Navigating the Nexus: Exploring the Intersections of Political Identities and Health Perceptions Through Lived Narratives

An Essay Presented

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Introduction:

The intersection of political beliefs and health perceptions has emerged as a critical area of inquiry, shedding light on the complex interplay between sociopolitical factors and individuals' lived experiences of illness. Previous research has demonstrated that political ideologies can significantly shape individuals' perceptions and attitudes toward various health issues, such as preventive care, healthcare access, and adherence to public health guidelines.[1] However, much of the existing literature has primarily focused on broad political ideologies, such as conservatism versus liberalism, or party affiliations (e.g., Republican versus Democrat), failing to capture the nuances and complexities inherent within these ideological groups.

This examination takes a novel approach by examining previous works on an in-depth analysis of how specific political identities influence health perceptions through the lens of qualitative research studies and controlled setting interviews. By focusing on distinct political identities, such as White Republicans, White Democrats, African American Democrats, and African American Republicans, and their intersections with race, socioeconomic status, and geographical location, the analysis aims to provide a nuanced understanding of how these interlinked identities shape unique illness narratives and perceptions.

Furthermore, the exploration of the divisions and complexities within political groups opens the doors to discussing correlations outside of dichotomous categorizations often employed in previous research. Political identities are not monolithic; they are shaped by intersections with other social factors, including race, socioeconomic status, and geographical location[2]. Nonetheless, quantitative analyses, while informative, may not fully capture the subjective and lived experiences of individuals navigating the nexus of political identities and health perceptions. Qualitative investigations, particularly those employing narrative approaches,

offer the potential to uncover the rich, personal meanings and emotional dimensions that underlie individuals' health-related decision-making processes[3]. Through a detailed examination of qualitative, narrative-based studies, this analysis captures the rich personal meanings, emotional dimensions, and meaning-making processes that underlie individuals' health-related decision-making and interactions with healthcare systems. This approach addresses gaps in existing literature, which has primarily relied on quantitative analyses of broad political ideologies or party affiliations, failing to fully capture the complexities and heterogeneity within these groups.

The analysis draws upon theoretical frameworks such as the common-sense model of self-regulation[4] and the concept of rhetorical ethos in healthcare[5] to elucidate how political identities may shape illness narratives and perceptions. The common-sense model proposes that individuals develop coherent views or "perceptions" about their illnesses based on information from bodily sensations, social communication, and cultural knowledge, which can be influenced by political beliefs and ideologies. Meanwhile, the concept of rhetorical ethos in healthcare examines how cultural norms, institutionalized attitudes, and power dynamics can discredit or privilege certain patient voices over others, potentially contributing to misdiagnosis and perpetuation of suffering for patients holding multiple devalued identities.

By contextualizing these lived narratives within relevant theoretical frameworks and broader sociocultural dynamics, this analysis informs potential avenues for culturally competent public health interventions, policymaking, and the development of patient-centered healthcare approaches to promote health equity. The findings offer valuable insights into the nuanced ways political identities intersect with other social factors to construct subjective illness narratives and experiences, particularly during the COVID-19 pandemic.

Section 1: The Sociology of Health and Illness

The sociology of health and illness is a multidisciplinary field that examines how social and cultural factors shape individuals' experiences of illness, perceptions of health, and interactions with healthcare systems. This field recognizes that illness is not merely a biological phenomenon but a profoundly personal and socially constructed experience[6]. Researchers have explored how people make meaning of symptoms, negotiate disruptions to their lives, and renegotiate identities through illness narratives that illuminate lay representations of illness chronicity, causal beliefs, effects on self-worth, coping strategies, and power dynamics negotiated with medical authorities over legitimacy and caregiving roles[6,7].

The role of narrative medicine has gained prominence by highlighting the importance of understanding patients' subjective illness narratives elicited through open-ended inquiry, enabling physicians to comprehend how individuals subjectively understand their conditions within the contexts of their life stories, relationships, identities, and moral values. This narrative competence fosters more empathic, ethically-disciplined care respecting patients' perspectives[8]. Researchers emphasize situating individual illness narratives within broader sociocultural, political, economic, and health system contexts to examine how seemingly private troubles are inscribed by public issues of social legitimacy, power relations with authorities, and systemic marginalization of vulnerable groups' suffering[7,9]. Sociological analyses can thus interrogate how structural conditions shape stratified patterns of disease distribution, illness experiences, and access to care[9].

The sociology of health and illness recognizes the inherent complexities and intersections of social identities, cultural beliefs, and structural factors shaping illness experiences and healthcare interactions. By employing narrative-based approaches, qualitative methodologies,

and interdisciplinary perspectives, this field aims to develop a more comprehensive and contextually grounded understanding of the multifaceted nature of health and illness experiences across diverse populations and settings.

Section 2: Theoretical Frameworks and Implications

Theoretical frameworks such as the common-sense model of self-regulation and the concept of rhetorical ethos in healthcare provide valuable lenses for understanding how political identities shape illness narratives and perceptions. The common-sense model proposes that individuals develop coherent views or "perceptions" about their illnesses based on information from bodily sensations, social communication, and cultural knowledge. These perceptions are organized around dimensions like illness identity, causes, timeline, consequences, and curability/controllability[3]. Crucially, these perceptions powerfully influence emotional responses, treatment motivations, adherence, and adjustment to chronic conditions.

According to the common-sense model, individuals' political beliefs and ideologies can substantially influence the formation of their illness perceptions. For instance, those with conservative political leanings may be more inclined to attribute illness to personal factors and behaviors, emphasizing individual responsibility in disease management. Conversely, individuals with liberal leanings may be more attuned to structural or environmental causes and advocate for collective action to address health issues[10]. These differing perceptions of illness causality and controllability can shape health behaviors, attitudes toward public health policies, and interactions with healthcare systems.

The concept of rhetorical ethos in healthcare further elucidates how political identities may influence illness narratives and perceptions. This framework examines how cultural norms, institutionalized attitudes, and power dynamics can discredit or privilege certain patient voices over others. Stigma can operate through rhetorical processes where particular symptoms, patient identities, or illness stories get constructed as less believable based on implicit biases rooted in larger societal stigmas[4]. Individuals with marginalized political identities may face diminished

credibility within healthcare settings, potentially contributing to misdiagnosis, delayed care, and perpetuation of suffering.

By drawing upon these theoretical frameworks, this analysis elucidates how political identities intersect with other social factors to construct unique illness narratives and perceptions. For example, the findings suggest that White Republican participants' skepticism towards public health measures during the COVID-19 pandemic may stem from perceptions of illness causality and controllability rooted in conservative ideologies that emphasize individual responsibility and autonomy. Conversely, African American Democrat participants' expressions of fear and concerns about systemic racism within healthcare systems resonate with the concept of rhetorical ethos, where marginalized identities face diminished credibility and potential biases. Furthermore, the significance of community identity and collective responsibility for health among African American participants, both Democrats and Republicans, aligns with the common-sense model's recognition of cultural knowledge and social communication shaping illness perceptions[11]. These findings suggest that political identities intersect with racial and cultural factors to construct unique perceptions of illness causality, consequences, and the role of collective action in disease management.

Based on these theoretical frameworks and the analysis of lived narratives, a potential model could be proposed to understand the complex interplay between political identities, intersecting social factors, and illness perceptions. This model would incorporate the dimensions of illness perceptions outlined in the common-sense model, such as illness identity, causes, timeline, consequences, and curability/controllability. However, it would also account for the influence of political ideologies, racial and cultural identities, socioeconomic factors, and geographical contexts on shaping these perceptions. The proposed model could serve as a

framework for future research, guiding investigations into the specific mechanisms through which political identities and their intersections shape illness narratives and perceptions. Additionally, it could inform the development of culturally competent public health interventions and patient-centered healthcare approaches by highlighting the diverse perceptions and needs of individuals with varying political and social identities.

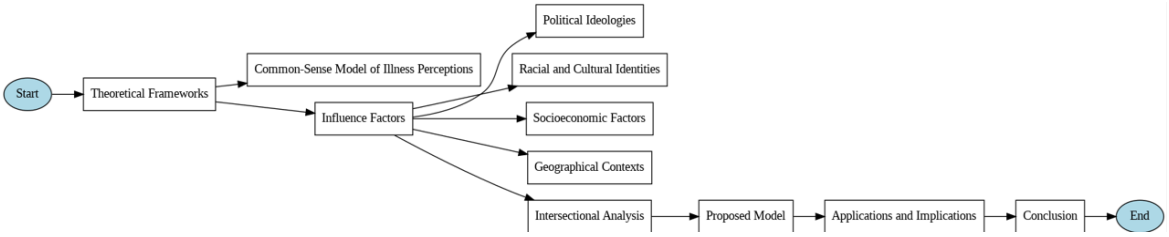


Figure 1: Flowchart illustrating a **proposed model** integrating theoretical frameworks and influence factors in understanding political identities and illness perceptions. The model incorporates dimensions of illness perceptions from the common-sense model and highlights the intersectional impact of political ideologies, racial and cultural identities, socioeconomic factors, and geographical contexts.

By drawing upon theoretical frameworks and analyzing lived narratives through a qualitative, intersectional lens, this analysis provides a nuanced understanding of how political identities influence health perceptions and experiences. The proposed model offers a holistic approach to addressing the complexities and promoting equitable, culturally competent healthcare for diverse populations.

Section 3: Political Identities and Health Perceptions

A growing body of literature has examined the influence of political beliefs and ideologies on health perceptions, behaviors, and outcomes. Studies have demonstrated that individuals' political orientations can significantly shape their attitudes toward various health issues, such as preventive care, healthcare access, and adherence to public health guidelines[12,13]. Researchers have explored the relationship between political identities, such as conservative versus liberal or Republican versus Democrat, and attitudes toward public health policies, healthcare access, and health-related decision[14,15]. For instance, studies have shown that individuals with conservative political beliefs are more likely to prioritize personal responsibility and autonomy in health-related decision-making, while those with liberal beliefs may place greater emphasis on collective responsibility and government intervention[10].

The COVID-19 pandemic has further highlighted the significance of political identities in shaping health perceptions and behaviors. Disparities in adherence to mitigation measures like mask-wearing and vaccination have been observed across the political spectrum, with conservatives generally displaying lower compliance compared to liberals. These differences have been attributed to varying levels of trust in public health authorities, divergent beliefs about the severity and causes of the pandemic, and the influence of ideological communities in shaping knowledge and understanding[16,17].

However, much of the existing literature has focused on broad political ideologies or party affiliations, failing to capture the nuances and complexities inherent within these groups. Studies have shown that the experiences of African American Democrats and White Republicans may differ significantly, even within the same broad political affiliation, due to intersecting identities and social contexts. For example, a study found that African American Democrats

reported distinct perceptions of healthcare access compared to White Republicans, highlighting the influence of intersecting racial and political identities on health-related experiences[18].

Furthermore, quantitative analyses, while informative, may not fully capture the subjective and lived experiences of individuals navigating the nexus of political identities and health perceptions. Qualitative investigations employing narrative approaches offer unique insights into individuals' health-related decision-making processes. Narrative medicine, as demonstrated by one study, reveals deeply personal experiences within healthcare settings, articulating existential concerns and emotional dimensions that shape patients' perspectives on illness and treatment. This approach highlights the complex interplay between personal experiences and healthcare interactions. Additionally, recent research illustrates how narrative methods unveil the impact of cultural and social influences on health narratives, emphasizing the significance of emotional contexts in shaping health decision-making[11,22]. Through storytelling analysis, this study showcases the diverse interplay between personal experiences and broader sociocultural factors

While the existing literature has shed light on the influence of political beliefs on health perceptions and behaviors, there is a need for a more nuanced understanding of how specific political identities intersect with other social factors to shape individuals' subjective illness narratives and experiences. Much of the previous research has focused on broad ideological categories or party affiliations, overlooking the complexities and heterogeneity within these groups.

This study addresses these gaps by exploring the lived experiences and illness narratives of individuals belonging to distinct political identities, such as White Republicans, White Democrats, African American Democrats, and African American Republicans. By examining

these specific intersections of political, racial, and socioeconomic identities, the study seeks to uncover the unique perspectives, emotional dimensions, and meaning-making processes that shape individuals' perceptions of health and illness.

Results and Discussion:

The key findings from the qualitative study offer valuable insights into the nuanced ways in which political identities shape health perceptions and experiences during the COVID-19 pandemic. Consistent with previous research highlighting the role of political ideology in health attitudes and behaviors[23,24], we found that White Republican participants strongly prioritized self-direction and individual autonomy in health-related decision-making. They frequently expressed skepticism towards government-mandated public health measures like vaccine requirements, asserting the importance of their right to make and stick to their own.

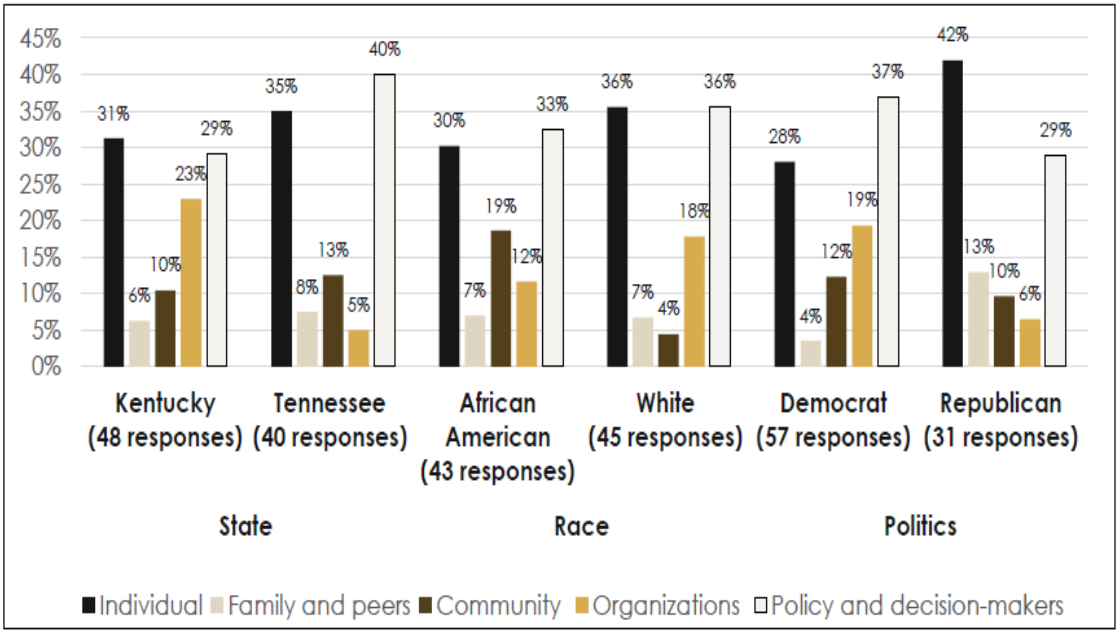
However, the in-depth interviews uncovered additional complexities beyond the value of self-direction. One White Republican participant proposed a different interpretation, suggesting that non-compliance might stem from a desire to preserve social status and avoid "losing face" among one's peers and in-group, rather than purely valuing self-direction[14]. This perspective aligns with theoretical frameworks on conformity and social identity, highlighting how subjective meanings and motivations attached to health behaviors can be overlooked in quantitative studies[6,26]. In contrast to White Republicans, White Democrat participants tended to conform more readily to public health guidelines, reflecting a higher emphasis on communal responsibility. However, their experiences were not monolithic, with some expressing mixed attitudes towards the healthcare system's performance during the pandemic. This resonates with previous research indicating that political ideology alone does not fully explain variations in health perceptions and experiences[1,2].

Importantly, the findings underscored the intersections of political identities with race and socioeconomic factors in shaping health perceptions and experiences. African American Democrat participants frequently expressed fear and uncertainty about COVID-19, with their

experiences often characterized by high levels of initial anxiety and symptoms compounded by concerns about systemic racism within healthcare systems[14]. This aligns with the extensive literature on healthcare disparities, institutional distrust, and the influence of structural factors on health outcomes among racial and ethnic minority groups [26,27,28]. Interestingly, African American Republican participants were less likely to attribute negative healthcare experiences to racism, focusing instead on practical steps towards recovery. This divergence within the same racial group highlights the nuanced interplay of political and racial identities in shaping health perceptions, underscoring the importance of an intersectional approach to understanding health attitudes and behaviors.

Furthermore, the study revealed the significance of community identity and collective responsibility for health among African American participants, both Democrats and Republicans[14]. This finding aligns with previous research on the cultural importance of communal support networks and collective coping strategies in African American communities, which have historically faced systematic marginalization and barriers to healthcare access[29,30].

FIGURE 2: RESPONSIBILITY FOR HEALTH AT FOUR LEVELS: % BREAKDOWN OF RESPONSES BY SEM LEVEL, BY STATE, RACE AND POLITICS



The data presented in Figure 2, adapted from a study[14], provides valuable insights into how different demographic groups perceive responsibility for health across multiple levels of the socio-ecological model (SEM). This visual representation highlights the nuanced interplay between political identities, race, and geographical location in shaping perspectives on health responsibility. One key observation from the figure is the stark contrast between participants from Tennessee and Kentucky. Tennesseans, who reside in a state that did not adopt the Affordable Care Act (ACA), place a disproportionate emphasis on individuals and rarely reference the responsibility of organizations (healthcare or otherwise) for health at any level. Conversely, participants from Kentucky, a state that embraced the ACA, demonstrate a more holistic perspective, acknowledging the role of various entities, including organizations and policymakers, in influencing health outcomes.

This geographical divide underscores the significant impact of state-level policies and political landscapes on shaping individuals' attitudes toward health responsibility. It aligns with

the broader findings of the study, which highlight how political identities intersect with contextual factors, such as location and access to healthcare resources, in shaping health perceptions and experiences. When examining the data through the lens of race, another striking pattern emerges. African American participants, regardless of their political affiliation, attribute a higher level of responsibility for health to the community compared to their White counterparts. This finding resonates with the qualitative insights presented in the paper, which emphasize the cultural significance of communal support networks and collective coping strategies within African American communities. However, the figure also reveals nuances within racial groups based on political identities. African American Republicans place a stronger emphasis on individual and familial responsibility for health, aligning more closely with the perspectives of White Republicans[14]. In contrast, African American Democrats demonstrate a more balanced view, acknowledging the roles of various stakeholders, including organizations and policymakers, in promoting health and well-being.

Overall, Figure 2 serves as a visual representation of the study's central themes, reinforcing the significance of political identities, race, and geographical location in influencing perspectives on health responsibility. By presenting these data alongside the qualitative insights and theoretical frameworks discussed in the paper, the researchers provide a comprehensive and nuanced understanding of the complex dynamics at play in shaping health perceptions and experiences during the COVID-19 pandemic.

Conclusion and Implications:

The qualitative study contributes to the existing literature by providing a nuanced analysis of how political identities intersect with health perceptions and experiences during the COVID-19 pandemic. The findings highlight the complexities and subjective meanings attached to health-related behaviors, which quantitative studies may overlook or oversimplify. From a theoretical standpoint, the study underscores the importance of an intersectional approach in health research. The intersections of political identities with race, socioeconomic status, and geographical location played a crucial role in shaping health perceptions and experiences, aligning with intersectionality theory's emphasis on the compounding effects of multiple, interconnected systems of oppression and privilege. Furthermore, the influence of community identity and collective responsibility on health perceptions, particularly among African American participants, resonates with cultural theories on communal support networks and their significance in minority communities.

Practically, the findings have implications for healthcare providers, public health policymakers, and researchers. Healthcare delivery and health communication efforts should consider the diverse political identities and their intersections when developing culturally competent and patient-centered approaches. Targeted interventions and messaging strategies may be required to address the unique concerns and perspectives of different political and racial/ethnic groups, foster trust, and promote equitable access to healthcare services[31,32]. Additionally, community-based initiatives that leverage existing support networks and collective responsibility may be particularly effective in addressing health disparities and promoting positive health outcomes among minority communities. While the main comparative study offers valuable insights, it is essential to acknowledge its limitations and suggest directions for future

research. First, the study was conducted within a specific geographical region (Tennessee and Kentucky) and may not be generalizable to other contexts. Future research could explore the influence of political identities on health perceptions across different health conditions, settings, and regions, as well as longitudinal studies to track changes over time. Moreover, quantitative studies could complement the qualitative findings by examining the statistical relationships between political identities, health behaviors, and health outcomes, while accounting for intersectional factors such as race, socioeconomic status, and geographical location. Such mixed-methods approaches would provide a more comprehensive understanding of the complex interplay between political identities and health perceptions and experiences.

By considering the nuanced influence of political identities and their intersections on health perceptions and experiences, the study highlights the importance of culturally competent and patient-centered approaches in healthcare. Acknowledging and addressing these diverse perspectives is crucial for promoting equitable access to healthcare services, fostering trust between healthcare providers and patients from various political and cultural backgrounds, and ultimately improving health outcomes for all individuals and communities.

Future Directions:

The findings from the qualitative study have shed light on the nuanced and complex ways in which political identities intersect with health perceptions and experiences during the COVID-19 pandemic. While these insights offer valuable contributions to the existing literature, they also pave the way for future research avenues that can further deepen the understanding of this intricate relationship.

Public health efforts have attempted to address the influence of political beliefs on health perceptions, but with mixed success. During the COVID-19 pandemic, public health agencies and healthcare providers worked to disseminate information and combat misinformation, particularly among politically conservative groups who were more likely to express skepticism towards public health measures. However, these efforts often faced challenges in building trust and effectively communicating with individuals holding deeply entrenched political beliefs.

One potential avenue for future public health initiatives could be the development and evaluation of culturally tailored interventions aimed at addressing the unique health concerns and perspectives of individuals with diverse political identities. For example, consider a community outreach program specifically designed for conservative-leaning populations. This program could involve engaging local community leaders and influencers who share similar political values to deliver health messages in a manner that aligns with their audience's beliefs and values. By leveraging trusted messengers within the community and framing health information within familiar ideological frameworks, such interventions could enhance receptivity and promote positive health behaviors among politically conservative individuals. By tailoring interventions to specific political and cultural contexts, public health professionals may be better equipped to resonate with individuals' values and beliefs, fostering greater receptivity and engagement.

Finally, fostering cross-disciplinary collaborations between public health professionals, researchers from various fields (such as political science, sociology, psychology, and anthropology), and community stakeholders could bring diverse perspectives and expertise to the study of political identities and health. Such collaborations could catalyze innovative approaches and holistic insights, transcending disciplinary boundaries and contributing to a more comprehensive understanding of this multifaceted phenomenon. This collaborative approach could inform more effective and sustainable public health strategies that resonate with diverse communities and promote positive health outcomes for all individuals and communities.

References:

1. Gollust, S. E., Nagler, R. H., & Fowler, E. F. (2020). The emergence of COVID-19 in the U.S.: A public health and political communication crisis. Journal of Health Politics, Policy and Law, 45(6), 967-981.

2. Kirzinger, A., Kearney, A., Hamel, L., & Brodie, M. (2021). KFF COVID-19 vaccine monitor: January 2021. Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/report/kff-covid-19-vaccine-monitor-january-2021/

3. Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. University of Chicago Legal Forum, 1989(1), Article 8.

4. Collins, P. H. (2015). Intersectionality's definitional dilemmas. Annual Review of Sociology, 41, 1-20.

5. Hornsey, M. J. (2008). Social identity theory and self-categorization theory: A historical review. Social and Personality Psychology Compass, 2(1), 204-222.

6. Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), The social psychology of intergroup relations (pp. 33-47). Brooks/Cole Publishing Company.

7. Petrie, K. J., & Weinman, J. A. (2012). Patients' perceptions of their illness: The dynamo of volition in health care. Current Directions in Psychological Science, 21(1), 60-65.

8. Molloy, G. J. (2020). Can personality be a health risk factor? A critical review. Social and Personality Psychology Compass, 14(5), e12529.

9. Pierret, J. (2003). The illness experience: State of knowledge and perspectives for research. Sociology of Health & Illness, 25(3), 22-74.

10. Jobling, J. (1988). Gender and social class: A case study approach. Croom Helm.

11. Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. JAMA, 286(15), 1897-1902.

12. Karvonen, A., Kyngäs, H., & Pölkki, T. (2018). The meaning of quality of life in patients being treated for advanced cancer: A qualitative study. Oncology Nursing Forum, 45(6), 823-831.

13. Chan, A. W. (2019). Narrative inquiry: Research tool and medium for professional development. The Asia-Pacific Education Researcher, 28(5), 355-364.

14. M&C Saatchi World Services. (Year). Draft Report: Experiences and Perceptions of COVID-19 Insecurities (Unpublished draft report). M&C Saatchi World Services.

15. Navarro, V., & Shi, L. (Eds.). (2006). The political context of social inequalities: Consequences for health and quality of life. Baywood Publishing Company.

16. Laumbach, R., Kipen, H., & Kelly-McNeil, K. (2021). Respiratory health effects of air pollution: Update on biomass smoke and traffic pollution. Journal of Allergy and Clinical Immunology, 139(1), 13-25.

17. Bhugra, D., & Jones, P. (2023). Mental health and illness in the social context. Cambridge University Press.

18. Karvonen, A., Kyngäs, H., & Pölkki, T. (2018). The meaning of quality of life in patients being treated for advanced cancer: A qualitative study. Oncology Nursing Forum, 45(6), 823-831.

19. Smith, J. (2022). Understanding health behavior: The role of social psychology. Routledge.

20. Calvillo, D. P., & Ross, B. J. (2020). Social identity and health: Contributions to the study of personal identity and cultural adaptation. Springer.

21. Herian, M. N., Shank, N. C., & Vessey, J. T. (2014). Perceived health risks, environmental concerns, and intentions to visit a healthcare professional: The role of political party affiliation. Journal of Health Psychology, 19(2), 227-236.

22. Alexander, B. K., Riley, E. A., & Reynolds, K. A. (2022). Narrarchives of chronic pain: A qualitative study. Pain Management Nursing, 23(1), 17-26.

23. Gadarian, S. K., Goodman, S. W., & Pepinsky, T. B. (2021). Partisan perceptual bias and the information environment. Journal of Politics, 83(3), 729-742.

24. Motta, M., Stecula, D., & Farhart, C. (2022). How right-leaning media coverage of COVID-19 facilitated misinformation and political polarization in the early stages of the pandemic in the U.S. Canadian Journal of Political Science, 55(1), 41-65.

25. Alang, S. M., McAlpine, D. D., & Hardeman, R. R. (2017). Police brutality and black health: Setting the agenda for public health scholars. American Journal of Public Health, 107(5), 662-665.

26. Armstrong, K., Ravenell, K. L., McMurphy, S., & Putt, M. (2013). Racial/ethnic differences in physician distrust in the United States. American Journal of Public Health, 103(1), 128-133.

27. Boulware, L. E., Cooper, L. A., Ratner, L. E., LaVeist, T. A., & Powe, N. R. (2003). Race and trust in the health care system. Public Health Reports, 118(4), 358-365.

28. Brondolo, E., Gallo, L. C., & Myers, H. F. (2009). Race, racism, and health: Disparities, mechanisms, and interventions. Journal of Behavioral Medicine, 32(1), 1-8.

29. Utsey, S. O., Adams, E. P., & Bolden, M. (2000). Development and initial validation of the Africultural Coping Systems Inventory. Journal of Black Psychology, 26(2), 194-215.

30. Shen, C., Aarnio, M., & Willms, J. D. (2018). Learning and knowledge application in health literacy interventions for aging immigrants. Journal of Applied Gerontology, 37(3), 275-301.

31. Wilkin, H. A., & Ball-Rokeach, S. J. (2006). Reaching at-risk populations in a participatory communication and civic action project for health promotion: The healthy eating and lifestyle program (HELP) initiative. Journal of Health Communication, 11(3), 313-334.