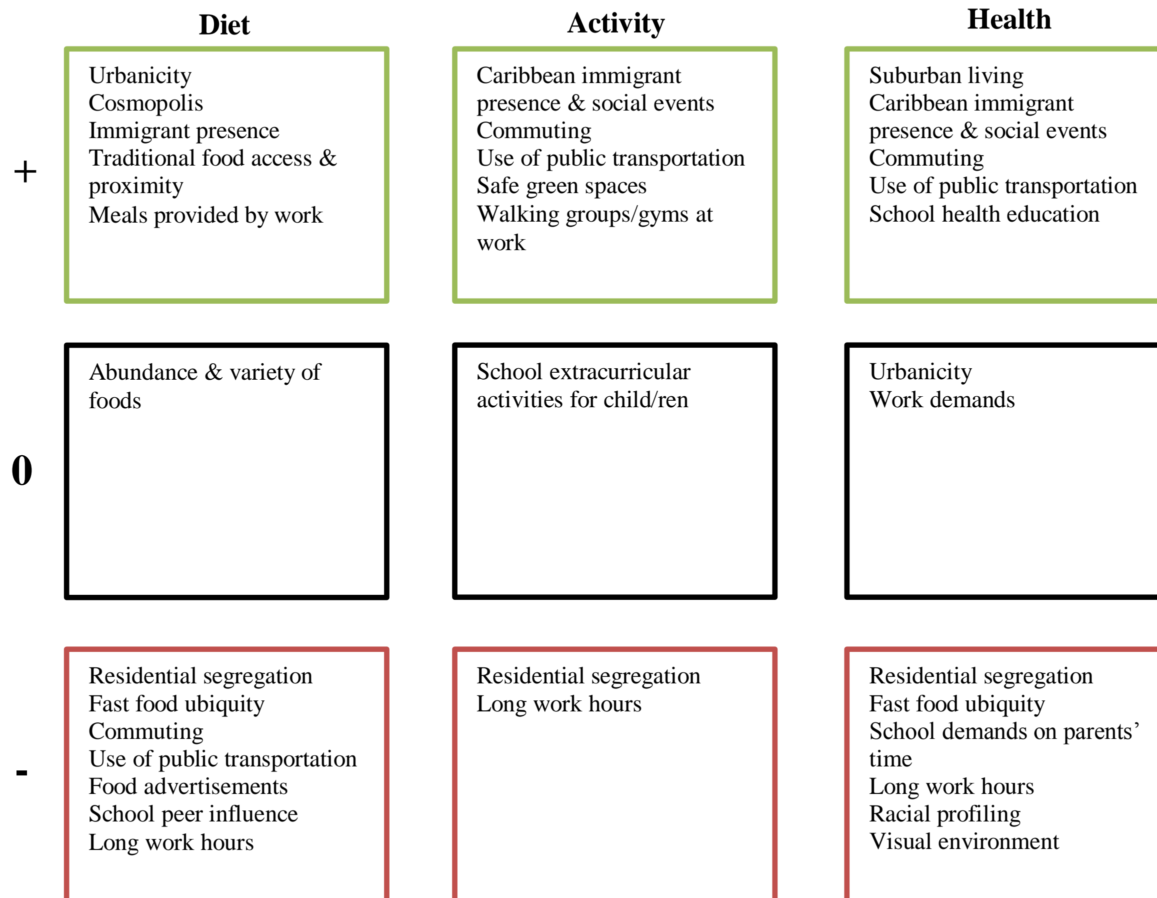

Figure 8: Factors from the physical and geographic environment that influence health based on participants' perspectives.
Potentially positive factors are in the top most row, followed by neutral and potentially negative influences.

Participants, generally, felt more supported in semi-urban environments where other immigrants, particularly those from similar nations, were visibly present, where some familiar foods and drinks were easily accessible, and where co-workers and neighbors shared an interest in aspirational accumulation and generational transfers of educational and class status. Those who were presently or previously poor or working class shared many of these aspirations and hoped for generational, upward mobility for their children. Residential segregation was described as something that could be detrimental to one's overall social status, wealth accumulation and environmental health risk profile; yet tolerable or preferred if a neighborhood or region was diversely Caribbean and majority middle class e.g. sections of Queens, NY. Conversely, experiencing the racial profiling and discrimination that accompanied searches for homes

was described as painful and maddening. The scale and population density of most metropolitan cities in the U.S. was initially overwhelming for most, but participants focused on getting to know a smaller area e.g. neighborhood or social group e.g. college peers in order to feel more comfortable with the differences in scale. As Denine shared:

> "I mean I found a lot of things strange in that sense. . .for starters just the sheer size. So I'm from Trinidad and Tobago. It's 1.3 million [people]. When I came here, you know, I first started in D.C. That was about the same—well, it's like about the same population size, but much smaller, geographically. So the amount of people that can fit in one spot, I think, was the first like big thing. . .And then the fact that I was in this place [country] that had like over, you know, 300 million people is sort of like the thing that, you know, in my mind that thing is sort of out of proportion. I had never been in a place this big."

Likewise, urban areas were viewed with ambiguity—participants appreciated, even desired cosmopolitan aspects of city living e.g. cultural diversity, yet longed for less densely populated areas and more land. Most participants aspired to live in or lived in suburban-type neighborhoods close to urban centers. Among those who had lived in multiple locations or regions of the U.S., the metropolitan areas of New York City, NY, Miami, FL and Boston, MA were described favorably. Only one lower income participant, living in the Northeast U.S., described potentially detrimental psychological or somatic effects of one's visual environment on one's health and well-being:

> It's stressful for me. Like seeing constant dirt. It doesn't have to be—it stresses me, because it doesn't have to be that way. And like the east side of Bridgeport, no banks, no supermarkets, because that ferry is going over there, everybody is going to get kicked out. . .It's not only the environment. It's the systematic nature of being on welfare, blocking resources, not being able to get around, not seeing friends, so-called friends, friends not being friends when you need their help. Seeing our children lost, I mean in what they wear, what they listen to. It bothers me because I know what their future is." (Kim)

One's physical and geographical environments are related to, but distinct from one's socioeconomic status, the next structural factor identified in analyses.

Socioeconomic Status Influences on Adaptation

When recounting how new routines and habits related to diet, activity and health came to be, participants mentioned social class as an important determinant of how they do things; yet, people were

more concerned with lower limits on one's ability to provide a certain standard of living for oneself and/or one's family. Among all types of immigrants, achieving a "middle class" standard of living was an explicit goal even though participants' means of achieving such a standard of living varied i.e. educational attainment and white collar employment or working multiple, steady positions and investing in real estate. Few participants mentioned material expectations outside of home ownership and steady, well-compensated employment. Some participants sought financial resources to send their children to private/Catholic schools or university. Though only some used the terms class or status, these discussions depict the influence of socioeconomic status (SES) on health. Across disciplines, SES is considered a fundamental determinant of health status and health outcomes, although ideas about the myriad pathways between SES and distal outcomes vary (Link and Phelan 1995; Solar and Irwin 2010). For the purposes of this analysis, SES is characterized by participants' self-reported income group and educational attainment.

In general, participants described "not living in poverty" as one of few, critical requirements of one's migration journey—this achievement was viewed as necessary and one of the few factors that made all other sacrifices worthwhile. Participants reported learning quickly that building a desirable standard of living in the U.S. required massive inputs of time and energy on the part of workers in the family. Time spent securing a standard of living as an immigrant left less time for traditional family gatherings and ways of living (and civic engagement?). The effortful achievement or approximation of the desired standard of living reinforced highly mediated ideas about hard-working immigrants. Mentions of lost time are of particular interest given discussions about lost time in personal relationships and meaningful engagement with other people.

Material wealth and accumulation changed over the course of immigration journey such that many participants reported early years with very little which evolved into more financially comfortable years irrespective of one's age. In terms of health, participants reported far more precarious situations during their first few years in the U.S. Their situations were characterized by poor neighborhoods, lack of health insurance, unsafe physical environments, poor knowledge about the U.S. health care system,

limited financial and social resources to obtain help or assistance, confusion, fear, stress and wonder. As participants adapted and moved from one neighborhood to another, they realized how important class had been in their early years in the U.S. For example, Ramon describes how moving just four miles into an affluent neighborhood changed his life and, possibly, his life trajectory:

> "When I was growing up, it was the Latinos, the poor kids and the black kids that I grew up poor with, and I didn't meet white people 'til I moved to a relatively affluent town. And seventh grade is when I realized, oh, there is a like a-whole-nother world out there that I don't even know about, like a world that I've only seen on TV, and it's like, yo, the next town over and we just moved into it. Crazy. That's when I started listening to like rock music. I remember falling in love with Green Day in eighth grade, and before that all I would listen to is rap music, you know? Like just a complete social influence because of where you are. I had to move to another town, a bordering town. I didn't move 50 miles away. I literally moved probably four miles from my childhood home for middle school, and there was maybe 10 more white kids per classroom and that changed my life, because—I don't know—white people are the rest of the world. There's poverty and then there's everyone else, everything else, the rest of the world. All I knew was poverty. . .and then it was like Leave It to Beaver. It was weird, and it wasn't even because we made a lot of money. It was just because my parents made a move like to a small apartment, sold the house, and moved to a smaller apartment just so I wouldn't have to go to school in the town that we lived in."

By living in the wrong neighborhood, many participants commented that they had been exposed to multiple health risks: fast food, food deserts, police presence, advertising for low quality foods & cigarettes, potential violence, lack of safe walking environments and daily stress. They had also been exposed to social risks from poorly resourced institutions in those neighborhoods such as schools. Public health evidence corroborates these findings. Ramon's parents' foresight involved a decision to sacrifice comfort for better outcomes for their children, in moving they protected future possibilities that they did not and could not have anticipated at the time and that were not available to peers in Ramon's old neighborhood.

In terms of participants' actual allocation of household resources, changes in food shopping habits were most discussed relative to one's SES. As participants perceived themselves as having more expendable income, the types of foods they bought, purchase locations, and food quality changed. Figure 9 outlines the changes mentioned during the interviews.

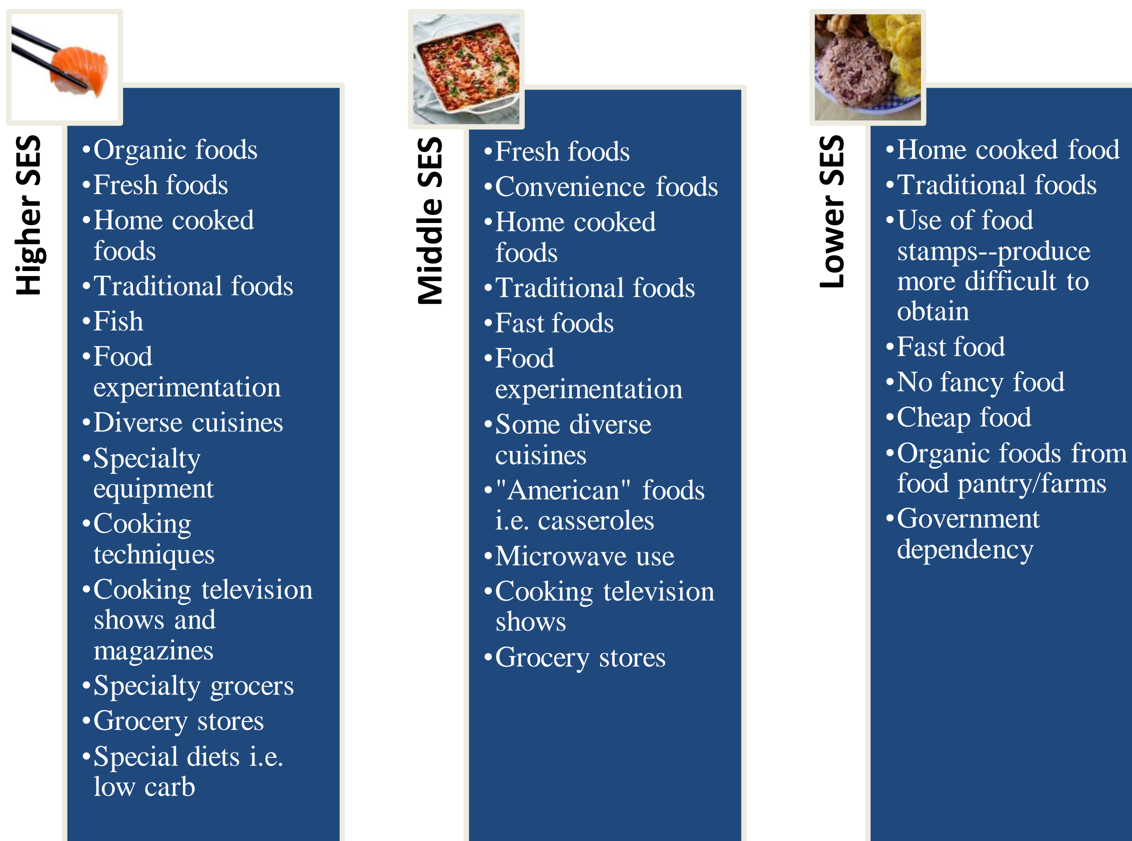

Figure 9: Food consumption patterns by socioeconomic groupings

High and middle SES participants emphasized their consumption of fresh foods, would occasionally shop at specialty (high-end or ethnic) grocery stores and expressed interest in food experimentation. The only participants who reported receiving food assistance during their time in the U.S. also talked about the limitations on food purchasing imposed by government programs such as food stamps and the limited availability of traditional foods in private assistance programs like food pantries: "the food that I eat are certified organic, so I have to go—I'm on food stamps, so I have to go to [a town 20-30 minutes away] where there is a cooperative and they have my sort of food there. That's where I buy my food. And then I do the farm vegetables when they have—um, you know, in the summertime, but that's where I get my fruits. . ." (Kim).

Money was described as a barrier to dietary and food-related practices, but not activity practices. Time (which may also be related to SES) was one of two explicitly identified barriers to physical activity. The other barrier to physical activity was ideational—the belief that participants belonged to a "sedentary culture." Time prevented participants from both engaging in traditional forms of activity e.g. dance, soccer, cricket, running and establishing new forms of activity that felt comfortable and life-affirming.

Participants' drive to achieve a certain class standard was accompanied by important emotional and behavioral commitments about which many were ambivalent. First, fear, in general, and the burden of paying one's mortgage, in particular, represented common worries among participants. Paying a mortgage entailed working hard and, sometimes, long hours and properly allocating one's financial resources so that mortgage payments were prioritized over other expenditures. It is of note that one participant believed that immigrants' living paycheck to paycheck and feeling dependent upon one's work for economic and social security in the U.S. was also related to limited political/civic engagement. He communicated the logic expressed by others in his Indo-Caribbean community—if something happened to one's job then the mortgage couldn't get paid, it would be best not to "rock the boat" if one is dependent on others for one's wages. He also described dislike of being dependent upon potentially capricious employers as one reason that so many Caribbeans save money working multiple jobs and then start their own businesses. In addition to fear, several participants mentioned envy and the siren-like draw of what rhetorically has been called "keeping up with the Joneses" in the U.S. Participants described this competitive comparison of one's material accumulation against others' as being marked against both Caribbean and non-Caribbean peer groups. Within Caribbean groups, implicit pressure to achieve a modicum of socioeconomic stability was described. Upward mobility or a standard of living was the ultimate draw for many immigrants, since the class mobility possible in the U.S. was viewed as nearly impossible in everyone's home country. Class was identified as the primary, stratifying category throughout the Caribbean; social mobility was perceived as limited.

Normative Ideological and Discursive Structures

While the structures described so-far sit well within the contemporary canon of social determinants of health, public health and epidemiological literature, social science recognizes different types of structures which may be less common among health scientists. Ideological and discursive structures are among these types of structures which may not be visible, but which structure society nonetheless through complex processes of interpretation, meaning-making, reproduction and resistance. Ideology refers to a body of beliefs, values and attitudes that underlie and maintain the status quo (Hall 1996). Ideologies justify social norms, needs or aspirations—they tell us how to see the world. Discourses are time-place specific expressions and manifestations of ideology; discourse is experienced through language, text, symbols and representations. Discourses shape our thoughts, interactions, and social practices, and reflect power by legitimating some dominant ideas, but not others (Hall 1992; Keller 2011). If ideology tells us how to see the world, then discourse provides the language, messages and representations that accompany that world view. Taking the case of the "good immigrant" discourse, prior to migrating to the U.S. individuals learn about the best communities and employment opportunities for immigrants. Upon arriving, individuals learn from Americans, media representations, and fellow immigrants that hard work, minding one's own business, not relying on government handouts and being productive are highly valued characteristics that may help guarantee one a standard of living and eventual U.S. citizenship. Individual immigrants align their behaviors with these ideas and ideals; over time they are regarded as both good immigrants and good citizens. Ideological discourse about how one makes for an ideal citizen interpellates willing subjects in search of a better life (Althusser 2006). Moreover, among practice theorists like Bourdieu and Foucauldian risk theorists such as Lupton, these less visible structures can be more durable, difficult to identify and challenging to change because: a) they typically require routinized or normalized, intellectual or behavioral investments from individuals affected by the structures, and b) they are representations of established power relations and bear stamps of legitimacy

from authoritative social institutions like science(Abel and Frohlich 2012; Bourdieu 1980/1990; Lupton 1999; Petersen and Lupton 1996).

Participant narratives about migration and adaptation revealed numerous ideological structures that helped shape the lives that participants lived in the U.S. Their stories also revealed time spent considering the meaning of their migration experiences as well as rumination over some of the more troubling or unsettling aspects of adaptation to the U.S. In terms of establishing new routines, participants described the influence of six primary discursive structures that helped lead them from their early days of confusion in the U.S. to their current circumstances: 1) rags to riches/American dream mythology, 2) belief that work was rewarded, 3) changes in time and time compression, 4) presence of diversity/difference, 5) media—conveyor of ideologies and dominant discourses, and 6) racial formation. These six assemblages of thoughts and logics were mentioned more frequently and regarded as more important than other ideological structures mentioned. Other ideas influencing participants' actions included: individualism, religion, emotional responses and emotion management and assumptions about U.S. natives' limited education and awareness of the world outside of the lower 48 states.

First, as discussed in earlier sections, ideas related the American dream and good immigrant mythologies loom large in participants' understandings of their migration and adaptation journeys. Belief in some version of an American dream begins prior to one's geographic migration. Around the world, perhaps, and certainly within the Americas, the United States is considered a beacon of opportunity, diversity and self-determination such that anyone who is willing to work hard may realize dreams of material adequacy or abundance, while enjoying greater freedoms. While the American dreams envisioned by different individuals vary, some themes recur: ability to secure employment, ability to earn and invest money per one's wishes, possibility of owning one's own home and/or land, achieving a respectable living standard and being able to transfer some cultural, economic and/or social capital to one's children or heirs. Prior to leaving their home countries, participants were already envisioning and building elements of their paths to an American dream. Depending on the friends and family with whom they were close, these paths may have been very detailed and/or felt more surmountable than the

challenges they would leave behind in their home countries. Even among participants who were less knowledgeable about life in the U.S., most described feeling certain that whatever they would be moving to in the U.S. would be better than their life at home: “I didn’t know what would be there, but I had no intention of coming back to live in Trinidad. My Dad said ‘Go ahead and see’” (Alice). The time-worn narrative of the U.S. as savior to global immigrants, refugees, the poor, and the oppressed helps construct an overall environment where immigrants can exchange work/labor and some sacrifice for the vestiges of productive citizens. This narrative ignores the role that the U.S may play or have played in the fortunes of other nations or the social inequities accepted in the U.S.; while simultaneously introducing aspiring citizens to an extreme individualism where they become responsible for their own outcomes, positive and negative. The American dream offers a version of hope built upon entrenched power relations that moralizes failures and mistakes as characteristics of the bad, lazy or unfit; imaginary possibilities trump reflections of U.S. shortcomings. Some of the conceptual trappings of the American dream also allow Caribbeans to embed notions of respectability and moral uprightness into their social strivings. Notions of respectability are rooted in historical, colonial and social structures and ideas that help constitute present day social relations in the islands of the Caribbean, in general, and in the islands of the former Commonwealth Caribbean, in particular. Respectability is also derived from social kinship models that value personal character and recognition. Imagined values are displaced and recombined to serve new aims of immigrant self-sufficiency.

Closely tied to the American dream is a narrative related to being a “good immigrant.” As a good immigrant one works, one takes care of oneself, one contributes more to society than one costs the society, one aspires to “leave no trace” and simply become American. What most participants learned once they arrived in the U.S. was that adaptation and social incorporation weren’t quite as easy as they imagined. Becoming American often meant becoming invisible—becoming so neutral that one never questioned American norms or beliefs; normalization meant glossing over differences. One would never want to be labeled foreign or, worse, un-American; yet, labelling was frequently a social process over which immigrants had little control. One’s skin color, accent, perceived race or ethnicity, limited

knowledge of U.S. history and nascent social capital could lead to labels, as well as social and geographic placements that were different than those imagined by new immigrants. The process of learning to which rights and responsibilities one could legitimately lay claim was not as simple as declaring one's allegiance to the U.S. flag. Despite the bumpy learning of unspoken rules and norms, many participants adhere to dominant ideas about both realizing their American dream and being a good immigrant. These ideas shaped their everyday practices. For example, in order to avoid applying for food assistance during difficult economic times, several participants described how they or family members worked more jobs or hours rather than ever be dependent on the government. Rather than being viewed as helpful for those in need, government assistance was generally viewed, negatively, as a mark against one's independence or work ethic. Two other participants described how working hard and being willing to sacrifice in the short term made them essentially different from the low status, African Americans with whom they may share some historic mistreatment and ancestral backgrounds. The fact that African American identity is enmeshed in particular ways to notions of the American dream and social incorporation is elided in their comparisons and will be discussed more in the section on the influence of racial formation below. The good immigrant trope urges immigrants on even when circumstances are difficult, while also performing boundary work that alienates immigrants from both "normal" Americans and Others (bad immigrants and other different Americans). This boundary maintenance ensures against collective knowledge and collective movements to change a status quo, while also minimizing state costs for productive immigrants.

In a 2005 book, *Consuming Citizenship*, Park described three variants on the immigrant, American dream that appealed to her research participants' imaginations: rags to riches (meager origins, abundant outcomes), martyrdom (abundant origins, modest outcomes), and morality (modest origins, modest outcomes) dreams. These narratives justify performing the good immigrant role, yet through different means. Among this study's participants, the rags to riches and morality variants were most common. A different version based on the idea of generational martyrdom was also quite pronounced.

Second, reflecting both U.S. notions of productivity and immigrant notions of self-determination, labor or work exchanged for money figures prominently in participants' values, repertoires and narratives about life. Arriving from countries where work shortages and economic, patronage systems have ruled historically, Caribbean immigrants are pleased by capitalist ideas of work, wages and opportunities for economic advancement. Quite simply, participants relish the idea that work can be rewarded; that their labor will be remunerated. Working in order to accumulate wealth feels different than working a piece of land or being without work. The idea that anyone, theoretically, can start a business and be an entrepreneur is invigorating. The overall organization of work, capital and resources and how they flow within the U.S. economy seem more open and freer than in their countries of origin. While one's work becomes a central part of one's identity for all people; work is also a means of authoritatively claiming citizenship when one is an immigrant, reinforcing its centrality to one's identity development. Unemployed participants included one retired person and one person who has experienced a series of troubling circumstances. The retired person volunteers many hours at a religious institution where she used to be paid for work. The other unemployed person has had difficulty keeping and maintaining a job despite completing post-Bachelor's coursework and, at one time, having the appearance of the American dream—a house, car, vacations. She now lives without these things in public housing and relies on government and charitable programs to assist her family of four with their livelihood, including her efforts to maintain a largely organic diet. She contemplates moving to Canada where life and work may be better—similar to many participants, she has relatives or friends from home there.

Third, participants spent a good deal of time talking about difference in time and their experiences of time compression. Time was seen as more personally valued in the Caribbean and more economically valued in the U.S. Everyone talked about their process of learning how clocks, alarms and timeliness were highly valued in the U.S. They all shared stories about missing an event or transportation or being embarrassed when they didn't arrive somewhere on time. For the societal value, placed on time, the majority of participants also highlighted a dissonance between how value was demonstrated in society so that one spent more time on work or on one's technological devices than with loved ones or

experiencing non-work life. A few described the U.S. tendency to live to work rather than work to live. Participants believed that although they valued work and the role of work in achieving their American dream, they placed a higher value on spending time relaxing with one's family and friends when compared to the typical American. Whether or not this value on socialization was exhibited under their current life circumstances, many participants aligned their perspectives on relaxation and enjoying life with imagined people from the Mediterranean, parts of Europe and South America. Paul's sentiment is representative of those who felt this way:

> "I feel like in anything in life, you have to work hard at it. You have to like really put the time in and stuff like that. Um, the only thing is, um, I do criticize—like in America, what I realize is like a lot of people, they, um, they live to work. Like, you know, like people like don't really get to enjoy their time…I've been back into the Caribbean and other places I've traveled, I just see people just living like a very nice peaceful life without worrying about business too much. They just live very nice—some people just live on a nice farm, like they eat natural. . .I notice that stuff. They just live without worrying about going to a 9 to 5 everyday… That's not me—that's the part I don't like about [America]."

In addition to comments about time expenditure in the U.S., participants conveyed their experiences with time compression. Time compression refers to what has sociologically been defined as time-space compression or time-space distanciation—through advances in technology, travel, communications and rationalized institutions like economics and bureaucracy, humans experience less space and faster, more frequent collisions of social objects and experiences (Giddens 1981; Giddens 1985; Harvey 1999). For example, foods consumed it the U.S. may be seeded from genetically modified seeds developed by labs in the U.S., grown in Mexico, transported to the U.S. and purchased as both crops i.e. tomatoes or components of packaged food products i.e. frozen lasagna. Further, the deterritorialization and global movements of foods also removes them from seasonality and geography. Social theorists describe time-space compression as a post-modern, result of global capitalism (Giddens 1981; Harvey 1990; Massey 1994). Participants experienced changes in time and space through their introduction, use and/or resistance to social products such as convenience foods, microwaves, a scarcity of naps and long meals, normalization of extracurricular activities and schedules for children as well as one's ability to move money easily between the U.S. and one's home country.

In terms of food and eating, processes of globalization and corporatization of food production countered many participants' beliefs in food quality, freshness and traditional cooking. For most participants, these changes and their migration precipitated changes in their eating practices such that dinner, rather than lunch, became their biggest meal of the day in the U.S. In the home countries represented by participants, lunch had historically been the longest and largest meal of one's day. Lunches were social and dinners were typically smaller and dependent on when one arrived home. Swapping lunch and dinner practices meant eating more at night than participants had in the past. Healthwise, such a change, depending on one's age, could have metabolic consequences. Regarding activity, two people from countries with less prominent Indo-Caribbean communities described being uncomfortable with the U.S. embrace of yoga or trying yoga due to its historical connections to Hinduism, a "foreign" or "distant" religion. Most study participants identified as Christian. While discomfort and dislike were predominately associated with time-space compression in participants' narratives, many also realized that such "evolutions" helped the U.S. become so diverse and (theoretically) welcoming.

Historical and contemporary deterritorialization and reterritorialization processes of people, goods and ideas, helped create the contemporary U.S. Alongside any challenges and dissonances encountered, Caribbean immigrants also arrived in a U.S. inextricably constituted by its diversity and multiple incarnations of difference. The U.S. symbolized one of the highest achievements of nation-state, ambition and moral rectitude, unity amid diversity. Here one encountered diverse people, lifestyles, foods, words, actions and choices. While diversity sometimes also signaled disparities, participants marveled at the worldliness possible if one lived in the U.S.—the possibilities for individual accomplishment within this diverse country was described as being important, freeing and informative as they grew more accustomed to life in the U.S. Whatever the U.S. promised would be not only better than what would exist at home, but also a life one could live in very few places on the planet due to its diversity, individualism and demonstrations of coexistence. In addition to adjusting practices around traditional foods, almost all participants also described introducing diverse or foreign foods into their diet

that they might not have encountered outside of the U.S. Exchanges of pad thai or lasagna for ripe tropical fruits and fresh goat were debated—some were uncertain about the overall flavor and health benefits of U.S. hyperglobalization. Nonetheless, by simply living as immigrants, participants also helped bolster and reproduce ideas about U.S. difference, diversity, and social inclusion.

Media was described as an influential messenger of both social norms and aspirations, but also a means for changing knowledge and perspectives on food and health. Since health-related ideas were of most interest in this study, other mentions of media will not be thoroughly discussed. However, it is of note that the role of media on the lives of those with children and in conveying ideas about race, ethnicity and citizenship were also discussed. In earlier discussions of children as agents of household socialization and norm adjustment, there were stories of children requesting specific changes in family habits or taste preferences—children's ideas were generally ascribed to two sources: school and media, corroborating the observation that these two concepts may cohere.

Interpreting participants' discussions of media, media channels, explicit influences on diet and health as well as representations of abundance and choice were most frequently described. Participants mentioned television and the internet as the channels over which most of their media were consumed. Participant mentions of television described viewings of scripted programming, reality and news shows. Food shows and the Food Network were considered important resources by a subset of participants who either were interested in cooking or who spent time actively trying to improve their cooking knowledge and skills. Cooking shows served an important role in changing the way that participants regarded food and cooking over the course of their time in the U.S. Whereas cooking was once predominately viewed as home-cooked meals prepared by a family member or hired domestic worker, the presence of cooking shows led to people think more about: cooking techniques, cooking styles, cooking as entertaining guests, how international and ethnic cooking are adopted by U.S. residents and what constituted normal American cuisine. For those who have been in the U.S. for decades, they once relied on co-workers, neighbors, in-laws and magazines for learning about American food norms. Those participants all reported shifting from print to electronic media when they had children or as multiple televisions per

household and internet access became more ubiquitous. Participants reported routinely turning to the internet for recipes today. Food televisions shows increased demand for products and instruments demonstrative of elevated cooking skills, but also revealed greater possibilities about how to cook, what to cook and why meals are important for participants. While only a two people mentioned seeing Caribbean cooks on television, reflections on their television representations on competitive reality shows revealed a bit about how media represents Caribbean food and their responses to these representations.

In general, the Caribbean food presented on television was viewed as mostly Jamaican or Cuban and based on the things that Americans, British and Europeans on travel in the Caribbean deemed most palatable. The chefs cooking Caribbean food on television seemed to decrease the spice level and accompanying starches and increase the fruit and vegetable contents in their meals. In the words of one these participants: "They're just trying to keep some flavor and stay on the show—they probably wouldn't serve that to their moms. . .not like that." The implication being that acceptance within U.S. environments might require some "watering down" of Caribbean norms. The erasure of Indian influences in representations of Caribbean cuisine seemed "strange" to one participant who noted that while Trinidad has many people of Indian descent, "Indian influence exists throughout the Caribbean like Jamaica, Guyana. . and there are a lot of Indo-Caribbeans in New York." These observations raise questions about how media representations of the Caribbean, its people and its norms are experienced by immigrants. Cuisines encountered during research observations also illustrate differential representation of the Caribbean in different U.S. cities. In the New York, tri-state area, Jamaican, Cuban, Bajan, Dominican, Guyanese, Haitian, Puerto Rican, Trinidadian and pan-Caribbean foods were available at restaurants; yet, in the Boston and Washington, D.C. areas, the variety of Caribbean restaurants narrowed.

Confusion around choices amidst such tremendous abundance was the last media related issue discussed. In terms of pursuing healthy lifestyles, participants thought that media presented an overwhelming number of health related messages, most of which were tied to morality (being a good person or doing the right thing) and interpreted through immigrant lenses as additional responsibilities of citizenship (being a good immigrant). Their feelings of extended responsibilities appear to be lived

experiences of medicalization/biomedicalization, where scientific knowledges are marshalled to tend to the care of bodies and the optimization of life (Clarke et al. 2003; Crawford 1980). Television and other electronic media platforms illuminate all manner of "healthy options," so that identifying such options could be less daunting, according to participants; yet, other, less healthy options are also featured. Some participants felt bombarded by health promotion messages around food and physical activity: eat less fat, eat less salt, drink water, eat less sugar, don't eat carbs, eat more vegetables, move more, walk 20 minutes every day, etc. However, the coexistence of health promotion messages alongside advertisements for cigarettes and fast food (perceived as "bad food" by many) was viewed as contradictory and also representative of the dominance of the U.S. value of capitalism—where the interests of money and corporations outranked the interests of the common people. Many participants believed that people in power could simply remove or reduce everyone's access and exposure to harmful items like cigarettes. Moreover, several participants pointed out the fact that Americans needed so many fad diets was because Americans had a difficult time with their own mythologized norm of moderation in their everyday lives.

The moral milieu of contradictions and government's inability or disinterest in truly helping its people served as an additional source of dissonance and disappointment for many participants. Coming from a region where cycles of authoritarian leadership and political repression have been common, participants who saw the U.S. as a model state became more familiar with the unpleasant outcomes (and externalities) of modern capitalism and corporatization. Though most agreed that there were still few other places in the world where they would rather live, suspicion about the role of government bureaucracy, corporations and population level decisions driven by profits was common. As several participants noted in similar passages: "if there is population level weight gain, it's got to be more than the food" (Koko). Beyond suspicion about formal institutions and the multiple messages they supported, a few participants voiced frustration or resentment about the notion that experts have sometimes identified traditional foods or those foods thought to be personally comforting as harmful. By contrast, other participants did not vocalize this resentment, but ruminated about a discomfort stemming from experts'

understandings of their home country foods. In the words of Lakshmi, I think the unspoken feeling resonated with others' articulations of resentment:

> "I think that there's a tension between how can we give up our food and still maintain health. And the argument that, "We've eaten this way for centuries, for generations. This is not what's making us ill." But of course, you know, just like with African-American culture, the foods also were accompanied by very rigorous and strenuous long-term labor, right? So, yeah, you always ate that way and the food didn't make you ill. The food fueled you, but now you're sedentary. Even the translation—even the difference of coming from the Caribbean to here, you're still talking about a more sedentary lifestyle. Because, as you know, the Caribbean people walk around a lot. You know, they take public transportation. You know, it's just different. So I think there's an awareness, but I think there's also a resentment when it comes to a discussion of adapting the way they cook. . .Although, you know, I really do say—think that, you know, as is often the case, it's the mothers, it's the grandmothers who sort of take it in hand and say, "Well, okay, I can try this. I can substitute this oil for that oil. I can use less of a fat. I can, you know, try—if I can afford it—to buy a better cut of meat."

In addition to resentment, this quote exemplifies the effects of changing physical or geographic locations on one's health. In several cases, participants noted few changes in their diet, but noted daily changes in their activity such that they were no longer required to walk or exert themselves physically in the same way that they did in the Caribbean. From these participants' perspectives, U.S. society may be misjudging the foods that have historically nourished them rather than considering their entire context

The final and, perhaps, most complex discursive structure discussed by participants was racial formation. Originally described by Omi and Winant in 1994, racial formation theorizes racial identities as dynamically constructed products of specific social, political and economic forces in society. Life in the U.S. is experienced through a variety of racial projects, taken up over time and space, in order to reproduce specific ideas about race, racial groups, and racial hierarchies. The U.S. racial hierarchy was discussed in each interview and stirred up intense emotional responses in most cases. Without exception, participants found their initial introductions to racial ideas in the U.S. confusing and most found the U.S. to be more racialized than expected prior to their migrations. Almost all participants had experienced situations tainted with mistreatment due to race, ethnic background, color or social class; yet most were surprised by the primacy of race as an organizing factor in social relations as the following quotes demonstrate:

> I don't think you can live in the United States without being part of the race discussion in one way or the other. Right? You hear it every day. So if you don't want to be part of it, you hate it, you don't want to be part of it, that's being part of the discussion. Right? You've made a decision to not be part of it and to speak of it like it's a hateful thing. And it is a hateful thing. And I think it's endemic. I think the white people have been doing it for so long, it's in their DNA now. The kids learn it. They pass it on to the kids. (Daymond)

> I've never experienced it until I actually came here to Atlanta and, in a way, I was really shocked because I felt that—with being Dr. Martin Luther King was here and there was the Civil Rights Movement and everything, it would be different, but it's really not. Um, it doesn't affect—I shouldn't say it doesn't affect me individually as a person. Um, I mean, I get angry and some things that are being done, like black males being killed, you know, only because they're black. I get angry with that (Happy).

Even though the participants represent different racial backgrounds and came to identify in a variety of ways when indicating their group affiliations in the U.S., the majority of participants had traveled from countries where social hierarchies were perceived to be based more on class status and skin color than race. Racial categories and having to choose a race on bureaucratic forms was despised by many participants; yet, many also believed that these categories were simply "the way" in the U.S. Most acknowledged that even when many humans know that racial categories are flexible and malleable, the use of race as a means of distinguishing groups had real consequences on people, in general and immigrants, in particular. One of the consequences of U.S. racial formation was the discounting and simplification of blackness as alluded to by Ramon, a "non-black," Dominican who grew up in New Jersey, when asked about his general experiences with race and class in the U.S.:

> Personally, I haven't had many issues with race. Like people haven't really called me any like derogatory names. Um, I mean but it's all around me, I guess, because Dominicans don't like black people, and like the Dominican and the Haitian situation is only getting more and more, uh, intense as like the years progress. So—and that's just because, generally, Dominicans don't like black people—even the ones that are black. It's funny because—it's ironic, because even black Dominicans don't like black people. It's very weird. It's hard to explain. Yeah. [Pause] Because they're all about like, you know, *blanqueamiento* which is like whitening the race and everything. The whole treaty and stuff was pretty messed up. But, um, in this area, the only racism I know now is like obvious black jokes and maybe a little bit of xenophobia because of all the terrorism baloney. But I don't think, uh—I don't think growing up around here I had any issues with race."[8]

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[8] Blanqueamiento refers to symbolic and biologic policies and practices that have been used, historically, as tools of Latin American governments to define and create increasingly white or European versions of their national identity.

Another consequence was the potential erasure of one's immigrant status due to preconceived ideas and images about who constitutes the population of U.S. immigrants to the U.S. Nilka believed she was not perceived as an immigrant, but as an African American until she spoke since current media focuses on Latinx and Middle Eastern immigrants.

Racial formation was most discussed in interactions involving housing and employment. Race was rarely mentioned with respect to health care or health outcomes which is of note given societal interest in health inequities sometimes defined along racial lines. Efforts to adapt to race in U.S. society included a range of emotional and behavioral responses including: trying to ignore race, cognitive efforts to depersonalize general comments, socialization with only other compatriots/Caribbeans/immigrants, social distancing from all things Caribbean, dating white, selecting identities not available in their home country e.g. mixed race or Hispanic/Latino, fighting to have new identities politically recognized e.g. Indo-Caribbean and never checking race boxes. Most who attempted to ignore race, found U.S. racial formation inescapable—leading to a kind of Caribbean "double consciousness" where immigrants frequently wrestled with the internalized social systems carried with them from their home countries as well as new racialized social systems within which their everyday encounters in the U.S. unfolded. Most participants also had to cope with their status and identities as minorities for the first time in the U.S. While participant reflections revealed multiple levels of rumination and analysis about race, most were clear about articulating an ongoing dialogue about convergences, divergences and co-constitutions among characteristics that made them immigrants and characteristics that labeled them as belonging to racialized groups; figuring out one's location within U.S. racial hierarchy became a type of social and political identity work that was necessary to assess risks to one's opportunities and life as well as to raise children and consider political engagement. A few participants explicitly identified this work of "living race" as being stressful. Understandings of race and racial formation were not simple and dichotomous, but

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Such practices have been noted in numerous countries where significant indigenous and/or African populations exist. For more see Andrews, 2004. Matibag, 2003, Wade, 2001 and Wade, 2008.

nuanced as several participants echoed Happy's observation about Afro-Caribbean and African American social conflict:

> "You feel [prejudice] and then you feel it from your own, among black people because you have some of the black Americans don't like us. They don't like the West Indians, sister, because they feel like we come here, we take the jobs that they should be having, and they feel like, you know,'Who are you?' But, I mean, when we come up from Jamaica, there's no job that's not good enough for us. We're willing to take any job to work as long as we're able to get ourselves from point A to point B. You know, so—and we go to school. We go to college, we go to school, you know, to achieve to get the things that we want. We work hard for it. So you get discrimination from your own people, you know, from black Americans, from white people, from, you know, just about I mean any race."

Despite different national and regional histories with race, ethnicity, caste and class in the island nations represented, the majority of participants found U.S. racial formation both immoral and thoroughly embedded into many aspects of U.S. society.

While dicourses about citizenship and racial formation influenced one's health-related practices by shaping people's mobility, geography, stress profiles and degrees of otherness; food practices were also shaped by other social discourses. Discourses about organic and "good" foods were present, but participants were more comfortable with ideas about moderation and consuming local foods. Despite conformity in appearances and actions, participants demonstrated some resistance to underlying beliefs associated with healthy lifestyles (Bourdieu 1979/1984; Veblen 1899). Food as nourishment seemed a dominant Caribbean discourse that also aligns well with many participants' religious beliefs. Channeling the resentment mentioned by Lakshmi, participants believed that U.S. society gave us "too much worries" and worrying about food was one worry that they would happily relinquish. Some mentioned they had other things that they would rather worry about than whether or not food was good for you. Participants offered meats, eggs, alcohol, coffee, carbohydrates, processed foods and natural remedies as among the products they were told to fear ingesting. Feeling exhausted by the worries and responsibilities of navigating these risks in society, some chose not to worry about how the foods they ate affected their health; others became vigilant label readers (Lupton 1999). Even among those who didn't want to worry

about healthy living, efforts were made to transfer ideas about both healthy eating and exercising to younger generations in their families. Ambivalence and uncertainty about the future led participants to hedge their bets by doing a little bit of "healthy" even if they were suspicious of existing data about what constitutes "healthy."

Reterritorialized Caribbean Norms

Demonstrating the embodied nature of living transnationally, participants also described home country ideas or norms which they had difficulty discarding or reconstituting for use in their new lives in the U.S. Reterritorialized norms describe acts where individuals separate sets of beliefs and practices from their context and try to revive reliance on those beliefs and practices in a new setting (Appadurai 1996). Ideas around land ownership and lack of household help were particularly difficult when forming households in the U.S. Many in the Northeast region found housing prices so prohibitive that home ownership (a steadfast, group aspiration) consisted of condominiums and small plots which were very different than the homes in their imaginations. Similarly, lack of household, domestic help, a norm among middle-class and dual income households in the Caribbean, meant new ways of addressing multiple household jobs including cooking, caring for children and managing household emotions. Domestic help in the U.S. was considered inaccessible due to both the absence of friends and family who might assist and the costs of formal care arrangements.

Second, differential ideas about kinship, belonging, fit and fellowship made it difficult for some participants to find social groups where they felt comfortable in the U.S. Among this group, spending time with similar Caribbean immigrant families was most desirable. Lower levels of belonging were identified among those representing the middle ages of life; whereas people under 30 years and seniors failed to mention this never-quite-recovered loss of belonging.

Rounding out home country norms which may influence one's health ideas or health status, about half of participants mentioned challenges with differing U.S. norms around alcohol use and religion and a few participants mentioned differing norms related to social prejudices and desires for distinction. In

brief, although alcohol was consumed across national environments, participants felt that the Caribbean had more relaxed attitudes towards drinking alcohol and fewer social prohibitions about its usage. Although alcohol was not originally among the topics discussed in the interviews; conversations with a few respondents and experts working on non-communicable diseases in Trinidad led to limited exploration of alcohol use related to adaptation. Alcohol abuse is of growing concern both in the Caribbean and among certain subsets of immigrants in the New York area (Maharajh and Ali 2004; National Alcohol and Drug Abuse Prevention Centre 2000; ECHORN Trinidad and Tobago Delegation Personal Communication 2015). Only two people described drinking alcohol as a means of coping with social isolation or stress. Another participant described community level problems associated with cricket games and subsequent domestic violence.

Religion was similarly described as being practiced quite differently in the U.S. and participants' home countries. In a notable theme about immigrant impressions of U.S. values, participants believed that even among religious people and churchgoers, Americans were experienced as much more focused on consumption and material goods than religion. The reader may recall Charlotte's earlier description of how U.S. materialism manifested during one of the most religious times of the year, Christmas, and felt quite different in the U.S. versus Jamaica. Despite sometimes changing denominations or church types, many participants viewed religion as an important coping mechanism and source of rejuvenation. The U.S. was experienced as a more secular society. Only two participants mentioned having little or no connection with religion or a spiritual social group. Although most participants were surprised by the influence of racial formation on U.S. society, several described being used to different sets of "outsider" groups against whom social prejudice and discrimination were more acceptable in their home countries e.g. homosexuals and atheists. Part of becoming American meant embracing a wider set of human manifestations and tolerating, at least publicly, new axes of difference. U.S. ideas about tolerance remain difficult for some. Finally, even though participants thought of individualism as an American value and norm, several participants perceived conformity that coexists with U.S. versions of individualism. As described, in the Caribbean, one is not typically working for individual recognition. Families often work

together or there is a collective sense of pride in family members' jobs. Individual level pride was expressed through possessions or characteristics that might distinguish one from their family and social network. Stories included distinction being represented through always having an outrageous outfit, cooking one dish really well or owning an advanced technological device—some way of standing out. However, even those distinguishing themselves would always look out for a neighbor or friend in need—something not observed among Americans in the U.S. by many participants. Individual and personal drive seemed starker during participants' initial time in the U.S; however, commitment to these ideal types of U.S. self-centeredness and Caribbean neighborliness may demonstrate the ways in which individualism and collectivism have different relationships in the U.S and other countries rather than absolute value positions.

Immigration amidst Globalization

Another indication of the porousness of national boundaries, participants implicated globalization in the diffusion of several societal or population level factors that might influence health. First, most participants wanted some recognition of prior waves of globalization that were responsible for the diverse nations that presently comprise the Caribbean region. Their island nations were populated due to previous waves of global investment, migration (forced, coerced and voluntary), labor and development. Just as the U.S. is a nation under constant development, participants' nations continued to develop and change when they left. Six participants speculated about the potential absence of true culture shock if a teenager from today's Caribbean moved to the U.S. Due to ongoing regional development, technological and resource advances as well as circular, transnational and retirement migration patterns, Caribbean nations are already exposed to much more U.S. culture than immigrants in almost any year prior to 2015 would have been. Likewise due to immigrant enclaves, healthcare niche labor and tourism patterns more Americans than ever before have been exposed to Caribbean cultures and/or people. The bidirectional flows of goods, money, people, and ideas means that today's immigration and adaptation process would already be different than the journeys taken by most of the study's participants. In fact, many participants discussed

new global norms around some ideas such as e.g. economism, convenience and packaged foods, automobiles and mobile communications. Moreover, global changes in food production, food and activity habits and transportation mean that health statuses may also begin to converge rather than remain distinct. Rising rates of non-communicable disease in the Caribbean and other regions in the Americas suggest that potentially, protective pre-migration health statuses may be fading into the past. In terms of disturbing elements of globalization, participants noted both the changes in agriculture and food production as well as the global spread of tribalism and racial/ethnic animus. In fact, reflecting on the most recent election in Trinidad, one participant described how she felt like Trinidadians were learning how to be more racist than ever due to their exposure to media and ideas from the U.S.:

> "So there was a divide between two parties. One is East Indian primarily, and the other one is Afro-Trinidadian primarily. And how it got—I mean, I never saw it like that before. I never—I mean people were like hitting...it was strange. I'd never seen it like that. Like even on Facebook, it just got ugly to the point that people were like, 'where did this come from?' But elections happen every five years, so we'll see what the next five years. But I think it's coming—it's mirroring a lot of what I've seen here, which is strange that we would choose that to pick up." (Denine)

Others also reported home country upticks in ethnicity related animosity that could not be corroborated by public records or literature.

Overall, participants' experiences of dynamic and reterritorialized norms support migration research which attempts to identify adaptation-related contributions from both sending and receiving societies, rather than exclusive consideration of receiving society context. Empirical and conceptual work by de Haas, Levitt and others focus conceptualize sending and receiving societies as intertwined nodes within historically-situated networks (Bhatia and Ram 2001; de Haas 2007b; Goldring and Landolt 2014; Grewal and Kaplan 1994; Khagram and Levitt 2008; Levitt and Lamba-Nieves 2011; Levitt and Schiller 2004; Schiller, Basch and Blanc-Szanton 2006; Sternberg and Barry 2011). Moreover, scholars drawing from feminist and postcolonial traditions, also reject the simplistic, dichotomous frames used to describe migration processes (Das Gupta 2010; Le Espiritu 2009). These scholars are most interested in broadening frames of inquiry to include the global circumstances (colonialism, resource exploitation, global racial-social order, etc.) that predate and frequently influence decisions to migrate. From a policy

perspective, Castles (2002) notes how simplistic and dichotomous framings of migration processes lead to frequent miscalculations in the policy arena due to frames that exclude: the social dynamics of migration processes, factors of globalization or transnationalism and factors within political systems. Dichotomous representations of migration reinforce broad comfort with oppositional frames, while also reifying the "foreign-ness" of immigrants. Such representations perform socially significant boundary work while also priming "zero-sum" resource and ethical frames used to suppress migration and immigrant rights (Beck 1986/1992; Bourdieu 1979/1984; Giddens 1991; Star and Griesemer 1989/1999). However, the changing global context of migration and different configurations of immigrant movement, identity and involvement across geopolitical boundaries suggests that there should be more space for theoretical approaches that grapple with transnational and global complexities of mobilities.

Chapter Summary

While the primacy of structure and agency will continue to be debated among social theorists, participants' narratives were replete with actions perceived as agentive as well as those shaped by structures. Participants identified numerous structural factors which may have influenced their adaptation processes in the U.S. as well as their health status and health outcomes. The structural influences discussed here vary in their grip, ubiquity and perceived power. Table 13 depicts participants' empirical identification of structural factors alongside structures commonly considered in two disciplines, sociology and public health. Though the complexities evident in project data do not support directionality, the table also includes arrows to demonstrate whether the identified factors were perceived as health affirming or health degrading.

Table 13: A snapshot of structures across disciplines

The arrows indicate potential directionality of structural influence on health based on empirical findings: ↑=Health affirming; ↕=neither health affirming nor health degrading; ↓=health degrading.

Study Findings	Sociological Structures	Public Health Structural Factors
• Legal status ↑ • Governments ↕ • Right to work ↑ • Mistrust of authorities ↕ • Geographical environment ↕ • Physical environment ↕ • Socioeconomic status ↑ • Housing segregation • Family expectations ↕ • Normalized ideological and discursive structures ↕ • Racism/discrimination ↓ • Media ↕ • Time constraints ↓ • Work expectations ↕ • Reterritorialized norms ↕ (transnationalism) • Globalization ↕ • Corporate interests ↕	• The state • Family • Religion • Socioeconomic position • Education systems • Employment/labor systems • Criminal justice systems • Economic systems • Race/racial formation • Science • Media • Normalized social institutions such as gender relations, marriage, heteronormativity, etc. • Classification • Exclusion	• Poverty • Family • Educational attainment • Environmental exposures • Housing and neighborhoods • Employment patterns • Incarceration • Access to health care or social services • Information asymmetries • Organization & policies • Funding • Facilities & logistics

Metaphorically, participants seemed to experience structural factors in three ways: structures as foundation, structures as borders/boundaries or structures as atmosphere. Foundational structures were those that established one's baseline or starting points for action. Foundational structures were viewed as largely outside of the individual's control. Examples of foundational structures include: poverty, geography, and environmental exposures and configurations. Boundary structures were viewed as normative and conventional, yet conquerable or evadable. These structures could be circumvented or avoided with awareness, planning and compartmentalization. Examples of boundary structures include: legal status, social expectations and norms, fear deriving from mistrust, socioeconomic status, racial formation and time. Though some of these structures may seem fixed to readers, participants viewed these structures as surmountable or evadable if one was able to accumulate money and material resources enough to buffer oneself and one's family from their effects. Atmospheric structures, like the air that we

breathe, were viewed as omnipresent and enveloping; however, with the proper filters (i.e. engagement, analysis and or alternate discourses) one could inhale and use only what was needed, exhaling toxic or otherwise undesirable elements. Atmospheric structures change with one's climate and geography, and were perceived as more malleable or maneuverable even when highly influential. Examples of atmospheric structures include ideologies, discourses, home country norms, and globalization. It is important to note that even though participants expressed feeling more powerful than certain structures, the process of ridding oneself of such structures seemed both potentially emancipating, but also laborious to those who imagined "rocking the boat." Figure 10 provides a metaphorical representation of individuals in relationship to the different structural factors discerned by participants.

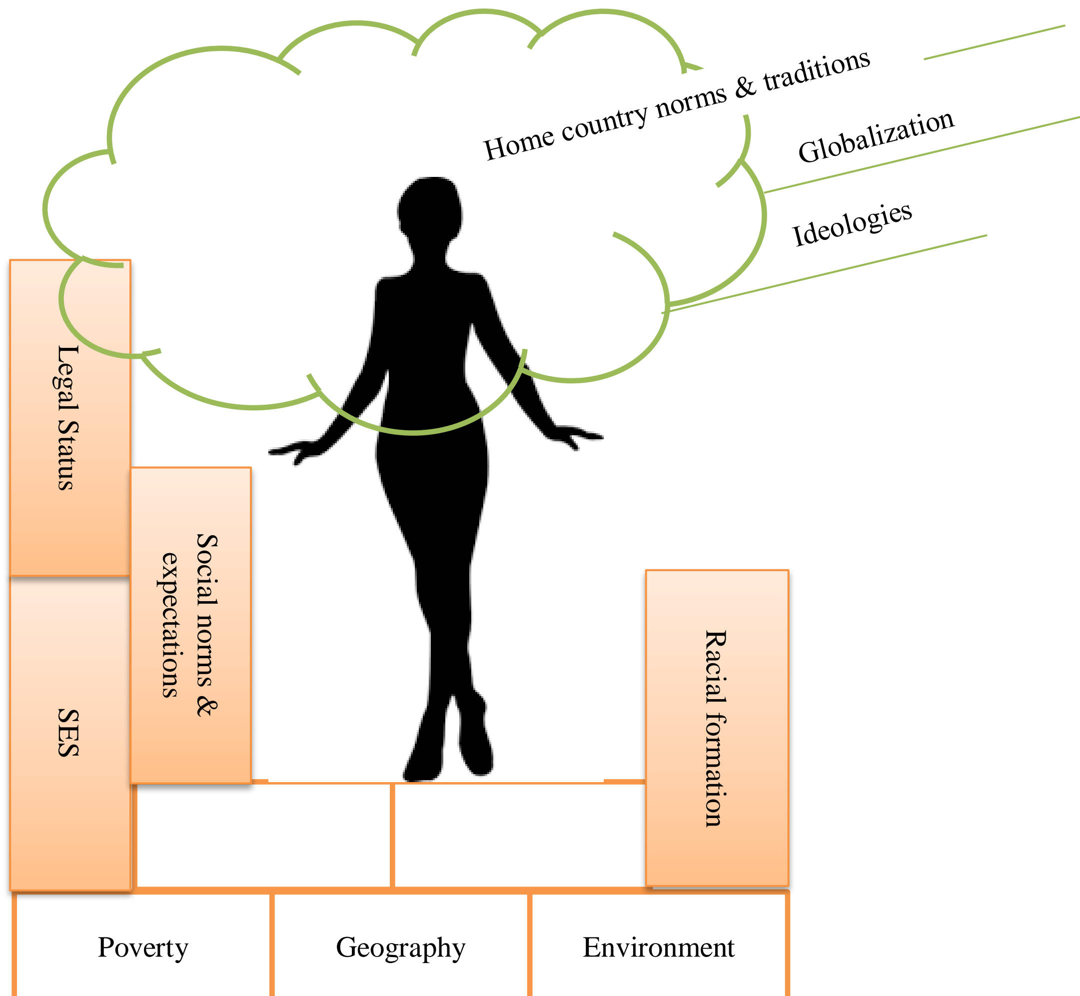

Figure 10: Metaphorical depiction of structural factors faced by study participants

In terms of ruling relations, this study reveals lay concern about power exercised by governments, corporations, and employers. The bureaucracies and logics of these institutions seem opaque and arbitrary. Participants recognized that in most places the aforementioned institutions hold sway over individuals. Participants were disturbed by the sway held over them by real estate and marketing professionals, schools and media. Participants described being most powerful, individually, when it came to decisions about family arrangements, number of jobs/hours to work and spending money they earned. Supporting persistent empirical relationships between agency and socioeconomic status, participants who reported high SES and others who had experienced swings in their income reported feeling more powerful when they had more money. As money influenced dietary and activity practices, their perspectives further support ideas about socioeconomic position being a fundamental, social determinant of health status.

More than fodder for theorists, social structures are identifiable by and matter to everyday people. This chapter describes multiple types of social structures influential in Caribbean immigrants' processes of adapting to U.S. society. Large organizations and institutions as well as norms around foods and activity were described as most influential on health status. Analysis provided here is merely suggestive and inconclusive, yet similar types of research may help align applied interest in structural factors with theorizing on structure in order to enhance the creativity and feasibility of future structural interventions. Weaving through these different types of structures, participants have actively imagined and woven together patchwork lives as immigrant Americans.

Chapter 9: Theorizing Health Acculturation

The purpose of this research was to explore migration, acculturation and globalization as factors relevant to the establishment of dietary and physical activity norms among immigrants to the U.S. By improving research understandings of contextual factors that contribute to practices and routines when one's geographic and/or political environment changes, this study sought to contribute to emerging knowledge about health related adaptations that follow migrations. More specifically, this project highlighted a range of emotional, social and structural factors, beyond political and economic factors, that might influence emergent or re-established diet and physical activity practices; analyzed relationships between understandings of health and adaptation, and identified some elements of quotidian life that advance, maintain or degrade health among one immigrant sample. Analyses of interviews, observations and discursive texts outlined a potential framework for more thorough understanding of the processes and interactions involved in one's transition from new immigrant to hyphenated-American to American. This chapter is designed to reflect on the journey taken over the course of this manuscript while asserting the limited, yet important contributions of this investigation. After outlining a detailed proposal the immigrant health adaptation (IHA) or health acculturation framework including ideas about how various factors and levels interact and inform individual decisions and actions, study engagements with existing literature, contributions to related fields of research and areas for future research inquiry will be discussed.

Theorizing health acculturation

Immigrant health adaptation (IHA) or health acculturation represents my efforts at middle range theorizing about the specific steps and processes that contribute to contemporary adaptation to societies like the U.S. where health and healthiness is valued by powerful interests and utilized as cultural capital by many to influence social outcomes. This theorizing has been informed by the study and observation of transnationally-engaged, Caribbean immigrants to the U.S, in particular; yet, hopes to posit insights for multiple individuals and groups. Within sociological traditions, middle range theorizing attempts to

connect empirical evidence with more abstract ideas about social action and social change. By definition, such theories are not grand in scale, but limited in scope and seek to harmonize ideas about observed phenomenon with more abstract ideas about our world. However, also influenced by post-modern, post-colonial and intersectional turns in the social sciences, this theorizing seeks to open up a realm of potential influences for further exploration rather than identify one universal truth about immigrant adaptation and how such adaptation influences one's health

Emerging from formal studies and informal observations of transnational immigrants, immigrant health adaptation involves multiple levels of action and systems and may be defined as a directed movement from one embedded understanding of health, its production, reproduction and consequences to another such understanding based on changes in one's geographic and/or social environment. The empirically-grounded process is neither uniform in its duration or effect, with some processes shifting dramatically and seemingly all at once, other processes meandering in contradictory directions and still other processes persisting, sometimes with modifications. Immigrant health adaptation is marked by signs of struggle and confusion, whether subtle or dramatic, and weighted with aspirations for life improvement or house/family improvement and hopes for more abstract value realizations (say, realizing freedom over one's right to work), despite having to learn new rules and games for living. IHA is consequential for immigrants and, potentially, others because it helps shape the resources available, sought and applied towards premature mortality and its various precursors. Embedded within social processes and institutions and negotiated amidst dominant ideas about health, IHA follows dramatic human movements even when resistance is present. One may be able to observe and/or assess gradations of intensity as well as social, economic and political consequences that accompany various stages of immigrant health adaptation. IHA involves one's beliefs and ideas, actions and motivations. Whether one aspires to optimal health/wellness, lack of symptoms or controlled illness depends on the formations and frictions that result when everyday activities encounter macropolitical, societal, and interpersonal level ideas, structures and boundaries. The current research identified five ideal type factors that influenced adaptations specific to understandings of diet and physical activity: political/legal, economic, emotional, sociocultural and societal/structural.

Within and across factors, fifteen important processes of health-related adaptation were also identified: emotion management, personal and collective emotion work around the concept of family, adapting emotional expressiveness, settlement practices, cooking practices, activity practices, health practices including weight monitoring and body disciplining, citizenship performance, legal/political administration, physical environment selection and risk assessment, norm negotiation, Caribbean norm reterritorialization, media consumption, cosmopolitanization and becoming more critical/skeptical. Subsequent research may identify other domains, conditions or processes.

Figure 11 revisits the general framework posed at the research's commencement and incorporates details and processes that emerged from the study. At the macropolitical level, individual actions may be shaped by globalization and global hierarchies as well as political and legal citizenship. Structural factors emerge from interactions between macropolitical and mediating concepts within specific time-space locations e.g. New York City in 2015. Next, the mediating level is where economic and more abstract or broad sociocultural factors can be found such as socioeconomic status, norms or discourse. Whereas, more concrete or direct, contextual factors such as one's interactions with one's family, one's body and emotional factors exist in the interpersonal and individual level of the framework. Many, but not all, contextualized practices, acts or behaviors may also be located at the interpersonal and individual level. The framework is a heuristic tool to capture multiple sources of influence and action within one frame focused on elaborating happenings inside the conceptual black box of immigrant adaptation or acculturation. Beyond broad conceptual factors, findings presented here also provide a rich exploration of the nuance and contingencies involved in establishing post-migration practices and considerations of health as one adjusts to live in the U.S.

In order to revisit the intricacies of this emerging framework and to provide exemplars of abstract ideas, a composite case biography of Zayna (in italics) will accompany elaborations of key concepts. While the perceived contributions of political/legal citizenship and economics will be discussed, it is my intention to focus on the factors that have been less apparent in formal studies of migration and health—

the emotional, sociocultural and structural factors that have influenced and shaped participants' appraisals of U.S. society, the role and purpose of health and adjustments made in order to live in the U.S.

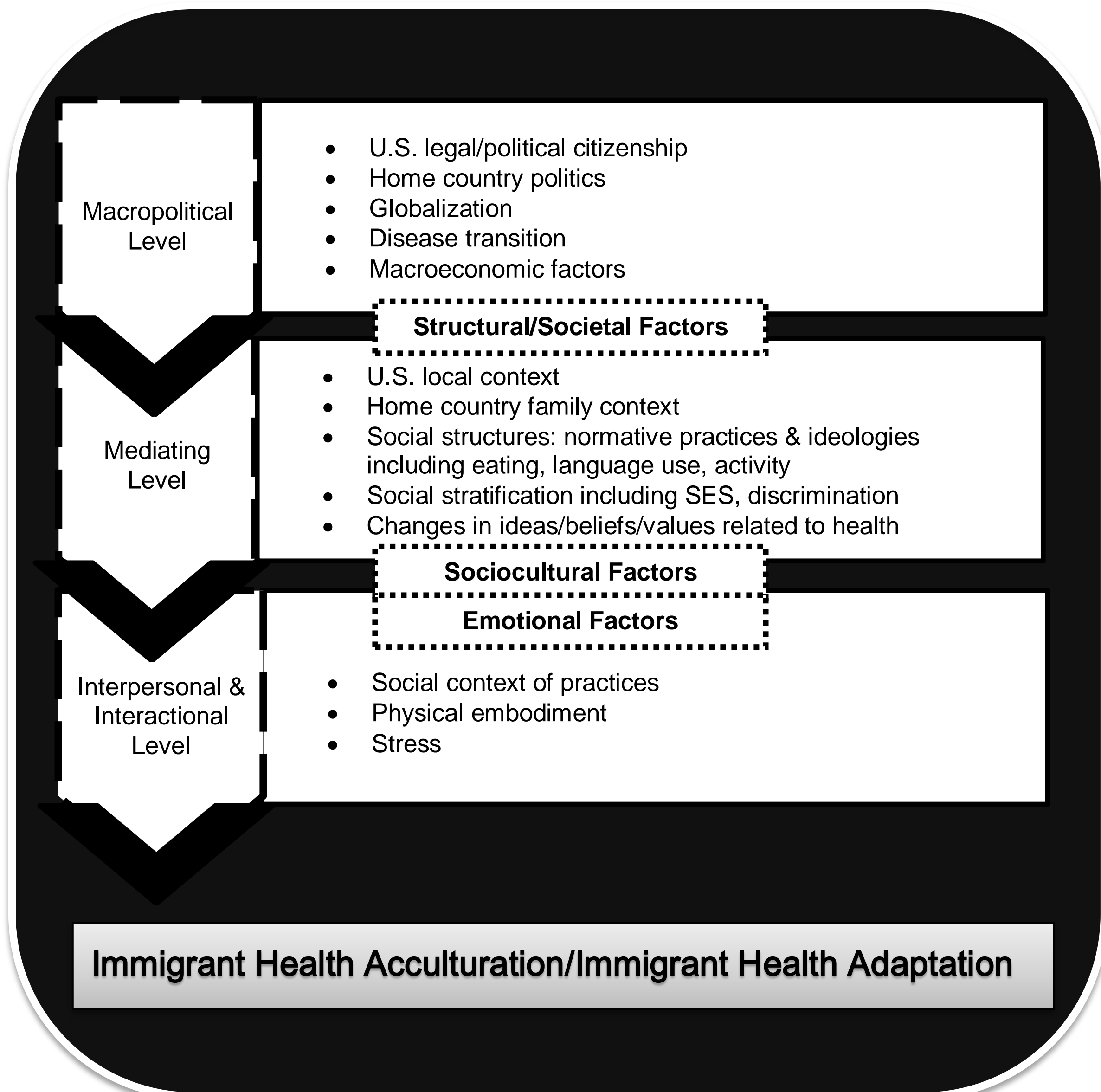

Figure 11: Immigrant Health Adaptation Model with Specific Factor Types Highlighted

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A Composite Case Highlighting Immigrant Adaptation Processes & Vulnerabilities

Zayna's high school exams demonstrated an aptitude for extended studies, yet she worried about the jobs she would find when she finished school. At the insistence of a family friend, Zayna looked into

U.S. colleges and universities. Through a local program, started by U.S. expats with island heritage, she applied to and was accepted at several U.S. colleges. Her parents decided on a college for her based on their knowledge of the schools' prestige. At seventeen, she flew to the U.S. one week before college began—her auntie met her at the airport and helped her travel from the city to the college town. She wasn't very close to her aunt, but was happy to know someone else in the U.S. She was also happy to have somewhere to go during shorter school breaks. Her parents helped her pack well and prepare for snow. She was sure she would miss her parents terribly, but didn't think about what she would eat until her Ma packed some seasoning.

As a curious and intelligent child, Zayna had difficulty imagining her future due to high rates of underemployment and unemployment on her home island [structural and individual factors]. Even with good educations, people could not always find jobs. Caribbean labor markets are shaped by complex factors including property ownership, government and enterprise organization, scale and globalization [structural factors]. Due to her family's island class position and status, she was aware of different opportunities and paths and decided to consider the U.S. for college [sociocultural factors]. Her parents' normative, island-middle class ideas about prestige led them to choose her college [sociocultural and individual factors]. Zayna flew from her island to a U.S. airport on a student visa and was greeted by an aunt who already lived in the U.S. Zayna's aunt was her initial touchstone in the U.S.—in her she had a relative, a driver, explainer of U.S. norms and oddities, a physical place to stay, when necessary, and a psychological anchor [macropolitical, sociocultural and interpersonal factors]. For months, she and her family planned how she would make the journey, communicate back home, stay on top of her studies and take advantage of her opportunity [structural and sociocultural factors]. Though her mother anticipated some changes in taste, due to what she had sampled in U.S. restaurants or multinational chains present on the island, they had never talked about food or how she would eat [sociocultural and interpersonal factors].

The first case paragraph demonstrates how macropolitical and structural factors might influence one's decision to move to and one's entry into the U.S. This paragraph also asserts specific island class

and status positions and logics [structural factors] that have helped shape Zayna's worldview. A migration trajectory and some migration expectations have been set; extreme differences like snow and isolation have been anticipated and discussed [sociocultural factors]. Finally, this paragraph demonstrates the taken-for-granted nature of food and eating such that changes in how one eats never arose, but fear and uncertainty set in once Zayna realizes that her mother packed seasoning both to help her feel at home in her new environment far from home, but also to provide a familiar taste [sociocultural factors] in case she didn't like the food. Not realizing or thinking about how food and diet might change was a common occurrence—eating was simply too ordinary or mundane to be planned [dietary practice/individual factor]. Concerned about extreme changes in temperature, many participants or their family members planned for snow.

During her week with her aunt, Zayna was overwhelmed by the newness and scale of everything in the city, but excited to embark on a new journey. She observed some differences in the timing of meals such as an earlier dinner and many options to shorten traditional meal preparation times such as packaged foods, Caribbean and American, microwave ovens, frozen foods, and food prepared for eating on the go or carrying home to eat. Caribbean foods were eaten for most dinners at her aunt's house, but her aunt cooked once every two to three days instead of everyday. Her aunt barely ate breakfast and drank coffee, but thought she might like oatmeal as a quick substitute for porridge. Her aunt ate lunch at work most days, so she left her a list of nearby cash and carry restaurants and some money and told Zayna to explore the area a bit, while staying within certain street boundaries. Her aunt took a couple of days off from her job as a nurse, but worked many hours on the other days Zayna stayed with her. Zayna began to understand the more jobs and more work in the U.S., also meant more time spent working. She was surprised by her aunt's schedule, but noticed that things were expensive. She was grateful for all her aunt did for her. Her aunt helped her think about other things she might need for college, bought some additional things for her including a smart phone, and then drove her to her college town about 2 hours away. Her aunt reminds her to keep herself respectable and be careful with some of the blacks.

This paragraph sheds light on some elements of Zayna's interactions with her only family member in the U.S., as well as her aunt's neighborhood, schedule and dietary habits [structural and sociocultural factors]. Her aunt's eating practices have changed due to her time in the U.S. as well as her work schedule. Zayna's eating practices shift to fit her environment and her aunt's time. Leftovers [structural factor] were new, but didn't seem like a big deal. The abundance of options pleased Zayna and it was possible to get something similar to island food [sociocultural and emotional factors]. Walking through the neighborhood was exciting and moved her body [sociocultural and emotional factors]. Though dangerous areas existed back home, they were a drive away; her aunt's warning introduced a new idea about neighborhood safety/risk [structural and sociocultural factors]. Her aunt also introduces her to some U.S. middle class norms of smart phones, prepared foods and wariness about some African Americans [structural factors].

At college, Zayna's minority background was pointed out more than it ever had been in her entire life. She knew that the U.S. and college would have white majority populations, but she never realized the extent to which race and difference came up in the U.S. Her roommates pried her with questions about her home which seemed fine. They also asked if she knew the other islanders at her school from back home which seemed strange—did all Americans know one another? Professors and RAs sometimes mistook her for other brown-skinned people even when they didn't look alike or share national origin backgrounds. Some people even asked to touch her—she wondered if they thought she had a tail! She was friendly with her roommates and classmates, but always felt like she missed something in conversations or couldn't talk about recent television, film, music or U.S. politics with ease. She talked much less than she did at home which seemed to change her personality. Though at home she was considered outgoing, in the U.S. she had become muted. . .smaller. She made a group of friends who all happened to be immigrants from another country and joined a Caribbean Student Association that seemed welcoming. Her first trips to the dining hall were miserable. She had no idea what to pick, what things would taste like before putting them on her plate, or why there were so many choices, options, add-ons and side dishes. The first dinner she asked what her roommates were getting and tried those dishes—the foods

were all bland or flavorless. In the morning, she watched what other people ate for breakfast—she picked up a muffin, something she had never had; yogurt, something she had rarely and tea. She didn't see porridge or oatmeal. But lunch was the worse—lunch featured salads and sandwiches and one hot casserole with lots of things in it. Lunch, which used to be her biggest and longest meal, was to last 30 minutes and she needed 5 minutes to walk to her next class. She had never eaten so much cold food and wasn't sure she would like the casserole. She really wanted some hot food, so she tried it—she still had no idea what was in it. She wanted to run back to her room for her bottle of seasoning. Her classes were going well, she got a long with her roommates, she talked to her parents frequently, connected with some home friends via smart phone apps, but she felt trapped between cultures. She didn't always know what was expected of her in social situations—sometimes she talked too much, sometimes she talked too little, she didn't get jokes and everyone seemed curt. Their speech was sometimes formal, but people's manners were lacking and no one but her on her entire floor ironed clothes or dressed well for classes. In order to meet more people, she started playing intramural soccer—she had always kicked around footballs with her brother at home. Soccer was great and gave her a new group of friends. She contemplated getting a job because her family did not anticipate extra costs i.e. books and clothes when they received her financial aid information. There were a few on campus and off campus places where other students worked. She thought she could look for work at one of the stores where she would need to buy new soccer clothes. She hadn't discussed it with her parents yet and wouldn't want her grades to suffer, but suspected that she would need extra money in a few months. She looked around the store for exercise stuff and then noticed someone following her. She looked back to hear, "Is there something I can help you with? Do you want to see the sale rack?" Although the frugality imparted by her parents would have typically led her directly to the sale rack, there was something about the way the man spoke and the way he was looking at her that made her feel like she didn't belong there. She decided not to ask about a job application and left the store. Months later when she heard two people talking about being followed in that same store, she understood what happened—she had been racially profiled as either someone who was going to steal or someone who couldn't afford to buy things in the store. As time passed, she figured out some dining hall

foods that were tolerable and she became quite familiar with peanut butter and bagels, but she looked forward to having access to a kitchen as a junior. If only she had a kitchen, she could eat what she wanted, she could eat more real foods; she would have to bring back some recipes from her parents and aunt. She hadn't really cooked before, but thought she would have to be able to do better than the dining hall.

This passage is where Zayna's day-to-day influences change from what they were at home and at her Aunt's and to those that would be established for her next four years. Starting college introduced new experiences, norms, customs and expectations—some seem reasonable for the setting and are easily replicated, others seem strange and are more difficult to adopt [sociocultural factors]. Within this period practices related to emotion management, communication, settlement, eating, activity, health and citizenship are re-established—some new practices are tested, some old practices resume in modified settings under new conditions and some old practices persist [structural, sociocultural and individual factors].For the first time, she is making day-to-day decisions on her own and she's not always sure what to base her decisions on. She takes cues from those around her, what her family might expect of her, as well as things she sees in media [structural, sociocultural and individual factors]. Here, Zayna is introduced to U.S. style racial formation and racial profiling [structural factor]. It took time for her to understand the reason behind some of her interactions. Eating, a once pleasurable and social task, began to become more instrumental and unpleasant [sociocultural and emotional factors]. She resists the idea that food is primarily instrumental, but does what she can to get on in life. Tolerable substitutions for the food she loved back home included more processed foods, more dairy products, sweets and different kinds of carbohydrates [structural, sociocultural, and individual factors]. She never looked forward to meals, but enjoyed getting together with friends [emotional and interpersonal/individual factors]. Zayna did not have the same discretionary, spending money that her peers had since her family could not imagine what one would need beyond room and board. She also began to realize how expensive things are and realized that she could help out by getting a job. She is reluctant to discuss a job with her parents because they will want her to focus on studying, as she has always done, but she thought it was time for

more responsibility and more money [structural, sociocultural and individual factors]. When Zayna encounters awkward or uncomfortable social situations or when people misrecognize her, she usually remains silent, staring and thinking about why this has happened to her [sociocultural, emotional and interpersonal/individual factors]. As much as Zayna was interested in taking control of her dietary destiny, she had not yet cooked [sociocultural factor]. In her imagination, the food she would cook tastes like her Mom's food with some American ingredients [structural and sociocultural factors].

After finishing college, Zayna gets a job in the U.S—she changes visas and thinks she has a chance of getting a green card. She moves close to her aunt and moves in with a Caribbean roommate. They cook together, share food, invite friends over for dinner and even begin to host dinner parties featuring fancy, non-Caribbean food. Work is great, generally, except for when peers she hasn't met yet assume she is an administrative staffer rather than a scientist. They always apologize, but there's really no explanation except for stereotyping. Her racialization reminds her that she also hates some things that happen on social media such as only getting dating requests from black people even though that is not her exclusive preference and comments she reads about people with darker skin being ugly and undesirable. Those things are minor; life is mostly good. She continues to play soccer with a local league, but playing soccer has not seemed to help her lose the twenty pounds she gained in college. She'll lose five pounds and then gain it back. She's down about ten pounds from graduation, but doesn't understand the weight gain since she is active and she eats everything in moderation. Her parents constantly ask her if she's staying in the U.S. or coming back. She's not sure yet. She would love to be a scientist at a university back home; but there are so few positions, she may never be able to find work back home. She's not sure what she'll do, but she'll work as much as she can until she decides to help support her future. She started a website design business to earn extra money since her hours are pretty reasonable. Right now, she has nothing to complain about, but her roommate is not having the same luck and may have to go back home soon. With her roommate by her side, she's been able to create a health- and life-affirming social environment that contributes much to her overall joy and well-being. She can't even imagine living life as an adult any other way. What would she do if her roommate leaves?

In this final case paragraph, Zayna has completed college and begun working in the U.S. [sociocultural factors]. Her political/legal status is stable and she aspires to get a green card [structural factors]. Her social network includes her aunt, her roommate, some friends from college and people she meets at work and soccer [sociocultural factors]. Starting a side business means that she'll also meet more people. [structural, sociocultural, and individual factors]. Her life is like many young adults, full of promise. She becomes more concerned that her only employment prospects will be in the U.S. [structural factors]. She can ignore her parents' requests as long as she is self-sufficient and happy [sociocultural, interpersonal, and emotional factors]. She experiences intermittent racism and discrimination, but they play minor roles in her life [structural f and emotional factors]. Her diet is more cosmopolitan and she has found a rotation of Caribbean and non-Caribbean items to eat, prepare and serve [sociocultural factors; dietary practices]. She continues to exercise because she enjoys soccer and she walks a lot living in a city, but she is still heavier than when she lived back home [structural, sociocultural and individual factors; activity practices]. She has no current health problems and doesn't think about health too much, she barely goes to the doctor [sociocultural and individual factors]. Her only concern is about her roommate and whether she'll leave—if her roommate leaves, her life will be dramatically different [structural, sociocultural and emotional factors].

The case of Zayna illuminates the social and relational nature of immigrant adaptation processes. For immigrants, adjusting to and living in a new environment involves relationships between individuals, families, other immigrants, majority others and minority others. Much contemporary research fails to account for how groups inform one another, react to one another, avoid one another, etc. Her experiences also demonstrate the shifting influence of her home country, group of Caribbean peers with whom she can practice some variations on Caribbean norms as well as her adaptation to U.S. mainstream, middle-class norms. Her decisions reflect stratifications from her home country as well as those found in the two U.S. communities to which she has been exposed, her aunt's neighborhood and her college town. Her variable adaptations demonstrate how her actions are contingent and negotiated across levels and resources. Health is never quite appreciated as an achievement worth the effort, yet its value as a resource fueling the

creation of economic and social capital through employment and consumption is cherished. The IHA framework helps identify factors shaping one's decisions and adaptations. Digging down into specific factors surfaces practices related to establishing new ideas and habits about eating and activity.

How health is produced, maintained or degraded

In addition to illuminating immigrant adaptation practices and factors influencing those practices, the study sought to understand how immigrants interpreted the effects of the various factors on their health and health outcomes. Health was not typically salient as individuals made decisions about the conditions of their eating or activity practices. However, health was part of other calculations such as those involving employment opportunities and one's fit as a good immigrant in U.S. society. By remaining healthy enough to work and contribute, immigrants attempted to avoid categorization as dependent, societal drains or those undeserving of a chance at America's dream life. In the words of many participants, health is shaped by fate or the accidents of life. Health is not the U.S. standard of physical fitness and eating salads, but being able to work and do what one wants to do. The low salience of health corroborates findings by other researchers (Donovan 1986; King et al. 2005; Scott 2001; Smith 2012). For example, Donovan (1986) reported that among British, Asian and Afro-Caribbean respondents, the importance of health was linked with immediate, everyday concerns such as work, children, happiness and having sufficient resources. The specific relevance of an illness was only weighed against these issues and one's ability to keep going (Donovan 1986).

Figure 12 summarizes the multiple factors identified as influencing immigrant health in the U.S. This research focused on identifying and describing emotional, sociocultural and structural factors influencing the health of study participants. These factors have been categorized by their perceived impact on immigrant health as health affirming, neither health affirming nor degrading and health degrading.

First, among the emotional factors, adaptability and the destressing effect of social meals were identified as health promoting. Factors such as emotional states, vigilance, stress and interest in body shaping were described as being neither health affirming nor health degrading. These factors moved in both directions depending on the circumstances. Finally, isolation, social withdrawal/retreat, mistrust, fatalism and resentment about traditional foods being "bad" were identified as potentially health degrading factors.

Second, health affirming sociocultural factors included social meals, availability of familiar ingredients, cooking skill, anticipatory thinking and activity norms among a subgroup of participants. Witihn the sample, migration trajectory, food variety, nutrition, prevention and healthism discourses, good immigrant and American dream discourses, religious engagement and civic participation were viewed as neither health affirming nor health degrading. Again, one's circumstances helped determine the directional influence of each factor identified. U.S.-style individualism, reported declines in physical activity, post-migration weight gain, lack of health insurance and cultural claims of sedentariness were all considered health degrading.

Third, health affirming structural factors included legal/political citizenship, immigrant-friendly environments, home ownership, right to work and food or activity-related entrepreneurship. Whereas, a long list of neither affirming nor degrading factors were identified including government, socioeconomic status, media, work expectations, and globalization. Finally, lack of formal citizenship status, racism/discrimination, occupational hazards, time constraints and degraded foods were identified as health degrading factors encountered by participants.

The practices and factors identified are not exhaustive; yet, understanding some of the steps and processes within the black box of US acculturation is a step forward. Factors that were experienced as neither strictly health affirming, nor strictly health degrading were not neutral, but contigent based on one's context and circumstances—factors that might be affirming under one set of circumstances, could be degrading under a different set of circumstances. Among this sample, adaptation varied per life

domain with some aspects remaining in constant negotiation even after decades in the U.S. The various influences at play help explain the mixed results about the impacts of immigration on health.

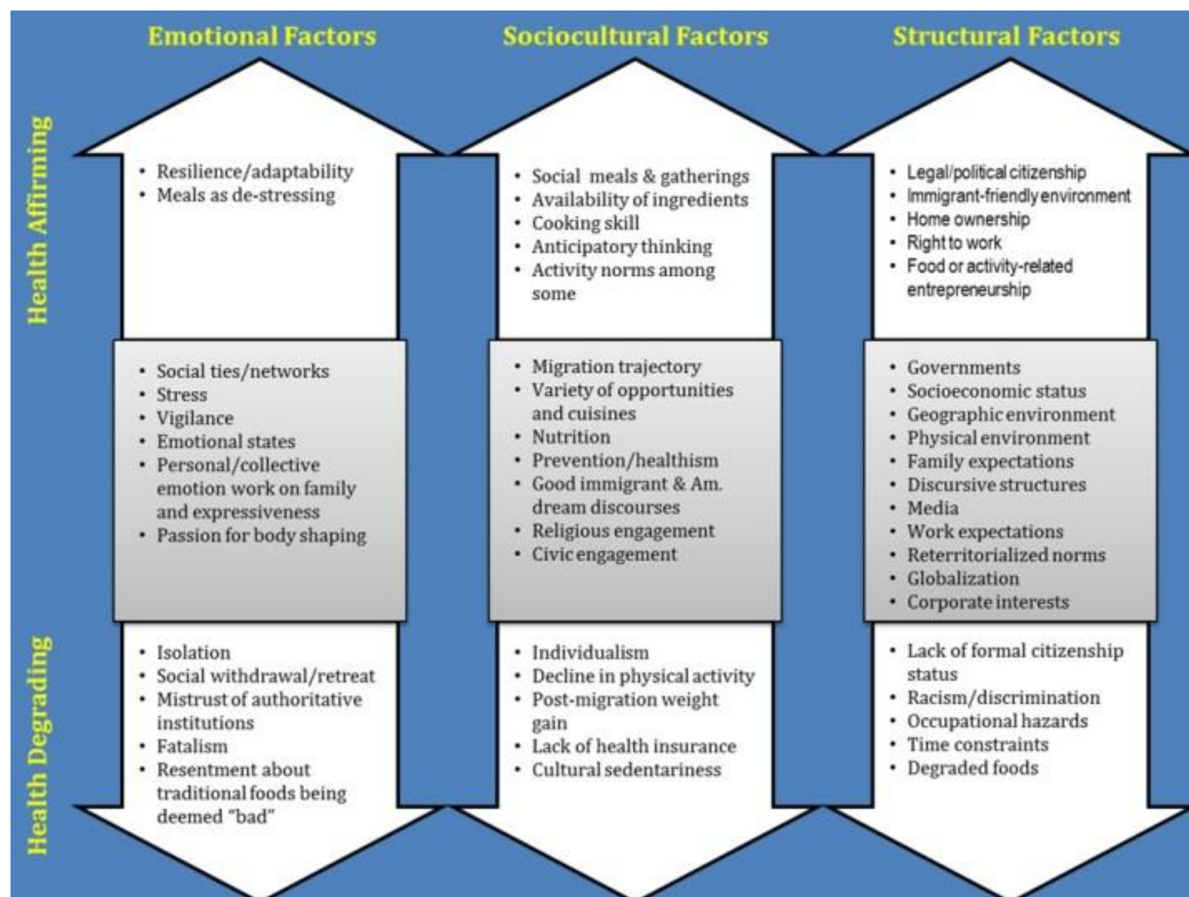

Figure 12: How Study Identified Factors May Affect Health

Participants are aware of expert perceptions and definitions of health, but most would trade expert belief in BMI for more widespread, normative beliefs about relaxation per their own definitions of health. Health is produced by luck, living a virtuous life and treating your body well. Health is maintained by eating in moderation, balancing damage caused by structural/social ills, maintaining physical and mental capacities to work as one wishes, and remembering the assets and resources that have benefitted one's life so far. Fit bodies and able bodies were not viewed equivalently; the former was related to marketing and aspirational, social norms, the latter capable of "getting on" to work, through the next day, and then through the next week or year, and so on. Individuals may strive to live a healthy life, but living right with God and doing everything in moderation was deemed sufficient by many. Per participant accounts, health

states can be degraded at various rates by corporate agriculture and food production, lack of fresh foods, limitations on people's time, not having enough money, weight gain, and being treated unfairly. Researcher interpretation of multiple data sources would add isolation, emotional retreat, unfulfilling social spaces, discrimination, segregation, occupational hazards, lack of health insurance and limited civic participation to this list for many people similar to those interviewed.

Conceptually tightening the connections between food and health is part of a process of living in a globalized world mediated by the process of migration such that conflicting ideas are manipulated into emerging U.S-norm influenced ideas of healthy, healthful living, healthy lifestyle and healthy food. Due to the global movement of ideas, people and things, this process is happening in Caribbean islands as well, yet appears to accelerate due to one's migration experience and need to create new habits. Even though health-food connections were not salient when making food decisions, immigrants reported thinking more about those connections presently than prior to or amidst the earliest months or years of their time in the U.S. Despite conceptual resistance and opposition, the emergent connectedness of food and health lingers, in part, due to immigrant concerns about cultivating health and protection in an U.S. environment full of risks, poor oversight/regulation, and increased acceptance of individual responsibility for longevity, combined with fears of being viewed as "dependent" within a new host country and understandings that U.S. individualism doesn't provide much social security. Besides the low salience of health among some Caribbeans, this study sheds light on the tensions between healthiness and one's daily existence as an immigrant; the idea of healthiness emerges amidst myriad social supports, healthy practices lag. Internalizing healthiness is an involved adaptation or acculturation process where U.S. identity is absorbed and practiced through aspirational, soul-unsatisfying behaviors in contrast to the more familiar externalized health risks common in Caribbean nations e.g. malnutrition, food availability, and food safety. Diet and activity are embedded within social, cultural and environmental relationships and are not necessarily easily modified. The low salience of health at individuals' point of decision about food and eating suggests moving beyond touting the health benefits of foods as a means of behavior change for this population. Participants rarely interpreted food as a path to illness. At various points during their

adaptation to the U.S., food appears as a cause, reaction and solution experienced by participants around diet, activity and health.

While risk has been the predominate frame through which health professionals discuss relationships between food, health degradation, and health maintenance, there are limits to the use of risk as a framework for meaningful behavior change. In this population of transnational immigrants, resistance to both technical information and the individualization of population-wide problems was noted.

Adaptation factors leading to vulnerability

Given the variety of factors contributing to immigrant health outcomes, I wondered about the conditions under which healthy immigrants' might become vulnerable to poor health outcomes. Per DeRose, Escarce and Lurie's (2007) identification of factors which may increase immigrants' vulnerabilities to poor health care and outcomes, this study found that transnational immigrants sources of vulnerabilities consisted of both traditional health risk factors such as sedentariness as well as several unconventional factors. Among the study participants, social marginalization or social stigma, lack of socioeconomic/societal resources, low socioeconomic status, limited social networks, lack of health insurance, as well as poor information about local programs and services made people more vulnerable to health problems over their migration trajectories. The previously described experiences of Kim, the only participant currently impoverished, illustrate how social vulnerability and health vulnerability are intertwined. In fact in her case, a decline in social status precipitated health and employment changes that lead to poverty and increasing health challenges for herself and her children. Poverty is a source of vulnerability for all people; for immigrants, changes in social factors may lead to unanticipated, sudden or systematic vulnerabilities in how one receives food or health care. In this sample of Caribbean immigrants, potential vulnerabilities were also noted with regards to emotion management, social isolation and passive resignation which may unwittingly lead to increased risks of morbidity, mortality and social malaise. Most of the vulnerabilities identified in participants' stories operate at the social and/or societal level, rather than at the individual level. Social and societal risks are problems to be solved

at a different register and would require different types of efforts than “eat fewer starchy vegetables.” Future efforts might embrace slogans like “take a meal together” or “cook together to deepen ties”. It is of note that such suggestions are realized in some of the contemporary “eat with others” dining movements, many launched by immigrants.These data suggest that social vulnerabilities can become health vulnerabilities; yet more research is needed to endorse and explicate this interpretative finding.

Engagements with Literature

The IHA framework and study findings related to the understudied factors of emotional, sociocultural and structural factors influencing health practices enters dialogues about migration and health that span disciplines and epistemologies. Five specific engagements with existing literature are described.

First, participant narratives as well as the IHA framework uphold practices as acts that are not easily isolable, but rather constellations of decisions, acts and repetitions embedded within strands of discourse, norms, and expectations. Family members, acquaintances, co-workers, employers, media and authoritative institutions have all provided messages, rules and social scripts for the appropriate training of individual citizens to: be within certain size parameters, be fit enough to be productive or contribute to society, avoid dependence on government benefits, follow changing health guidance, and consume products and services including specific types of health services e.g. cancer screenings in order to fulfill one’s citizenship responsibilities. Adapting to life in the U.S. and aspiring to a healthy life in the U.S. involves learning, understanding, adopting and, possibly, modifying U.S. ways of thinking prior to enacting new routines or practices. Post-migration practices may consist of new practices in a new location, old practices in a new location, or some mix of old and new practices in a new location. This view of practices supports Warde’s (2005) view of practices as more dynamic and complex entities than the visible or tangible acts often measured as behaviors in health research.

Furthermore, the uncertainty and meaning-making efforts around unfamiliar and dominant norms and discourses affirm Ong's (2003) perspective of becoming citizens as being a two-step process of embracing philosophies about life and specific practices. As this study was concerned with the re-establishment of everyday practices, the findings also demonstrate how among immigrants aspiring to their version of the American dream, even seemingly apolitical acts like eating and activity may be influenced by beliefs about where one fits in society (political and social citizenship) more than the possible health-boosting benefits of a healthy lifestyle. Framings of diet and physical activity as practices that can improve or worsen immigrant health may be missing the mark about what motivates and drives immigrant decision-making and priorities. Even when health was deemed important to an individual, actual practices rarely indicated interest in optimizing health or preventing illness over optimizing other types of social gains until or unless health declined. This observation necessarily raises considerations of health as cultural or social capital as well as an invisible, yet meaningful, political economy of citizenship and belonging within which symbolic accounts are filled, drained, borrowed against and exchanged based on one's choices and the relationship between those choices and the social and political needs of the day. What may have earned capital for immigrants in one era may require more or less effort in other time periods.

While not foci of this study, findings also suggest that not all forms of cultural capital are created equally. Participants sought to accumulate capitals and convert them into economic capital; economic capital did not work equally across social groups, however, participants believed that accumulating a certain amount of economic capital could either make up for social capital not obtainable due to bodily features or lack of experiences or minimize the social and symbolic costs of being non-native and minority. As hypothesized by Ong (2003), this sample perceived and/or experienced "social structural constraint[s]" on their ability to have cultural capital recognized. The embodied characteristics that served as symbolic deficits in their U.S. migration experiences included: phenotype, accent, tastes, and skin color.

Beyond cultural capital, participants relied on social friction to help lubricate their everyday equilibriums or periods of calm. Friction was evident in some participants' choices of creative interpretations of U.S. social norms or opportunistic use of U.S. or home norms even when participants did not believe in the norms. This friction was commonly observed in stories about individualism and collectivism. Participants overwhelmingly identified the U.S. as individualist to a fault, yet many also revealed a guilt or hesitancy to characterize U.S. individualism as negative (per a home country norm) since they relished the free time, occasional selfishness, individualistic pursuits, relief from familial surveillance, breaks from tradition and feelings of autonomy that they associated with that sense of individualism. Similarly, some participants selectively used their foreign-ness to sidestep contentious conversations, racial/ethnic stereotyping, or examination of their home country norms e.g. "We don't exercise." In practices, friction allows for the acceptance of mediocre substitutions for home foods as well as the possibility of reviving the meaning of meals by recreating the social rather than material elements of such meals. Friction is critical for helping immigrants "get on" with life in new locations because friction allows for flexible meanings and responses to context.

In terms of social determinants of health, this research supports the use of immigration as a social determinant of health. Immigration intersects and interacts with other social determinants such as socioeconomic status, age, and gender, yet there are many more angles to explore about the unique influence of immigration on one's health and social outcomes. Empirically, in this study, being an immigrant limited access to specific social positions, some of which were politically or socially precarious if not precarious in other ways. Different social positions often result in different (not always worse) health outcomes. Moreover, living as an immigrant also created different exposures, different vulnerabilities to health conditions and brought different material and symbolic resources to bear when addressing life's problems. Different social positions, exposures and vulnerabilities may result, individually and collectively, in different political, social, economic, and health consequences for immigrants when compared to non-immigrant groups. Different immigrant groups also seem to experience different outcomes in their post migration periods. Therefore, based on the WHO definition of

a social determinant of health, immigration seems to meet the threshold requirements for consideration and endorsement.

The final consideration of the literature explores how this study engages with contemporary framings of biological citizenship and biocommunicability. Biological citizenship connects citizenship projects and ideas about citizenship to our existence, stability and proliferation in genetic, biological and somatic forms. In this study, I was struck more by collectivizing aspects of biological citizenship and biopolitics than individualizing aspects. Participants were largely aware of differential distributions of life, health and illness in both their home countries and the U.S. although their experiences of the two types of environments were quite different. In general, Caribbean islands were viewed as nations of widespread poverty or sufficiency with a minority of families and individuals who were extremely wealthy. The U.S. was experienced as a place abundant with sufficiency, yet an almost cruel exclusion and social entrapment of certain populations e.g. the impoverished and certain ethnic or language groups. These social undesirables were blamed for the own circumstances, even when the circumstances were not of their own making—this blame perpetuated ideas that these types were to be avoided and were undeserving of assistance. The concentrated damage and insufficiency in certain neighborhoods and towns seemed to unfairly dole out shorter and more ill lives to the poor and undeserving. Aspiring to find respectable places within their new society, all participants were aware of and remarked on this socioeconomic gradient. Participants were less conscious about how their efforts to become American relied on performing citizenship in ways that reproduced illusions of democracy.

Rose's notion of biological citizenship posits that educating citizens to be active participants and consumers signals recognition of shifts in responsibility for day-to day risk management from the state or authorities to individuals and mollifies citizens' feelings about contributing to society in lieu of civic and political engagement. When individuals kept abreast of relevant information and heeded authoritative advice, they were performing a duty of citizenship. As mentioned in earlier discussions of citizenship, many participants substituted civic or political engagement for performing the good immigrant or aspiring to the American dream. However, their citizenship practices sought invisibility (blending in) and rarely

altered the distributions of life and health in society. In their case, abundant information and choices did not promote trust in science, government, and the value of risk calculation, rather constant changes and divided authorities made the fields of science and government seem chaotic, non-authoritative and easily swayed by moneyed, corporate interests—even among health professionals and policy workers, these fields were regarded with skepticism.

Moreover, in terms of biosociality, experiencing life as a Caribbean immigrant draws Caribbean-descendant folks together in new ways, but also generates new categories of "corporeal vulnerability" and "somatic suffering" based around shared genetic and somatic status (Rose 2007; Rose and Novas 2003). Being minority or being black in the U.S. are new forms of corporeal vulnerability experienced by Caribbeans since these social statuses are accompanied by mistreatment and denial of rights and privileges i.e. safe homes that may pose new and unimagined dangers and risks. Furthermore, even if very different, perceived shared genetics with African Americans, a population regarded by many as among the lowest rungs of society, makes Afro-Caribbeans, in particular, susceptible to authoritative and, sometimes, scientifically-backed discriminatory practices such as unemployment, underemployment, criminalization, and poor educational opportunities. Somatic responses to the new forms of responsibility and vulnerability perceived by immigrants include social isolation, social retreat and fatalism—whether there is suffering seems dependent upon the individual. Independent of participants, migration, globalization, confusion about genetic, historic and "constitutional" overlap with African Americans has also created a new fear category, the Caribbean, within certain communities. Changes in the social positioning of some Caribbean immigrants may curtail their aspirations and diminish societal value attributions about their worth. The responsibility/activism imperative within biopolitics may ask that Caribbeans either reject stereotypical collectivizing of people of African descent or African Americans themselves with whom Caribbeans may share social, cultural and residential affinities.

Discourse and media instruct immigrants about what healthy looks like, how healthy products can be purchased and the benefits of a healthy lifestyle; however, dominant discourse may not be framed in ways that are helpful or useful for certain individuals. Norms naturalized through the dissemination and

reproduction of discourse led to resentment from some participants. This resentment was expressed as depression, sadness, decreased joy from eating and reluctance to consider unhealthy attributes of foods that have nourished themselves, their relatives and ancestors for years. Despite the abundant options and choices presented to contemporary, biopolitcal consumers, some participants experienced freedoms being eroded by normative expectations. One common example was how normative shoulds and oughts killed the simple joys of eating. The implications of biopolitics and biocommunicability exist alongside other material and symbolic burdens of being an immigrant; with the passing of time and daily life activities, one easily disregards or discounts the opportunity to be an active and informed, healthy citizen.

Contributions

While I hope that this chapter's case, its analysis and descriptions of how this research engages with existing literature demonstrate the value of this partial and preliminary inquiry, I believe that this project makes four contributions to the sociology of health and illness and the study of migration and health. First, by developing the IHA framework and providing in-depth analysis of three understudied realms of factors that help shape diet and activity practices, this study illustrates immigrant adaptation as multiple processes, occurring at various levels of action and ideation. Rather than a simple change of state reflecting sending and then receiving locales, IHA processes of various durations and complexities comprise the black box of things that happen when one moves from Jamaica to New Jersey. The researcher does not expect that all processes or aspects within the "black box" have been identified, but believes that this work helps researchers identify steps that bolster, maintain or damage health and recognize the messiness of cognitively and practically linking individual acts and their variable relationships to health, an accomplishment to which responsible citizens should aspire. Health is both a product and achievement of sociocultural, economic, political and biological conditions. Migration related experiences clearly influence the day-to-day production and achievement of health; more qualitative and participatory methodologies are needed to help researchers discern how.

Second, this research importantly asserts the role of emotions in aspects of health-related adaptation beyond the psychological. While migration is described as being highly emotional, outside of psychology, emotions related to migration, loss, adaptation, etc. have rarely been studied. Migration and its constellation of related outcomes and experiences are actualized through the physical bodies of people who experience multiple emotions. Moreover, recent evidence about biopsychosocial pathways to chronic disease augment the importance of improved understandings of how physiological, emotional and social systems interact (Gee et al. 2006; Geronimus et al. 2006; Kuzawa and Sweet 2009; Peek et al. 2010; Wildsmith 2002). By examining the emotions present in participant narratives as well as reflecting on absences, silences and ramifications of emotions being experienced by particular bodies, this study supports biopsychosocial theorizing and expands researcher possibilities regarding the exploration of pathways to health inequities. Participant narratives and health outcomes depict several ways in which biopsychosocial experiences become internalized in or inscribed on the physical bodies of individuals. Moreover, group expectations of emotion management and emotion work may help hide damage caused by some emotional experiences as well as lead to generational misunderstanding and dampened baseline levels of emotional accessibility which may reduce the diagnostic value of mental health measures among this population. Furthermore, this study demonstrates how emotions can help structure human experiences and co-constitute generational transfers of knowledge.

Third, this study highlights disjunctures and similarities between not only research and practice, but also discourse/beliefs and actions. Individuals and collectivities may endorse one set of beliefs, yet engage in practices that do not support their belief. Further whether one adopts conventional or alternative discourses about life and/or health, diet and activity practices may be shaped and constrained by factors beyond one's reach e.g. safety, know-how or availability. Ultimately, most immigrants as emissaries of their families and kinfolk aim to provide a certain standard of living or achieve a certain amount of success abroad; fulfilling this promise may preempt and displace many other expressions of beliefs and values. Two examples stand out in this regard. While a few participants thought health aspiration was overrated, most participants aspired to be healthy, but didn't or couldn't invest time and energy into

thinking about what healthy eating and activity decisions would be in their lives. Some surrendered the topic to God or fate and others decided not to worry about health until it was really a problem. Similarly, many participants expressed disgust or disdain for U.S. racial formation and its resulting social outcomes, yet by sticking to their scripts for being a good immigrant for fear of failing to provide for their families, their beliefs in equity were silenced while discriminatory social arrangement were reproduced.

This study's final contribution to the field is its effort to untangle critical and nuanced differences about how structural factors are identified and addressed across different disciplines. While most relevant to epidemiological studies concerned with diet and activity as risk factors, extensions of structural factors and interventions within public health may help researchers and practitioners better frame upstream contributions to health outcomes including health inequities or disparities in health. Social science understandings of structures may fill in some of the gaps in policy-level and structural intervention planning. As discussed by participants, the structures requiring intervention go beyond public housing stairwell prompts to "Take the Stairs for Health" and greenspaces and exercise equipment I low income neighborhoods; participants wanted to know why brokers continue to redline or redirect them around buying homes in whichever neighborhood they would like. While housing policy and environmental efforts to address overweight have been advocated; the structural interventions deemed most helpful operate at a very different level than these efforts. Social structures go beyond socioeconomic status and neighborhood to include media, perceived time constraints, classifications, discrimination, sites of exclusion/absence, and bureaucratic arrangements between authoritative institutions such as science, corporations and governments. More importantly, perhaps, this study demonstrates that structural factors were perceptible and identifiable among lay individuals, not merely to those seeking orderly research frameworks or theories. Several structural factors of different types were identified in narratives; structures were salient as shaping factors among participants. Some structures were experienced as surmountable or avoidable usually through having more money; other structures were deemed out of participants' control. Adaptation processes highlighted areas where participant agency seemed

constrained or domain-specific. Beyond structure and agency, luck or fate was described as responsible for health outcomes.

Limitations of the Study

Despite its contributions, the present study had many limitations. First, the research project as designed was not implementable due to constraints of time, finances and the researcher's mobility. The project initially sought to explore the research questions of interest in both the U.S. and specific Caribbean sites in order to compare and contrast findings and potentially distinguish factors of globalization from those related to migration and adaptation. The researcher unsuccessfully sought funds to implement the study as planned and was unable to financially underwrite the study. Moreover, while several interviews were conducted with professionals from and presently working in the Caribbean through professional conferences and meetings or internet-based telecommunications, a Caribbean lay sample was not interviewed. Modifications to the research plan necessarily limited the range of findings as well as the scope of research interpretations. Though this research is suggestive of the need to breakthrough methodological nationalism in order to thoroughly understand changes brought about by migration, the evidence here is limited to participant accounts of changes in their home country, attempts at reterritorializing Caribbean norms in the U.S., and expert perspectives from interviews and discursive texts. Efforts were made to keep immigrants' sending and receiving societies in their contextual frames, so as to not miss potential influences despite the researches inability to travel to the Caribbean during the research period.

Second, although interviews were in-depth enough to achieve theoretical saturation around core themes and several participants provided follow up comments or supporting documents, the sample of lay participants was smaller than desired. In fact, the 28 minute interview is misleading since the person also submitted email responses to four questions as well as provided written materials about their professional work and their experiences with the Caribbean and health. Recruitment of eligible participants went quite well at various community locations and via social media; however, interview scheduling and completion

rates were lower than anticipated. It is understandable that a research interview may be low on the priority list of busy individuals—most people participated due to a desire to help, rather than for the sake of science or the minimal incentive. As one who has recruited for numerous projects and studies since the mid-1990s, I believe that it is harder to recruit than in past years to the multiplicity of competing demands including smartphones. Efforts to recruit through friendly community agencies only helped with spreading the word, but not converting interest and eligibility into actual interviews. If designed today, I would purposefully gather different types of participant data i.e. from internet fora, social media, informal conversations and supplement those data with in-depth interviews resulting from direct recruitment and/or follow ups to data gathered from other sources. Though saturation was reached on some conceptual ideas, a slightly larger sample of 25-30 lay participants would increase confidence in my interpretations, overall interpretive framework, as well as the potential applicability of findings to other populations or related topics. Interestingly, though there was a significant lull just before I ended formal recruitment in late 2016, brief presentations about the study have resulted in a new list of individuals ready to be interviewed. I will interview as many of these people as I can in the interest of future publication opportunities.

Related to the sample size and characteristics of the lay sample, this study sample appears to be different than the general population of Caribbean immigrants in the U.S. in some important ways. Though data about Caribbean immigrants are limited, the sample appears to be more educated and more affluent than Caribbean immigrants in the U.S. and represents a narrower band of ages and family structures. Age variation among male participants was more limited than that among female participants. Finally, although I was pleased with the ethnic diversity of participants given the identified similarities and differences in their migration and adaptation experiences, having more equal numbers of participants from specific national origin and /or ethnicity combination groups would have improved the ability to analyze data by subgroups. Analyses presented here focus on Caribbean, rather than Trinidadian or Indo-Trinidadian experiences.

Analytically, several theories that were consulted in the design of the study became less relevant as data were analyzed. Different analysis, led by a specific theory might have led to different interpretations of the findings and different ideas about what was important in the data. I attempted to use my background knowledge and analyze participants' lived experiences based on their accounts of how things happened rather than only analyzing specific theoretical constructs. Use of different theoretical or analytical lenses such as intersectionality, actor-network theory or Caribbean theory may have resulted in different results and possible interpretations. The dissertation is a finite project and the theoretical scope of this project was focused on better understanding taken-for-granted migration and adaptation processes. I anticipate writing at least one future manuscript based on a more closed theoretical interpretation of data relying on a specific social science theory; rather than drastic changes in findings, I expect that points of emphasis will differ.

Finally, the study was not able to produce and test potential survey items to measure health-specific aspects of immigrant adaptation or acculturation. The smaller than planned sample size limited my ability to model the potential performance of new survey items about adaptation in comparison to conventional proxy measures of time in the U.S, language and/or intermarriage. This project remains a work in progress that I should be able to achieve by pooling survey data from multiple studies. Despite these limitations, I believe this study has merit and has made incremental contributions to our understandings of migration and health adaptations.

Recommendations

Building on lessons about the complexity of immigrant adaptation as well as growing interest in social and environmental determinants of health, this study elaborates steps in the process of people moving between poles of healthy immigrants and potentially vulnerable citizens. By focusing on everyday practices and norm re-formation related to food and eating, my research attempts to illuminate health-relevant pathways of adjusting to new environments including non-individual level, contextual factors. Findings suggest that consumption of US ideas about food, activity, health and responsibility

support specific types of social citizenship and incorporation. This project also identified social factors beyond residency, language and marriage that may contribute to immigrant health such as social isolation, role pressure and mistrust of institutions. Recommendations based on this research include:

- to improve the measurement and analyses of migration and adaptation processes
- to support additional research on biopsychosocial pathways to chronic disease
- to develop greater understanding of health areas where structures or agency dominate immigrant decision-making and action; and
- to recognize complexity in health intervention and policy formation since diverse, sometimes opposing, factors influence health.

Future research

As this study fits well within my research interests, future research related to this study is anticipated. Future research directions include conducting island-based interviews and surveys to understand changes in diet and activity attributed to globalization and return, cyclical and inter-Caribbean migration. The sociologist in me became intrigued by the social and biomedical production of sedentariness as a category, the reterritorialization of Caribbean, hierarchical class beliefs within the U.S. social system, as well as more in-depth research into the social conditions of unfairness and stress that may shape health outcomes. As a public health practitioner, I believe more research is needed to unearth more meaningful variables that better capture and represent immigrant adaption processes; the following may be promising survey variables: presence of children in the home, family separation during migration, foreign-born partners, residential segregation, changes in physical activity, and underemployment. Additional research might examine the health effects of downward mobility on immigrant populations and of the gap between aspirations and reality. Among this population, health promotion messages fail to address what matters most—longevity and health are important in an abstract sense, but work and accomplishment are more important, concretely. Immigrant health adaptation (IHA) or health

acculturation are processes of various lengths and ease, contingent on factors like age and desire to forget/leave home, that consist of ongoing navigation and negotiations for many. Measuring such phenomena with two or three closed-ended items minimizes the lived experiences of immigrants as well as what we, as researchers, might be able to understand about processes of migration and adaptation for greater social benefit.

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Appendices

A: Study Interview Guide, Forms and Instruments

B: Participant Summaries

A1. TRANSNATIONAL ADAPTATION, DIET & ACTIVITY (TADA) STUDY SEMI-STRUCTURED INTERVIEW GUIDE

INTRODUCTION

Thank you for meeting me and agreeing to spend some time talking with me. I am interested in hearing about your migration experience, food, eating and your everyday activities. I want to learn how people who are connected to two different countries think about these things.

Before we get started, I want to make sure you understand what this project is about and make sure you still want to share your experiences.

1. We can go through this consent form together. [Consent Form Review and/or Verbal Consent here or END.]

2. So that it easier for me to remember what we talk about after I leave, I would like to record our conversation today. Would that be OK? [Wait for consent to record or END. Begin recording.] Thank you.

3. This research is about people who now live in the U.S, but who have important and consistent connections to another country. You have this kind of connection with [insert country name from eligibility screen here]. The questions I'm going to ask about are mostly about your typical activities, food, and things you've heard about health, and how these things fit with other parts of your life. At the end, I'll ask some questions to help me describe the people I am interviewing—like age and the amount of time you've lived in the U.S—and ask you to complete a survey on a tablet. How does this sound to you?

4. Feel free to take as much time as you need answering a question. I'll also answer any questions you have for me before our meeting ends.

WARM UP QUESTIONS

- So why don't you tell me where you were born and how you came to live in the United States?
- (***Only if non-conflict migration experience described***) What would you say was you or your family's main reason for coming to the United States?
- Can you think back to how you used to eat in [country-specific name]? What were typical meal times like? What was the setting like? Who were the people around you? Try to describe typical mealtimes for one day in [country].
- What types of foods/drinks did you eat/drink every day?
- How did you/your family decide what to eat during a typical week?
- Tell me a story or memory related to food or eating that sticks out to you from [home country].

CORE QUESTIONS

- Describe the foods that are most important to you from [country].
- How did you feel about eating when you were in [country]?
- Describe how foods and eating changed when you moved to the U.S.?
- Tell me a story or memory related to food that sticks out to you from your time in the U.S.

- You've talked about how the foods changed, how did your feelings about the food or eating change?
- How do you make decisions about what to eat now?
    - What factors or things help you decide what you are going to eat during a typical week?
    - Ask about importance of access to food/food availability
    - Ask about expense and food scarcity
- Describe typical mealtimes for one day in the U.S.
- What types of foods/drinks do you eat/drink every day?
    - Prompt: Do you regularly eat: [list of foods from pilot, lit review]
- Which things from [country] have you tried to keep or reinvent for eating in the U.S?
    - Describe how you have reinvited this dish or how you make it with U.S. ingredients
- How have you learned about American foods and eating customs?
- In what ways do you think about how food/eating relates to health?
- How have your thoughts about food and health changed after living in the U.S.? [Probe for before and after comparison.]

****Other possible relationships to food to explore if they come up**:

- Time
- Family
- Other people, social life for you
- Your identity or how you think about yourself
- Care or acts of caring
- Stress

- What are the major differences between foot and eating in [country] and the U.S.?
    - What are the similarities?
- How would you describe the ways government talks about food or eating in both places?
- What messages from media [television, radio, newspaper] about food or eating stand out to you?
- What kinds of things have your friends, family said to you about food or eating when they're giving you advice?
- What messages from the internet stand out to you?
- What types of things do you worry about when you're thinking about what you should eat?
    - What limits your food choices? [Potential prompts: money, time, know-how, etc.]
    - What would your ideal meals be if there were no limits?
- Talk about how important food or restaurant brands are to you.
    - Which brands or types of foods do you have more confidence in?
- Where do you get advice or ideas about what to eat, where to eat or what kinds of things to eat?
- Food labels (only when mentioned): Describe how you use food labels or packaging in making decisions about what to eat?

STRESS AND SOCIAL NORMS

- Which types of things caused stress for you in [country]?
- Please describe an example of a stressful situation in [country] and how you dealt with that situation.
- Which types of things cause stress for you in the U.S.?
- Please describe an example of a stressful situation in [country] and how you dealt with that situation.
- Immigrants may sometimes be perceived as outside of the U.S. mainstream—are there things about you that you think make typical Americans view you as different from Americans?

- Describe some of the values you think of as American.
    - How are these similar to or different from [country] values?
    - What are some of the American values or norms that bother you?
    - Which norms would you change and why?
- Other than papers or legal status what things make you feel like you are part of U.S. society
    - Are there things you believe you must acquire or display in order to show your American-ness? What types of things?
    - How have you learned about what people thing is “normal” in the U.S.? Describe how you learned what an American way of eating might be.
        - What about ideas about health? Or Exercise?
- Race and ethnicity may sometimes seem more important in the U.S. than in other places. Can you talk about your experiences with race or ethnicity in the U.S.?
- <u>Only if not mentioned elsewhere</u>: Can you also tell me a little about what you think about class in the U.S.?
    - What types of things have you observed about people or neighborhoods that are well off?
    - What types of things have you observed about people or neighborhoods that are poor?

<u>ACTIVITY [OPTIONAL OR IF LOTS OF TIME]</u>

- Tell me about the ways you use your body in a typical day.
    - Work: Does your job require lots of movement, walking or lifting? Describe what you do.
    - When are your longest periods of walking, running or dancing? Describe what’s happening here.
- Describe the ways in which you believe you get exercise during a typical day or week.
    - How would you describe your level of physical activity?
- Describe the most common types of physical activity your remember in [country]
- Describe the types of physical activity most common among people you are close to
- Describe what you hear about exercise in the U.S—whether from friends, health professionals, media, etc.
- What types of things do you worry about when you’re thinking about your physical activity?
- Where do you get advice about physical activity or exercise?

<u>TRANSITION OUT QUESTIONS</u>

- What does health mean to you?
- Describe one [country] food or food experience that you really miss or cannot recreate in the U.S.
- What things make you feel really [country]?
- Describe one American food or food experience that was a welcome addition to your life. How does this food/experience make you feel? Affect your life?
- What things make you feel really American now?
- Can you describe a time when you traveled home to [country] to obtain health care or a medical treatment? What are the reasons that you decided to get that service at home?
- Is there anything that came up during this interview that you had never thought about before?
- Is there anything else you would like to share with me?

<u>DEMOGRAPHICS</u>

Transition to demographics

Now, I have some survey questions that everyone I talk to will be asked. You can answer on paper, electronically on a tablet (?) or I can read them to you and write your answers. . .whatever is easiest for you. [Demographic Sheet]

A2. TADA DEMOGRAPHIC QUESTIONNAIRE

1. Month & Year of Birth ______________________________
2. Do you think of yourself as ☐ Female ☐ Male ☐ Both ☐ Other
3. Country and town of birth: ______________________________
4. In what year did you come to live in the U.S.? ______________________________
5. Ethnic group: ______________________________
6. Primary language: ______________________________
7. Other languages spoken regularly: ______________________________
8. U.S. racial or ethnic category: ______________________________
9. Are you currently working? ☐ Yes, fulltime ☐ Yes, part-time ☐ No
10. How many trips do you make to [home country] per year? ______________________________
11. When was the last time you were in [home country]? ______________________________
12. How often do you call, text or email friends or family in [home country]? ______________________________
13. Who is the person you are closest to in [home country]? ______________________________
14. Do you send things other than money back to [home country]? If yes, how often? ☐ No ☐ Yes: ______________
15. Do you send money back to [home country]? If yes, how often and how much typically? ☐ No ☐ Yes: ______________
16. Do you have health insurance? ☐ Yes ☐ No
17. How often do you have physical exams by a doctor or nurse? ______________________________
18. How would you rate your general health status?

☐ Very good 5
☐ Good 4
☐ Neither good nor poor 3
☐ Poor 2
☐ Very poor 1

19. Do you have any of the following medical conditions?

☐ High blood pressure ☐ Cholesterol problems ☐ None
☐ Heart problems ☐ Depression or similar problems

- [ ] Diabetes or blood sugar problems
- [ ] Other major illness or health problems (Specify:)

20. What is your estimated height? ______________________

21. What is your estimated weight? ______________________

22. Would you describe yourself as underweight, average weight, overweight or really overweight?

- [ ] Underweight 1
- [ ] Average weight 2
- [ ] Overweight 3
- [ ] Really overweight 4

23. Which income category best describes your household's annual income?

- [ ] $0-20,000 1
- [ ] $20,001-$40,000 2
- [ ] $40,001-$60,000 3
- [ ] $60,001-$80,000 4
- [ ] $80,001-$100,000 5
- [ ] $100,001-$150,000 6
- [ ] $150,001-$200,000 7
- [ ] $200,001 or more 8

24. How many people are in your household? ____________

25. Which category best describes your relationship status?

- [ ] Single/Not in committed relationship 1
- [ ] In committed relationship 2
- [ ] Married 3
- [ ] Living with partner 4
- [ ] Separated 5
- [ ] Divorced 6
- [ ] Widowed 7
- [ ] Other: 8

26. What best describes the level of education you have completed?

- [ ] Did not finish high school 1
- [ ] Finished high school or equivalent 2
- [ ] Some college/university courses 3
- [ ] Finished a AA degree or a two year technical certification program 4
- [ ] Finished a BA/BS degree or equivalent 5
- [ ] Some courses after BA/BS degree 6
- [ ] Have a graduate level degree 7
- [ ] Other, please specify: 8

27. Which category best describes where you eat most of your food?

- [ ] Food cooked by me/family, eaten in home 4
- [ ] Food prepared by store or restaurant, eaten in home 3
- [ ] Food prepared and eaten in restaurant 2
- [ ] Food prepared by store or restaurant and eaten in the car 1

28. Where do you buy most of your food? ______________________

29. At which restaurant do you get most of the food that you eat?

30. How would you assess your general health compared to the health of others of your own age?

- [ ] Much better 5
- [ ] Slightly better 4
- [ ] Neither better nor worse 3
- [ ] Slightly worse 2
- [ ] Much worse 1

31. In the last 12 months, how often have you worried about whether your household's food would run out before you got money to buy more?

- [ ] Often worried 3
- [ ] Sometimes worried 2
- [ ] Never worried 1
- [ ] Prefer not to answer 0

32. In the last 12 months, how often has the food you bought run out and you did not have money to get more?

- [ ] Often 3
- [ ] Sometimes 2
- [ ] Never 1
- [ ] Prefer not to answer 0

33. How would you describe yourself in terms of your religion or religious background?

34. Would you like to recommend someone else for this interview either in the U.S. or in your home country?

- [ ] Yes 3
- [ ] No 1
- [ ] Maybe 2

We will contact you later by email or text so that you can refer your friend or family member.

A3. Three Validated Scales

WHO Five Well-Being Index

Please indicate for each of the five statements which is closest to how you have been feeling **over the last two weeks**. Higher numbers mean you have felt better.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a "X" in the box with the number 3 in it.

	Over the last two weeks	**All of the time**	**Most of the time**	**More than half of the time**	**Less than half of the time**	**Some of the time**	**At no time**
1	I have felt cheerful and in good spirits.	5	4	3	2	1	0
2	I have felt calm and relaxed.	5	4	3	2	1	0
3	I have felt active and vigorous.	5	4	3	2	1	0
4	I woke up feeling fresh and rested	5	4	3	2	1	0
5	My daily life has been filled with things that interest me	5	4	3	2	1	0

Perceived Stress Scale 4

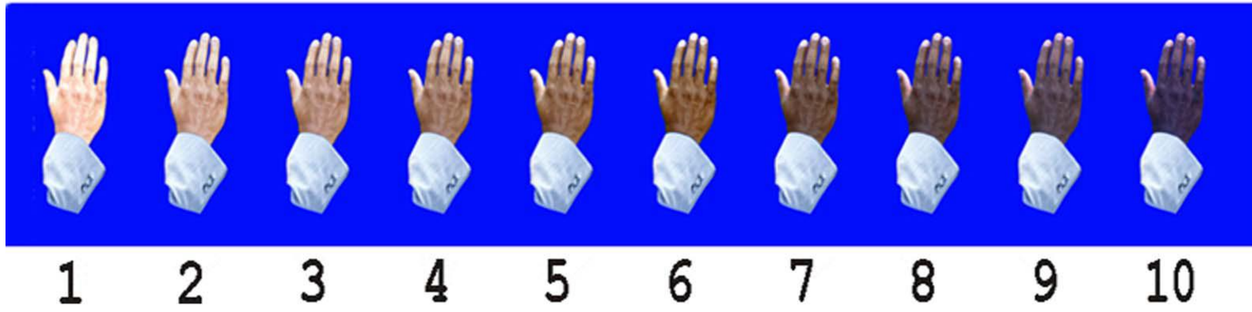
The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, please indicate with an X or √ how often you felt or thought a certain way.

Times in last month	**Never**	**Almost never**	**Some-times**	**Fairly Often**	**Very Often**
1. In the last month, how often have you felt that you were unable to control the important things in your life?	5 **0**	4 **1**	3 **2**	2 **3**	1 **4**
2. In the last month, how often have you felt confident about your ability to handle your personal problems?	5 **4**	4 **3**	3 **2**	2 **1**	1 **0**
3. In the last month, how often have you felt that things were going your way?	5 **4**	4 **3**	3 **2**	2 **1**	1 **0**
4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	5 **0**	4 **1**	3 **2**	2 **3**	1 **4**

Self-Administered New Immigrant Survey (NIS) Scale of Skin Color

As you know, human beings display a wide variety of physical attributes. One of these is skin color. We are interested in the range of colors represented—it doesn't matter if you are of African, Asian, Caribbean, European, or Latin American in origin. Which of the hands pictured here best describes your current skin color?

Scale of Skin Color Darkness



A4. Sample recording form used for the study
Body Measures for TADA

Study ID: _____________

Date: _________________

Measure	Interviewer/1st	Participant/2nd	Mean BP
Weight			
Height			
Waist (1 " above navel)			
BP			
NIS Skin			

Notes:

A5. Expert/Key Informant Interview Guide

TRANSNATIONAL ADAPTATION, DIET & ACTIVITY (TADA) STUDY

INTRODUCTION
Thank you for meeting me and agreeing to spend some time talking with me. I am presently exploring how immigrants who maintain some connection with their home country experience, food, eating, activity, health and stress. I want to learn how people who are connected to two different countries think about these things and make decisions about everyday activities.

So that it easier for me to remember what we talk about after I leave, I would like to record our conversation today. Would that be OK? [Wait for consent to record or END. Begin recording.] Thank you.

This research is about people who now live in the U.S, but who have important and consistent connections to another country. As an expert or professional, you have spent some time working with people like the people I am interviewing.

- What are some of your observations about how immigrants [from ___ country, if applicable] adjust to food and eating norms in the U.S.?
- How do you think people receive food and eating practices in the U.S. when they first arrive?
    - What do you think they think about these practices?
    - What do they do in response?
- What are some of the more different practices that people bring with them?
- How do people adapt?
    - What do they do? What are the steps?
- How do you think people learn about U.S. customs and expectations around food and eating?
    - Activity?
    - Health and fitness?
- Do you have your own experiences with this process?
- Do you have reflections about learning about customs or practices in another country and how you adapted to those?
- Describe what you think eating practices look like for the average person in the U.S.
    - What does healthy eating look like? Who are the people present? What are the sights, sounds and smells?
- How have the immigrant families that you know or have worked with decided what to eat during a typical week?
    - Is there a case that is particularly memorable for you?
    - What factors or things help you decide what you are going to eat during a typical week?
    - Ask about importance of access to food/food availability
    - Ask about expense and food scarcity
- Describe the foods that are most important to people from [country].
- How if at all do you think people's feelings and emotions about the food or eating change in the U.S.?
- How have you learned about American foods and eating customs?
    - What norms of what is good, edible or class appropriate foods/ habits?
- In what ways do you think food/eating relates to health?
- Do you have specific observations about how meals, food or eating may differ between [country] and the U.S. thinking about
        - Time

    - Family
    - Other people, social life
    - Care or expressions of caring
    - Stress

- What are the major differences between food and eating in [country] and the U.S.?
    - What are the similarities?
- How would you describe the ways government talks about food or eating in both places?
- What messages from media [television, radio, newspaper, internet] about food or eating stand out to you?

STRESS AND SOCIAL NORMS

- Which types of things caused stress for immigrants in [country]?
- Which types of things cause stress for immigrants in the U.S.?
- Immigrants may sometimes be perceived as outside of the U.S. mainstream—are there specific things that you think make immigrants stand out as different from Americans?
    - Which of these might be difficult to hide or change?
    - Which might Americans ignore?
    - Are there things that you believe immigrants try to acquire or display in order to show their American-ness? What types of things?
- Describe some of the values you think of as American.
    - How are these similar to or different from [country] values?

TRANSITION OUT QUESTIONS

- What does health mean to you?
- Is there anything that came up during this interview that you had never thought about before?
- What do you think the biggest challenge is facing [immigrants] who move to live in the U.S.? Why?
- Is there anything else you would like to share with me?

DEMOGRAPHICS

Position/Title/Occupation:	
Primary responsibilities:	
Gender:	
Race/ethnicity:	
Year of birth:	
Religion:	
Immigrant origin or not:	
Most used grocery store:	
Most used restaurant:	
Youth class background:	
Current class background:	
Highest level of education achieved:	

B1. Summary Descriptions of Participants

	Pseudonym	Brief descriptions of U.S.-based participants
1	Alice	64 year old Trinidadian American woman who moved to the U.S. for educational opportunities as a young adult; identifies as Asian American Pacific Islander; presently lives in California. Married to non-Caribbean immigrant husband and has adult children. Middle income family.
2	Charlotte (Key Informant)	38 year old Jamaican American woman who moved to the U.S. as a child; identifies as Jamaican or Black; presently lives in Connecticut, but has lived in Florida and Massachusetts. Married to non-Caribbean immigrant husband and has two children. Professional work presently conducted in the Caribbean and among immigrants living in the U.S. Upper income family.
3	Daymond	48 year old Guyana-born and Trinidadian-raised man with parents from Trinidad and Guyana; moved to U.S. as an adult to pursue economic/employment opportunities; identifies as Indo-Caribbean; presently lives in New York City. Single. Low-middle income adult.
4	Denine	27 year old Trinidadian who moved to the U.S. for educational opportunities as a young adult; identifies as Afro-Caribbean; presently lives in Connecticut and previously lived in Washington, D.C. In health professional training. Single. Low income adult student.
5	Happy	54 year old Jamaican American woman who moved to the U.S. for educational opportunities as a young adult; identifies as Jamaican; presently lives in Georgia, but previously lived in New York City. Divorced from Caribbean-immigrant husband of different national origin. Middle income adult.
6	Joanie	Elder Jamaican American woman who moved to the U.S. as an adult to pursue economic/employment opportunities; identifies as Jamaican or Black; presently lives in Connecticut. No demographic information collected. Upper income adult.
7	Karima	26 year old Jamaican American woman who was born in the U.S. and moved in and out of the U.S. as a child; identifies as Afro-Caribbean and Indo-Caribbean; presently lives in Connecticut as a graduate student and has lived in New York and Pennsylvania. Married to second-generation Caribbean husband of different national origin. Low income adult student.
8	Kim	44 year old Jamaican American who moved to the U.S. as a child; identifies as a Jamaican of African descent and as both woman and man; presently lives in Connecticut but has lived in New York. Divorced from an American man; presently in a committed relationship and has three children. Very low income family.
9	Koko	43 year old Trinidadian American woman who moved to the U.S. as an adult to pursue economic/employment opportunities; identifies as Black; presently lives in Connecticut, but lived in New York City and travels to Europe. Married to a second generation Trinidadian American man; has two children. Middle income family.
10	Lakshmi (Key Informant)	47 year old American woman of mixed Trinidadian and Other heritage; born in the U.S., but her professional career has focused, in part, on Caribbean cooking and culinary heritage and takes her to the Caribbean often. Raised in New York City, spent time as a child in Trinidad and presently lives in a New York suburb. Married and has children. Limited demographic information collected. Upper income family.
11	Lameshia	30 year old Trinidadian woman who moved to the U.S. for educational opportunities as a young adult; identifies as Caribbean; presently lives outside of the U.S. Single and participated as a graduate student living in the U.S. Travels in the Caribbean and Southeast Asia for research. Has worked as an adult in Trinidad. Low-middle income adult.

	Pseudonym	**Brief descriptions of U.S.-based participants**
12	Laura	Elder Trinidadian American woman who moved to the U.S. for educational opportunities as a young adult; identifies as Black Caribbean; presently lives in New York. Married and has adult children. No additional demographic information collected.
13	LizEtta (Key Informant)	35 year old Jamaican American woman who moved to the U.S. for educational opportunities as a young adult; identifies as Afro-Caribbean; presently lives in Massachusetts, but has lived in Minnesota, Maryland and Connecticut. Single. Professional work involves public health and social science research in the Caribbean. Middle income adult.
14	Marco	28 year old Dominican American man who moved to the U.S. as a child and moved back and forth between the U.S. and the Dominican Republic; identifies as Hispanic; presently lives in California, but previously lived in New York City. Single. Middle income adult.
15	Nilka	31 year old Trinidadian woman who moved to the U.S. as an adult to pursue economic/employment opportunities; identifies as Black Caribbean; presently lives in New York. Single with one child. Low income family.
16	Paul	30 year old Trinidadian-Haitian American man who moved to the U.S. as a child from Trinidad; identifies as African American; presently lives in New York City and has lived in China before. Single. Low-middle income adult.
17	Ramon	30 year old Dominican American man who moved to the U.S. as a child; identifies as Dominican; presently lives in New Jersey, but has lived in New York City and California before. Single. Low-middle income adult.
18	Vance	48 year old St. Lucian man who moved to the U.S. for educational opportunities as a young adult; identifies as St. Lucian or Black; presently lives in Connecticut. Married. No demographic information collected. Middle income family.

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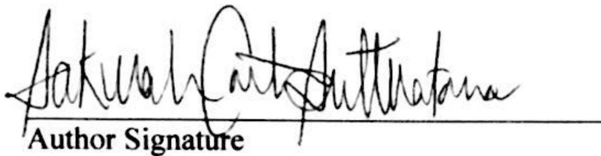

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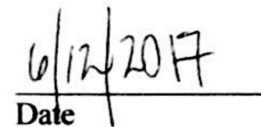

Date