# Chapter 13
# I Pity the Poor Immigrant: Stigma and Immigration

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## Introduction: Global Movement, Local Interventions

In 2013, the United Nations Population Division reported a mid-year International Migrant Stock of 231, 522, 215 people [1]. The percentage of immigrants in any country ranged from about 85 % of the population, in the United Arab Emirates, to fractions of a per cent [1]. Multiple factors influence who immigrates and why, including global socioeconomic determinants, safety, politics, work opportunities, health-care needs, and family reunification. In 2013, the majority of immigrants (nearly 59 %) lived in developed countries—North America, Europe, Australia/New Zealand, and Japan [2]. Of the immigrants in developed countries, 60 % came from developing countries; the large majority of immigrants (86 %) in developing countries came from other developing countries [2].

Immigration may be a global phenomenon, but its demographics are local. For example, in 2013, the United States was about 14 % immigrant, but 37 % of the population of New York City is foreign born, including nearly 50 % of Queens residents; foreign-born mothers account for 51 % of births in the city [3]. Where are the immigrants coming from? In the United States overall, Mexicans account for approximately 30 % of the immigrants, followed by people from China, India, the Philippines, El Salvador, Vietnam, Cuba, Korea, the Dominican Republic, and Guatemala. In New York City, however, Dominicans are the largest group, but account "for only 12 % of the foreign born. Six countries on the nation's top 10 list—Philippines, El Salvador, Korea, Vietnam, Cuba, and Guatemala—were not

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among the city's top ten groups, and the last 3 not even among the city's top 20 groups" [4].

These trends support the notion that, broadly speaking, immigrants make choices about where they will live based on larger socioeconomic factors like work opportunities, health-care availability, and family reunification but these choices are also influenced by their place of origin. For example, 143,770 Bosnians were resettled in the United States between 1993 and 2006, the majority in Chicago and St. Louis, but there were class and religious differences in the Chicago and St. Louis populations that reflected socioeconomic and cultural factors from when they were in Bosnia [5].

The vastly diverse migrant population includes physicians and other health-care workers, as well as those who will come into health-care systems needing care. In health-care systems, among the plethora of policies typical of the modern medical world ranging from hand hygiene to not talking about patients in elevators are ones that reflect medical encounters with immigrants. One increasingly common policy is that if somebody's first or preferred language is not English (not uncommon in a place like New York City with between 200 and 800 languages spoken [3, 6]), a medical interpreter needs to be present for an interview, not the patient's child or uncle, not a passing dietician who speaks a similar language, not the physician's butchered efforts to shout a few words remembered from a college class—a medical interpreter, in person or on the phone.

The policy is in place for a clear medical reason: optimal patient care requires an accurate and nuanced history. Deaf, hard-of-hearing, and non-English speaking patients—the latter group typically comprised of migrants, first-generation citizens, refugees and tourists, and less often second-generation children of immigrants—all deserve optimal care. In the United States, the policy is also a political intervention. It runs counter to a nativist approach that insists, "You're here, you should be speaking English."

Another hospital policy, more controversial on a national scale but adopted by a number of large hospital systems in New York City, is that nobody is turned away on account of immigration status. In an era of widespread and popular anti-immigrant sentiment, policies of this nature are not universally observed, beyond national mandates to provide emergency and obstetric care; in fact, some hospitals have shown themselves to be willing to deport patients who are undocumented [7].

Interpreter services and providing care regardless of immigration status result in better public health: preventing people from getting the medical care they need will not make any population healthier. But these policies also directly resist *stigma*, both in the health-care setting itself and in larger society by setting an example.

Goffman famously defined stigma as a "deeply discrediting" attribute that reduces the bearer "from a whole and usual person to a tainted, discounted one" [8]. These hospital policies oppose stigma precisely because they do not accept that a language or a type of documentation taints somebody as meriting insufficient

medical care, nor do they acquiesce to the diminution of a person. Your language or place or birth does not mean you have a less privileged place in the (usually) highly valued doctor-patient relationship.

Why should it matter if hospital systems have interventions that can reduce stigma? What is so bad about stigma, other than its general unpleasantness? Stigma has significant and immediate public health consequences for immigrant communities—and therefore for the communities in which immigrants live. These include frank barriers in access to care, as happens when clinics are expected to check documentation, dissuading people from seeking services, and perceived barriers (e.g., reticence to come to services because of concerns about how you will be perceived in a clinical milieu); there are also barriers in the provision of care, such as decreased services for vulnerable populations (consider pregnant migrants put into detention centers or asthmatic child migrants who are not brought to a primary care physician); and subsequent public health hazards (populations who are suspicious of public health surveillance may be less willing to get treatment for reportable and contagious illnesses).

The ramifications of stigma for already vulnerable populations are pervasive throughout health care. Stigma exacerbates vulnerability. Rarely is stigma applied to the powerful, and inequalities that are pervasive in society disproportionately fall upon those who are more stigmatized; and then social inequalities bleed into worse health-care disparities. This in turn feeds a downward cycle, where, for those already burdened with worse access to health care, stigmatization prevents access, while stigma itself may affect both structural-level and community-level and individual constructions of the self, resulting in less healthy lives [9].

This chapter examines the relationship between anti-immigrant sentiment and stigma in the health-care field, beginning with an examination of the tight parallels between anti-immigrant sentiment and stigma, and how both are often characterized as a "natural" phenomenon. This is followed by a closer examination of three domains where stigma and anti-immigrant sentiment intersect prominently with health, often to the disadvantage of immigrants: in epidemiology, in health-care politics, and in the notion that immigrants harbor more stigma toward medicine (particularly mental health). Given the prominence and power of stigma as rhetoric [10], it is imperative to look at how stigma infiltrates discourses in and around the practice of health care, to reveal the operations of stigma and point to the strategies required to counter its pernicious efficacy. This is followed by a section reviewing ways of countering stigma in relation to immigrants in health care. The chapter ends with concluding thoughts about what, ultimately, an investigation of stigma and anti-immigrant sentiment demands of us. The purpose is to not so much to show that stigma has negative health consequences, which has been adequately and comprehensively demonstrated, but to see *how* this happens in immigrant populations and, ultimately, how stigma is a way of avoiding important questions raised by immigration.

## Migration and Stigma

Both stigma and anti-immigrant sentiment can appear to be natural ways of thinking, partly because they are so ubiquitous and partly because, like everything else, they can be given evolutionary explanations: for example, fear of contamination or encroachment into one's own ecological niche and competition for finite resources, respectively. But although they are prevalent and powerful, they are not necessarily natural or instinctive.

The movement of creatures across the Earth is an enduring feature of life itself. From the migration of blue whales across oceans and of monarch butterflies across continents to frogs hopping from pond to pond, creatures move. Geographical movement is an ecological process responsive to fluctuations in temperatures, changes in competition, and the flourishing of edibles, and it is a driving force for evolution, speciation, and diversity; it is why we are not still single cells bubbling in a thermal vent deep under the ocean.

Throughout human history, people have migrated. They have done so for ecological reasons and also with an innate human curiosity about new frontiers. Two million years ago, *Homo erectus* left Africa; approximately 140,000 years ago, *Homo sapiens* spread out across Eurasia and, 12,500 years ago, crossed Beringia into the Americas—these time frames remain a matter of debate, but then controversies are never far from the topic of migration [11, 12].

As humans migrated, they established societies and civilizations, mapping a social geography of families, kinship systems, communities, villages, towns, principalities, sovereign states, countries, and nations, each nurturing languages and customs, over the physical topography of the Earth. Migration became more than a geographical movement; it became a movement across social boundaries into new cultural landscapes, where one might find churches instead of mosques, baklava instead of chocolate sundaes. These differences in the cultural landscapes have provoked shock as well as fascination, fear as well as respect, and disgust as well as desire.

With such strongly evoked emotions, it is not surprising that the history of migration has often been marked by aggressive encounters between peoples: migration has been colonial and exploitative, associated with war, domination, and genocide. Indeed, human history is a long narrative of conquest, atrocities, and violence, in which migrants have been victims, perpetrators, and both.

There is another history of migration, also based on how people experience the emotional and psychological shock of cultural difference. This is the history of migrations that have been peaceful, convivial, and beneficial for both the migrants and those that they arrive among, spurring curiosity, friendships, new ideas, cuisines, and the sharing of expertise and customs. Pleasant though this is, the contentious debates that have always swirled around migration are sometimes more revealing about what is at stake in migration than rose-tinted views of camaraderie, chop suey, and chicken vindaloo. Migration challenges core concepts of who we are: migration challenges the atavistic idea that we belong to or own a particular

patch of land or a certain part of our shared Earth, the extent to which we are defined by where we come from and how much of who we are is constituted by our nation, our origins, our race, and our ancestry. Underneath the insults about who is civilized and who is not (in which we are typically more civilized than they are) are difficult questions about the nature of civility itself: what do we owe each other as hosts and guests? What respect do we afford differences within this host-guest relationship?

Stigma is a way of avoiding these questions; it creates a discourse in which these questions are precisely not asked. Stigma takes the problems we face in our encounter with another person (e.g., who are we to make claims about ourselves and our place on Earth, and what do we owe to those who have come to our doorstep?) and insists that the problems belong to them. This is one of the ways, along with intimidation and passion, in which stigma effectively modulates a discourse: it denaturalizes a natural set of problems into another's error or sin, it places the burden of problematization onto the Other, and in doing so, it reifies superiority.

To hear this dynamic in anti-immigrant sentiment, and how close it so often comes to issues of health and hygiene, consider the words of Michael Savage, the radio talk show host: "We're getting refugees now who have never used a telephone, a toothbrush, or toilet paper. You're telling me they're going to assimilate? They will never assimilate. They come here and they bring their destitute ways to this country, and they never assimilate" [13]. The way Savage explains it, the problem is in them. There is no concession that the problem at hand is shared and involves dialogue and blending—how we welcome migrants and how we employ them and protect them and invite them in with the promise of a dream with statues in harbors: these issues are solved by transposing the problem onto their intransigence and their failure to stop being who they are. And they remain marked and lesser; they are, according to Savage, neither competent in the basic modes of civilized conversation and hygiene nor willing to become so.

In this manner, the immigrant is stigmatized as naturally uncivil by those whose ability to detect the natural incivility elevates them into a position of perspicuous civility, a process that simultaneously erases the immigrant's civility and the incivility of the prejudiced. There is no necessarily natural or instinctive basis for anti-immigrant sentiment, but the rhetoric insists that there is and simultaneously justifies the prejudice.

Anti-immigrant sentiment and stigma are natural companions, which is why they so often encounter one another in the biomedical world. Social cognitive models of stigma define the visibilities and assumed relationships as attributions and stereotypes, which then result in prejudice and discrimination (see, e.g., Corrigan [16]). Link and Phelan, ever attentive to the social pragmatics of conceptual models, strive to include these pragmatics within the definitions of the models themselves; they insist that to understand stigma, one has to also account for the role of power. As they say, "it takes power to stigmatize" ([17], pg. 375).

Stigma and anti-immigrant sentiment are rooted in fundamental (and easily manipulated) fears of strangers, of the unknown figure knocking at the door, bearing sickness and contagion; in both, primal, genetic, atavistic sentiments about the dangerousness of the unknown Other are immersed in legendary stories of tribal

victory and defeat, danger, toxicity, and undetectable murderousness and then justified by contemporary anecdote, the filters of experience, and the missampling inherent in stories (*crazy person pushes man into subway*, *immigrant from West Africa taken to hospital with flu*); and in both, links are formed between what is invisible (fears, threats, hidden dangers) and what is visible (the attribute that becomes "deeply discrediting"), in which a relationship is assumed between an invisible underlying danger and the phenotypes. As an example, consider how "bearded" became metonymic with religious terrorism in the years after 9/11 [14, 15].

What is less remarked upon, but worth observing, is how both stigma and anti-immigrant sentiment intimate a secret: a hidden motive, a sneaky propensity toward violence and murder, and a smuggled pathology. In a twist typical of discriminatory practices, the act of stigmatization provides ostensibly self-evident justifications to exert power: the fact that they are exposing their secret with the mark of stigma without divulging it makes them dishonest, spies, and inherently untrustworthy, and they therefore must be excluded.

For this reason, both stigma and anti-immigrant sentiment are associated with physical and psychological pathology and contagion. The bearers of a dangerous secret may be bearers of a dangerous disease, and vice versa, the one being a metaphor for the other. And where there are metaphors of health, there will be real consequences in health-care systems. We now turn to look at how these notions of secrecy and danger infiltrate paradigms for understanding migrants—in other words, how stigma influences medical practices.

## Dangerous Secrets: Stigma and Epidemiologies of Immigration

A historical, epidemiologic reality underlies a fear of the transmission of disease through migration, in so far as the movements of people have long been associated with the movements of disease, whether it is the exchange of smallpox and syphilis between the Old World and the New or the spreading of epidemics such as the *Ebola* virus or severe acute respiratory syndrome. But as reflected in Savage's claims, there is also a significant and lengthy history of associating immigration with sickness and morbidity beyond conventional epidemiology, representing a frank, or subtle, belief in the dirtiness and dangerousness of the foreigner: the soiled, the unwashed, the lice-ridden, the shaggy and dissolute bearers of worms, transporting disease and madness from afar. This becomes a way of insisting that there is a natural rationale for anti-immigrant sentiment, which can then shift political stigmatization into the ostensibly neutral realm of public health. And the natural sciences become implicated.

In the *Washington Times*, Stephen Dinan begins a report about a detention facility by saying, "Communicable diseases continue to be a problem at the New Mexico facility built to house illegal immigrant families surging across the U.S.-Mexico

border, and the immigrants themselves aren't taking their own health care very seriously, according to an audit released Monday" [18]. What on the surface appears to be a plain opening sentence is profoundly political: the use of the militaristic "surge," not only echoing strategies for the "surge" in Iraq but also, in this case, evoking an invasion: the euphemism of "house" as a verb, when the facility is not so much housing people as preventing them from creating a new house in the United States. Layered over this is the ersatz blandness of public health's passive voice, where communicable diseases "continue to be a problem" (for whom? How?) and the glib, casual slur that immigrants aren't taking their health care very seriously, suggesting some combination of idiocy, ignorance, and savagery. The author of the report, General John Roth, echoes Michael Savage, adding that, "Family unit illnesses and unfamiliarity with bathroom facilities continued to result in unsanitary conditions."

Blame is placed on the immigrants. How an unhealthy situation created by the New Mexico facility is *causing* these problems, rather than the immigrants themselves, is glossed over. Dinan does report that one "hiccup the investigators did find is that some CBP [Customs and Border Protection] officers at one facility weren't trained in how to segregate immigrant children with communicable diseases." This is an impressive act of elision: a single problem was indeed found (so the facility is not perfect!) and yet the problem is not the segregation of these families into a facility, but how to further segregate them. If you recall the notion that stigma involves a dangerous secret, notice how the children themselves are problematized, where the secret, hard-to-detect pathology is located in them; and, in a stunning rhetorical flourish, this problem is a mere hiccup: *they* have disgusting diseases that require quarantine; *we* occasionally get the hiccups—mild, transient, more amusing than worrying, and very public. That is the difference between stigmatizing them and our bemused self-deprecation.

The easy adoption of the empirical tones of public health for perpetuating stigma does not mean that public health is necessarily stigmatizing, but nor can it be ignored how epidemiologies, however neutral they may try to be and however benign their intent, can replicate or reify associations between migration and pathology. The search itself as well as any correlations uncovered suggests that the foreign bear the contagion of the mysterious world from which they've come, carry the parasites, and smuggle in disease and mental disorder.

The principles and work of epidemiological research in immigrant health can be involved closely in policing borders and defining immigrants in such a way that the immigrants will be stigmatized (see, e.g., Davidovitch and Zalashik [19]), but they may also be benevolent, sincere, and efficacious: for example, by identifying health needs (including unfamiliar diseases, or by noting that migration may increase the risk of psychosis [e.g., Cantor-Grae and Selton [20]] or elevated prevalence of PTSD and depression in refugee populations [e.g., Zimbrean [21]]), justifying interventions, determining outcomes, providing focused services, and ensuring that physicians check for etiologies that may not be common in native-born populations.

Nevertheless, recalling that stereotype plus power results in discrimination, the assumption of a foreigner's propensity to disease, whether communicable or not, is

put to use to argue for segregation and for imposing rules that control the movement of people. The historical use of real or imagined correlations between migration, illness, and mental illness to create unsatisfactory policy around immigration or to perpetuate myths that then validate prejudice and bigotry requires that we reflect on how epidemiology can be complicit in stigma (for an example from Australia, see Bashford [22]; for a fascinating historical overview of how different locales construct and use epidemiological correlations, see Markel and Stern [23]).

A difference between epidemiological inquiry and the generation of stigma is not just a matter of intent. If epidemiology is bound to the rules of its science, stigma is not so easily contained. One of the pragmatic dangers of stigma is that its boundaries blur so that it can easily adopt the empirical language of epidemiology (for a parallel example, consider how self-interested arguments clamoring for "sound science" usurp very real uncertainties and humilities of scientific inquiry to undermine a political response to the findings of climate science). Scientific ambiguities and imprecisions (e.g., the *risk* of increased psychosis; the ongoing questions as to *why* there is a risk) can bleed into general bigotries, just as studies of populations can be translated into stereotypes. A visceral response to stigma, even when associated with a calmer, more sensitive epidemiology, can generalize into racism and xenophobia, providing a rationale for disenfranchisement.

Such blurring, in epidemiology, is a problem, but the science of epidemiology is designed to restrict the blurring and to relegate it to accident, or chance, using statistical models, as best it can. The blurring associated with stigmatization is not an accident. It is an active process. The rhetoric of stigma blurs boundaries between confidence and speculation, mimicking but undermining the dynamic between confidence and speculation in scientific discourses.

We see this in how the contours of anti-immigrant rhetoric are sharply defined, while the insinuations are simultaneously precise and imprecise, certain but speculative (in much the same way as a stereotype can be simultaneously precise and imprecise, certain but speculative). For example, when a school board did not renew the contract of a principal who reportedly mandated an English-only policy in school, there was an unsurprisingly critical response by commentators in the media, including Laura Ingraham who said,

> You're not helping these kids, right, by giving these kids a sense that they don't have to speak English to get ahead. You do have to speak English to get ahead. You do have to speak English to assimilate. Now a lot of these kids are probably illegal aliens in this school, I would imagine. Right? Maybe some of them have parents who are illegal aliens, and so they have that kind of situation they're dealing with [24].

Speaking Spanish (the appreciable marker) is easily and comfortably associated with criminality ("illegal"). Indeed, speaking Spanish is an indicator itself of a criminal person; it is a smoking gun, a snapshot of someone at the scene of a crime. But the rhetoric is one of cool scrutiny with just enough hedging ("probably," "I would imagine," "maybe") to suggest thoughtfulness. The confidence and hidden uncertainty of stigmatization move from opinion to fact.

## Evil Intent: Stigma and the Stealing of Health Care

Ideally, epidemiology seeks to uncover the hidden prevalence of disease in a population; stigma seeks to expose a population to discrimination on account of a hidden danger, a secret that is not being revealed. The hidden danger is typically evil, aggressive intent: often, random murder in the case of the madman, a desire to infect in the case of the sick person, and stealing in the case of the immigrant. The epidemiological discourse around immigration and health can inform the stereotypes of stigma. The health policy discourse around immigration and health care is already heavily informed by stigma—in this case, by cultivating a sense of the immigrants' dangerousness not only through disease but in accusations of theft and exploitation.

Many public, televised debates around health-care policy are infused with the rhetoric of stigma. Immigrants, so essential to the economy, so hard-working, heeding promises made by societies that require immigration so that they have laborers and paying more into the economies and health-care systems than they are taking out of it (see, e.g., Zallman et al. [25]) are treated as though they are thieves, stealing health care. They are implicated in a moral crime that is no crime (wanting decent health care) and told that their movement is somehow intrinsically sneaky (as though nobody else ever sought work for health benefits) and that the health-care system is suffering from their pernicious robberies.

These debates have infused the writing of legislation. The Personal Responsibility and Work Opportunity Reconciliation Act states worriedly that the availability of public benefits would "constitute an incentive for immigration to the United States" [26]. Kullgren observes that there is no evidence that public benefits "lure undocumented immigrants to the United States" [27]. But even if it is true, blaming immigrants for wanting public benefits is a perverse mechanism for making their very ambition (a purportedly celebrated virtue of the immigrant) into a sin. Public infrastructure is a logical and meaningful incentive for migration and indeed is folded into the attractive possibilities of the American Dream.

In the PRWORA, however, and in much of the rhetoric around immigration and US health care, the United States is cast as a victim: they are coming here to steal services we've paid for; they come here to make use of our medical care and to exploit our system. The implication is that the immigrant is no longer the go-getting newcomer drawn to citizenship but rather the thief in the night, the conniving outsider. The shared fear at the heart of stigma and anti-immigrant prejudice is revealed: they are trying to make victims of us.

The PRWORA, however, still allows for "emergency medical care" and "immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease." These have significant pragmatic ramifications for the delivery of barebones public health provisions and recognize a fundamental moral need to provide the most basic and immediate medical care. Kullgren, however, identifies multiple public health problems associated with this approach (including,

e.g., a lack of preventative care that would *prevent* people from showing up with a chronic but untreated illness for emergency care) [27]. The medicolegal act also frames "aliens" as people with sly, selfish goals, as leeches on the body politic, and then imagines them as bloody, damaged beings (careless enough to require emergency services) who probably have dangerous diseases (need immunizations) and are trying to have children here (dropping their anchor babies on American soil).

Even as PRWORA construes health-care systems as the victim and diminishes immigrants, there is an ethical halo: a Good Samaritan beneficence in the provision of emergency care and a worldly Public Health perspective in providing immunizations (even if the public health effects of this act are counterproductive), giving the enactment an imprimatur of *our* ethics, community orientation, and science against *their* sneaky, insidious thievery. It should be understood that health-care systems or practitioners that limit the care they are willing to provide to groups of people to emergency and prenatal care are not operating essential medical services; they are providing moral cover for their failure to do so while promoting stigmatizing perceptions of those populations.

## Health-Care Stigma Within Immigrant Communities

But what about stigma and health *within* immigrant communities themselves? Stigmatizing others can exist within stigmatized populations: indeed, stigma is no barrier to stigma. It has been suggested that stigma around physical and mental health is more prevalent in immigrant populations [28–30] and that this subsequently results in suboptimal care (e.g., Wynaden et al. [31], and Interian et al. [32]). There are three notes of caution to inject here.

First, it is worth questioning whether the concept of stigma is being used to explain unfamiliarity with a new system (which may manifest in reticence, awkwardness, discomfort, and embarrassment, not dissimilar to the shame so often associated with stigma). Returning to the *Washington Times* article, notice how the delivery of services is characterized:

> Part of the issue is the immigrants themselves, some of whom have never seen a doctor before, don't follow up afterward, either for themselves or their children.
>
> "If detainees do not attend sick call or stand in line to receive daily medications, they remain sick and their illnesses tend to get worse," the inspector general said.

In this overcrowded facility, who among the inmates knows how to attend "sick call," and when to stand in line, and what for? Would a journalist or inspector general know the procedures and regulations and organization of health care should they suddenly show up in a detention facility in a foreign country? Would they know how to "follow up," either for themselves or their children? Explanations for why people do not seek services require an inside-out approach, not an overarching explanation of "stigma" [32] or, as in the Dinan article, the intimation of ignorance or callousness.

Second, it has been argued that stigma may be related to how people present to services and, in particular, that somatic complaints replace psychological ones because the stigma associated with what is perceived as psychological illness is greater than with what is perceived as physiological illness. For example, colleagues treating children in an emergency room argued that children in one population came in with headaches and neurological symptoms because those symptoms were less stigmatized than underlying anxiety, which was more often the etiology of these symptoms. This somatization hypothesis has been challenged, for example, in a study by Montesinos et al. [34] in female Turkish migrants. The somatization hypothesis also reflects a bias: somatic symptoms are very much part of psychopathology [34] and may be understood as such in native-born populations but then perceived as excuses, or a response to stigma, in non-native-born population. To put it another way, the assumption that we recognize somatic symptoms but they do not is infused with the stigma associated with foreignness: they are doing something devious with their somatic symptoms, masking the reality of the disorder, while they are also more bodily, less conscious of their minds.

Stigma toward people with physical and mental disorders will be present in migrant communities, but cannot be seen as a sole, or even predominant, explanatory for how migrants access health-care services or communicate within those services. Stigma is produced within cultures, and as cultures are diverse, when it does appear, it will appear differently in different populations [29, 36]. In one study that looked at stigma and depression in immigrant and native-born women, Nadeem et al. [37] showed ethnic differences in stigma (measured by three questions about what might keep people from services: "being embarrassed to talk about personal matters with others," "being afraid of what others might think," and "family members might not approve") and found that in immigrant women in general, elevated perceptions of stigma was correlated with less help seeking. But Nadeem et al. also show how perceptions of stigma may be less powerful than expected: the very same research found that immigrant Latinas were most likely to want mental health care and were among the most likely to report stigma [37].

Any assumption that immigrants attach more stigma to health is itself problematic. In fact, what happens is that migrants' presumed treatment of a stigmatized population (the mentally ill, epileptics, etc.) becomes stigmatizing. For example, migrants are stigmatized as people who do not understand the reality of psychiatric or medical illness, in part because of their presumed cruelty to people who have these illnesses. The discourse around stigma may reproduce the stigma, exoticism, and stereotyping, cultivating the view that the migrant is more primitive and therefore more likely to have lurid, theological, unenlightened views of mental illness.

Finally, when examining stigma within migrant communities, there may be a parallel cultural gamesmanship at work, where health services are imagined as operating in cultural opposition to "traditional" services (despite findings that, e.g., in Cambodian refugees in the United States, use of alternative and complementary medicine was positively associated with an increased use of "Western" providers [38].

## Countering Stigma Around Immigration Within Health Care

So how do we address stigma? How do we address stigma toward, and within, vulnerable populations? A primary way of addressing stigma is through education and public relations campaigns: advertisements in newspapers and billboards on subway walls. Interventions of this type assume that stigma or prejudice is a natural state, albeit an ignorant one, that can be counteracted with more information. This, unfortunately, is just scratching the surface. Anti-stigma campaigns that address the symptoms of stigma—isolation, internalization, and misunderstandings—through peer support may be more effective (see, e.g., Yang et al. [39]), but many campaigns involve spending money at ad agencies and in glossy magazines without much evidence of efficacy.

Within a health-care setting, in order to address stigma against migrant populations, an individual approach of respect for migration can be adopted. When working with immigrant populations, health-care workers can begin by not treating migration as a single event, but a process, typically divided up into pre-migration, migration, and post-migration, all of which can be useful for a clinical history but also for understanding the person (see Table 13.1).

Clinical attentiveness to immigrants in the individual encounter can be cultivated in health-care systems. A more politically active approach can be more effective at reducing stigma. Identifying and fighting stigma through policy and legislation against discrimination have been effective against stigma around certain illnesses in certain places and times (consider the partial success in reducing stigma around HIV in some, but not all, parts of the world). This tends to be more effective around physical illness and less effective with mental illness and with immigration (even in racist societies, frank racism is less acceptable than anti-immigrant rhetoric). Why is this the case? There are certainly compounding effects (e.g., class and race,

**Table 13.1** Using a tripartite model to explore migration

| | |
|---|---|
| Pre-migration | Tell me about the reasons why you left your home country. What are the things that compelled you to leave? What are the things that attracted you to coming here?<br>What happened prior to departure? |
| Migration | Tell me about your journey here and any challenges you might have had along the way.<br>How did you get to where you are now?<br>Did your whole family come at the same time, or were you separated for a while? How was that separation for you? |
| Post-migration | Tell me about the family and friends you left behind. How do you keep in touch with them? Do they plan to come join you?<br>Describe any concerns about your life right now. What are you most happy about? What are your plans looking ahead?<br>What do you hope to achieve?<br>Where are you going to find support here? |

Adapted from Henderson SW, Sung D, and Baily C [citation from immigration chapter in cultural diversity book]

socioeconomic drift, and legal problems) that compound stigma around immigration and the relative concealability of the stigmatized features [40].

Another reason why stigma is so hard to dissociate from immigration and mental illness is that the categories of foreignness and madness are so heterogeneous and so mutable that stigma itself helps us understand what they are, in a way that is not necessarily true of, say, racial stigma, sexual stigma, or stigma around physical disability. Stigma around madness helps us define mental illness; stigma around immigration helps us identify the targets of anti-immigrant policy. Stigma is not an ideal way of making sense of immigration and mental illness, to say the least, but recognizing its role here is necessary to avoid two pitfalls: romanticism and fungibility.

Romanticism, in this case, is when mental illness and immigration fall prey to an anti-stigmatic correction where the stigma is flipped on its head. In this case, the madness or anti-immigrant sentiment no longer provokes disgust; it provokes desire; the secret is now purportedly enviable, rather than dangerous. The process is similar to when supposedly positive stereotypes are used to replace negative ones, purportedly countering stigma. We see this when the immigrant is not seen as hiding a dangerous secret, but where the secret is a delicious mystery (usually exotic or erotic) or when the madman whose secret is not a desire to attack but a connection with the otherworldly or creativity itself. Romanticism may be more pleasant than stigma in its mood, but it is not a counter to stigma; it replicates the workings of stigma, only it is excited about the secret, instead of fearing it.

The other pitfall is fungibility: this is when there is an attempt to change stigmatized language in order to replace the stigmatized concept, but the stigma merely follows along. A long-standing example is the trail of the words used to describe what it is currently called intellectual disability. As *moron*, *imbecile*, and *idiot* gave way to *mental subnormality* and *mental handicap*, through to *mentally retarded*, the theoretically unstigmatized terms became markers of stigma [41]. Stigma is fungible: it can move unchanged into whatever is thought to replace it.

Education and polite advocacy risk more than just a romanticism or fungibility; they risk tepid success or frank failure. Given the widespread use of madness as pejorative (*crazy* or *lunatic* is ubiquitous in political debates), how prisons are repositories for many with mental illness, and the marginalization of mental health in the health-care system, and the widespread proliferation of anti-immigrant sentiment, the casual imprisonment of immigrants at borders, and the ease with which medical care can be refused immigrants, it is clear that the efforts of many in these arenas have been marginally successful at best. If the underlying mechanisms of stigma are not addressed, the stigma will confound the sentimental efforts of romanticizing and the attempt to change attitudes only through a change in language. So how can stigma be addressed?

A broader approach to defeating stigma is to foster the principle of welcome (see, e.g., Lobo [43]). Instead of putting up barriers to protect hospitals from migrants, hospitals can welcome migrants, with policies like those described at the beginning of the chapter—having medical interpreter services and not checking migration status. Stigma traffics in insinuation, suspicion, and implication to drive people away; principles of welcome bring people in by opening up communication

to confront or dispel insinuation and implication, and contact can bring about a leap into trust that no dangerous secret is being harbored. Religious traditions are full of examples of moments when instead of driving somebody away, arms are flung open in welcome, a celebration of shared humanity: popes hugging people with diseases, priests caring for the contagious, and churches becoming sanctuaries to prevent immigrants from being deported [44]. This can be a model for medicine as well.

There are limits to an attitude of welcome as a cure to stigma. The leper may appreciate the papal touch and still may not want to be reduced to a symbol of the Godliness and compassion in another. Cosmopolitanism [45], welcome, and miscegenation appropriate difference from the grips of stigma and make those differences interesting. But people don't necessarily want to be interesting; people do not want to be specimens explaining themselves. Patients may want culturally competent doctors, nurses, social workers, and other care providers, but they may not want their culture of origin to excite the physician. This is the thorny area where curiosity meets microaggression, with prickly questions like "But where are you from?" or "Where is your family from?"

Nevertheless, patronizing, pitying, or curious breaches of difference may be better conversations to be having than stigmatizing cries for quarantine or murder, and they are conversations where common grounds can be found, misunderstandings negotiated, and core values not only espoused but interrogated (see, e.g., Derrida [46]).

These principles become more powerful when they become enforced. Responses can begin in individual, local, policy-based interventions in health-care systems, as noted at the outset of this chapter with hospital policies that guarantee medical interpreters and that refuse to make their services dependent upon citizenship documentation. Comprehensive policies can guarantee that immigration status is not a barrier to services while addressing real concerns, like language and paperwork.

In the fields of health, this means:

1. Identifying the bigotry and prejudice in rhetoric that uses, or abuses, the tools and concepts of epidemiology, medicine, and psychiatry to isolate and stigmatize immigrants, such as political practices acting as though they are public health ventures: prison camps for immigrants are not places where people are "housed"; the public health problems associated with the prison camps are not because the imprisoned families are immigrants.
2. The next step is recognizing how effective these rhetorics are at cultivating and naturalizing stigma toward immigrant populations when they become legitimized. Policies and laws based in stigma must be opposed, even if they appear to have a Good Samaritan halo, such as the presumed beneficence of the PRWORA.
3. Partner with powerful institutions to delegitimize how they or their representatives participate in the social sanctioning of stigma against immigrants (an example of this process is when the American Psychiatric Association formally rejected the association of homosexuality with mental illness in 1973, followed by the American Psychological Association [42]). The same organizations can wholeheartedly refuse to participate in practices that stigmatize immigrants, including, for example, taking stands against those that require their practitioners refuse services to some or any migrant populations.

4. Contextualize the stigma. *The stigma is operating effectively for a reason*. Addressing stigma requires understanding and addressing the political power of stigma and therefore the structures that benefit from the stigma. To see how these operate in action, immigrants are stigmatized as sickly people who are coming to steal for a health-care system they did not pay for. In one respect at least, incorporating stigma into debates about health care is distraction. The notion that the world's hordes are begging to get health care in the United States is a comforting one, but illusory, based in patriotism and exceptionalism that serves a dual purpose: if the system is so great, we do not need to pay more for it (while its deficits are not a function of funding, but of exploitation by immigrants); and stigma in health-care debates pulls the eye away from the extent to which public health care has atrophied and how health-care dollars are siphoned into private insurance and investors.

   It is also part of a larger attack on public institutions: we need private health care, so that we can ensure that "illegals" don't get what they don't deserve. Let us be clear: the stigma about immigration and public health-care funding benefits those who would use the contagions of stigma to poison public institutions. Addressing this stigma needs to address these larger issues: empowering and financing public institutions not from a position of the phony Good Samaritan (as we see in PRWORA) but as essential, cost-effective, cost-reducing, disparity-reducing public health investments.
5. Understand the role of those generating the stigma and make them accountable for it [41]. Stigma is an intentional misunderstanding; a misunderstanding is not nonsense, surreal, or absurd, but a mishandling of the truth, a misapprehension of the real. Stigma falls into the category of misunderstandings that are not susceptible to simple correction and are reinforced not just by selective sampling of facts but by the benefits that accrue to stigmatizing. A misunderstanding of the Krebs cycle could be corrected. The misunderstanding fomented by stigma is protected from correction through cognitive strategies (particularly the metaphorical grain of truth; latching onto that grain of truth as synecdochal for a whole truth), emotional bluster, and its own vindictive logic: the problem is not in the attributions of stigma, but in the stigmatized, where if there is "misunderstanding," then the "mis" belongs to the stigmatized. Anti-stigma campaigns should therefore be addressed to those who are stigmatizing and they should address not only the stereotypes and the discrimination, but the benefits the stigmatizing are accruing from the stigma.

## Conclusion

Migration is fundamental to human nature. This has produced great adventures and great changes in cultures and societies but has also posed, and continues to pose, great challenges, particularly in how we see ourselves and others. For health-care providers and researchers, these challenges cannot be ignored. The close parallels

between stigma and anti-immigrant sentiment become visible in the encounter between migrants and health-care systems, influencing epidemiology and health policy and affecting the delivery of care for individual migrants. To address the problems of stigma and anti-immigrant sentiment, it is important to discern how stigma influences interventions that do not appear to be directly influenced by stigma and to move beyond education campaigns to address root causes.

## Future Directions

All too often, stigma is a general explanation for diffuse if powerful experiences of exclusion, encompassing many different experiences, social pressures, and expectations. Research can be conducted into more precise dissection of stigma and the actual mechanisms through which stigma prevents people from getting care (see, e.g., the work of Paterson et al. [47] on how stigma has been researched in populations with hepatitis C). Given the extent to which anti-stigma initiatives are informed by the research, more granularity and specificity in understanding stigma will improve interventions and prevent naïve or stigmatizing perpetuations of stigma.

At the same time, returning stigma to broader social contexts will guide comprehensive principles for anti-stigma initiatives. Immigration, sickness, and madness generate the types of fear produced by difference—unfamiliar looks, tongues, attitudes, and customs and practices—indicating that the Other is not quite human: an animal, a predator, a monster (see, e.g., Santa Ana [48]; Casanavo [49]). Stigma is a way of acting on this difference to turn the fear into a social practice.

In research and anti-stigma initiatives, stigma is seen as a bad thing, understandably so. But another question needs to be asked: why does stigma attach itself to a particular difference at a particular point in time? In this chapter, the discussion has revolved around connections—metaphorical, real, and stigmatized—between sickness, madness, and foreignness. These connections do not adequately or wholly elucidate an affinity or correlation between illness and foreignness, but rather describe a common pathway in how difference is understood and then stigmatized. *Why* is stigma operating so effectively here and mapping itself over this connection between illness and foreignness? One could argue that stigma is itself fundamentally, if metaphorically, a confused, sick, foreign response to difference, or, alternatively, that concepts of sickness and madness necessarily imply the kinds of difference that can be exploited and magnified in stigma. To put it another way, stigma *adequately* describes a confused, foreign response to difference that constitutes the categories of immigration, sickness, and madness.

Migration challenges core concepts of who we are. Madness and sickness also challenge core concepts of who we are: our identities, our moods, our rationality, our bodies, our mortality. Where these entwine with the five components of stigma identified by Link and Phelan [50]—a socially salient difference, stereotyping, differentiation into “us” and “them,” active discrimination, and the exercise of

power—the questions are lost and displaced onto another, who is defined, derided, and disempowered.

Confronting stigma against migrant populations, then, is not simply a matter of education or protest. It entails a willingness to ask those questions about oneself, one's own ownership of selfhood and of a place (in geography, in society), as well as one's indebtedness to and trust in others, without foreclosing the answer. Defeating stigma against migrant populations means being able to address hard questions in oneself, not in others.

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