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Discrimination and psychological distress: Does Whiteness matter for Arab Americans?

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ABSTRACT

The white racial category in the U.S. encompasses persons who have Arab ancestry. Arab Americans, however, have always occupied a precarious position in relationship to Whiteness. This study examined differences in reporting racial/ethnic discrimination among Arab Americans. It also investigated whether and how the association between discrimination and psychological distress varies by characteristics that capture an Arab American's proximity to/distance from Whiteness. We used data from the Detroit Arab American Study (2003; $n = 1016$), which includes measures of discrimination and the Kessler-10 scale of psychological distress. A series of logistic regression models were specified to test the discrimination–psychological distress association, stratified by five measures that capture Whiteness – subjective racial identification, religion, skin color, ethnic centrality, and residence in the ethnic enclave. Discrimination was more frequently reported by Muslim Arab Americans, those who racially identify as non-white, and who live in the ethnic enclave. Conversely, the association between discrimination and psychological distress was stronger for Christian Arab Americans, those who racially identify as white, who have dark skin color, and who live outside the ethnic enclave. Even though Arab Americans who occupy an identity location close to Whiteness are less subjected to discrimination, they are more negatively affected by it. The findings illuminate the complex pathways through which discrimination associates with psychological distress among 'white' immigrants. Further research on discrimination and health among Arab Americans can help unpack the white racial category and deconstruct Whiteness.

Introduction

Discrimination has received increasing recognition as one of the main mechanisms to explain racial and ethnic inequities in health in the United States (U.S.) (Gee & Ford, 2011; Williams & Mohammed, 2009). Racial/ethnic discrimination is a chronic stressor that arouses physiological responses such as anger, frustration, and helplessness. These stress responses, in turn, affect health directly through immune, neuroendocrine, and cardiovascular mechanisms, or indirectly through psychological coping mechanisms (Clark, Anderson, Clark, & Williams, 1999). The exponential growth in the number of empirical studies on discrimination and health over the last two decades has led to the publication of exhaustive reviews on the subject (Krieger, 1999; Paradies, 2006; Williams & Mohammed, 2009; Williams, Neighbors, & Jackson, 2003). These reviews highlight three main themes. First, ample evidence supports the presence of a positive association between discrimination and poor health. Second, though there is empirical support for the link between discrimination and hypertension, low birth weight, and self-rated health; the strongest evidence corroborates the effect of discrimination on mental health and psychological distress. Third, the association between discrimination and poor health is conditional, whereby its strength varies by individual, group identity, and contextual influences.

Research has sought to examine how sources of individual variability, such as coping style and racial centrality, can intensify or mitigate the discrimination–health association. Personal coping responses can range from passively accepting a discriminatory situation to actively confronting it. Studies on discrimination, coping, and health have yielded mixed evidence showing that, whereas active coping generally mitigates the harmful effects of discrimination, it can also precipitate poor health outcomes (Clark et al., 1999; James, Hartnett, & Kalsbeek, 1983; Noh, Beiser, Kaspar, Hou, & Rummens, 1995; Paradies, 2006; Williams, Yu, Jackson, &

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Anderson, 1997). Racial centrality, a construct which captures the strength of positive identification with one's racial group, has been reported to play a role in buffering the discrimination–health association. For example, Sellers and Shelton (2003) found that African Americans who view their race as a central component of their identity are less negatively affected by discrimination. Similar findings from research on other racialized groups support the importance of racial/ethnic centrality in relieving the pernicious health consequences of discrimination (Mossakowski, 2003; Walters & Simoni, 2002).

In addition to coping style and racial centrality, racialization based on phenotype has received limited attention in research on discrimination and health. In many cultures, dark skin tone is negatively stereotyped and darker skinned people experience more discrimination. In the U.S., Caribbean Hispanics who are racialized as Black experience more structural discrimination (in the form of residential segregation) compared to Hispanics of mixed racial ancestry (Denton & Massey, 1989). Skin color also exerts an effect on the life chances and social mobility of immigrants in the U.S., with evidence from the New Immigrant Survey showing that lightest skin immigrants of any background report 17% higher wages compared to those who have dark skin (Hersch, 2008). Evidence supporting the mediating effect of skin color on the discrimination–health association is scant and has primarily focused on hypertension (Klonoff & Landrine, 2000). One study by Borrell and colleagues, however, examined how discrimination and skin color interact to influence the self-rated and mental health of African Americans (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006). Even though their findings did not reveal a skin color effect, the study nonetheless evoked the important question of whether and how this phenotypic characteristic may modify the discrimination–health association.

In the U.S., much of the conceptual knowledge on racial/ethnic discrimination and its complex association with health has been constructed around the experiences of African Americans and, increasingly so, Latino and Asian Americans (Gee, Ro, Shariff-Marco, & Chae, 2009; Moradi & Risco, 2006; Viruell-Fuentes, 2007). This is understandable given that members of these groups have historically borne the brunt of racial oppression and continue to do so, as they negotiate blatant and subtle forms of discrimination in their daily lives. In qualitatively different ways, racial stratification also shapes the experiences of immigrant or ethnic groups who are officially classified as white. One such group is Arab Americans who have the option to identify as white but who hold a discursive position in relationship to U.S. racial categories. Arab Americans are highly diverse with respect to national origin, religious affiliation, and socioeconomic background. The category Arab American encompasses second-generation U.S.-born citizens who may not speak Arabic and newly arrived immigrants seeking naturalization. Further, Americans of Arab ancestry exhibit diversity in how they construct racial identities. Though the Office of Management and Budget classifies persons who have ancestry in any of the 22 Arab countries of the Middle East and North Africa as white (OMB, 1997), a significant proportion identify as non-white (Abdulrahim, 2008; de la Cruz & Brittingham, 2003). Given this diversity, examining Arab American members' differential vulnerability to discrimination and its negative health outcomes is warranted.

Racial/ethnic discrimination and Arab American health

Much of the research on Arab Americans adopts an acculturation framework, which assumes that the health of immigrants improves as they integrate into a white, American mainstream. This framework has come under critique in that it casts white culture as normative and does not acknowledge the role racialization plays in impeding the social and economic integration of immigrants (Viruell-Fuentes, Miranda, & Abdulrahim, in press). Only a handful of studies have examined the impact of racial/ethnic discrimination on the health of Arab Americans. Postulating that the collective experience with discrimination in the aftermath of September 11 would have negative health consequences on Arab Americans, Lauderdale's (2006) analysis of birth certificate data in California revealed that women of Arab ancestry who gave birth in the period immediately after the terrorist attacks experienced an elevated risk of poor birth outcomes. Similar findings could not be replicated in Michigan, where there was no difference in birth outcomes of Arab American women before and after September 11 (El-Sayed, Hadley, & Galea, 2008). In fact, Arab ancestry of mother was associated with lower risk of adverse birth outcomes compared to the general population, and mothers residing in Dearborn, a city with a high Arab American concentration, exhibited a low risk for low birth weight (El-Sayed & Galea, 2010). Though the authors postulated acculturation as a plausible mechanism, the protective effects of living in an "Arab ethnic enclave" in buffering against the adverse health effects of discrimination may also explain this observation.

One of the earliest studies examining the relationship between discrimination, coping, and health among Arab Americans showed a strong relationship between self-reported discrimination and psychological distress that was modified by sense of personal control (Moradi & Hasan, 2004). The conditional association between discrimination and psychological distress was further confirmed in a recent study by Rousseau, Hassan, Moreau, and Thombs (2011) whose results showed that Muslim Arab Canadians experienced more psychological distress associated with discrimination compared to Christian Arab Canadians (Rousseau et al., 2011). Disaggregating data on Arab Americans by religious affiliation has become common practice in research studies, given the racialization of Islam since September 11 (Hagopian, 2004). Evidence highlights that Muslim Arab Americans who are assimilated into dominant society report higher levels of discrimination compared to both their less assimilated religious counterparts and to assimilated Christian Arab Americans (Awad, 2010). Whereas research has increasingly examined the buffering effects of religion and area of residence, as of yet, no study has questioned the group's white racial status or investigated how the health of an Arab American may be differentially influenced by her/his proximity to or distance from Whiteness.

Whiteness and Arab Americans

An offshoot of Critical Race Theory, Whiteness studies have primarily focused on documenting the highly contested process through which European immigrant groups at the turn of the twentieth century gained white racial status (Brodkin, 1998; Ignatiev, 1995; Roediger, 2005). A historical analysis of Arab Americans' relationship to U.S.-based racial categories provides a powerful indictment of "race" as a biological construct and exemplifies a case study in Whiteness. When the right to U.S. citizenship was premised on eligibility in the white racial category, Arabic-speaking immigrants took a similar approach as European immigrants and actively appealed for inclusion in the racial hierarchy as whites. Initially, immigrants arriving to the U.S. from modern day Syria and Lebanon based their claims to Whiteness on religious arguments and advanced that, as Christians and as the mediators of Western civilization, they are naturally eligible for inclusion in the white racial category (Gualtieri, 2009; Majaj, 2000; Samhan, 1999). However, as the number of court decisions denying them citizenship increased, members of the group began to employ new arguments that explicitly separated them from Blacks and