

Whiteness Matters for Health: Measuring Racialization Among Latinas and Latinos in the U.S. Using Self-Identified Race, Street Race and Ascribed Race

Nancy López, PhD  
Edward D. Vargas, PhD  
Lisa Cacari-Stone, PhD  
Melina Juarez  
Sonia Bettez, PhD

**Abstract**

Against the backdrop of debates about whether Hispanics are a racial or ethnic group, we focus our attention on how health status may differ according to how Latinos and Latinas believe others see their race in the U.S. context. This research aims to test a new measure of race, “street race” or how you believe other Americans see your race if you were walking down the street. Using the 2015 Latino National Health and Immigration survey (N= 1,493) we examine how the health status of Latinos who report their race as “White” compare to those who report their race as “non-White.” Results show “Whiteness” in health status held for all measures of race. Future research should expand the measurement of race and racialization to include “street race” in order to advance our understanding of the heterogeneity of the Latino experience in the U.S.

**Key words**

Latinos/Latinas; racialization; street-race; gender; intersectionality; health

## **Introduction**

Social scientists have long grappled with the question of how to measure race for interrogating inequality across a variety of policy relevant domains including health, education, criminal justice, housing and employment. A major challenge is using the concept of race without essentializing it (Duster 2006: 488). While all of the major scholarly associations in sociology, anthropology, and psychology subscribe to the mantra that “race is a social construction,” important methodological questions remain of how to operationalize race in research as an empirical matter (AAA, 1998; ASA, 2003; AAPA, 1996).

The conceptual and methodological challenges related to measuring and operationalizing race are particularly salient for research on Hispanics also known as Latinas and Latinos (López 2013a,b; LaVeist-Ramos et al., 2011; Rodriguez et al., 2011).<sup>1</sup> Currently there are almost 57 million Latinos/as living in the United States from heterogeneous national origins, ethnic backgrounds, histories of colonization and enslavement. The U.S. Office of Management and Budget and the Census has defined Hispanic as an ethnic group and includes Cubans, Mexicans, Puerto Ricans, South and Central Americans, or other Spanish culture or origin regardless of race (Rios-Vargas, Saenz and Morales, 2015).

Using the 2011 American Community Survey data, Saenz and Morales (2015) unearth major differences in health, education and employment outcomes across diverse Hispanic national origin groups that point to the existence of a color line within Hispanic communities. Because the 2010 Census included one questions on Hispanic origin (e.g.,

Mexican, Puerto Rican, Cuban) and a second question on race (e.g., White, Black, Native American), as well as a write-in for “some other race”, the percentage of Latina/os identifying as White ranged from a high of 85% among Cubans and 66% among South Americans, to a low of 30% among Dominicans. It is noteworthy that about half of Mexicans and Puerto Ricans identify their race as White (Rios-Vargas, 2011). Saenz and Morales (2015) conclude that Hispanic national origin groups that tend to identify as White and tend to be of lighter skin have better social outcomes (e.g., schooling, employment, wages) than those that tend to be darker skinned even controlling for nativity and educational attainment.

Research on Latina/o health and other outcomes usually homogenize Latinos and treat national origin and race as if they were analytically equivalent (Weinick et al., 2004). This results in several compelling research gaps including: 1) when to investigate discernible differences in health status among Latinos/as based on self-perceived race; 2) differing health patterns by gender; and 3) the need to move beyond the use of race as a social construct to empirically capture the subjective assessments of racialization. To address these gaps, we examine the utility of employing more than one measure of race to examine within group patterns of health differences that are often overlooked when Latinos/as are racially homogenized. We use the 2015 Latino National Health and Immigration Survey (LNHIS), which is representative sample of 1,493 adults of diverse Hispanic origins to explore if there are any differences in both physical and mental health status. In order to accurately capture racial inequity, we test a new conceptual measure of subjective appraisals of reflected race that we call “street-race” to identify differences among racially stigmatized individuals across self-rated health and mental health.

### **Conceptualizing and Contextualizing Health Inequity: Individual Racism**

Health inequities can be defined as differences in health status or the distribution of health determinants between different population groups that are unjust and avoidable (World Health Organization, 2015). Like structural racism (see Bonilla-Silva, 2003; Williams and Mohammed, 2013; Feagin, 2005), individual racism - inter-personal prejudice and discrimination – plays an important role in health inequities (Monk, 2015). Latino/as who have reported experiencing racial discrimination have increased unhealthy days per year and higher odds of reporting fair or poor health outcomes compared to those who have not experienced racial discrimination (Otiniano and Gee 2012). Other studies have found that experiences of racial discrimination among Latino/as exacerbate pre-existing health conditions and are a form of chronic stress (Flores et al., 2008). Moreover, there is a gender effect in the way discrimination affects health as perceived discrimination has a greater effect on men's general health than on women's (Flores et al. 2008).

Although literature addressing the effects of perceived discrimination on the physical and mental health of Latinos is growing, there are several limitations to these studies. Many of the studies on discrimination and Latino health focus heavily on Latinos of Mexican origin and have not found gender differences in outcomes (Araújo and Borrell, 2006). Additionally, because of the varied sociopolitical contexts and migration histories of different Latino subgroups, studies focused on one subgroup cannot be generalized to all Latinos (Araújo and Borrell 2006; Saenz and Morales, 2015). To address these gaps in the literature, we draw on racial formation, critical race and

whiteness theories and an intersectionality framework to conceptualize our measure of “street-race.”

### **“Street-Race”: An Innovative Measure of Racialization at the Micro-level**

Omi and Winant’s racial formation theory (2015) states that the social construction of race at the micro-individual and macro-structural levels is largely accomplished via visual associations: “this process of selection, of imparting social and symbolic meaning to perceived phenotypical differences, is the core, constitutive element of what we term “*racialization*’ (Omi & Winant, 2015:111).” Using the National Survey of American Life, Monk (2015) found that subjective and contextualized appraisals of skin color (which he conceptualizes as ‘embedded bodily capital’) are an even stronger predictor of health outcomes than interviewer-rated skin color. Monk (2015:20) concludes that it is imperative that we consider the “relationality” of skin color as the meaning of race in a given context has the potential to shape the pathways of wellness and illness through racialization and embodiment.

Critical race legal scholar Harris (1993) makes a second very important point about what the social construction of Whiteness or what Frankenberg (1993:6) calls the social construction of Whiteness or what McIntosh (1998) has labeled the “invisible knapsack” of White privilege or the benefits of “looking white” in a racially stratified society that is organized along White supremacist logics (See also Vidal-Ortiz, 2004; Sue, 2014; Telles and Ortiz, 2008). Harris (1993:276) argues that race as a social status can actually be conceptualized as property: “My grandmother’s story illustrates the valorization of Whiteness as treasured property. In ways so embedded that it is rarely

apparent, the set of assumptions, privileges, and benefits that accompany the status of being White have become a valuable asset.”

Intersecting identities such as gender, class and colorism matter for health, particularly for how dynamics of discrimination shape the experiences of individual Latinas and Latinos (Gravlee & Dressler, 2005; Gravlee, 2009; Sue, 2014; LaVeist-Ramos, 2011). Specifically, the racialized-gendered social determinants of health is a multi-level framework that interrogates intersecting systems of stratification including: 1) the micro/individual level or “lived race-gender” (López 2013); 2) the meso/institutional level or neighborhood level; and 3) the macro/structural level of society including federal policies and political economic structures at the national and global levels (Richardson et al., 2011).

### **Hypotheses**

Drawing from the above theoretical concepts, we test three main hypotheses related to “street-race”:

1. Physical and mental health status differs by self-reported, ascribed, and street race.
2. Latinas and Latinos who report their street-race as white will report optimal physical and mental health.
3. Street race will impact health inequities differently by gender.

### **Data and Methods**

The LNHIS (N=1,493) is a unique survey that examines the relationship between race/ethnicity and Latino health and well being. LNHIS relies on a sample provided by a mix of cell phone, landline households and web-based surveys. A total of 989 Latinos

were interviewed over the phone and an additional 504 latinos were sampled through the Internet to create a dataset of 1,493 respondents.

Pacific Market Research in Renton, Washington administered all phone calls. The survey has an overall margin of error of +/- 2.5 per cent. Latino Decisions selected the 44 states and Puerto Rico with the highest number of Latino residents that collectively account for 91% per cent of the overall Latino adult population. Respondents across all modes of data collection could choose to be interviewed in either English or Spanish. All interviewers were fully bilingual. A mix of cell phone (35 per cent) only and landline (65 per cent) households were included in the sample, and the data are weighted to match the 2013 Current Population Survey universe estimate of Latino adults with respect to age, place of birth, gender, and state. The survey was approximately 28 minutes long and was fielded between January 29, and March 12, 2015.

### **Measures**

We are interested in estimating the probability of optimal health; the primary health outcome variables of interest are self-rated physical health status and self-rated mental health status. The self-reported health status questions included in the LNHIS is very close in wording to the item included in the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) [Jones et al. 2008; Macintosh et al. 2013; Vargas et al. 2015)]. Both questions utilize a 1 to 5 Likert scale, with respondents rating their health status from excellent to poor. We used the following survey questions: “How would you rate your overall physical health -- excellent, very good, good, fair, or poor?”, and “How would you rate your overall mental health?” The categories of the



dependent variable for self-rated physical and mental health are collapsed into binary variables. From the original 5-point Likert scale, we dichotomized 1 (poor health), 2 (fair health), and 3 (good health) = 0, and 4 (very good) and 5 (excellent) = 1. While, a number of health scholars have recently identified challenges in using self-rated health status to examine variation in health across diverse racial/ethnic and immigrant populations. Our self-rated health measure takes into the consideration the recommendations by Sanchez and Vargas (2015), who confirm Viruell-Fuentes et al. (2011), work that researchers should be using “mas o menos” instead of “regular” as the Spanish translation of “fair” health (as “regular” overinflates poor health). We acknowledge these recommendations and use “mas o menos” rather than the traditional “regular” in our analysis.

Our main explanatory variables include: street-race, self-reported race, and socially assigned race/ascribed. The survey wording and distribution of these response categories are listed in Table 1. It is important to note that the aforementioned question formats not only varied in the question wording but each had slightly different response categories. For example, like the 2010 Census the first two questions in the survey first asked about the specific Hispanic national origin and then asked about self-identified race as back-to-back questions as we wanted to make sure that we did have a Hispanic participant. Later in the survey we then asked the “street-race” question because we wanted to have the respondent reflect on how they believed other “Americans” viewed their race in their local context. To create our new “street race” measure we blend two previous formats. First, we use on Jones et al.’s (2008) measure of “socially assigned race” Or what we call “ascribed race.” Second, we build on Dowling’s (2014) question on Mexican American racial ideologies in Texas: “*If you were walking down the street*

*here in [city name], and someone were to see you, how do you think that person would label you in terms of your racial or ethnic background? Do you think that some would be able to tell from looking at you that you are [Mexican American/Hispanic/Mexican]?"*

Our specific question on “street race” was: “*If you were walking down the street, what race do you think other Americans who do not know you personally would assume you were based on what you look like?*” Note that unlike the previous question format, this question specifies who the “other people” are by specifically invoking the term “other Americans” and does not probe about racial and ethnic background in the same question. This question allows for the participant to reflect on her/his subjective reflected understanding of how she/he is seen “on the street” by other Americans. We included the racial category “Arab” in both formats and immigrant in the ascribed question to test if individuals who were U.S.-born were seen as perpetual foreigners (Selod and Embrick, 2013).

To compare how street race measures up with self-reported race and ascribed race, we also utilize self-rated White and ascribed as White and compare differences across health outcomes (See Table 1). We believe this exercise allows us to better understand the utility of street race on health disparities within the Latina and Latino pan ethnic umbrella. And finally, the very last question of the survey inquired about gender (e.g., man, woman, transgender) so we can combine any of the aforementioned measures (e.g., a “street race-gender,” Etc.)

The categories of Asian American (n=29), Native American/American Indian (n=27), and some other race (n=60) are dropped due to small sample sizes. The five

street-race categories are White, Latino, Black, Arab, and Mexican totaling 1,304 respondents. The distributions of all race categories are displayed in Table 1.

<Table 1 about here>

We also control for a handful of measures that previous research has found to be correlated with Latina/o health status. Among the demographic variables, we include standard measures of income, educational attainment, age, marital status, gender, and insurance coverage. To assess income we have included several dummy variables representing different income categories: \$20,000-\$39,999, \$40,000-\$59,999, \$60,000-\$79,999, \$80,000-\$99,999, \$100,000-\$149,999, \$150,000 and above, with less than \$19,999 serving as the reference category. We also include a variable of “unknown” income in the model that includes respondents who did not report their income as a means of saving cases.

### **Statistical Analysis**

We utilized survey weights to account for the complex survey design. Our analytical approach is intended to determine the relationship between street-race and other measures of race including self-identified race and ascribed race, on self-reported health status within a nationally representative sample of Latino adults (18-98).

We analyze social outcomes of Latinos who identify their race as White and compare them to each of the non-White categories in each of the different questionnaire formats for race (Collins, 2007). This analysis helps us understand the measurement of health disparities within each race measure, therefore we model White as the reference category in our analysis. Finally, we control for other demographic factors including U.S.

citizenship and language of interview. We also include a measure for whether respondents are of Mexican-origin, as this population has been found to have unique health outcomes relative to Latinos from other backgrounds (CDC 2011; Mulvane-Day et al., 2007).

Summary statistics for all variables used in this analysis are listed in Table 2.

<Table 2 about here>

Our analytical approach is intended to first determine the relationship between multiple measures of race (e.g., self-reported, ascribed, and street-race) on self-reported physical and mental health within a nationally representative sample of Latino/a adults. In this analysis we estimate models that compare self-reported White race, ascribed White race, and street White race relative to all other racial categories within their respective response categories. Our primary focus is to determine the utility of street race relative to other measures of race on explaining optimal physical and mental health.

Next, we disaggregate the street-race measure to better understand self-rated health within the street race categories, using ascribed as White as the reference category. We run separate models for men and women to better understand the association between street race-gender and physical and mental health. Given that our health outcomes are binary, we estimate a series of logistic regressions to examine the differences across racial categories on the probability of reporting very good and excellent physical and mental health, controlling for multiple covariates.

## **Results**

After dropping missing data, our final models have a sample size of 1,197, which exclude street race categories that are less than 50 observations. Table 2 displays the distribution

of our sample. On average, around 43 percent of the sample reported that they had very good and excellent physical health. Sixty percent of the sample stated they had very good and excellent mental health. For our measures of street-race, 22 percent report White, 46 percent report Latina or Latino, 24 percent report Mexican, 4 percent report Black, and 4 percent report Middle Eastern/Arab. The other race categories show that 45 percent of the sample self-reported as White and 14 percent of our respondents reported White as their ascribed race. The mean age in our sample is 46, and the majority of our sample has a high school education. Moreover, just over half of our sample completed the survey in Spanish, and just over half of our sample was female. In regards to citizenship, 77 percent of our sample is a U.S. citizen; it is important to note that this figure includes U.S.-born (64 percent) and naturalized citizens (36 percent). Lastly, over half of our sample is of Mexican origin, 53 percent reported being married, and just over 15 percent of our sample was insured.

Our first set of categorical regression models tests racial differences using street race White, self-reported White race, and ascribed White race on self-reported physical health, controlling for a vector of variables, treating White within each of these race measures as the reference category (Table 3). We then estimate models that test the difference between White race categories on self-reported mental health, controlling for a vector of variables (Table 4). The next set of estimates disaggregate street race and test the difference between street-race categories on physical health (Table 5), and mental health (Table 6), controlling for a vector of variables (using street race White as the reference category). In estimating our models in table 5 and 6, we run a full model and then stratify the sample by gender.

The results of our first set of models are depicted in Table 3. Our first set of results in this table estimate three separate logistic regression models that includes various measures of White race (street-race, self-reported race, and ascribed race) on physical health, controlling for age, education, gender, insurance coverage, citizenship, marital status, income, Mexican origin, and language of interview (these controls are used in all analyses). In these models we find that there are only differences between self-reported White race versus all other racial categories on the probability of reporting very good and excellent physical health. In fact, respondents who self-report their race as White opposed to non-white, increase their odds of reporting very good and excellent by a factor of 52 percent, holding all else constant. We do not find differences for ascribed as White versus non-white, and street-race White versus street-race non-white on optimal physical health.

<Table 3 about here>

The results of our second set of models are depicted in Table 4. Our first set of results in this table estimates three separate logistic regression models that include various measures of White race (street-race, self-reported race, and ascribed race) on mental health, controlling for a vector of covariates. In these models we find that there are differences between street-race White versus street-race non-white on the probability of reporting very good and excellent mental health. In fact, for respondents who report their street race as White as opposed to street-race non-White, their odds of reporting very good and excellent increases by a factor of 41 percent, holding all else constant. We find marginal differences for self-reported White race versus non-white, and no differences between ascribed as White versus ascribed as non-white on optimal mental health.

<Table 4 about here>

Our next set of models disaggregate our new street race variable to better understand disparities within this framework both in a full model and by gender to better understand the role gender plays in how individuals are seen on the street on physical health (using street race White as the reference category). In this analysis, we estimate a logistic regression to examine the probability of reporting very good and excellent physical health, controlling for a vector of covariates (table 5). There is strong support for these results only after stratifying our sample by gender, as we find that there are differences between street-race Latino males and street-race White males on the probability of reporting very good and excellent physical health ( $p < 0.05$ ). In fact, being seen as street-race Latino as opposed to street-race White increases the odds of reporting very good and excellent physical health by a factor of 67 percent, holding all else constant. We do find marginally significant differences between street-race Arab/Middle Eastern and street-race White on the likelihood of reporting optimal physical health, holding all else constant. Among females, we find that street-race Mexican females are less likely to report optimal physical health relative to street-race White females. In other words, being seen as street-race Mexican female as opposed to street-race White female decreases the odds of reporting very good and excellent physical health by a factor of 52 percent, holding all else constant.

<Table 4 about here>

Our last set of models also disaggregate our street race variable to better understand differences within this framework both in a full model and by gender to better

understand the role gender plays in how individuals are seen on the street on optimal mental health (using street race White as the reference category). In this analysis we estimate a logistic regression to examine the probability of reporting very good and excellent mental health, controlling for a vector of covariates (Table 5). There is strong support for these results in our full model as we find that there are differences between street-race Arab and street-race White on the probability of reporting very good and excellent mental health ( $p < 0.01$ ). In fact, being seen as street-race Arab as opposed to street-race White decreases the odds of reporting very good and excellent mental health by a factor of 58 percent, holding all else constant. We do find significant differences between street-race White and street-race Latino, street-race Mexican, and street-race Black on the likelihood of reporting optimal mental health, holding all else constant. After stratifying street race by gender, we find street race Arab males to be less likely to report optimal mental health relative to street-race White males, holding all else constant ( $p < 0.01$ ). We also find street race Latino males to be less likely to report optimal mental health relative to street-race White males, holding all else constant, which is marginally significant.

<Table 5 about here>

Regarding demographic control variables in our street race models, we find that across the models, education, age, Mexican origin, income and insurance coverage are strong predictors of Latino health, as we find those who are more educated are more likely to report optimal health, and if they are insured and as they get older respondents are less likely to report very good and excellent physical and mental health, which is consistent and expected given the health disparities literature. We also find statistical differences



between U.S. citizens and non-citizens (in our physical and mental health models), as U.S. citizens are more likely to report very good and excellent physical and mental health. Lastly, we do find income differences across our models but tend to see much more variation in our mental health models. These findings could be attributed to cultural differences in reporting mental health and the role acculturation might play in health seeking behaviors.

## **Discussion**

One of the unintended consequences of the racial homogenization of Latinos/as is that it may impede our ability to investigate, map and interrupt any potential differences in health outcomes among Latinos/as who may be of the same national origin but nevertheless experience racialization in very different ways. Our analysis found that asking people to subjectively reflect how they believe others see them (i.e. street-race) may be the most important for predicting mental but not physical health status and that this may differ by gender. One limitation of the study is that it did not employ interviewer-assessed measures of race (Telles, 2014). Future research using triangulated data collection should include third party assessment of race in a given context as racial status may vary for the same individual depending on what they look like (Gravlee and Dressler, 2005; Candelario, 2007; Sue, 2014; Roth, 2012).

Among the contributions of this study is that street race enables researchers to have more than one empirical measure of race and includes subjective appraisals of reflected race and its intersection with gender. A second contribution is that phrasing the question in the aforementioned manner may make the complex concepts of race as a multidimensional and relational social construction more accessible. This phrasing can

dismantle the resurgence of genetic reductionist definitions of race (Morning, 2011; Shiao et al., 2012). Another contribution is that it affirms the importance of disaggregating the heterogeneity of Latino experiences with racialization for unpacking the so-called Latino epidemiological paradox whereby low socioeconomic status Latino groups have better health outcomes than would be expected given their social status (Morales & Saenz, 2015; Vidal-Ortiz, 2004; Crenshaw, 1993).

We believe these findings point to new avenues for future research, including the need to unpack the different racialization that individuals in the same ethnic or national origin group or even within the same biological Latino families may experience based on the meanings assigned to what they look like. More research is necessary to unpack how if at all these differences in subjective appraisals of reflected racial status lead to feedback loops that contribute to pathways of embodied health inequities (Duster, 2006; Gravlee, 2009; Williams and Mohammed, 2013; López, 2015). It is our hope that “street-race” can “travel” to other contexts for probing social inequities and advancing social justice.

**Disclosure statement**

The authors reported no potential conflict of interest.

---

---

## References

- American Anthropological Association. 1998. "Statement on Race." Washington, DC.
- American Association of Physical Anthropologists. 1996. AAPA Statement on Biological Aspects of Race, *American Journal of Physical Anthropology*, (101):569-570
- American Sociological Association. 2003. *The Importance of Collecting Data and Doing Social Scientific Research on Race*. Washington, DC: American Sociological Association.
- Araújo, Beverly, and Luisa N. Borrell. 2006. "Understanding the Link Between Discrimination, Mental Health Outcomes, and Life Chances Among Latinos," *Hispanic Journal of Behavioral Sciences*, 28(2): 245-266.
- Bonilla-Silva, E. 2003. *Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in the United States*. 2nd ed. Lanham, MD: Rowan and Littlefield.
- Candelario, G. 2007. *Black Behind the Ears: Dominican Racial Identity From Museums to Beauty Shops*. Durham, NC: Duke.

- 
- Centers for Disease and Control and Prevention. 2011. Child and Teen BMI. Division of Nutrition, Physical Activity, and Obesity. Accessed:  
[http://www.cdc.gov/healthyweight/assessing/bmi/childrens\\_bmi/about\\_childrens\\_bmi.html](http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html).
- Collins, Patricia Hill. 2007. "Pushing the Boundaries or Business as Usual? Race Class, and Gender Studies and Sociological Inquiry," in *Sociology in America: A History*. Chicago: University of Chicago, pp. 572-604.
- Crenshaw, Kimberle. 1993. "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," in *Critical Race Theory: The Key Writings That Formed the Movement*. Kimberle Crenshaw, Neil Gotanda, Gary Peller, and Kendall Thomas. New York: The New Press, pp. 357-383.
- Dowling, Julie A. 2014. *Mexican Americans and the Question of Race*. Austin: University of Texas Press.
- Duster, Troy. 2006. "Lessons from History: Why Race and Ethnicity Have Played a Major Role in Biomedical Research," *Journal of Law, Medicine and Ethics*, Fall: 487-492.
- Feagin, J. 2005. *Systemic Racism: A Theory of Oppression*. New York: Routledge.
- Flores, Elena, Tschann, Jeanne M., Dimas, Juanita M., Bachen, Elizabeth A., and Cynthia L. de Groat. 2008. "Perceived Discrimination, Perceived Stress, and Mental and Physical Health Among Mexican-Origin Adults," *Hispanic Journal of Behavioral Sciences*, 30(4): 401-424.
- Frankenberg, Ruth. 1993. *White Women, Race matters: The Social Construction of Whiteness*. Minneapolis: University of Minnesota.

- 
- Gravlee, C., and W. Dressler. 2005. "Skin Pigmentation, Self-Perceived Color, and Arterial Blood Pressure in Puerto Rico." *American Journal of Human Biology* 17: 195–206.
- Gravlee, Clarence. 2009. "How Race Becomes Biology: Embodiment of Social Inequality," *American Journal of Physical Anthropology*, 139:47-57.
- Harris, Cheryl. 1993. "Whiteness as Property," in *Critical Race Theory: The Key Writings That Formed the Movement*. Kimberle Crenshaw, Neil Gotanda, Gary Peller, and Kendall Thomas. New York: The New Press, pp. 276-291.
- Jones, C., B. Truman, L. Elam-Evans, C. Y., Jones, CA, Jiles, R., Rumisha, SF and Perry, G.. 2008. Using 'Socially Assigned Race' to Probe White Advantages in Health Status." *Ethnicity and Disease*, 18 (4) : 496–504. *Ethnicity & Disease*. 18(4):496-504.
- LaVeist-Ramos, T., Galarraga, J., Thorpe, R., Bell, C., Austin, B. (2011). Are black Hispanics black or Hispanic? Exploring disparities at the intersection of race and ethnicity. *Journal of epidemiological community health*, 10(1136): 1-5.
- López, Nancy. 2013. "Contextualizing Lived Race-Gender & the Racialized-Gendered Social Determinants of Health," in *Mapping "Race": Critical Approaches to Health Disparities Research*. Laura Gómez and Nancy López, editors. New Brunswick, NJ: Rutgers University Press, pp. 179-211.
- López, Nancy. 2013a. "Contextualizing Lived Race-Gender and the Racialized Gendered Social Determinants of Health," in *Mapping "Race": Critical Approaches to Health Disparities Research*, Laura Gómez and Nancy López (editors). New Brunswick, NJ: Rutgers University Press, pp. 179-211.

- 
- López, Nancy. 2013b. "Killing Two Birds with One Stone? Why we need two Separate Questions on Race and Ethnicity on the 2020 Census and Beyond," *Latino Studies Journal*, 11(3): 428-438.
- López, N. 2015. "What's Your Street Race-Gender?" Why We Need Two Separate Questions on Hispanic Origin and Race for the 2020 Census & Implications for the African Diaspora and Urban Communities," Washington, DC, February 19<sup>th</sup>. Video.
- Macintosh T, Desai MM, Lewis TT, Jones BA, Nunez-Smith M. 2013. Socially-assigned race, healthcare discrimination and preventive healthcare services. *PLoS One*. 2013;8:e64522.
- McIntosh, Peggy. 1998. "White Privilege, Color, and Crime: A Personal Account," In *Images of Color, Images of Crime*, Coramae Richey Mann and Marjorie S. Zatz, Roxbury Publishing Co, Los Angeles, CA.
- Monk, Ellis. 2015. "The Cost of Color: Skin Color, Discrimination, and Health Among African Americans," *American Journal of Sociology*, 121 (2):1-49, forthcoming.
- Morning, A. 2011. *How Scientists Think and Teach About Human Difference*. Berkeley: University of California.
- Otiniano, A. and Gee, G. 2012. "Self-Reported Discrimination and Health-Related Quality of Life Among Whites, Blacks, Mexicans and Central Americans," *Journal of Immigrant and Minority Health*, 14: 189-197.
- Omi and Winant. 2015. *Racial Formation in the United States*. New York: Routledge.
- Richardson, L. J. Hussey, & K. Scruz. 2011. "A Life Course Perspective on Maternal and Child Health," in *Maternal and Child Health: Programs, Problems and Policies in Public Health*, edited by Jonathan B. Kotch, chap. 4. 3rd Edition.

- 
- Sudbury, MA: Joes and Bartlett.
- Rios-Vargas, Albert 2011. *The Hispanic Population 2011: 2010 Census Brief*.
- Rodriguez, C., G. Agueros, and M. Miyawaki. 2011. "Does Race and National Origins Influence the Hourly Wages that Latino Males Receive." In *Invisible No More: Understanding the Disenfranchisement of Latino Men and Boys*, edited by Pedro Noguera, Edward Fergus, and Aida Hurtado, 207–17. New York: Routledge.
- Roth, Wendy. 2012. *Race Migrations: Latinos and the Cultural Transformations of Race*. Stanford: Stanford University.
- Saenz, Rogelio and Maria Cristina Morales. 2015. *Latinos in the U.S.: Diversity and Change*. New York: Policy Press.
- Sanchez, Gabriel R. and Edward D. Vargas. (2015) "Language bias and self-rated health status among the Latino population: evidence of the influence of translation in a wording experiment," *Quality of Life Research*, October [Epub ahead of print]
- Selod, S. and Embrick, D. G. (2013). "Racialization and Muslims: Situating the Muslim Experience in Race Scholarship." *Sociology Compass*, 7: 644–655.
- Shiao, Jiannbin, Thomas Bode, Amber Beyer, and Daniel Selvig. 2012. "The Genomic Challenge to the Social Construction of Race," *Sociological Theory*, June 2012 30: 67-88
- Sue, Cristina. 2014. *Land of Cosmic Race: Race Mixture, Racism and Blackness in Mexico*. Oxford: Oxford University Press.
- Telles, E., and V. Ortiz. 2008. *Generations of Exclusion: Mexican Americans, Assimilation, and Race*. New York: Russell Sage.
- Telles, E. 2014. *Pigmentocracies: Ethnicity, Race and Color in Latin America*. Edward

- 
- Telles and the Project on Ethnicity and Race in Latin America (PERLA)*. Chapel Hill, NM: University of North Carolina.
- Vargas, E., Sanchez, G., and Kinlock, B. 2015 “The Enhanced Self-Reported Health Outcome Observed in Hispanics/Latinos Who are Socially-Assigned as White is Dependent on Nativity,” *Journal of Immigrant and Minority Health*, 17(6) 1803-1810.
- Vidal-Ortiz, S. 2004. “On being a White person of color: using autoethnography to understand Puerto Ricans racialization.” *Qualitative Sociology*, 27(2): 179-203.
- Viruell-Fuentes, Edna A., Jeffrey D. Morenoff, David R. Williams, and James S. House (2011). Language of Interview, Self-Rated Health, and the Other Latino Health Puzzle. *AJPH*, 101: 1306-1313.
- Weinick RM, Jacobs EA, Cacari Stone L, Ortega AN, Burstin H. (2004). Hispanic healthcare disparities: challenging the myth of a monolithic Hispanic population. *Med Care*. Apr;42(4):313-20.
- Williams, D. R. and Selina Mohammed. 2013. “Racism and Health I: Pathways and Scientific Evidence,” *American Behavioral Scientist* 57(8): 1152-73.