

A New Perspective on Racism and Health: How White Men are Hurt By Their Own

Racial Attitudes

By

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INTRODUCTION

Over the past two decades, men's health has become a topic of continuously growing interest among researchers, policy makers, and clinicians. Accordingly, this increased focus on men's health has resulted in the production of a breadth of knowledge and more structured interventions pertaining to men's health issues. However, even today, the state of men's health in the U.S. is still significantly worse than the health of women- as the gender disparity in health outcomes continues to persist. For example, men in the U.S. are more at risk for hypertension, are more likely to get cancer, and have lower life expectancies than their female counterparts (Williams 2003). There is an abundance of evidence supporting that a major underlying contributing factor to these disparities is that men are much less likely to seek preventive care than women, which can be largely attributed to the hegemonic masculine ideology engrained in so many men, which influences them to not consider their own health a priority (Springer and Dawne 2011). Additionally, men of low SES are even less likely to seek preventive health measures than men of high SES (Lorant, Humblet and Deliége), and consequently, are at a particularly high risk for poor health outcomes in comparison to men of high SES (Williams 2003). The intersection of SES and gender is important to consider, as both hegemonic masculine ideology and limited access to quality healthcare resources put men of low SES at a clear disadvantage in regards to health outcomes. However, recent changes in U.S. health care policy have the potential to help reduce gender and SES health disparities.

The passage of the Affordable Care Act (ACA) in 2010 represents a historic moment in the United States. Under this policy, every American citizen is guaranteed access to health care (Kocher, Ezekiel, and DeParle, 2010). One major selling point of the plan is that many free preventive services- such as cancer screenings, diabetes screenings, and immunization vaccines are available for no cost (Healthcare.gov). By providing men with incentive to visit their doctors and access to treatments they otherwise might not have been able to afford, the ACA can potentially help reduce gender and SES disparities in health. However, despite the obvious benefits, the nation is clearly divided in its opinion on the ACA. Since the ACA is designed to help low income Americans access healthcare services they otherwise might not be able to afford, the split in opinion might be conceptualized as SES-based. Additionally, researchers have argued the divide is political, with democrats being in favor of the ACA and republicans rejecting it (Brodie, Deane and Cho 2011). However, the most powerful predictor for one's stance on the ACA is, in fact, race. Simply put, black men are overwhelmingly in support of the ACA and white men are overwhelmingly against it (Tesler 2012). Together, this all alludes to the fact that, paradoxically, low SES white men still oppose this policy even though it is designed to benefit them. This discrepancy raises a major question- why is it that white men of low SES oppose the ACA even though it can benefit them both economically and biologically?

Ultimately, this paper will provide a unique perspective on the health consequences of prejudice. It is well established that racism hurts the health of black men in the United States. Perceived discrimination and racial prejudices felt by Blacks causes

increased levels of stress exposure (Williams and Mohammed 2009). Consequently, increased stress exposure can be detrimental to the physical health of black men both directly, as allostatic load from stress have been shown to lead to a variety of health problems, and indirectly- as coping methods to combat stress such as smoking, poor diet, and drug use also lead to negative health consequences (Mezuk et al. 2013). However, this paper will reveal that white men are hurt by their negative racial attitudes towards Blacks as well. To do so, this paper aims to: (1) expose the underlying causes of the racial polarization of the ACA 2) illustrate the subtle, yet unmistakable coded rhetoric used by white men to mask the racist nature of opposition to the ACA; and (3) demonstrate that this coded rhetoric is used by low SES white men in arguments against the ACA. On the whole, this paper asserts that low SES white men are hurt by their own prejudices: they are not objects of discrimination, yet their rejection of the ACA illustrates that racial prejudices trump both their economic and biological self-interests.

LITERATURE REVIEW

Race relations in the United States have a long, sordid history. Although policy changes throughout the history of the United States reflect a shift towards racial equality, discrimination against and marginalization of Blacks has endured. The period of slavery marked a time when an egregious two-caste system existed in which Blacks were considered little more than property to Whites. In the Reconstruction era that followed, Blacks were granted their freedom; however, the Jim Crow system that developed in following century still legalized racial

segregation and discrimination. The civil rights revolution marked the end of Jim Crow and the two-caste system of racial relation- effectively replacing it with a formal system of equality in the United States (Sears et al. 1997). Nonetheless, racism still persists in society today- it has just simply taken a new, more subtle form.

The elimination of Jim Crow also resulted in a decline in its supporting ideology. This ideology, called “old-fashioned racism”, includes belief in the biological inferiority of Blacks and support for racial segregation and discrimination (Sears et al. 1997). In today’s society, openly expressing negative racial sentiments is considered backwards and condemnable. Most white Americans appear to support the ideals of racial equality and true integration; however, many of these same white Americans openly reject the implementation of specific policies designed to alleviate racial disparities in today’s society- such as the gaps in health and wealth (Rabinowitz et al. 2009). This “principle-implementation gap” is indicative of a new, implicit form of racism that perpetuates the ideologies of old-fashioned racism (Rabinowitz et al. 2009). The new form of racism, known as “symbolic racism”, allows Whites to express racist ideologies in a politically correct manner: through the opposition of policies they conceptualize as unjustly aimed to help Blacks- such as Affirmative Action and opposition to bussing (Sears et al 1997).

According to Sears and Henry 2003, symbolic racism is, “described as a coherent political belief system whose content embodies four specific themes: the belief that

(a) Blacks no longer face much prejudice or discrimination, (b) Blacks' failure to progress results from their unwillingness to work hard enough, (c) Blacks are demanding too much too fast, and (d) Blacks have gotten more than they deserve". The term *symbolic* represents how the form of racism targets Blacks as an abstract, collective group and has roots in abstract moral values (Sears and Henry 2003). In other words, symbolic racism evolved from a blend of two equally contributing components. First, the "anti-black affect" describes the feelings Whites harbor towards Blacks: it is not feelings of hatred or hostility, but instead, feelings of discomfort, uneasiness, disgust, and fear (Sears and Henry 2003). The second component is deeply rooted in American history- it is the traditional, conservative American moral ideology embodied in the protestant work ethic, particularly individualism: the belief that hard work equals success (Sears and Henry 2003). Combined, the "anti-black affect" and individualism form a distinctive psychological construct known as the "racial resentment framework" -the belief that Blacks violate traditional nonracial values (Byrd, Saporta, & Martinez 2011). The racial resentment framework and symbolic racism appear to be very similar; however, the distinction is that symbolic racism mediates the effects of racial resentment on racial policy preferences- as symbolic racism gives political meaning to the psychological predisposition (Sears and Henry 2003).

However, symbolic racism does not just impact white's racial policy preferences; it also has a slightly weaker, yet still highly pertinent influence on Whites attitudes towards policies that are inherently nonracial. Recent studies have demonstrated

that symbolic racism also influences Whites' opposition to policies that are more racially ambiguous (Rabinowitz et al. 2009). Literature has provided strong evidence that negative racial attitudes- such as the stereotype of Blacks as "lazy"- lead Whites racialized social welfare policies such as food stamps, disability, and unemployment (Gilens 1995). Thus, Whites reject welfare policies out of the belief that the policies facilitate the lazy behavior in Blacks and give Blacks more than they deserve as a group.

Accordingly, the concept of symbolic racism can provide insight as to the racialization of the Affordable Care Act. As mentioned before, symbolic racism has a stronger influence Whites' opposition towards policies explicitly designed to help Blacks than policies whose beneficiaries are racially ambiguous (Rabinowitz 2009). However, literature supports that President Obama's strong association with the ACA substantially polarizes opinions on the policy by race and racial attitudes (Tesler 2012). Studies have provided a solid foundation of evidence demonstrating the racialization of the ACA; revealing that, although more Americans were in favor of health care reform than opposed to it, a majority of Whites oppose it and a majority of Blacks are in favor (Byrd, Daniels, and Saporta 2011; Tesler 2012). Additionally, studies have demonstrated that Whites are much more accepting of the principles of the ACA when they were framed as president Clinton's 1993 health reform efforts- indicating that feelings towards the policy are based on race and racial attitudes, not partisan reasons (Tesler 2012). Furthermore, data analysis revealed that the racial resentment framework is directly correlated with stance on

the ACA; the stronger the feelings of racial resentment, the more likely they were to view the ACA negatively (Byrd, Daniels, and Saporta 2011). Thus, the ACA is a particularly appropriate subject for the study of symbolic racism, as there is a clear racial divide in attitudes towards this highly controversial policy.

Although current research on symbolic racism has yielded significant evidence supporting the theory's validity, it has been met with critique that reveals particular opportunities to advance the knowledge on the subject. Studies have consistently demonstrated that symbolic racism has a significant impact on Whites' policy preferences, even when controlling for other confounders such as political conservatism, attitudes towards government, and/or attitudes towards redistributive government policies (Sears et al. 1997; Sears and Henry 2003; Rabinowitz et al 2009). However, a salient critique of contemporary studies on symbolic racism is that their findings do not address the notion that opposition to social welfare policies does not necessarily indicate that an individual is a symbolic racist (Sniderman and Tetlock 1986). Criticism of existing studies reveals a serious gap in the understanding of symbolic racism; thus far, research has demonstrated how symbolic racism impacts political thinking, but has failed to consider how to identify symbolic racism in the context of political debate and how it is distinguishable from other motivations for rejection of welfare policies. This is largely due to methodological issues of current studies: the mutual shortcoming of contemporary research is a result of reliance on interpretation of hard data solely from surveys, questionnaires, and polls. Consequently, studies have produced little

insight regarding the dialogue of symbolic racism. Thus, this paper asserts that the deficiency in knowledge of symbolic racism can be addressed by evaluating how the ideology is expressed in the rhetoric of Whites' opposition to welfare policies.

As previously mentioned, symbolic racism is the mediator between Whites' racial resentment and rejection of welfare policies- masking the underlying racial basis for their rejection. Thus, in debate over the ACA, there might be a coded rhetoric to symbolic racism that enables Whites to veil the true nature of their opposition. Exposing this coded rhetoric would enable this paper to examine symbolic racism in a lexical context. Consequently, evaluating when and how it is reflected in debate can answer pertinent unknown questions regarding symbolic racism, including: What is the frequency of symbolic racism in policy debate? What types of people use symbolic racist language? What facilitates symbolic racist language/ what tempers it? And, how, if at all, does this alter the current understanding of symbolic racism?

METHODS

Samples

In order to evaluate the linguistics of symbolic racism, this study utilized two separate sources that debated the Affordable Care Act. First, three semi-structured focus groups were conducted in 2013 in Nashville, TN. Members were recruited with the goal of obtaining a group of participants representative of diverse segments of working-class men. They were recruited from community based local organizations, churches, nursing homes, rec centers, work sites, community political

events, and sporting events in effort to reach working class white men who represent a myriad of perspectives and backgrounds. Each of the three groups contained 6-12 participants, who were asked questions regarding general health, race, masculinity, and American health policy. The focus groups were then transcribed and transcriptions were used for analysis.

Additionally, this study analyzed a public opinion poll from the website, *debate.org*. The poll probed the question, “Is the passing of Obamacare bad for the American public?” With hundreds of respondents, 72% voted “yes”, while the remaining 28% voted “no”. After voting, each participant was required to provide a minimum 50-word defense of his or her stance, each of which was immediately posted directly on the page under the “comments” section for the public to view. 100 comments from those who voted “yes” were randomly selected for evaluation.

Measures

In order to analyze the lexical context of symbolic racist ideology, I developed a code by integrating concepts from contemporary literature. The code was applied to both samples to explore when and how symbolic racism was used in discussion of health politics. The code consists of four salient verbal indicators of symbolic racism in the debate surrounding the Affordable Care Act. Descriptions of indicators are provided below.

1) The “O-Word”

"Obama and Biden= Osama Bin Laden. He's a socialist and is ruining this country. He loves war and isn't even a U.S. citizen. He's a fraud. He uses drones to kill people in Arab countries and claims he is nothing like Bush. He doesn't care about your wealth or safety and Obamacare is just a way to tax everybody and force you to live like a slave." - Anonymous comment from debate.org public opinion poll

On October 1st, 2013, the television program, *Jimmy Kimmel Live!*, aired a segment called "Six of One". For this bit, Kimmel sent a crew out on the streets to ask people the simple question: "Which is better, the Affordable Care Act or Obamacare?" Obviously, as Kimmel explains, "Obamacare is just a nickname for the Affordable Care Act; they're the same thing". However, the results of this social experiment were quite telling, as the white people who were approached overwhelmingly favored the Affordable Care Act over Obamacare. Participants had some harsh words for Obamacare- claiming it is "anti- American", "socialist", and "forcing everybody to pay"- while at the same time, being much more accepting of the "more American" and "more affordable" Affordable Care Act. Moreover, they agreed with tenets of Obamacare when asked about them separately from the policy- such as insurance companies not being able to exclude those with preexisting conditions, young people being allowed to stay on their parents policies till they are 26, and companies with 50 or more employees providing health care- yet were still quick to dismiss Obamacare as a whole.

While this social experiment was used for comedy, it actually exemplifies a more serious issue. That is the “O-Word”-Obama- has a powerful impact on the collective thought process of White America. For many Whites, it seems as if the sheer mention of the “O-Word” in relation to a policy results in blind disdain towards the policy, regardless of personal beliefs or self-interest. The influence the “O-Word” has on Whites is particularly relevant to the current health care debate, as studies have provided substantial evidence that President Obama’s strong association with health care reform polarizes public opinion on the topic by race and racial attitudes (Tesler 2012). While some researchers have argued that racialization of health care debate is caused by Obama’s political party affiliation, studies have demonstrated that health care policies were substantially more racialized when attributed to President Obama than when those same proposals were framed as President Clinton’s 1993 health reform efforts- indicating that Whites’ negative feelings towards the policy are not rooted in partisanship, but instead, reflective of their racial attitudes (Tesler 2012). This indicator aims to identify how the apparent toxicity of the “O-Word” for white people is reflected in and permeates through the debate surrounding the ACA. It considers the following potential markers: (a) the use of “Affordable Care Act” vs. “Obamacare” (unless responding to a question that uses the term “Obamacare”), (b) “name calling”: use of ad hominem arguments directed at President Obama as justification for opposition to the ACA, and (c) Agreement with individual tenets of ACA and subsequent rejection of policy. Further, the indicator evaluates how the “O-Word” may catalyze racial language in Whites.

2) Racial stereotypes as proxy for race

“Obamacare sucks because once again the liberals want to take from hard working Americans and give it to lazy, stupid people...Why do I have to pay for a bunch of ghetto gang bangers who would rather sell drugs and cause trouble then go out and get a job.” – Anonymous comment from debate.org public opinion poll

In the United States today, saying things that sound or can be perceived as racist is considered taboo to most. However, that does not mean Whites do not talk about race in public; instead they cloak their racial views through the avoidance of direct racial language (Bonilla-Silva 2002). In other words, Whites conceal racial dialogue by omitting words such as “black” or “African American”. Yet, there might be other terms that Whites utilize as substitutes for race in order to continue racial discussion in a more socially acceptable manner. This indicator explores the use of racial stereotypes as a substitute for race in Whites’ opposition to the ACA.

Although political correctness has become a cultural norm in the United States, stereotypes about Blacks are not fading (Devine and Elliot 1995). Studies have demonstrated that stereotypes of Blacks, especially that of Blacks as “lazy”, have a profound impact on political thinking in Whites (Gilens 1995). As discussed earlier, one component of symbolic racism- “the anti-black effect”- describes how Whites’ negative attitudes towards Blacks (which are founded in longstanding, culturally

constructed stereotypes) contribute significantly to their opposition to social welfare policies (Sears et al. 1997; Sears and Henry 2003). Specifically, negative stereotypes of Blacks lead to the notion amongst Whites that Blacks abuse the system by exploiting government programs. This indicator evaluates how the anti-black effect is embodied in rhetoric surrounding the ACA debate; racial nature of arguments are masked through the use of racial stereotypes as a proxy for race. The list of terms considered to be signals of indirect racial language include (but are not limited to) the following: the stereotypes of Blacks as- lazy, poor, unemployed, unintelligent/uneducated, violent, criminal, urban, ghetto, and drug users. It is important to note that the more of these terms present in a statement, the stronger the indication of symbolic racism.

3) "Us vs. Them": Assertion of unfairness and perceived racial difference in values as proxy for race

"We should not have to pay for others to have insurance. Whatever happened to people having to work for what they have? Obamacare is going to be the downfall to American society" – Anonymous comment from debate.org public opinion poll

The American Dream is often considered the defining characteristic of the country's culture. Many citizens take pride in the notion that anyone in the U.S. can be successful through hard work and determination- as they consider individualism to embody the spirit of the "land of opportunity". However belief in this traditional

American value leads some Americans to also believe in the reverse- that lack of success is a result of not working hard enough. This indicator considers how many Whites believe that Blacks as a group violate this traditional American value and, consequently, attribute “un-Americanness” to Blacks and social welfare policies they perceive as unfairly beneficial to Blacks.

As mentioned earlier, the racial resentment framework- the psychological root of symbolic racism- is the belief among Whites that Blacks fail to live up to the traditional American values; they believe Blacks as a group do not work hard, so they are unsuccessful (Sears and Henry 2003; Byrd, Saporta, and Martinez 2011). Accordingly, racial resentment also leads to bitterness towards social welfare policies, as it induces the notion that these policies unjustly facilitate lazy behavior in Blacks. This indicator is used to analyze the lexical manifestation of the racial resentment framework in opposition to the ACA. Markers for this indicator include the following: (a) distinguishing self as “hard working”/“American”, (b) General reference to “others” who unfairly benefit from the hard working Americans, and (c) Description of ACA users as “entitled” and/or “un-American”.

4) Comparison of ACA to other social welfare programs

“People who support ObamaCare are probably using food stamps, government housing, unemployment, and all those entitlements.”- Anonymous comment from debate.org public opinion poll

Finally, the last indicator simply considers how association of the ACA to other social welfare policies in opposition to the policy exemplified hidden racial rhetoric. Literature supports that symbolic racism predicts Whites' opposition to social programs whose beneficiaries are racially ambiguous (Rabinowitz et al. 2009). Additionally, studies have illustrated that racial attitudes are the most important source of opposition to welfare policies such as unemployment, food stamps, and disability (Gilens 1995). This indicator evaluates how comparison of the ACA to other social welfare policies as justification of opposition implicitly reflects racial foundation of disdain towards the policy. Policies considered include, but are not limited to: welfare, unemployment, food stamps, and disability.

It is important to note that separately, each indicator does not provide strong evidence of symbolic racist language. However, evidence of symbolic racism in rhetoric of opposition to the ACA becomes stronger with the presence of multiple indicators and/or higher frequency of use in arguments.

RESULTS

The findings from this study confirm my hypothesis. Results suggest that there is a coded rhetoric to symbolic racism prevalent in debate surrounding the Affordable Care Act and that this coded rhetoric is dominant in low SES Whites' justification for opposition to the policy, indicating that racial prejudices trump both their biological and economic self-interest.

Public Opinion Poll

First, the code was applied to the aforementioned randomly selected debate.org public opinion poll comments to evaluate the frequency of symbolic racist language in justification of opposition to the ACA. Out of the 100 posts, 3 were omitted from evaluation, as they were arguments supporting the ACA. For the remaining posts, 63 out of 97 (about 2/3) utilized at least one indicator of symbolic racism to validate opposition to the ACA. To be more precise, 34 contained no indicators, 24 contained exactly one indicator, 16 contained two, 16 contained three, and finally, 7 contained all four indicators. Further, out of the 40 comments that contained either one or two indicators, 24 were composed entirely of symbolic racist language as basis of opposition to the ACA. As a whole, the public opinion poll data validates the merit of my coding system, as each indicator was very prevalent in these comments. Consequently, it also demonstrates that coded rhetoric is frequently utilized in arguments against the ACA- indicating that much of the opposition to the policy is rooted in symbolic racism.

Focus Groups

Coding the focus groups resulted in two key findings. (1) White men were all overwhelmingly against the ACA, and (2) There was an inverse relationship between SES and prevalence of symbolic racist language: this language was seen frequently in arguments in the low-income group, occasionally in the low/middle-income group, and very rarely in the high-income group. The findings support my

hypothesis that coded symbolic racist rhetoric is dominant in low SES Whites' justification for opposition to the ACA, indicating that racial prejudices trump both biological and economic self-interest.

My hypothesis was further supported by analyzing the contrasting language used by white men before and after the mention of Obamacare. During the focus groups, before being asked to discuss Obamacare, participants were first asked about their opinions regarding what role the government should play in promoting health. The differences in language pre- and post- Obamacare mention were particularly revealing, as the shift in arguments and language was radically different for each group.

First, for the low-income group, there were dramatic differences in the discussion before and after Obamacare was mentioned. When asked about what role government should play in promoting health, the conversation immediately turned to insurance. However, while not explicitly mentioning the Affordable Care Act, the group surprisingly agreed that government should provide insurance, as participants claimed- "Government needs to give us insurance... some companies don't even offer insurance"; "we should have a healthcare plan for people that's really sick"; and, "[government should provide insurance for] people that already have a preexisting condition". This is incredibly noteworthy that before the mention of the Obamacare, this group was supportive of certain tenets of the act and government provided insurance as a whole. They did express some concerns with

the new government insurance policy, mainly complaining that, “they’re trying to force everybody to have some kind of insurance”, and “you’ll get fined for it if you don’t [have it]”. This too is crucial, as their reasons for opposition to government health care sound distinctly different when discussing the ACA.

In contrast, the conversation for the low-income focus group became incredibly racialized once Obamacare was mentioned. As a whole, this group overwhelmingly opposed the ACA and most arguments contained indicators of symbolic racism. Symbolic racist language was highly prevalent in their claims of who they believe benefits from the ACA, such as- “Its people who are able to work but don’t...they’re abusing the system”; “[people who] would rather sit home on the couch with their food stamps and their disability check; and, “Obama...Let Obama give up his paycheck”. Clearly, the rhetoric used here provides strong indication of symbolic racist language. Furthermore, the change the group’s dialogue about government insurance policy before and after the mention of Obamacare was particularly telling. For one, most definitely agreed with tenets of the ACA when discussing the general idea of government providing insurance; however, they all strongly opposed the ACA. Additionally, while before Obamacare was mentioned, they were displeased with the ultimatum of being forced to buy insurance or pay a fine; after, they expressed strong disdain towards the notion of the government taking their “hard earned money” and giving it to “these people who sit on the couch and get food stamps but are able to work”. Together, this all provides strong evidence that

opposition towards the ACA among the group of low-SES white men was racial in nature, indicating that their racial prejudices superseded self-interest.

Second, for the low/middle income group, there was some evidence of a shift to symbolic racist language after the mention of Obamacare; however, the evidence was much weaker than that of the low-income group. When asked about what role the government should have in promoting health, this group's consensus was clear. For the most part, they agreed that the government should have "no role whatsoever". Similar to the low-income group, they expressed frustration towards the government, angry that the government is "telling people that they have to buy insurance" and "gonna fine you if you don't have it". One participant claimed, "the government should make services available, but not required", but overall, the focus group was furious with the notion of being forced to buy health insurance or paying a fine.

In this group, Obamacare was discussed explicitly before they were asked, "who benefits from Obamacare?". However, while there were no indicators of hidden racial language before this question was posed, some indicators of symbolic racist language did begin to manifest when asked directly about Obamacare. For example, when asked who benefits, some participants claimed, "Obama", while also describing the policy as "socialism". Also, one participant used the words "indigence" and "uneducation" to describe beneficiaries. However, this group mainly cited fines for not having insurance and general mistrust in government as their

reasons for disdain towards the ACA. It is important to note that this group's strong opposition may very well have been rooted in symbolic racism. Yet, based on the coding system, the language surrounding the low/middle-income group's opposition provided sparse evidence of symbolic racism.

Lastly, for the high-income group, the language used was not altered after Obamacare was referenced. When asked about what role government should play in promoting health, there were a few sentiments shared by this group. The following quotes were selected from the group to represent the group's consensus views: "we individually, we're responsible for our health...we'd like the government to stay out of it"; "It's just the old adage that the government, every time they get involved in something and it's something that works, they're gonna screw it up"; and, "maybe a role of government should be research and providing information." Taken as a whole, the group agreed that government involvement in health care should be limited to promoting healthy behavior by providing the public with information. They were also receptive to government agencies that protect the health interests of the public- such as the FDA and the CDC, but not government programs that aim to improve the health of the public. Collectively, the high-income group expressed a general mistrust in the government and belief that the individual is ultimately responsible for his or her health.

Unlike the other groups, the mention of Obamacare did not result in a shift of dialogue for the high-income group. Instead, the justifications for their opposition to

the ACA were directly reflective of their blatant disdain towards government. For example, participants argued- “ [The government] messed up the insurance company. They talked about how bad our insurance situation was....they are the ones that messed it up”; “I’d like to compare it to the government running the post office and we know what happened there. Post office is bankrupt. I predict the same thing will happen with Obamacare”; and, “I see how much fraud is involved...I just don’t want the government controlling what I can take and who I should go see for medical care.” Also, they expressed logistical concerns with the ACA, such as- “you’re going to need so many more doctors and so many more nurses and there’s already a nursing shortage”. In general, these arguments reflect how, much like their opposition to government involvement in health care, opposition of the ACA stemmed from a general mistrust of government and disapproval how the government operates. Additionally, their assessment of who benefits from the ACA and who suffers was very significant. They did agree that they would suffer from the policy, claiming- “I may lose my insurance”, “my mother worries...they’re going to cut the senior citizens”, and, “its gonna probably raise our taxes”. However, unlike the other groups, no indicators of symbolic racism appeared when discussing who benefits, as they only claimed that “government employees” and “people who do not have insurance” would benefit from the ACA. Overall, for the high-income group, not a single indicator of symbolic racist language was present in opposition of the ACA, as arguments against the ACA were founded in distrust of government.

DISCUSSION

Interpretation of Results

As expected, the rhetoric surrounding low-SES Whites' rejection of the ACA did suggest that their opposition was racial in nature. However, while current literature asserts that Whites subscribe to symbolic racist ideology regardless of SES, the study provided little evidence of symbolic racism being reflected in the language of middle-income Whites, and none in the language of high-income Whites. There are a few possible explanations for this.

First, the language indicators might have just simply not shown up in the high- and low/middle- SES focus groups' discussions of the ACA. The individuals in the higher SES groups may have indeed subscribed to symbolic racist ideology, but did not convey that in their arguments. If more focus groups were conducted, it is very possible that a hidden racial rhetoric would be present in debate over the ACA for all SES-stratified focus groups.

Second, the distrust in government expressed by higher-SES groups might have been indicative of a more nuanced form of symbolic racist language that is beyond the scope of the coding system. Studies have found that, during the Obama administration, government distrust is racialized- Whites are much more likely to distrust the federal government than Blacks. Moreover, much of distrust amongst Whites stems from a belief that federal government providing "special favors" for black Americans (Warren 2012). Evidently, symbolic racism does contribute to

distrust of government for many Whites, suggesting that the anti-government sentiments expressed in the higher income groups might indicate their rejection of the ACA was rooted in symbolic racism. However, in the focus groups, the rhetoric of distrust in government seemed to be a more nuanced form of symbolic racist language, making it a weak indicator of symbolic racism. When discussing distrust in government as reason for opposition to the ACA, participants from the higher-SES focus groups did express opinions reflective of individualism by arguing that government should have no role in health care. Yet, there was a noticeable absence in evidence of racialized language in the higher-SES groups' discussion- thus making it difficult to contend that opposition to the ACA was rooted in symbolic racism for the higher-SES groups. The racialization of distrust in federal government needs to be further explored in order to better identify the specific lexical ways in which rejection of welfare policies through expression of anti-government sentiments might be reflective of symbolic racism.

Finally, symbolic racism might be amplified in those of low SES- as disdain towards the ACA may not just fueled by negative attitudes towards Blacks, but also frustration and insecurities about their own group position in society. In the focus group, the most salient argument against the ACA for low-income white men was that they felt it was unfair that they “have to work hard to earn money and the government takes it away and gives it to those who don’t work, but can”. For these low-income white men, it is clear that they are frustrated. Their arguments reflect how they feel that they have upheld the traditional American value of working hard,

but have not experienced the success that should come with it. Further, the symbolic racist language in their opposition to the ACA reflects how they blame Blacks for their lack of success- they feel as if they policy unjustly helps undeserving Blacks at their expense. Additionally, they express envy towards the rich, making claims such as, “its always rich people getting jobs” and the rich benefit from the ACA because “they can afford it”. Clearly, they feel that these policies exclusively hurt them, not the rich, amplifying their frustration even more. Jointly, these sentiments expressed by low-income Whites suggest that their disdain towards the ACA is intensified with frustration over their own position in society.

Limitations

My study had several limitations. For example, there are several methodological concerns with the use of focus groups. For one, focus groups often have one or several group members dominating the discussion. The opinion of the dominant members then becomes the dominant thought, with dissenting opinions being largely ignored (Smithson 2000). While this weakness was addressed by making the focus groups homogeneous, there did appear to be dominant voices in the group. Thus it is quite possible that other members of the group had different views that went unnoticed. In addition, it can be argued that focus groups occur in specific, controlled settings rather than as natural discussions. As a result, the opinions stated in focus groups do not necessarily belong to the individuals within the group or reflect the group as a whole, but instead, the opinions are socially constructed discourses that emerge in the context of the group (Smithson 2000).

My study would have benefited from more focus groups stratified by SES to further probe if differences in language used to reject ACA were actually related to SES or if they were simply a result of differing, isolated discourses. Lastly, due to both the small size and number of focus groups, there was no opportunity to reach a point of data saturation.

Second, the focus groups were conducted a few months before the ACA's insurance exchanges went live online in 2013. As this paper illustrated, much of the negativity white Americans felt towards the ACA at the time stemmed from uncertainties, anxieties, and misinformation about the policy. My study would have benefited from the inclusion of focus groups conducted more recently, as it would have been useful to observe if Whites are more informed about and/or less apprehensive towards the ACA two years later.

Third, the public opinion poll data has a few caveats. For one, since the responses are anonymous, there is lack of pertinent demographic information- such as race, gender and SES of commenters. Such information would have been incredibly useful for deeper analysis of symbolic racist language. Additionally, the question, "Is the passing of ObamaCare bad for the American Public?" is, obviously, stated in the negative. The framing of the question must be considered, as it gives a negative connotation to the ACA that might have influenced some respondents to vote "yes". It would be interesting to see if asking the question, "Is the passing of ObamaCare good for the American Public?" would yield different results more supportive of the

ACA. Furthermore, it would be interesting to consider if posing the question, “Is the passing of the Affordable Care Act good for the American Public?” might yield results even more supportive of the ACA- as the negative impact of Obama’s association with the ACA on public opinion of the policy is well established in this paper.

Furthermore, when utilizing data such as public opinion polls and focus groups, it is important to be wary of over interpretation and misinterpretation of comments. Although confirmation bias was considered when analyzing data, it is unavoidable and must be accounted for.

Finally, the potentially huge impact of masculinity on men’s opinions of the ACA needs to be addressed further. As mentioned earlier, men have much worse health behaviors and are much less likely to seek preventive health care than women, and a major underlying cause is that- simply put- men do not care about their own health. In the focus groups, one common frustration with the ACA was that men did not want to be “forced to pay for insurance they don’t need.” This collective sentiment reflects how many men might not see health insurance as a necessity and thus, oppose the ACA because they just do not care about the benefits the policy would grant them. Including separate focus groups composed entirely of women would have helped improve my understanding of how masculinity influences men’s attitudes towards the ACA

Future Research

Future research should further explore the hidden, racial rhetoric used by Whites in policy debate. The code constructed for this paper can be modified to evaluate the underlying racial language surrounding other welfare policies.

Furthermore, even though they may agree with parts of the ACA, it is clear that white men do not accept the policy as a whole. Future research should probe what Whites actually know about the ACA and what they like and dislike about the policy. With the Republic Party now controlling the House of Representative and the Senate, there is expected to be a major overhaul of the ACA. Understanding specifics of Whites' attitudes towards the ACA can have huge implications for revamping this policy in order to make it more widely accepted.

Implications

The findings of this paper have implications for the framing of the Affordable Care Act. Specifically, they suggest that white men might be more receptive to the Affordable Care Act if it was framed differently. First, this paper has built on evidence from existing literature that Obama's association with the ACA contributes greatly to distain towards the policy amongst Whites. Thus, this policy clearly needs to be called "The Affordable Care Act", and not "Obamacare" when targeting Whites. Second, the symbolic racist nature of rejection of the ACA by white men reveals that they do not feel the policy benefits them. So, Whites need to be educated on how the ACA can benefit them by advancing society as a whole. There is a vast amount of

research supporting the notion that greater inequality in a society leads to poorer overall population health (Wilkinson and Pickett 2006). Clearly, population health is an issue in the United States, as the country is ranked #34 in life expectancy. Presenting this information to Whites may persuade them that the Affordable Care Act is not just designed to help Blacks, but in fact, can make the United States healthier as a whole.

CONCLUSION

Through the analysis of coded language used by white men to reject the ACA, this paper provides evidence suggesting, for low-SES white men, racial prejudices trump both their economic and biological self-interests. This builds on the current understanding of racism in a few significant ways. First, while prior research did not consider the implications racism has for white people, this paper reveals a way in which white men can be hurt by their own racism. Second, this paper added to the current knowledge of symbolic racism by identifying how the theoretical construct can be tangibly identified in debate. By doing so, this paper has opened doors to a new field of study- the coded linguistics of racism today.

REFERENCES

Banks, Antoine J. "The Public's Anger: White Racial Attitudes and Opinions Toward Health Care Reform." *Political Behavior* 36, no. 3 (September 1, 2014): 493–514.
doi:10.1007/s11109-013-9251-3.

Blumer, Herbert. "Race Prejudice as a Sense of Group Position." *The Pacific Sociological Review* 1, no. 1 (April 1, 1958): 3–7. doi:10.2307/1388607.

Bonilla-Silva, Eduardo. "The Linguistics of Color Blind Racism: How to Talk Nasty about Blacks without Sounding 'Racist.'" *Critical Sociology* 28, no. 1–2 (January 1, 2002): 41–64. doi:10.1177/08969205020280010501.

Brodie, Mollyann, Claudia Deane, and Sarah Cho. "Report from the States: Regional Variations in Public Opinion on the Affordable Care Act" 36, no. 6 (December 2011): 1097–1103.

"Is the Passing of ObamaCare Bad for the American Public?" Debate.org. N.p., n.d. Web. 16 Nov. 2014.

Devine, Patricia G., and Andrew J. Elliot. "Are racial stereotypes really fading? The Princeton trilogy revisited." *Personality and Social Psychology Bulletin* 21 (1995): 1139-1150.

Gilens, Martin. "Racial Attitudes and Opposition to Welfare." *The Journal of Politics* 57, no. 4 (November 1, 1995): 994–1014. doi:10.2307/2960399.

Goodnough, Abby. "In Kentucky, Health Law Helps Voters but Saps Votes." *The New York Times*, September 16, 2014.

<http://www.nytimes.com/2014/09/17/us/politics/kentucky-elections-obama-health-care-act.html>.

Griffith, Derek M. "An Intersectional Approach to Men's Health." *Journal of Men's Health* 9, no. 2 (June 1, 2012): 106–12. doi:10.1016/j.jomh.2012.03.003.

"Preventive Care Benefits." *HealthCare.gov*. U.S. Centers for Medicare & Medicaid Services, n.d. Web. 16 Nov. 2014.

Kawachi, Ichiro, Norman Daniels, and Dean E. Robinson. "Health Disparities By Race And Class: Why Both Matter." *Health Affairs* 24, no. 2 (March 1, 2005): 343–52. doi:10.1377/hlthaff.24.2.343.

Kocher, Robert, Ezekiel J. Emanuel, and Nancy-Ann M. DeParle. "The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges." *Annals of Internal Medicine* 153, no. 8 (October 19, 2010): 536–39. doi:10.7326/0003-4819-153-8-201010190-00274.

Lawley, Erin. "Tennessee Men Receive Failing Grades on Health Report Card." Accessed September 22, 2014. <http://nashvillecitypaper.com/content/city-news/tennessee-men-receive-failing-grades-health-report-card>.

Lorant, V., B. Boland, P. Humblet, and D. Deliège. "Equity in Prevention and Health Care." *Journal of Epidemiology and Community Health* 56, no. 7 (July 1, 2002): 510–16. doi:10.1136/jech.56.7.510.

Mezuk, Briana, Cleopatra M. Abdou, Darrell Hudson, Kiarri N. Kershaw, Jane A. Rafferty, Hedwig Lee, and James S. Jackson. "'White Box' Epidemiology and the Social Neuroscience of Health Behaviors The Environmental Affordances Model." *Society and Mental Health*, March 27, 2013, 2156869313480892. doi:10.1177/2156869313480892.

Rabinowitz, Joshua L., David O. Sears, Jim Sidanius, and Jon A. Krosnick. "Why Do White Americans Oppose Race-Targeted Policies? Clarifying the Impact of Symbolic Racism." *Political Psychology* 30, no. 5 (October 1, 2009): 805–28. doi:10.1111/j.1467-9221.2009.00726.x.

Sabo, Don. "Men's Health Studies: Origins and Trends." *Journal of American College Health* 49, no. 3 (November 2000): 133–42.

Sears, David O., and P. J. Henry. "The Origins of Symbolic Racism." *Journal of Personality and Social Psychology* 85, no. 2 (August 2003): 259–75. doi:http://dx.doi.org.proxy.library.vanderbilt.edu/10.1037/0022-3514.85.2.259.

Sears, David O., Colette Van Laar, Mary Carrillo, and Rick Kosterman. "Is It Really Racism?: The Origins of White Americans' Opposition to Race-Targeted Policies." *The Public Opinion Quarterly* 61, no. 1 (April 1, 1997): 16–53.

Smithson, Janet. "Using and Analysing Focus Groups: Limitations and Possibilities." *International Journal of Social Research Methodology* 3, no. 2 (April 2000): 103–19.

Sniderman, Paul M., and Philip E. Tetlock. "Symbolic Racism: Problems of Motive Attribution in Political Analysis." *Journal of Social Issues* 42, no. 2 (July 1, 1986): 129–50. doi:10.1111/j.1540-4560.1986.tb00229.x.

Springer, Kristen W., and Dawne M. Mouzon. "'Macho Men' and Preventive Health Care: Implications for Older Men in Different Social Classes." *Journal of Health and Social Behavior* 52, no. 2 (June 1, 2011): 212–27.

Stephan, Walter G., Kurt A. Boniecki, Oscar Ybarra, Ann Bettencourt, Kelly S. Ervin, Linda A. Jackson, Penny S. McNatt, and C. Lausanne Renfro. "The Role of Threats in the Racial Attitudes of Blacks and Whites." *Personality and Social Psychology Bulletin* 28, no. 9 (September 1, 2002): 1242–54. doi:10.1177/01461672022812009.

Taylor, Marylee C., and Adriana M. Reyes. "The Impact of Local Black Residents' Socioeconomic Status on White Residents' Racial Views." *Social Science Research* 43 (January 2014): 16–29. doi:10.1016/j.ssresearch.2013.08.001.

Tesler, Michael. "The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race." *American Journal of Political Science* 56, no. 3 (July 1, 2012): 690–704.

Wade, Jay C., and Chris Brittan-Powell. "Men's Attitudes toward Race and Gender Equity: The Importance of Masculinity Ideology, Gender-Related Traits, and Reference Group Identity Dependence." *Psychology of Men & Masculinity* 2, no. 1 (January 2001): 42–50.

doi:<http://dx.doi.org.proxy.library.vanderbilt.edu/10.1037/1524-9220.2.1.42>.

Warren, Dorian T. "What Race Tells Us About Anti-Government Attitudes." *The Nation*, March 21, 2012. <http://www.thenation.com/article/166972/what-race-tells-us-about-anti-government-attitudes>.

Wilkinson, Richard G, and Kate E. Pickett. "Income Inequality and Population Health: A Review and Explanation of the Evidence." *Social Science & Medicine* 62, no. 7 (April 2006): 1768–84. doi:10.1016/j.socscimed.2005.08.036.

Williams, David R. "The Health of Men: Structured Inequalities and Opportunities." *American Journal of Public Health* 93, no. 5 (May 1, 2003): 724–31.
doi:10.2105/AJPH.93.5.724.

Williams, David R., and Selina A. Mohammed. "Discrimination and Racial Disparities in Health: Evidence and Needed Research." *Journal of Behavioral Medicine* 32, no. 1 (February 2009): 20–47.

doi:<http://dx.doi.org.proxy.library.vanderbilt.edu/10.1007/s10865-008-9185-0>.