Racializing the White Woman: The Need for Improving Racial Education in Structural Competency Informed Curriculum

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Thesis

Submitted to the Faculty of the

Graduate School of Vanderbilt University

in partial fulfillment of the requirements

for the degree of

MASTER OF ARTS

in

Medicine, Health, and Society

August 13, 2021

Nashville, Tennessee

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ACKNOWLEDGEMENTS

This year challenged me beyond what I knew I was capable of. Successfully finishing an expedited master's program is an accomplishment that I can honestly say is a collaborative effort. I want to thank Dr. Picard for being my writing coach for every semester of the program. You gave me the space to struggle through the hard parts of developing an argument while still providing the support and feedback necessary for me to learn. Thank you to Dr. Griffith, my primary thesis advisor, who always gave me the answer I needed even if it wasn't the answer I wanted at the time. Finally, I want to thank Dr. Petty for making the time for so many meetings and emails. I often entered the meeting with a feeling of confusion, exhaustion, or stress, and Dr. Petty would put whatever issues I had to rest without making me feel more overwhelmed. All three of you have been incredibly encouraging and my thesis would not be as well developed as it is today without all the consistent feedback and support.

To my parents, you both have always supported my passions, and this degree was no different. You both have taken away so many burdens to ensure that I am happy and healthy. I will always be grateful for your depth of love and support that you have always provided me. Whether it was my mom who faithfully called weekly to check in, or my dad who always tells me I am capable of anything, I never felt alone in Nashville. It was a weird experience to be living far from home for the first time. However, this experience has pushed me to grow into the independent and confident woman that I am today. The process of getting the degree and being away from home was life changing, and I thank my parents endlessly for making that possible.

Completing this thesis has been a whirlwind experience that has proven itself to be extremely mentally taxing. To the one person who I was spending my days with during the height of the pandemic, Fernando, you have no idea how much I appreciate your support.

Whether it was cheering me on through the seemingly endless revisions and writing assignments, or reminding me of the power of rest, you have helped make every step of the way a happy experience. I love you and cheers to starting the next chapter of the rest of our lives!

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS ii

LIST OF FIGURES v

Introduction 1

Literature Review 3

Methods 11

Ethics 11
Participants 11
Study Design and Data Set 13
Data Analysis 15

Results 19

Demographic Findings 19
Theme One: Representation 20
Theme Two: Racial Privilege/Income 22
Theme Three: White Disease 24

Discussion 27

Limitations 30
Recommendations 31

Conclusion 32

APPENDICES 34
Appendix A: Code Book 34
Appendix B: Theme Book 37

REFERENCES 40

LIST OF FIGURES

Figure Page

1 Percentage of Students in Racial/Ethnic Categories 12

2 Percentage of Students in Gender Categories 12

3 Percentage of Students taking Number of MHS courses 13

4 Effexor Advertisement 14

5 Comparison of Previous and Current Exam Results 20

INTRODUCTION

There is a famous video that circulates introductory psychology courses across the United States. The students are asked to watch a video of people passing a basketball. Students are asked to count how many passes took place during the video segment. However, the surprise is that counting passes was not the point of the video at all. The surprise is that while students were busy focusing on the people passing the ball, a person in a gorilla suit walks right through the crowd of people. The point of the video is to explain the concept of selective attention (Simons & Chabris, 1999). This video captures how people can be looking directly at something without ever registering its existence. In this paper, I evaluate the ways in which students recognize and analyze race when the subject is a white woman. The idea is that, just like the students watching the video who miss the gorilla, people can see a white person without ever acknowledging the ways in which the woman's whiteness, a structure of privilege, is playing a role in a highly racialized society such as the United States.

One framework that is meant to teach the recognition of structures of privilege and whiteness is structural competency. This concept uses structure as organizing principle to teach students receiving medical education about symptoms, attitudes, and diseases that carry implications from upstream determinants of health (Metzl & Hansen, 2014). Given that race as a structural determinant of health is supposed to be addressed by structural competency informed education, this paper describes an evaluation of the efficacy of structural competency training on the ability of undergraduate students who are graduating from an interdisciplinary pre-health undergraduate program to identify and analyze race. In 2020, the Structural Foundations of Health Survey was answered by 175 graduating MHS seniors. Within that survey, I will be

looking at responses when asked about an anti-depressant advertisement where the subject is a white woman.

Structural competency training should prepare the students to successfully identify and analyze racial structures of health. Previous exit exams indicate that students often failed to connect race to larger structures when evaluating the advertisement and only did so about 5% of the time (Metzl & Petty, 2017). In addition to evaluating the student's structural competency in relation to the advertisement, this study also will be analyzing what the undergraduate students who successfully acknowledge the role of race discuss. This step is taken in the effort to understand if these themes reflect some of the four core structural competencies that a graduating MHS undergraduate would be expected to demonstrate.

In the paper that follows, a literature review will be conducted to understand the gap of knowledge that exists in relationship to structural competency training outcomes. Following this background information, the methods section describes how I conducted quantitative and thematic qualitative analyses of the survey responses to the advertisement. The thematic analysis is modeled after the framework created by Braun and Clark (2006). After describing the general research design, I will report and analyze the results. Finally, I will end with a discussion of how these results inform further action taken on curriculums teaching structural competency.

LITERATURE REVIEW

For decades, American clinicians have been aware of the vast racial health disparities in health outcomes and quality of care seen throughout the medical field. The reasoning behind these differences has been argued across the health fields, and many have tried to identify solutions that will address the abhorrent outcomes that were and still are occurring. Cultural competency is one of these notable interventions that has been seen in different disciplines throughout America as far back as the Civil Rights Movement in the 1960's with its first documented name being ethnic competence (Gallegos et al., 2008). Although there is not one agreed upon definition of cultural competency, for the purposes of this paper, the definition is the trained skill of recognizing and respectfully operating in cross cultural environments through a system of policies, attitudes, and behaviors (Cross et al., 1989) To understand someone's culture is to recognize patterns of human behavior that extend from "thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, social, or religious groups" (Cross et al., 1989) The goal is to incorporate the importance of culture and acknowledge cultural differences among people.

The cultural competence in healthcare framework has three major components. First, this framework integrates the importance of social and cultural influences on health beliefs and behaviors. Secondly, the framework advocates for understanding the way these previously mentioned factors affect the dynamics between primarily physicians and patients. Finally, this information should be addressed by developing interventions that account for these issues and adapt for more diverse patient populations to have their needs met. The goal is to teach physicians to be more vigilant and recognize when their patients have unique needs (Betancourt

et al., 2003). With the framework being heavily focused on the interaction between the physician and patient, when cultural competence is operationalized, there has been a focus on identifying individual biases and improving communication (Beach et al., 2005).

Cultural competency has been highly scrutinized for decades for contributing to racist ideas for the homogenous and static conceptualization of culture. In this concept, culture is being used to encompass race, nationality, ethnicity, and language. By doing so, physicians are taught that someone's cultural stereotype directly informs how to treat that patient rather than understanding how factors outside of the person's culture shape their health (Kleinman & Benson, 2006).

A similar concept called cultural humility is defined as a lifelong process of self-reflection and personal critique of one's own beliefs and identity in conjunction with an exploration of other cultures (Tervalon & Murray-Garcia, 1998). This concept developed largely in response to criticism of cultural competency's emphasis on knowledge acquisition and lack of attention to power structures (Campinha-Bacote, 2018). Rather than aiming to discount the extensive knowledge base that cultural competency advocates for, cultural humility pushes for a simultaneous addition of realistic and on-going self-appraisal. In this way, the healthcare worker is not only required to learn about different cultural backgrounds but also change their attitude and behavior.

In the early 2000's, medical institutions throughout the United States started to put more sustained effort into addressing the problem of racial health disparities. In 2000, the Association of American Medical Colleges publicly stated that their medical schools would teach students about diverse cultures and belief systems. Additionally, the American Psychiatric Association came up with a list of core cultural competencies that would be used during clinician-patient

interaction (Metzl, 2010). In 2002, the Institute of Medicine published a report titled "Unequal Treatment" that synthesized the large body of research that empirically showed racial and ethnic minorities receiving a lower quality of health care even after accounting for access to care (Institute of Medicine et al., 2002). In this report, the sources of disparities in quality of care were identified as the health systems, physician bias, and larger structures that regulate laws and politics. This report inspired a plethora of different medical education interventions to try and address these negative health outcomes. Within the course of a few years, medical schools and hospitals across the country were part of the new standard toward better cultural understanding and patient centeredness in the hopes of addressing the differences in access and treatment (Saha et al., 2008).

Unfortunately, even with the aforementioned interventions, as well as many others that are unmentioned in this paper, racial health disparities in quality of care and health outcomes continued to persist. Even with the efforts to instill cultural competency throughout the medical field, cultural competency standardizes experiences of different cultures in a way that is stereotypical and ultimately harmful (Campinha-Bacote, 2018). There also is a clear conflation of culture and racism in a way that doesn't serve justice to the centuries of racial discrimination seen in every part of American society (Kleinman & Benson, 2006).

In 2010, Dr. Jonathan Metzl, conceptualized another theory that aims to focus on the structural determinants of health rather than the individual interactions between patients. He coined the term structural competency in his book, *The Protest Psychosis: How Schizophrenia became a Black Disease,* to address the shortcomings he saw within the discourse surrounding cultural competency of placing importance on the individual rather than acknowledging the racialized history that healthcare in the United States is built on (Metzl, 2010).

In 2014, Jonathan Metzl and Helena Hansen built off the initial theorizing in Metzl's 2010 book, and they defined structural competency as the trained ability to recognize how symptoms, diseases, and attitudes are interwoven with downstream effects of structures in society (Metzl & Hansen, 2014). These structures include but are not limited to health care and food delivery systems, zoning laws, urban and rural infrastructure, medicalization, and even the definitions of what health and illness are (Metzl & Hansen, 2014). Structural competency includes five core components: 1) recognitions of structures that influence clinical interactions 2) developing a clinical language for identifying structures 3) articulating what was previously considered cultural formulations using structural terminology 4) comprehension and innovation of structural interventions and 5) developing structural humility (Metzl & Hansen, 2014). Structural humility is defined as the ability of health care professionals to understand that they cannot individually overcome structural oppression and privilege but it is their responsibility to work collectively to come up with ways to combat the decisions of upstream determinants of health (Downey & Gómez, 2018).

Where cultural competency lacked in incorporating bias beyond the physician, the goal of structural competency is to train students and clinicians to recognize how large structures in our society affect disease and symptom prevalence and presentation (Metzl & Hansen, 2014). This approach to medical education was largely developed around a North American context of health in combination with other disciplines like critical race theory, sociology, economics, and anthropology (Metzl et al., 2018). These disciplines inform people in the medical field about the structures that shape larger societal issues contributing to racial health inequality. Therefore, after people receive this education, they can understand how economic and political conditions are contributing to the reproduction of health inequalities.

Given that structural competency training is relatively new to academia's effort to address health disparities, understanding ways of improving this framework is integral to achieving the intended outcomes in the medical field. Structural competency training has been integrated into the undergraduate curriculum of the Department of Medicine, Health, and Society (MHS) at Vanderbilt University. This department is an interdisciplinary undergraduate pre-health program that combines humanities and social sciences with the health sciences normally found in a pre-health major. Structural competency training was identified as a "central unifying rubric" of the curriculum after it was reformulated in the 2012-2013 academic year (Metzl & Petty, 2017). After completing a degree in MHS, the proposed core structural competencies that the student should be able to do is 1) link health outcomes at the individual or family level to structural factors and broader social, political, and economic factors 2) link cultural differences to structural contexts 3) demonstrate comprehension of the mechanisms through which structural factors shape health outcomes and 4) demonstrate comprehension of the relationship between race and health as an outcome of cultural and social factors (Metzl & Petty, 2017). In response to this curricular change, the Structural Foundations of Health (SFH) evaluation instrument was developed through an analysis of course syllabi and additional frameworks that exist and are designed for students entering medical school. This focus on students who are getting their baccalaureate education is grounded in the idea that knowledge of the medical field is better integrated before receiving a formal medical education. This additional time spent developing a skill set is supposed to allow students to be better able to apply their knowledge (Metzl et al., 2018).

The SFH survey consists of closed and open ended questions that were designed to illuminate students' understanding of the social and structural determinants of health by

examples of relevant patient cases (Metzl & Petty, 2017). Each year, this survey is distributed as an exit exam to graduating MHS seniors. However, this data has been tested against various other groups at Vanderbilt in the hopes of recognizing what the curriculum is excelling at and what it needs to improve on. The first-time data was collected from the SFH survey in 2015, the instrument was still being developed. Eighty-five randomly selected MHS students were given the survey in hopes of correcting any issues of clarity and error. According to the initial outcomes, students had a high level of awareness of the impact of social and cultural determinants of health on medical outcomes. In addition, the students also demonstrated their knowledge of structural competency by indicating when institutionalized racism was a contributing explanatory factor for health disparities. However, only 5% of students recognized race when answering a question where the subject in the photo was white (Metzl & Petty, 2017). This result was notable because one of goals of this evaluation tool was measure the way students acknowledge race as a determinant of health even when the person is of a dominant racial group (Metzl et al., 2018).

When the SFH survey was distributed the second time, both MHS graduating seniors and graduating premed students were assessed. The premed students consisted of a variety of different departments that aid the pre-health track. The sample size was 155 students. Overall, the MHS students consistently identified structural explanatory factors as opposed to a most individual approach that was identified amongst other premed students. When evaluating a drug advertisement depicting a white woman needing antidepressants, 38% of all students addressed the woman as being racialized (Petty et al., 2017).

The third time that the SFH survey was conducted, a combination of incoming pre-med freshman, graduating premed science majors, and graduating MHS majors all answered the same

questions. By conducting an analysis of the SFH data that involved more than one group, scholars are better able to control for biases in assessing if the MHS major in comparison to others is increasing students' knowledge of determinants of health and structural competency. However, the SFH data suggests that MHS students were not more likely to identify and/or discuss race as a structure of privilege when evaluating a white subject.

When this research design was conducted once again with the three groups of premed and MHS graduating seniors, and first term MHS students, the expected results were consistent. The vast majority of MHS seniors were able to identify structures in their analysis of prompts regarding heart disease and obesity. As seen before, the respondents were equally likely to identify or discuss structures of privilege. There was no significant difference between premed and MHS seniors when analyzing whiteness in relationship to the pharmaceutical advertisement with a white woman. However, MHS seniors were three times more likely to analyze whiteness than MHS freshman (Metzl et al., 2019).

In all the iterations of the testing MHS students with the SFH survey, it is clear that some objectives of structural competency are being met in the MHS department considering the level of understanding students consistently have at the end of their baccalaureate education. However, it also is clear that identifying structures of privilege and analyzing race and whiteness when the subject is white is not something that the curriculum is effectively doing. The major issue underlying this outcome is the suggestion that students are unable to identify structures of privilege and whiteness when viewing any white person. In the United States, discussions of the factors that contribute to health disparities focus on minoritized groups. However, when students, particularly white people, are conditioned to view oppression as outside of themselves, this lens can end up pathologizing blackness (Mueller, 2017). It is important that whiteness is

characterized for its conditioned invisibility so that structures of privilege are able to be recognized and integrated into scholars understanding of health. If not, structural competency training runs the risk of reinforcing one of the very structures that it was formulated to address. In this study, I describe the findings from the latest iteration of the SFH survey to see if the outcomes for MHS students.

In the next section, the analyses of data from the 2020 SFH survey is evaluated to determine how often do Medicine, Health, and Society graduating seniors saw race as relevant to their analysis of the advertisement depicting a white woman? In addition, when students do mention race in their analysis of the advertisement, what do they discuss?

METHODS

Ethics

The SFH survey used for the data set received IRB approval to be given exempt status because the survey is being distributed to students for the purpose of Medicine, Health, and Society program evaluation. One of the questions of the survey details whether the students consent to their answers being used for research. However, for the purposes of research, the supervisors of the survey only shared the identified data with the names of the students hidden from the primary researcher for discretion of the participants.

Participants

The participants in the study were undergraduate students at Vanderbilt University. These students were all completing their degree in Medicine, Health, and Society. This degree program is a pre-health interdisciplinary program dedicated to combined coursework in health sciences, humanities, and social sciences. The goal of the degree is to teach students how to understand health and illness by having knowledge of the many diverse social issues that can impact health, healthcare, and health policy (Metzl et al., 2019). There were 177 participants who responded to the exit exam. Of these 177 responses, there were two missing values due to participants not completing the exit exam after beginning. The students that were evaluated were both male and female, had varying ethnic backgrounds, and had at least completed 36 hours of course work related to their major in MHS. Under normal circumstances, the entire graduating class is required to complete this exit exam. However, given that the spring of 2020 was heavily impacted by the COVID-19 pandemic, this was not the case. The

graduating class of MHS majors in Spring of 2020 consisted of 214 students. This means that 82% of students answered the exit exam.

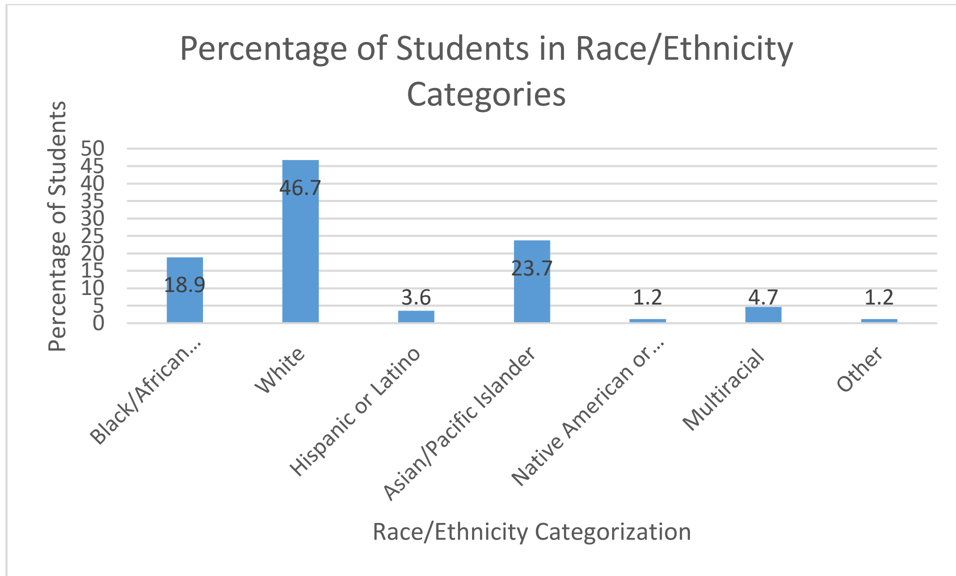

Figure 1: Percentage of Students in Racial/Ethnic Categories. The population of MHS seniors in this data pool were primarily white.

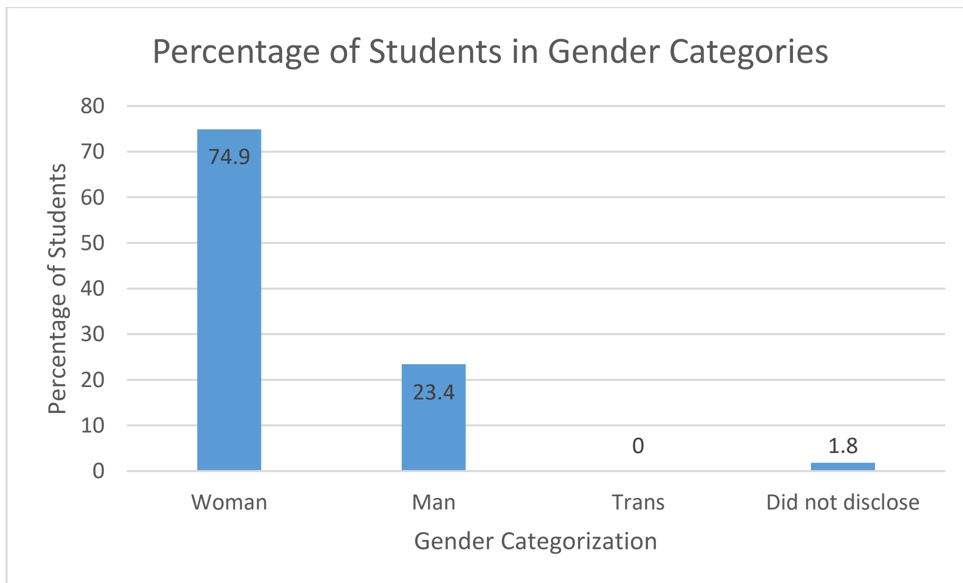

Figure 2: Percentage of Students in Gender Categories. The population of MHS seniors in this data pool were overwhelmingly women.

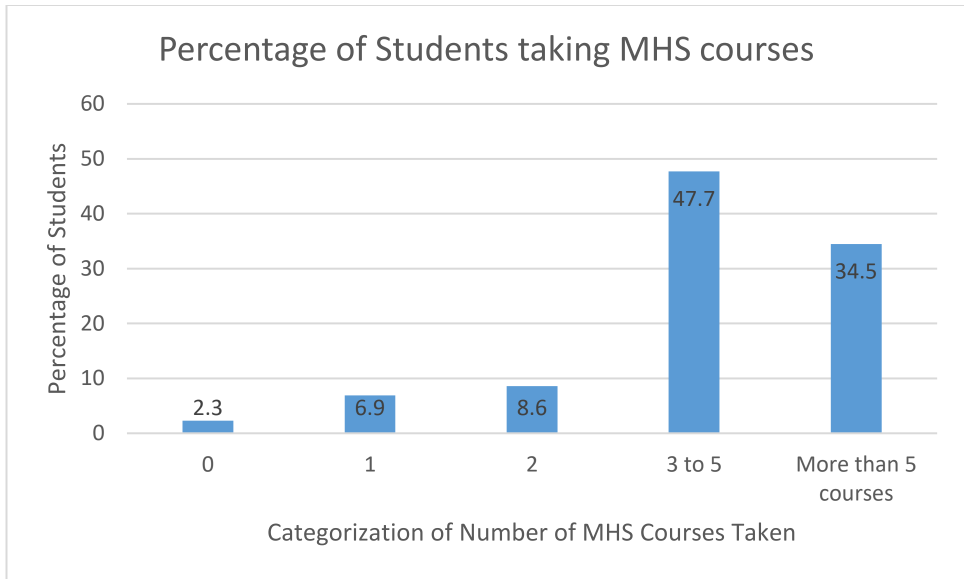

Figure 3: Percentage of Students taking Number of MHS courses. Given that MHS is interdisciplinary, students may end up graduating with a varying level of courses taken that are within the MHS department. This graph depicts the percentage of students taking an amount of courses within the department.

Study Design and Data Set

The data set being studied was from the Structural Foundations of Health (SFH) survey given in 2020 to MHS undergraduates. This survey is an instrument used to evaluate students' acknowledgement of the way structural determinants of health shape health outcomes with a particular emphasis on core structural competency themes. These themes include the production of health inequality, structural racism, and detecting race among people not just in minoritized populations (Metzl et al., 2019). This survey was created by Jonathan Metzl and JuLeigh Petty, the director and assistant director of the MHS department. The SFH survey's questions consist of health disparities-related professional preparation, educational and career characteristics, obesity, heart disease, and depression. Although other analyses of the survey have been conducted on all sections and questions, this design is

specifically focused on the portion of the survey that asks students about the depression advertisement. Much of the survey consists of close-ended questions. However, in this study, the portion of data being studied is from the section that posed three open-ended, short answer questions.

In the section that was studied, students were shown the following advertisement depicted below (Figure 4). The advertisement is for the serotonin-norepinephrine reuptake inhibitor antidepressant, Venlafaxine HCl (Effexor XR), and appeared in the *American Journal of Psychiatry* in 2001.

Figure 4: Effexor Advertisement. This advertisement was taken from the 2020 MHS Structural Foundations of Health survey

The students were asked the following three open-ended, short-answer questions about the advertisement:

1. What is your initial response to this advertisement?

2. What messages does the advertisement convey about mental illness?

3. What role might social, political, economic, or cultural factors play in shaping the message of the advertisement?

The goal of this portion of the study was to assess the ways in which the students recognized race and connected this with broader themes about determinants of health. The section being evaluated in this study was intentionally designed to not mention race or privilege in the structure of the questions. This is because of the importance of recognizing whiteness as a structural factor influencing the woman's health.

Data Analysis

The data analysis was conducted using the approach to analysis that was introduced by Braun and Clark in 2006. The goal of this approach is to categorize and explore the themes mentioned throughout the data through an inductive process that is guided by theory (Braun & Clarke, 2006). Although this approach was initially introducing thematic analysis specifically into the field of psychology, multiple disciplines and applied health research have adopted this methodology (Braun & Clarke, 2014; Kenny et al., 2016; Smith & Sparkes, 2016; Wiles et al., 2012). To assure trustworthiness, and rigor in the thematic analysis that follows, specific attention was paid to detailing the procedure to allow the reader to understand the decision-making process by the researcher. Trustworthiness is defined as pragmatic choices for researchers who are concerned with the usefulness and acceptability of the study (Nowell et al., 2017). The researcher in this study ensured trustworthiness by closely mimicking published journal articles that conducted thematic racial analysis to confer with similar methods, structure, and codebooks. In addition, trustworthiness was assured through replicating as closely as possible the procedures and wording used in prior versions of this study. Rigor is defined as

research having the quality of being very exact and conducted with precision (Cypress, 2017; Roberts et al., 2019). The researcher provided detailed descriptions of the methods in the hopes of allowing replication through thorough explanation. In addition, the researcher frequently conferred with supervisors when met with an unclear coding classification.

Before beginning the thematic analysis framework of Braun and Clark, the first step in this analysis was to decide what was to be counted as a response that mentioned race. This list of indicators includes the words: white, race, racial, racism, people of color, and person of color, and naming an ethnicity or racial category of any kind. Naming an ethnic or racial background of any kind was used to indicate the significance of students comparing the woman in the picture to another racial category.

Following this initial phase of analysis, descriptive statistics were taken from those that identified race to evaluate the following factors: the number of course hours taken, the participant ethnicity, and the participant gender. These descriptive statistics were tallied with the use of SPSS software.

In step one, the researcher took notes to familiarize themselves with the data while marking down ideas for a possible coding scheme. This allowed the researcher to understand the responses through an iterative process of reading and re-reading the content several times to develop a thorough understanding of the types of responses. During this phase, note taking is imperative to recognition of recurring ideas (Braun & Clarke, 2006). After the researcher had successfully acquainted themselves with the content being studied, the second step of the analysis process is to formulate some initial codes of what is notable about the responses. This initial code is supposed to be indicative of the most basic elements of the information whether or not that is within the response or implied by the response (Boyatzis, 1998). These codes need

not be too broad because through the rest of the process, these ideas will get consolidated after further analysis. The goal is to initially identify as many patterns as possible.

In step three, the researcher had to take the initial coding scheme and refocus the analysis on a broader scale. This step is done by collating the identified codes into any overarching themes that arise. A theme is defined as a patterned response within the data set (Braun & Clarke, 2006). Although each researcher may choose to identify themes in a variety of ways such as tables or graphics, in this instance, the researcher came up with definitions for the themes and then conferred with a supervisor to discuss the interpretation before moving forward.

By the end of this phase of research, the goal is to not have a list of finite themes, but to have an initial assessment of possible themes seen within the data (Braun & Clarke, 2006). It is also important to note that given the iterative nature of the process, keeping track of all work being collated as a way of assuring that the researcher does not lose track of their ideas. This thematic analysis largely was at the semantic level because the responses were interpreted from their description rather than an unspoken idea being interpreted. No ideas taken from the responses were entirely abandoned at this phase. The researcher conducted this step multiple times by trying out combinations of themes and subthemes to make a candidate list.

In the fourth phase of this methodology, the candidate themes were reviewed and again refined with the researcher and their supervisor. The goal in this step is to recognize when a theme does not have enough data to support the pattern or if the range of codes within the theme is too diverse. This step is imperative to assuring that all of the codes within one theme are forming a coherent pattern (Braun & Clarke, 2006). Once the researcher and supervisor recognized each theme as being consistent with the codes, then the entire data set was conceptualized to consider whether the theme is an accurate representation of the responses

overall. For this reason, this step involves yet another re-read of the responses to make sure that nothing was done looked over or done incorrectly in the coding process. To complete this step, the researcher had a list of refined and consolidated themes. In step five, the researcher named and defined the list of themes to determine what each theme is capturing about the data. To allow for replicability, a report of the themes was developed by the researcher for ease of understanding.

RESULTS

Demographic Findings

Of the three demographic categories, race/ethnicity, gender, and # of course hours taken, there was no significant correlation with the presence of racial identification or analysis. Out of the 175 respondents who completed the survey, 80 students identified race in their response to the advertisement. This represents 45% of respondents. Identification of race was decided simply by marking when a student uses the previously coded words to indicate they "saw" race. For example, the following response was categorized as an identification of race with no racial analysis.

1. *U.S. consumers always want quick easy fix; also white upper middle class has picture of mothers as needing to balance roles between being provider and still a "girl" gender role who would be playful.*

Of the people that identified race, only 65 students included a racial analysis. This represents 37% of students. A response was considered an analysis if the student connected the race of the woman with an idea indicating they are explaining why the decision was made, or the effect this decision has on the messaging of the argument. The following response was categorized as an example of a racial analysis.

1. *It does not take into account racial diversity and the complexities of mental health…and is not inclusive of a wide variety of individuals from differing socioeconomic and racial/ ethnic backgrounds.*

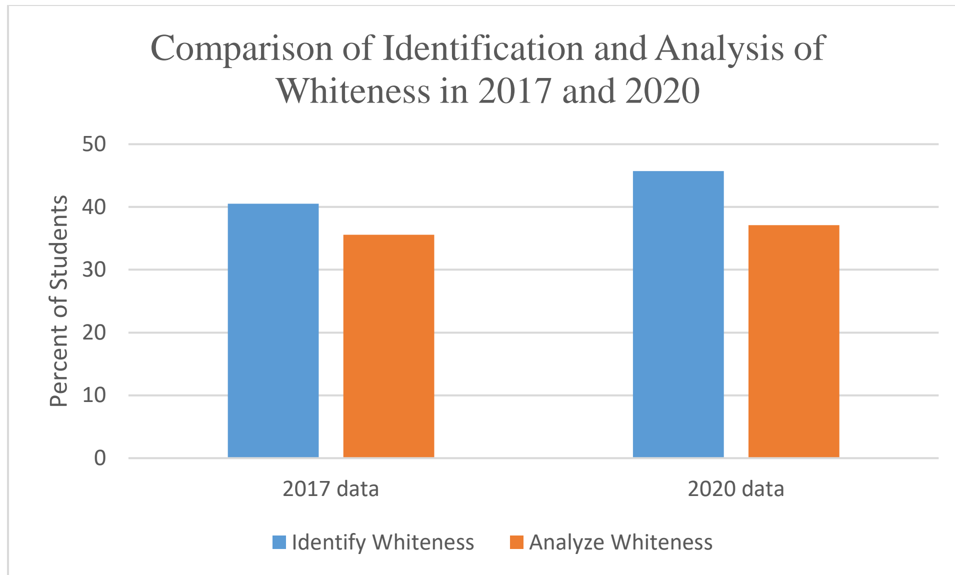

Figure 5: Comparison of Previous and Current Exit Exam Results: This graph compiles results from the 2017 iteration of the SFH survey results with the 2020 data. The graph is comparing the students' identification and analysis of whiteness.

In Figure 5, the results of the 2017 data were combined with the previously mentioned results found in the current study. Given how similar the prevalence of identification and analysis of whiteness is in this comparison, this result goes to show that the curriculum has not made measurable changes in relation to its coverage of whiteness as a racial structure of health.

Thematic Analysis

Theme One: Representation

Of the group of students who included a racial analysis in their assessment of the advertisement, roughly half of students identified a lack of representation. This theme was the predominant way the students analyzed race. For this thematic analysis, the definition used is identifying insufficient representation or inclusion of a diverse experience of mental illness (Moreno & Chhatwal, 2020).

Just as was found in the previous studies, students often commented on the "targeting" of the white woman (Metzl et al., 2018). However, some seemed to use the word targeting in the sense that the white woman actor is a strategical move by the journal publisher, or by the people marketing the pharmaceutical. Often when the woman's race was being considered as marketing tactic, the messaging about whiteness was normalized as a means to an end.

1. *I believe that this advertisement plays a role socio-politically and economically in the fact that it seems to target a white and female audience based on the character portrayed. This may lead people to believe that depression is a normalized condition in the white community. There may be an assumption being made by the drug company that their main audience is white, and perhaps predominantly female.*
2. *Social, economic, and cultural factors may be at play in the audience who will be reading the American Journal of Psychiatry and who this advertisement is targeted at. This advertisement was likely created to connect the most with its target audience. Additionally, these factors are already at play in the placement of the article in this journal and in the demographics of people who receive psychiatric treatment.*
3. *As for as economics this company may believe they will get the most profits from targeting white bothers who may have higher SES and access to these medications. Culturally it is targeting white middle-aged moms.*

Others took another approach and identified targeting of white people as a way that deters other communities away from the advertisement. Identifying the harm of the lack of representation was not consistently seen through the responses. While the students did not have any overt instructions on the types of analysis that was expected, it is notable that identification

harm was uncommon to see even when in conversation with the idea that the advertisement is not recognizing other demographic's experience of mental illness.

1. *The race of the mother and child on the advertisement may have social implications, as it portrays the conventional target audience as being Caucasian and unintentionally produces a bias towards a certain ethnicity. Additionally, the family-based goal of regaining strength of a mother may not be reflective of greater populations of depressed individuals, who are often not child-bearing or do not have strong family ties which may even serve as a factor for depressive symptoms/feelings.*

2. *It portrays a white woman with a child, creating the feeling of white middle-class suburbia as the target of this ad. It ignores the way people of color experience mental illness and says nothing about how medication can be accessed.*

3. *They target a certain demographic and ignore others. They make it seem as if white, middle class women are the only ones impacted by mental illness, when that is not the case at all.*

Theme Two: Racial Privilege and Income

Of the 65 respondents who were classified as having done a racial analysis, just under 31% of students connected whiteness with racial privilege and income. For this analysis, this theme was defined by an acknowledgement of historical connection of race shaping of socioeconomic status and other privileges associated with whiteness (Kawachi et al., 2005).

Given the wealth gap between white people and others racial groups, students often explained that white people are more likely to have health insurance and be able to afford the medication.

1. *The individuals pictured on the advertisement are white, and you get the sense that they are from a middle class family, at least one that is not poor. Prescription drugs can be very expensive, and the ad seems to target individuals with health insurance who can afford the treatment.*

Another notable finding was that students usually associated the woman's race with her being middle or upper class. Some of these claims were substantiated with evidence of why they made this distinction such as the clothes the woman was wearing. However, there was an inconsistency in the way students stated their analysis of access. Some would say that the advertisement or pharmaceutical company was assuming access. Other students would assume the access themselves.

1. *The advertisement is catering to white individuals or perhaps anyone with greater privilege. That is, both the mother and child are white and dressed in new clothes and the message is about getting playfulness "back."*

Another common way of mentioning racial privilege was through an explanation of white people having a higher rate of diagnosis for psychiatric disorders due to possible increased likelihood of seeking treatment and the decreased stigma of pharmaceuticals within the white community.

1. *I immediately noticed that the woman and child are white, so they are more likely to be clinically diagnosed and treated for depression than racial minorities.*

2. *This is aimed at white people, who are disproportionally more likely to be diagnosed with mental health issues, partially because of the decreased stigma within especially white society.*

Finally, a small handful of students explained the way in which the advertisement messaging reinforced ideas of a white-centered world and discussed ways in which white people are portrayed as the only ones "allowed" or "deserving" enough to have a mental illness.

1. *They are targeting middle class white women. This is assuming that the person who might take the drug is in a stable social, political, and economic state and of the dominant culture.*

2. *They all have an influence. For example, the models used in the ad appear to be non-hispanic white, middle class, and physically attractive. Such attributes are all preferred by the mentioned factors of our world.*

3. *They show who can and cannot be affected by depression and anxiety. There is a culture of "deservingness" surrounding mental illness, and it is typically wealthy white people who are allowed to have it. All these factors have crafted this culture of deservingness and therefore, craft the culture that is implicit in this advertisement.*

Theme Three: White Disease

The final theme identified was White Disease. This category's definition is relating to the historical characterization of white woman overmedicalizing their depression as a way of treating the "everyday worries" of being a housewife (Metzl, 2003). Of the 65 respondents

analyzing race, 23% of the students made this connection. Because this analysis is heavily influenced by gender, it was common to see students characterize the advertisement as showcasing a “white mom disease” or a “white woman disease.” Others stated it as a “white person disease.” Given the small number of respondents, there was no distinction in coding relating to mention of gender, or familial role.

Throughout the responses, this theme was specifically identified when students stated in some way the reinforcement of historically informed stereotypes about psychiatric disorders. Several responses identified the race and explained a similar idea of the advertisement only appealing to white people, or only representing white people. However, this classification was distinguished from representation and racial privilege and income by the surrounding explanation of the student’s response. If the student explained their reasoning as being specifically because of access/privilege or related their ideas to a lack of inclusion of other narratives, then it was coded accordingly. Additionally, if the student mentioned their SES with no further analysis of social positioning, then this is not an indication of the racial privilege theme. Given the highly specific methodology of inclusion and exclusion created by the researcher’s codebook, this category ended up being the smallest number of respondents.

The responses were highly intertwined with the topic of medicalization of mental illness. Students frequently mentioned how the woman’s whiteness interacted with the idea that depression is easily fixable and can be treated with pills alone.

1. *My first response was that this looks like a very stereotypical ad for depression/depression medication. But I think that's the problem: the fact that this is the image of depression that companies continue to run "depressed, middle class, white mother of 2 given her life back after taking x medication"*

2. *I feel like the advertisement gives the sense of mental illness as being a white housewife's problem. Like "bored at home? Just take this pill and you'll want to play with your kid again!" I think it also sends the message that mental illness is curable and easy to deal with - not that it is a process with many highs and lows and for most people it isn't something you just "recover" from.*

DISCUSSION

This study examines the portion of students who saw race as relevant to their analysis of the advertisement in addition to the portion of students who just identified race in 2020. Furthermore, when students do mention race they discussed representation, white disease, and privilege/income. This study found that 45% of students referenced the woman's race and 37% of students critically analyzed the woman's race. In comparison with the 2017 results, it does not appear that the curriculum has made measurable changes in helping students to identify and describe whiteness as a racial structure of health.

Based on these results, it cannot be said whether the students who did not conduct a racial analysis are unaware of structures of privilege and whiteness as a racial category. However, the prompt was designed to "detect student recognition of ways racial structures also potentially shape the health of privileged groups" (Metzl et al., 2018). If one were to interpret the theme of racial privilege and income as a measurement this goal, then only about 10% of the students taking the exit exam were able to do this. Given that the survey is built by design to evaluate the effectiveness of a structural competency informed education, this result at the very least implies that the survey could be altered in further iterations to test this knowledge in a different way to see if the questioning itself is producing flawed results that are not representative of the student's knowledge. Alternatively, one could take this outcome to indicate a lack of understanding among students about whiteness and privilege. However, given that the SFH tool is not designed to test specifically for recognition of whiteness and structures of privilege, this conclusion can only be speculated and requires further research. While this current study was being constructed, the 2021 exit exam was published an additional two questions focusing on whiteness. Metzl and

Petty are currently looking to assess how the students characterize their answers with special attention to responses characterizing issues as individual or structural.

In years past, the data from previous exit exams has consistently suggested that MHS students develop the skill of diagnosing and analyzing race, determinants of health, structural stigma, and health economics. Yet another consistent result contradicts these general outcomes because the students consistently do not recognize whiteness as racial category (Petty et al., 2017). The structural competency informed education that MHS provides does not affect these results because throughout several years of study, MHS graduates recognized and evaluated whiteness as a racial category just as much as an MHS freshman and premed graduate. Another finding is that 5% of people connected the woman's race with larger social or socioeconomic formations (Metzl et al., 2018).

The scope of these findings must be considered when thinking about next steps for research. Structural competency informed education has proved itself to be helpful in familiarizing MHS students with structural determinants of health and health outcomes. The value of the program speaks for itself when comparing these outcomes with MHS freshman and premed graduates as has been done in previous studies. But regardless of its value, having a consistent outcome of difficulty recognizing whiteness and privilege indicates room for change. Whether that change is reflected first in the wording of the SFH depression advertisement prompt, or whether this change needs to be part of the curriculum is up for interpretation. In a previous study, Metzl and Petty have acknowledged these results and suggested there is a need for "better pedagogy and assessment focused on mainstream as well as minority bodies" (Metzl et al., 2018). The question going forward is how can structural competency education best

implement these changes? Additionally, what types of theories could help inform students about recognizing and analyzing race in meaningful ways, no matter the race of the person?

Many theories have been discussed to understand why it is that people often do not recognize and analyze race when the subject is a white person. One of the more popularized proposals is that of colorblind racial theory. Although colorblind racism has its roots in the politics of the 1960s and 1970s, this theory is argued to be the dominant way that white Americans think and talk about race (Bonilla-Silva, 2017). The theory of colorblindness is comprised of five components: (1) covert nature of racial discourse and practice; (2) avoidance of direct racial terminology; (3) a racial political agenda pushing for covert racial references; (4) the subtle mechanisms of reproducing racial privilege; and (5) the rearticulation of some past racial practices (Bonilla-Silva, 2015). An important implication of students not recognizing race when the subject is white relates to the harmful ways that colorblind racism currently is manifested in the medical field and far beyond. The racism being discussed is not involving overt discrimination or ideology but rather an insidious, covert form of racism that is grounded in the unknowing reinforcement of institutionalized white supremacy.

The Coin Model of Privilege and Critical Allyship has been proposed as a framework for assisting people in positions of privilege to aid in stopping the reproduction of health inequities by resisting the unjust structures that contribute to it (Nixon, 2019). Part of this framework is conceptualizing privilege as a piece of understanding health inequity. The Coin Model introduces privilege in the explanation of inequity by the metaphor of a coin. The coin itself is the social structure that is going to give advantage or disadvantage to people existing within it. One side of the coin represents the people with unearned advantages and the other side represents those of which who are unfairly disadvantaged. If the coin represents the social

structure of heterosexism, the advantaged side of the coin is those of which who are heterosexual, while the disadvantaged side represents sexual and gender minorities. Most of the time health inequity is discussed through the lens of the people being marginalized. However, by excluding conversations of privilege from health inequity, proposed solutions and education will always orient themselves toward the oppressed. When framing the problem, education needs to include understandings of how people in positions of privilege are aiding in reproducing these systemic inequities (Nixon, 2019).

Ultimately, the literature on how to train undergraduate students to critically analyze the role of race in health is very limited. Structural competency informed education is being suggested through the department of Medicine, Health, and Society, that this is one framework that can train students with these skills. By designing this research to evaluate further the recognition and analysis of race in the context of prior results, I am reorienting the conversation to be more specifically about what is wrong with the outcomes of this program. Recognition of whiteness and privilege is the *only* negative outcome associated with the exit exam. There are clear benefits and high efficacy of understanding among a large variety of issues being taught. However, scholars must not negate the importance of whiteness and privilege as a part of understanding race and health in the United States.

Limitations

A thematic analysis methodology is not entirely agreed upon in scholarly discourse. Over the years, many different researchers have come up with their own procedure and definition of what a thematic analysis is (Willig & Rogers, 2017) (Boyatzis, 1998) (Crabtree & Miller, 1999) (Braun & Clarke, 2006) (Roulston, 2001). Many researchers have built off other scholarly work to fit their own data set. This array of interpretations of a thematic analysis

highlights its inherent flexibility and lack of concrete theory. However, while this flexibility allows for a wide variety of data sets this method can work on, it is limited by this feature as well because higher level analysis can be difficult given how broad the interpretations can be (Braun & Clarke, 2006). Without having an analytic framework to anchor the interpretive claims, some arenas of academia may argue its validity. However, to combat this issue, extensive measures were taken throughout the analytic procedure to ensure trustworthiness, rigor, and replicability within the confines of the methodology.

Another limitation of this methodology is the incomplete participation of the entirety of the undergraduate class of Medicine, Health, and Society that was graduating in the spring of 2020. Therefore, the sample is not representative. However, of the graduating class, only 82% participated in the exam. While the participation rate is usually 100%, the unprecedented circumstances of COVID-19 in the Spring of 2020 did not allow for complete representation.

Finally, there is inherent limitations to the SFH evaluation tool. This study is evaluating student responses to a question that was not overtly worded to test for comprehension of whiteness. By not directly asking students if they can identify and analyze race, the answers being produced will not necessarily reflect the student's comprehension of race. Given that my argument is advocating for improved racial education in structural competency informed curricula, this limitation is important in understanding to what degree this evaluation tool can be used as evidence.

Recommendations

Regardless of the study's limitations and the ability of the SFH evaluation tool to effectively measure student's understanding of whiteness as a racial category, this research

further reiterates previous conclusions about MHS requiring pedagogical change in relationship to critically understanding whiteness. Structural competency is a concept centered around institutions that hold power and contribute to privilege. The clear connection of whiteness as a structure of privilege should be implemented in courses aiming to explore health disparities. The explanation of the Coin Model above highlights that privilege is the other half of oppression. Students who learn about the structural oppression and vulnerability placed on certain populations need to recognize how other populations are being unfairly advantaged as well. Without the concrete connection of whiteness as a racial structure of health and a structure of privilege, students can fall into the trap of white normativity and viewing minoritized population as an "other."

I recommend that the SFH survey be revised to overtly question the students understanding of whiteness as a racial category. Not only should they be able to answer a question demonstrating a racialization of whiteness, but they should also be able to explain whiteness' role as a structure of privilege and how presentations of health and illness are potentially being influenced. There is plenty of scholarly discourse already taking place to explain the role of whiteness as a determinant of health (Efird & Lightfoot, 2020; Koum Besson, 2021; Lipsitz, 2006; Malat et al., 2018; Metzl, 2019). By integrating literature that explains whiteness as a determinant of health, students would be more effectively meeting the 4th core structural competency for the undergraduate program which is: demonstrate comprehension of the relationship between race and health as an outcome of cultural and social factors (Metzl & Petty, 2017). Furthermore, as these students go on to be professionals in different health fields, they will have a deeper understanding of the importance of overcoming the colorblind ideology,

and not be playing a role in perpetuating the invisibility of whiteness in health disparities research.

CONCLUSION

MHS aims to educate students about core structural competency principles by teaching ways to critically analyze the way structural determinants of health impact health, healthcare, and health policy. In this study, the goal was to evaluate the degree to which the MHS curriculum helps students identify and understand how to consider the role of race as a determinant of health. In addition to prior iterations analyses of MHS exit exam results, this study's results further indicate a recurring presence of students having difficulty with assessment of race as a determinant of health when looking at a pharmaceutical advertisement with a white woman. This study has great significance given that one of the purposes of structural competency is to detect the impact of race on non-minoritized populations. However, beyond structural competency, students interested in joining a health-related career need to be able to have this recognition to effectively not reproduce racial ignorance and racial illiteracy in the work force. Implicit racial stereotypes and lack of understanding of the ways in which whiteness functions only aid in perpetuating health care disparities. Further action is necessary to help reform structural competency education in meeting its desired goals.

APPENDIX A

Initial Codes Scheme

CODE Name	Definition	Qualifications/ Exclusions	Example
White Centered Culture	A response that uses the reasoning that a white woman was chosen because they are an assumption of the norm	Includes instances where idea of 'norm' is mentioned Includes mention of whiteness being preferential	*The models used in the ad appear to be non-hispanic white, middle class, and physically attractive. Such attributes are all preferred by the mentioned factors of our world.*
Assumption of Access	Response that connects the person's whiteness to increased access to either insurance, psychiatrist, medication	Usually this is seen as a mention of higher SES Excludes instances where decreased stigma is connected to explanation. Excludes explanation of "more likely to seek treatment"	*The individuals pictured on the advertisement are white, and you get the sense that they are from a middle class family, at least one that is not poor. Prescription drugs can be very expensive, and the ad seems to target individuals with health insurance who can afford the treatment*
Portrayal of white disease	Response is acknowledging the historical portrayal/stereotype of depression/anxiety/mental illness being a problem that only white people experience.	Not distinguishing between additional characterization of white mother, white person, or white woman Excludes explanations including preference. See white centered culture.	*Women having higher (reported) rates and being more likely to seek treatment, postpartum influences with the baby, that depression is a white person's disease (racial representation), drug companies make huge profit off of direct to consumer advertisements (doctors very likely to prescribe if patients ask)*

Acknowledgement of Harm/Bias	Response identifies that the characterization being shown in the ad is harmful in some way to people not being represented	Excludes instances ONLY mentioning lack of representation In the data set, there were no instances of acknowledgment of harm without the addition of another differently coded analysis	*There are many lasting impacts that an advertisement like this could have. As a Black woman, my experience is not represented here and the promotional idea of recovery negates my experiences with the disease.*
Lack of inclusion of other narratives	Response acknowledges the exclusion of other representations of mental illness	Excludes instances where representation is mentioned but not overtly race (age, gender) Excludes mention of diversity without race	*There is also a young white woman on the cover, which the advertisement seems to convey that depression / anxiety was the only factor at play in her mental health. It does not take into account racial diversity and the complexities of mental health, the nuance of how much medications can and cannot help an individual, and is not inclusive of a wide variety of individuals from differing socioeconomic and racial / ethnic backgrounds.*
Primary Audience	Response acknowledges whiteness as being the primary audience to either the drug or the consumer of the advertisement	Can includes mention of "primary user" Excludes whiteness as preference without identified reason of marketing	*It depicts a mother playing with a child, which is a very relatable role for a lot of people. While I don't know what magazine this ad was in, the magazine could have a primary audience of white women.*

More likely to seek treatment/receive diagnosis	Response calls attention white people having more diagnoses because they are more likely to seek treatment or receive a diagnosis	Excludes mention of only decreased stigma	*I immediately noticed that the woman and child are white, so they are more likely to be clinically diagnosed and treated for depression than racial minorities.*
Less Stigma	Response identifies how white people experience less stigma regarding mental health treatment and diagnosis	Must include overt mention of stigma	*This advertisement does not show the underlying factors contributing to mental illness and instead shows that it can easily be fixed with an SNRI. It does not acknowledge any other ways to treat depression, and also perpetuates the notion that mental illness is less stigmatized in white people.*

Source: 2020 SFH Survey Pharmaceutical Ad Data

APPENDIX B

THEME LABEL	DEFINITION	DESCRIPTION	QUALIFICATIONS OR EXCLUSIONS	EXAMPLES
REPRESENTATION	Identifying insufficient representation and inclusion of diverse experiences of mental illness (Moreno & Chhatwal, 2020).	Demonstrating knowledge of lack of diverse representation of mental illness	1. Including monopolization of white representation of mental illness. 2. Does not include mention of classification of depression/mental illness being a white disease. See theme definition for white disease 3. Includes reference to marketing tactics	*It does not take into account racial diversity and the complexities of mental health…and is not inclusive of a wide variety of individuals from differing socioeconomic and racial/ ethnic backgrounds.*
WHITE DISEASE	Relating to the historical characterization of white woman overmedicalizing their depression as a way of treating the "everyday worries" of being a housewife (Metzl, 2003)	Describes depression or mental illness as being portrayed exclusively as a white problem	1. Includes mention of stereotypes about white women, and white people. 1. Excludes mention of white people only being represented	*The stereotype that mental illness only plagues white women with nothing better to do than to be sad*
RACIAL PRIVILEGE AND INCOME	Acknowledgement of historical connection between socioeconomic status and other privileges with white people (Kawachi et al., 2005)	Describing an assumption of access, higher SES, and greater probability of diagnoses and treatment	2. Excludes mention of marketing tactic	*Being that this advertisement is targeting a white, middle-aged, potentially well-off woman, it automatically assumes that this demographic has access to this drug both financially and socially.*

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