

# Lay-Theories Reflect, Reproduce, Deny, and Acknowledge Racism: Explaining COVID-19 Racial Health Disparities in the United States

Grace N. Rivera<sup>1</sup>, Phia S. Salter<sup>2</sup>, Jaren Crist<sup>3</sup>, Michael Perez<sup>4</sup>, Masi Noor<sup>5</sup>, Rebecca J. Schlegel<sup>6</sup>, Ciara Cogger<sup>2</sup>

[1] *Psychology Department, University of Mississippi, University, MS, USA.* [2] *Psychology Department, Davidson College, Davidson, NC, USA.* [3] *Psychological Science Department, Gustavus Adolphus College, Saint Peter, MN, USA.* [4] *Psychology Department, Wesleyan University, Middletown, CT, USA.* [5] *School of Psychology, Keele University, Keele, Staffordshire, United Kingdom.* [6] *Department of Psychological and Brain Sciences, Texas A&M University, College Station, TX, USA.*

Journal of Social and Political Psychology, 2025, Vol. 13(2), 239–255, <https://doi.org/10.5964/jspp.10813>

**Received:** 2022-12-28 • **Accepted:** 2025-06-17 • **Published (VoR):** 2025-09-30

**Handling Editor:** Inari Sakki, University of Helsinki, Helsinki, Finland

**Corresponding Author:** Grace N. Rivera, 304 University Cir, University, MS, 38677, USA. E-mail: [gnrivera@olemiss.edu](mailto:gnrivera@olemiss.edu)

**Supplementary Materials:** Data [see [Index of Supplementary Materials](#)]



## Abstract

Lay-theories are sets of interconnected ideas people use to understand and explain their worlds. We used a reflexive thematic analysis to investigate participant-generated lay-beliefs about COVID-19 disparities between White and Black communities ( $N = 150$ ) and between White and Latinx communities ( $N = 145$ ) in the United States. We extracted six themes from lay-beliefs about COVID-19 racial health disparities: perceived non-compliance with guidelines, beliefs about biological health, the assumptions about cultural differences, concerns about working conditions, acknowledgement of structural barriers, and naming racism as the problem. Informed by Critical Race Psychology perspectives, we discuss how racism is reflected and reproduced in lay-beliefs about Black and Latinx communities by overlooking evidence-based realities, reproducing negative stereotypes and racist tropes, culturally pathologizing, positioning racial differences as biological, and/or denying the role of racism.

## Keywords

racism, lay-theories, health disparities, qualitative psychology, reflexive thematic analysis, critical race psychology, COVID-19

In March 2020, Bill Cassidy, a Louisiana state senator and medical doctor, sat down with NPR’s David Greene to discuss his state’s COVID-19 racial disparities. At the time of the interview, Black and Latinx<sup>1</sup> people had higher risks of exposure, less access to testing, and higher death rates after contracting COVID-19 ([Centers for Disease Control and Prevention \[CDC\], 2021a](#)). During the exchange, Greene pointed to systemic racism as a relevant factor for understanding these racial disparities, which Cassidy dismissed as “rhetoric”, pointing to pre-existing conditions like obesity and diabetes as a more fundamental problem, “no matter your race”. When challenged, Cassidy asserted, “But as a physician, I’m looking at science” ([Greene, 2020](#)) suggesting that his views on disparities were more objective and ostensibly race-neutral.

1) We use “Black” to refer to communities who trace their roots to Africa and the African diaspora, including the Caribbean; at times we use African American when data references that specific ethnic group. We use “Latinx” to refer to communities who trace their roots to various countries in the Western hemisphere extending from Mexico to South America, including the Caribbean; at times Latino/a is used interchangeably. We use “White” to describe people of European descent in the U.S. We use the term “People of Color” when referring broadly to U.S. minoritized racial/ethnic groups.



In the present work, we consider the lay-beliefs Americans hold about racial health disparities in COVID-19 through a critical race psychology lens and discuss how these explanations may serve to reflect, reproduce, deny, acknowledge, or work to counter racism in the United States (U.S.). Despite the senator's dismissal of systemic racism as a fundamental factor, research suggests that structural conditions (e.g., racial segregation) have produced inequitable community conditions in access to beneficial health education and quality healthcare (Johnson-Agbakwu et al., 2022). Although the CDC considers systemic racism a public health crisis necessary to understand ongoing disparities (Wamsley, 2021), scholars have noted that public narratives may align more with Senator Cassidy's views, blaming marginalized groups for their own disparities or presenting disparities without acknowledgement of historical inequalities that fostered these conditions (e.g., Kendi, 2020).

## Lay-Theories and Health Beliefs

Lay-theories are everyday reasonings people construct to help them make sense of their social worlds (Levy et al., 2006). These theories are influential in shaping individuals' attitudes and behaviors (Molden & Dweck, 2006). Prior research has taken both descriptive and predictive approaches in understanding lay-theories about a variety of psychological attributes, groups, and social issues (Zedelius et al., 2017).

In the health domain, lay-beliefs can influence perceptions of health and health-related outcomes. For example, lay-theories about obesity as due to diet (versus exercise) are related to lower food consumption (McFerran & Mukhopadhyay, 2013). People who endorse more incremental lay-theories (i.e., one is largely in control of one's own health) report greater COVID-19 protective behaviors like mask-wearing (Zhang & Kou, 2022). Importantly, lay-theories are not limited to views towards one's own health and behaviors. The lay-theories individuals hold about the causes, cures, and contributors to physical and mental health phenomena can guide group perceptions and attitudes. For example, lay-theories of self-control as fixed predicts negative perceptions of smokers and obese individuals (Freeman et al., 2013). Clinicians who endorse lay-theories of mental illness as genetically-based see their clients as less blameworthy for their condition, but also express less empathy (Lebowitz & Ahn, 2014).

Individuals also hold lay-theories about race and racism (e.g., Haslam et al., 2006; Rosner & Hong, 2010). For example, White and Black Americans may hold different lay-theories on what constitutes racism in the first place – White people are less likely to see subtle behaviors that reflect discomfort/unfamiliarity with Black people, or denials of current racism, as constituting racism (Sommers & Norton, 2006). Lay-theories about race can carry influential personal and social consequences. For example, biological and essentialist lay-beliefs about race predict more stereotypical attitudes towards racial minorities (Haslam et al., 2006) and greater acceptance of current racial disparities (Williams & Eberhardt, 2008). Given that lay-theories dynamically shape and reflect our understanding of health and racial perceptions, this integration seems valuable for understanding views on racial health disparities within COVID-19.

## A Critical Race Psychology Lens

Through the lens of a Critical Race Psychology (CRP) framework, we use lay-theories to examine how Americans reflect, reproduce, deny, or acknowledge racism in their beliefs about the causes of health disparities between marginalized groups and White people. CRP engages Critical Race Theory (CRT; Crenshaw, 1995) as an analytic framework to be applied in psychological science (e.g., Jones, 2024; Perez & Salter, 2020; Salter & Adams, 2013; Volpe et al., 2019). Articulations of CRP have highlighted six core tenets for understanding how race and racism continue to manifest in society including: racism as a systemic force, how neoliberal individualist discourse masks racism's role in society, societal change and stagnation as a function of interest convergence, possessive investment in Whiteness, intersectionality and matrices of oppression, and counter-storytelling as a tool for combating racism (Salter et al., 2024). All six tenets are relevant to this work, but two key intersecting ideas were especially helpful for our analysis: (1) racism is systemic, deeply embedded in the fabric of US society and (2) culturally-dominant narratives in the US—e.g., neoliberal discourses about individual choice, color-blindness, personal responsibility, and meritocracy—reproduce racism by obscuring racism's central role in structuring society. These dominant narratives appear race-neutral but functionally obscure the ongoing significance of racism and need for reparative action during crisis (e.g., Bonilla-Silva, 2022). CRP explicitly challenges these ostensibly identity-neutral narratives that minimize the impact of race and racism on our

perceptions and behaviors. Moreover, a CRP analysis prompts consideration of how perceptions of Black and Latinx communities are racially and culturally complex, shaped by both overlapping and divergent histories, experiences, and representations in the US.

Culturally-dominant narratives about race and racism can shape individual-level views of the world, which are then reproduced in individuals' preferences, attributions, and behaviors (see Salter et al., 2018; Skinner-Dorkenoo et al., 2023). While dominant narratives and lay-theories are distinct—the former being largely expressed in cultural products, institutions, and social representations, the latter being expressed by individual actors—they are mutually constituted (e.g., Markus & Kitayama, 2010). For example, existing dominant narratives about personal responsibility in the US government, media, and popular health campaigns promote views of poor health outcomes as the result of individual choices that are independent of structural forces (Hook & Markus, 2020). In turn, people offer advice, support policies, and troubleshoot problems in line with those views. People's beliefs and choices develop within the cultural and social context and the context reflects those views. In the US, colorblindness can manifest in four key ways: using abstract language to discuss race or racism, naturalizing racialized outcomes, attributing racial differences to cultural practices, and minimizing racism (Bonilla-Silva, 2022). Thus, people may generate individual level lay-theories that integrate existing narratives about race to fit the present context of COVID-19.

Given the long history of discriminatory practices, abusive experimentation, implicit bias, and institutionalized policies that harmed Americans of color (Feagin & Bennefield, 2014), a CRP framework may be particularly useful for examining racial health disparities. Recent research suggests greater perceptions of health disparities (i.e., perceiving COVID-19 as impacting People of Color worse) among White Americans predicts less COVID-19 fear, which in turn predicts reduced support for COVID-19 safety precautions (Skinner-Dorkenoo et al., 2022). A critical implication of this research is that the consequences of conversations around COVID-19 are not race neutral; the racialized context in which they are discussed have social, psychological, and policy implications. Volpe and colleagues (2019) suggested that psychology could address racial health disparities by using CRT to conceptualize health disparities within historical, social, and contextual frames that acknowledge racism. While Volpe and colleagues focus on psychology as a field, it is also important for psychologists to consider how racial health disparities are discussed and deployed broadly.

## Overview

We conducted a qualitative study where we asked people to share possible reasons for racial health disparities during COVID-19<sup>2</sup>. We focused on two key research questions: What are the lay-theories that people use to make sense of racial health disparities (RQ1) and how do these lay-theories reflect, reproduce, deny, acknowledge, or counter racism (RQ2)? We chose an exploratory, inductive approach to this research and examined the lay-theories using a critical, identity- or race-conscious lens (Adams & Salter, 2011). Our analysis focuses on how explaining and rationalizing racial health disparities might reveal the everyday operation of racism in the context of an ongoing global pandemic.

## Positionality

The research team included psychologists with various racial and gender identities, career stages, and qualitative research experience, each intrinsically tied to our subjective positions as researchers. Five researchers have conceptions of race grounded in the U.S. who identify as White and Latina, a Black woman, a Black man, a Latino, and a White woman. Two researchers' conceptions of race were influenced by experiences living in the United Kingdom and/or Afghanistan. One identifies as a Person of Colour and a member of multiple minoritized groups. The second identifies as a White woman. Coming into this research, all members of the research team shared the perspective that racial disparities in COVID-19 outcomes are influenced by foundational racism in the United States.

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2) This qualitative study relies on data that were originally collected for a larger research project. The project included quantitative data that were not analyzed in this study.

## Method

### Participants

A sample of 298 U.S. Americans were recruited for a larger research project. We included 295 participants ( $M_{\text{Age}} = 38.1$  years,  $SD = 14.4$ ; range 18-77 years) who answered the key open-ended question. Psychology undergraduates ( $n = 42$ ) received participation credit and Amazon Mechanical Turk workers ( $n = 253$ ) received \$1.25<sup>3</sup>. Reported racial/ethnic background included 214 White/European Americans, 21 Hispanic/Latinx Americans, 19 Black/African Americans, 17 Asian/Asian Americans, 17 Multiracial individuals, two Native American/Alaskan Natives, one Native Hawaiian/Pacific Islander, one Not listed, and three missing responses. There were 145 women, 142 men, one Transgender man, one non-binary individual, three undisclosed, and three missing responses.

### Procedure

After providing consent online, participants either responded to a prompt about disparities between Black and White Americans ( $n = 150$ ) or disparities between Latinx and White Americans ( $n = 145$ ). This open-ended prompt read:

“In the United States, Black [Latino] communities are experiencing worse outcomes due to COVID-19 (e.g., higher death rates, higher rates of hospitalization) than their White counterparts. What are all the possible reasons this illness impacts Black [Latino] communities differently? Take a few minutes to generate at least 3 reasons you can think of. These can be reasons that you personally believe are true or reasons that other people might believe are true.”

Then, participants answered questions for the quantitative survey. Data were collected June through July 2020 (prior to vaccine development; coinciding with nationwide Black Lives Matter protests). Texas A&M University’s Institutional Review Board approved the study. For full text responses see [Rivera et al., 2025S](#). Responses ranged from one word (e.g., “Racism”) to 181 words (e.g., a paragraph detailing five distinct reasons;  $M = 35.54$  words,  $SD = 26.36$  words). Participants often mentioned at least three reasons; even among the 29 responses that were 10 words or less, participants identified an average of two reasons, with 11 participants identifying three reasons.

### Analysis

We used a reflexive thematic analysis ([Braun & Clarke, 2022](#)) and a collaborative coding approach ([Cornish et al., 2013](#); [Saldaña, 2013](#)). Philosophically, our analytic approach is aligned with constructivist perspectives in that we understand our participants, their responses, and ourselves as actively co-constructing meaning in relation to existing systems of power (e.g., [Ponterotto, 2005](#)). Although our data was collected within a positivist research paradigm (see [General Discussion](#)), we approached our analysis with relativist assumptions that there would be multiple meanings embedded in the lay-theories. Our goal was to extract meaning from the different lay-beliefs expressed with respect to our research questions. Using the systematic procedures of thematic analysis, we analyzed the data in six phases ([Braun & Clarke, 2006, 2013](#)).

Phase 1 included familiarization with the data by team members who made notes and observations about the data. After Phase 1, we decided the approach to coding would be primarily inductive and data-driven, and that we would consider each listed reason on its own, rather than focusing on each participant (i.e., one participant could generate multiple, seemingly incompatible lay-theories). We also decided to use collaborative coding where two non-independent coders worked together to sort and code each dataset. Coding teams were made up of insider-outside pairs ([Cornish et al., 2013](#)) with one member identifying with the group experiencing the disparity; Rivera and Noor coded participant re-

3) We retained responses from these two sources because we wanted to consider a range of possible responses from US adults. The residential college sample provided access to a sample experiencing the COVID-19 pandemic often away from home, while the crowdsourced sample allowed for a wider age range. The college student ( $M = 3.81$ ,  $SD = 1.74$ ) and crowdsourced samples ( $M = 3.47$ ,  $SD = 1.82$ ) were similarly politically-oriented (near midpoint, but slightly liberal on 1-7 scale;  $t(290) = 1.12$ ,  $p = .26$ ).

sponses to the Latinx-White disparities prompt, and Salter and Schlegel coded participant responses to the Black-White disparities prompt. Pairs were able to discuss responses from different vantage points as a part of the analytic process and whenever they came up, dual meanings or divergent interpretations were part of our analyses (e.g., “They stay together” could mean a living situation or they are always around each other). When notable divergent interpretations were generated within a coding pair, they were brought to the research team. When multiple interpretations were deemed meaningful, we included them in our analysis. In other instances, a shared interpretation emerged after discussion.

Phase 2 included three steps: (1) coding teams generated initial codes from the first third of respondents with QDA Miner-Lite software; (2) the research team met to discuss initial codes across the two coding teams; (3) the remaining two-thirds of responses were coded incorporating feedback and insights from the research team. In Phase 3, the research team met to sort the codes into potential themes and track overarching patterns. To audit our assumptions, values, and positionalities, we wrote and discussed what surprised us, intrigued us, and disturbed us about the codes as a part of our reflexive, analytic process. After the initial sorting was completed, individual team members added notes and brief descriptions of the potential themes. In Phase 4, coding teams checked whether the proposed thematic categories worked in relation to the data, and vice versa. Coding teams then drafted descriptions of the thematic categories and proposed names, drawing upon excerpts of data. Descriptions were discussed in team meetings and individuals provided feedback.

In Phase 5, we further developed the potential themes. First, team members considered RQ2 for each potential theme individually (i.e., writing their own notes), we then discussed and subsequently included these insights into our description of themes. Second, to codify defining features of each theme, we again checked tagged data against the overarching thematic categories. During our final write-up (Phase 6), our analysis remained iterative. We examined the Black/White and Latinx/White responses in conversation with one another; refined or pruned themes as needed; and where relevant, broadened our analysis from a descriptive to an interpretative level in relation to prior findings and public discourse.

## How Are Racial Disparities in COVID-19 Explained?

One goal of a CRP analysis is to explicitly examine and challenge ostensibly race-neutral narratives that minimize the impact of race and racism in society. We generated six overarching themes (see [Table 1](#)) that captured existing lay-beliefs about why Black and Latinx communities might be disproportionately impacted during the pandemic: 1) perceived non-compliance with guidelines; 2) beliefs about biological health and susceptibility, 3) assumptions about cultural values and lifestyle differences, 4) concerns about precarious working conditions, 5) acknowledging structural barriers to good health, and 6) naming racism and discrimination as the problem. In line with CRP, we discuss how explanations of racial health disparities reflect, reproduce, deny, acknowledge, or counter racism within each theme. Individualistic (versus structural) themes are generally presented first.

Recall that participants responded to Black-White or Latinx-White health disparities. We specify “Black response set,” or “Latinx response set” if the prompt they responded to cannot be easily inferred from a direct quote. In some cases, we insert the terms [Black Americans] or [Latinx Americans] into quotes to clarify which group the participant is referring to. Race, gender, and ages of participants are in brackets.

### Theme #1: Perceived Non-Compliance With Guidelines

Across both response sets, participants referenced a lack of behavioral compliance to CDC guidelines to explain the disparities (e.g., not social distancing, wearing masks, washing hands, nor seeking healthcare). This first theme was perhaps unsurprising given our collective understanding of COVID-19 as a socially communicable disease and Western tendencies to draw on internal attributions for others’ behaviors (e.g., [Morris & Peng, 1994](#)). If there are differential health outcomes between two groups, zeroing in on behaviors that have been publicized as increasing negative outcomes seems like a fairly straightforward application of attributing problems to something about the group rather

Table 1

Summary of Themes and Subthemes

|  |
|--|
| <b>Theme #1: Perceived Non-Compliance With Guidelines</b>                    |
| They are irresponsible and rebellious  |
| They distrust the medical system (and police)                                |
| They are uneducated and believe they won't get it                            |
| <b>Theme #2: Beliefs About Biological Health and Susceptibility</b>          |
| Maybe COVID impacts their bodies differently.                                |
| Pre-existing conditions and unhealthy habits.                                |
| <b>Theme #3: Assumptions About Cultural Values and Lifestyle Differences</b> |
| They live in close-knit communities.   |
| Maybe they are here illegally. <sup>a</sup>                                  |
| They live in low-income urban areas. <sup>b</sup>                            |
| <b>Theme #4: Concerns About Precarious Working Conditions</b>                |
| <b>Theme #5: Acknowledging Structural Barriers to Good Health</b>            |
| <b>Theme #6: Naming Racism and Discrimination as the Problem</b>             |

<sup>a</sup>Subtheme predominantly appears in Latinx response set.<sup>b</sup>Subtheme predominantly appears in Black response set.

than considering the context. Without critical interrogation, this fits with an individualistic understanding of health disparities seen in previous literature (e.g., [McFerran & Mukhopadhyay, 2013](#)).

However, through a critical analytical lens, these perceptions of differential compliance appear to run counter to empirical evidence. According to a nationally representative sample of the US, Black, Latinx, and Asian respondents were *more* likely to report mask-wearing in response to COVID-19 compared with White respondents ([Hearne & Niño, 2022](#)). Moreover, their results show White men were least likely to wear a mask from late April 2020 to early June 2020. This potential disconnect between perceptions and empirical evidence—and those highlighted in later themes—is one way these lay-theories can reflect and reproduce racism.

The following sub-themes offer insight into perceptions of where this perceived non-compliance stems from.

### Sub-Theme #1: They Are Irresponsible and Rebellious

When referencing perceived non-compliance with CDC guidelines, some participants made attributions that explicitly suggested Black and Latinx Americans lack responsibility (“[Black Americans] *irresponsibility in doing the right things and taking charge of their lives*” [White man, 51], are rebellious (“*some [Latinx Americans] are rebellious like me and refuse to wear a mask*” [White man, 55]), or generally hold lax attitudes towards the pandemic (“*I believe at the start, some minority areas did not take the illness very seriously. I feel they [Black Americans] still do no[t] take it seriously*” [White woman, 35]).

Some participants also made references to protesting as a reason for disparate outcomes for the Black community, “*They don't social distance, they are out next to each other by the tens of thousands protesting*” [White man, 33]. This was striking given the concurrent social movement was noted to be a highly multiracial coalition ([Buchanan et al., 2020](#)). Responses like “*Mostly blacks are rioting and not wearing mask[s]*” [man, race not indicated, 21] seemed to reflect a readiness to denigrate a cause they already disagreed with by blaming those actions for worse COVID outcomes. Indeed, there was a lot of publicity around this time regarding anti-lockdown protests (mostly White Americans) that responses referencing protests did not seem similarly concerned about (e.g., [Budryk, 2020](#)).

In these quotes, we see examples of times participants explicitly invoked negative stereotypes of Black Americans ([Niemann et al., 1994](#)). Invocation of the stereotype that Black Americans are antagonistic is captured by participant references to Black Americans as defiant, “*rioting*”, and not adhering to government guidelines. For Latinx Americans,

assigning characteristics such as “*stubbornness*” to the group and suggesting “*they don’t follow the rules, like everyone else*” [White man, 63] also evoked antagonistic and bad attitude stereotypes (Niemann et al., 1994). While such comments were present across both response sets, language related to *responsibility* and *taking charge* seemed relatively unique to the Black response set, mirroring work that suggests American participants see Black Americans as particularly in need of messages promoting personal responsibility (Salter et al., 2016). This subtheme largely reflected and reproduced racism by drawing on negative/racist stereotypes and overlooking evidence-based realities.

### Sub-Theme #2: They Distrust the Medical System (and Police)

Some participants wrote that members of Black and Latinx communities have a mistrust of authority which prevents them from following CDC guidelines and from seeking healthcare (“[Black] *community distrust of health information sent out by white people in authority.*” [White man, 32]). Some participants suggested mistrust was the consequence of larger systemic issues (“[Black Americans] *are afraid to wear masks because of interactions with the police*” [White man, 45]; “*Some Latinx individuals may be undocumented so they do not want to go to testing sights for fears they may be reported and deported*” [White man, 27]). Many others gave little context, referencing a general mistrust. We note that despite commonality in referencing mistrust, specific references to *police* only came up in the Black response set, while specific references to *immigration-status* only came up in the Latinx response set. Many examples in this subtheme seemed to acknowledge racism by highlighting how marginalized communities’ trust in authorities are rooted in historical injustices. Others reflected racism by positioning mistrust as an essentialized element of these communities rooted in misconceptions of authorities’ benevolent intentions, without delving into historical injustices that may have shaped such mistrust.

### Sub-Theme #3: They Are Uneducated and Believe They Won’t Get It

In both response sets, participants indicated that people might lack understanding and education (“*Because [Latinx Americans] probably don’t understand what to do and why*” [White woman, 57]; “[Black Americans] *are not educated enough to understand the importance of [adhering] to government guidelines*” [White man, 36]), an explanation that seemed rooted in stereotypes of Black and Latinx Americans as uneducated (e.g., Niemann et al., 1994).

In 2018-2019, high school graduation rates among White, Black, and Latinx students were 86%, 80%, and 82% respectively (National Center for Education Statistics, 2024). While racial educational disparities are certainly an on-going problem in the US (one exacerbated by COVID-19; Ong, 2020), the majority of U.S. students graduate high school. Further, when we consider that many elementary schools reopened under the premise that school-aged children could successfully learn to follow CDC guidelines, it becomes even more stark that the assumption Black and Latinx communities could not understand CDC guidelines due to lack of education is rooted in racist stereotypes. One participant expressed the belief that education outside of the U.S. is inferior and to blame (“[Latinx Americans] *may not have had a good education in their native country*” [White man, 20]). This response also stood out to the authors as rooted in assumptions of Latinx Americans as predominantly immigrants (an assumption returned to in Theme 4) and in ethnocentric assumptions of poorer education systems outside the U.S.

Strikingly, within the Latinx response set alone, participants described beliefs about invulnerability, (“*The Latinx community (I am Mexican) think they can overcome anything and everything that comes at them. I believe they keep going out to places and gatherings because they believe they won’t get it.*” [Latina, 24]). This participant leveraged insight from her own identity to explain perceived non-compliance which did not seem to reflect stereotypical assumptions about not understanding the risk, but rather a faith in one’s own resilience despite the odds. While this subtheme overall seemed to reflect and reproduce racism, this last example offers an alternative account highlighting community resilience.

## Theme #2: Beliefs About Biological Health and Susceptibility

Theme two suggested beliefs that Black and Latinx communities were differentially impacted because biological vulnerabilities make them more susceptible to contracting the virus and experiencing adverse impact. The sub-themes offer insight into where the perceived biological vulnerabilities come from.

### Sub-Theme #1: Maybe COVID Impacts Their Bodies Differently

Specific references to genetic differences were striking (“*A genetic predisposition to experiencing worse cases for covid 19*” [White woman, 29, Black response set]; “*different races are more or less prone to certain illnesses based on genetics*” [White woman, 30, Latinx response set]). Lay-beliefs that position Black and Latinx people’s genetics, immune systems, and health as “inferior” (e.g., “*I think it may be as a result of a generally inferior immune system.*” [White woman, 32, Latinx response set]) are ideas explicitly rooted in scientific racism; reflecting conceptions of racial groups as biologically discrete categories (Smedley & Smedley, 2005). Responses also included generic references to “*bad immune systems*” and vague phrasing such as “*infected more easily.*” Notable divergent responses here explicitly acknowledged racism (“*The constant stress of institutional racism may somewhat suppress African-Americans’ immune systems*” [White woman, 29]).

### Sub-Theme #2: Pre-Existing Conditions and Unhealthy Habits

Responses suggested that Black and Latinx community members were more likely to have pre-existing conditions such as diabetes, obesity, and heart disease. At times, responses made connections between pre-existing conditions and broader systems (see Themes #2 and #5); others listed these conditions as self-evident (“*Black people have more cases of diabetes and obesity.*” [White woman, 68]; “*Latino people may have more of the preexisting conditions such as heart issues or obesity*” [White woman, 43]).

Responses also blamed vulnerabilities on ‘controllable’ factors (“[Latinx Americans] *do not take care of their health properly*” [White man, 45]; “*Poor decisions related to nutrition - unhealthy diets*” [White woman, 69; Black response set]). In both response sets, explicit racist tropes about hygiene appear (“[Latinx Americans] *lack of fundamental standards of basic hygiene*” [White man, 33]). One participant stated as a matter of fact, that Black Americans did not have the same hygienic practices as other groups, “*Black people have poor hygiene (take fewer showers thus exposing themselves to more bacteria)*” [White male, 34].

Vague references to biological factors reproduce racism by implying racial categories are biological versus socially constructed, minimizing structural influences on health outcomes, and normalizing Whiteness as the standard of good health. The flip side of assuming that these communities have biological deficiencies or make poorer decisions is that their White counterparts are assumed to have superior biological profiles or make better health decisions. But, this assumption runs counter to prevalence rates of relevant COVID comorbidities, like obesity. In 2021, Black adults had age-adjusted obesity prevalence rate of 49.6%, followed by Hispanic adults (44.8%), White adults (42.2%), and Asian adults (17.4%; CDC, 2021b). The assertion that Black-White and Latinx-White COVID disparities can be explained by disproportionate obesity rates only holds if White is the standard of comparison. If Asian Americans are the comparison group, then three groups struggle with obesity.

## Theme #3: Assumptions About Cultural Values and Lifestyle Differences

Theme three captures the social and cultural contexts in which Black and Latinx people were assumed to have increased risk. The sub-themes describe perceived cultural differences and included general references to “*lifestyle choices*” [White man, 51, Black response set].

### Sub-Theme #1: They Live in Close-Knit Communities

Some responses centered on housing situations such as living in smaller homes, in multi-generational households, and with larger families. Such responses often referenced physical and psychological closeness. For some, this was linked to differences in family values:

*“Generally speaking, in Latinx families, the elderly are kept in the family homes rather than in an independent living or nursing home so they’re more likely to get sick because the family members they live with are essentially, but poorly paid, workers and the elderly have the highest likelihood of a bad outcome.”* [White man, 36].

For others, references to larger communities, multiple families, and closeness seemed connected to assumptions of economic need-based living situations (“[Black] communities also tend to have smaller spaces where people are closer together. This is often attributed to economic issues in those communities” [Latina, 20]).

Although these responses did not explicitly denigrate Latinx or Black communities, we noted some responses engaging in cultural pathologizing, or, taking perceived group differences that are otherwise relatively neutral (or positive) and positioning them as deficits. Participants shared lay-beliefs that both Black and Latinx communities are *close knit* and thus are more likely to continue to get together, which would increase risk for COVID transmission. Similar to the cultural racism facet of colorblind racism (Bonilla-Silva, 2022), cultural values were recruited as a way to blame health outcomes disparities on behaviors of these groups without explicitly naming such values as bad. Take for example, “Latinx people come from cultures that value closeness and human touch so they are not properly social distancing” [White man, 27]. Here, speculation about a lack of proper social distancing is attributed to a cultural norm typically associated with collectivism. However, it is individualism that was associated with breaking social distancing rules (Feng et al., 2023). Overall, this subtheme seemed to reflect and reproduce racism. Vague references to *large families* and *many children* map onto racialized stereotypes of Black and Latinx Americans as having too many kids (Reny & Manzano, 2016; Turner, 2022). Religiosity, as a possible risk factor (“Religious affiliation is stronger in Black communities” [White man, 64], “[Latinx Americans] tend to be more religious (especially catholic) which has them meeting in large groups with communal sacraments.” [White man, 36]), also stood out amidst a fair amount of publicity around White Christians defying shutdowns to attend church services (Martin, 2020).

### Sub-Theme #2: Maybe They Are Here Illegally

Connections between COVID and immigration concerns were uniquely generated within the Latinx response set. At times, responses seemed to recognize how such concerns could be serious barriers to proper healthcare:

*“Given the situation of Latinx people at the border waiting to get in, the horrid conditions of being stuck in a cage with hundreds of other people seem to be perfect conditions for people to get a respiratory disease, so maybe as they start to come into the country, they carry the disease with them and infect their communities even further.”* [White man, 18].

On the other hand, these beliefs also highlight perceptions of Latinx individuals as “perpetually foreign” (Devos et al., 2010) and this seemed salient to the authors when immigration concerns were cited without further context using language like “*illegal immigrants status (don’t want to be deported)*” [White woman, 28]).

When immigration concerns were overgeneralized and paired with words such as “illegal”, this evoked stereotypes of perpetual foreignness and criminality (e.g., Dixon & Williams, 2015). These responses obscured many nuances of immigration. Before the pandemic, only 33% of Latinx Americans were foreign-born, and when considering foreign and U.S.-born Latinos together, about 79% are U.S. citizens and 70% are English-proficient (Noe-Bustamante & Flores, 2019).

### Sub-Theme #3: They Live in Low-Income, Urban Areas

Explanations referring to urban areas stood out in the Black response set: “*it is noticeable that black communities tend to be focused in cities. With cities having a higher population density than living in suburban or rural areas, the transmission rate for COVID will be higher.*” [White man, 19]. Another striking pattern was that, at times, these explanations seemed in line with racial stereotypes about Black living spaces as poor, dirty, and rundown (Yantis & Bonam, 2021).

*“The reason for this is because people of poverty-stricken environments tend to have more unsanitary locations, therefore, there are many black people in these types of communities, thus leading way to the rise in illness primarily on the African American race.”* [Asian man, 18].

Some participants countered these stereotypes by explaining the systemic factors underlying living conditions (“*Due to centuries of systemic racism, many BIPOC live in “red-lined” communities.*” [White woman, 21]; this was uncommon. More often, responses simply mentioned that Black people live in low-income areas, as a reason itself for the disparity.

The conception of Black Americans as urban and poor was relevant across themes, especially in discussion of access to resources and jobs. While poverty disproportionately impacts Black communities; many responses treated poverty as

a natural characteristic of the community (i.e., “*Black people are generally poorer*” [White woman, 34]). In 2020, 19.5% of Black Americans lived below the poverty line (Shrider et al., 2021). These rates are important to consider in the context of overall U.S. poverty rates (11.4%), overrepresentation of Black Americans at lower socioeconomic status (SES) levels, and wage-gaps between Black Americans and White Americans (Patten, 2016; Shrider et al., 2021); however, over-simplifying such considerations can sustain racialized stereotypes that position poverty and living in cities as essentialized features of Black communities (Semuels, 2016).

#### Theme #4: Concerns About Precarious Working Conditions

Another theme referenced precarious working conditions in terms of increased exposure risk and longer-term risks associated with low wages and lack of benefits. Responses in this theme highlighted the entanglement of healthcare and employment in the U.S.

Regarding immediate risk, participants indicated that members of both communities were more likely to be essential, on-site workers (“*many black people have blue collar jobs and were unable to work from home, therefore putting them on the “front line” and exposing them to greatest risk*” [White woman, 45]). Other participants mentioned the role of poor working conditions in many service industry jobs (e.g., crowded, unsafe, lacking PPE; “*Some Latinos work in jobs that pack folks together like sardines*” [White man, 58]). These responses are in line with research showing workers of color were overrepresented in risky “essential jobs” during COVID-19 (Rho et al., 2020).

Regarding longer term risks, participants tied working conditions to a lack of benefits, inadequate health insurance, and the struggle to afford insurance/medical treatment. One participant explained, “*Lack of good jobs that provide paid sick days. Lack of health care, because many low-wage jobs don't provide it*” [White woman, 60, Black response set].

Notably, some made explicit connections between working conditions and systemic racism,

*“The reasons have less to do with their health and instead with the trickle down of systemic racism. Latino/Latinx communities are still working in this pandemic and don't have the luxury of working from home as others do.”* [Black woman, 20].

The above quote acknowledged racism’s role in structuring working conditions, and therefore, health. However, many simply referred to working conditions as a base rate issue without such explicit connections, leaving acknowledgements of systemic racism implied or unsaid. We also noted within the Latinx response set, explicit references to particular occupations reproduced stereotypes via alignment with stereotypical media portrayals such as manual labor and maids (e.g., Reny & Manzano, 2016; “*Many of the jobs they must do are in working with others (maids, food service, picking crops)*” [White man, 56]) versus other high exposure occupations (e.g., nurses, doctors).

#### Theme #5: Acknowledging Structural Barriers to Good Health

In both response sets, we saw explanations highlighting differences in access to resources, healthcare, information, and insurance benefits. One participant summed things up by saying, “*Black people have less access to healthcare. They also have higher unemployment rates which denies them access to adequate insurance.*” [White man, 77]. Participants indicated that even when members of Black and Latinx communities are able to access healthcare, there are differences in healthcare quality. Some responses linked financial resources to the quality of care received (“*Most [Black Americans] cannot afford quality health care due their low income status*” [Black man, 37]) and others linked these differences in healthcare quality to racism and discrimination (see Theme #6). Reduced access to COVID-19 supplies (e.g., PPE, testing, and treatment) also mattered. For example, “*Latino communities are worst impacted by this virus because they don't have easy access to supplies so they have to constantly go out to get stuff.*” [Latino, 19].

Responses also highlighted inadequate information resources in Latinx communities (“*Lack of reliable communication about the virus and prevention*” [White/Latino, 44]). Discussions included society’s failure to provide information in Spanish (“*lack of materials in Spanish/Portuguese*” [White woman, 51]). However, some responses discussed language barriers in a way that seemed focused on capabilities (“*Latinos can't understand some things if they only speak spanish*” [Asian man, 20]). Responses considering our societal responsibility to address language barriers seemed distinct from remarks about lacking education, understanding, and intelligence (see Theme #1).

Responses acknowledging social conditions, access, and structural barriers to good health align with calls to dismantle and address racism in the healthcare system. Overall, we were surprised by the centrality of structural mentions. We frequently returned to this theme because when responses mentioned “access” or “SES”, it was not always clear whether they were referring to structural racism, specifically. Acknowledging economic disparities can be anti-racist, but this acknowledgement can also reproduce racism if used as a counterpoint to anti-racist arguments (e.g., it is not race, but class driving health disparities: *“There is some noise bubbling up about racism, but I am not too sure about that. But being poor can also mean poor insurance and therefore poor medical care”* [White Man, 69, Black Response set]). An exclusively economic focus can reflect a stereotyped, essentialized view of communities of color (“they’re poor”) or ultimately fit within meritocratic, individualistic frameworks that continue to blame anyone who fails to overcome poverty as lacking the will (e.g., “poor decisions”). This aligns with prior work suggesting that efforts to address structural racism may be met with resistance by healthcare providers who highlight other social and behavioral determinants (e.g., access to healthcare, insurance, health literacy) as more valid explanations than racism and discrimination (Gollust et al., 2018).

## Theme #6: Naming Racism and Discrimination as the Problem

Both response sets named racism in different forms (i.e., systemic racism, prejudice, racial bias, unconscious racism, discrimination). Some responses used individual-level frameworks, referring to racial inequalities in terms of who is prioritized for treatment or subjected to racial biases (*“Latino people sometimes cannot get health care as easily as White people due to things like income or location or prejudice of medical staff”* [White woman, 43]; *“Also [Black Americans] are definitely discriminated against by healthcare workers, at least the racist ones,”* [White man, 27]). Others explicitly linked disparities to historical forces or systemic racism (e.g., *“The reasons have less to do with [Latinx Americans’] health and instead with the trickle down of systemic racism.”* [Black woman, 20]). Salient responses directly named racism in a way that highlighted its impact on the health and well-being of Black and Latinx communities.

Sometimes responses alluded to contextual forces beyond the individual without naming racism explicitly (*“This illness impacts Black communities more because historically Black communities are less wealthy than White communities”* [Black-White Biracial woman, 48]). This response points out economic disparities between racial groups; but, naming racial differences in outcomes (as a state of affairs) and naming ‘racism’ (as an account of why those differences exist) are not exactly the same thing. Responses such as this acknowledge race as a central issue, but only imply that racism may be the problem. Notably, some participants acknowledged, but expressed skepticism, about racism attributions themselves (*“Correlation vs. Causation. We can’t be sure. Cultural? Less access to healthcare? Less personal responsibility? Genetic? Lower socio-economic conditions? Racism by doctors and nurses?”* [White man, 57, Black response set]).

## General Discussion

The purpose of this research was to explore lay-theories underlying U.S. Americans’ explanations of COVID-19 health disparities among Black and Latinx populations. We presented six themes as a result of our analyses: 1) perceived non-compliance with guidelines; 2) beliefs about biological health and susceptibility, 3) assumptions about cultural values and lifestyle differences, 4) concerns about precarious working conditions, 5) acknowledging structural barriers to good health, and 6) naming racism and discrimination as the problem. Many of the explanations could be framed as race-neutral (e.g., essential workers are more at risk for COVID-19 exposure); however, another important aim of our study was to bring a race-conscious lens to the science of lay-theories. Our analyses suggest that lay-theories of COVID-19 racial health disparities reflect an acknowledgement of systemic inequalities, but also bear the traces of existing racist structures and ideologies embedded in American society.

Lay-theories about racial health disparities are based on a set of implicit or explicit assumptions about others (Prilleltensky, 1997). These assumptions draw on unfair evaluations of systematically disadvantaged groups while using advantaged groups as an implicit, default standard (Sue, 2004). Buried in these assumptions are perceptions and stereotypes likely to fail tests of reality (e.g., assumptions about pre-conditions, divergent behaviors). Yet, these ideas have the power to affect individuals’ willingness to support or give equally appropriate care to members of marginalized

groups (Gerber et al., 2013; Penner et al., 2014). Indeed, ascribing health disparities to social determinants (versus individual responsibility) is associated with greater support for social programs (e.g., food stamps, affordable housing, minimum wage; Price et al., 2014). Further, greater endorsement of lay-theories attributing COVID-19 health disparities to external causes (e.g., systemic racism) predicted greater perceived COVID-19 threat, adherence to CDC guidelines, and support for government policies to combat COVID-19, even after controlling for political orientation, participant race, and attributions to other factors such as genetics, personal choices, or culture (Crist et al., 2023).

Given discussions of how pervasive U.S. neoliberal ideologies obscure systemic forces by overly focusing on the role of individuals (e.g., Adams et al., 2019; Perez & Salter, 2019), we did not expect much attention to structural, environmental, and systemic forces in health disparities. We admittedly anticipated more explicit responses denying racism's role in health disparities like *"I really don't see how it would impact one race differently than another"* [White woman, 21, Black response set]. During our analytic process, we discussed our surprise as evidence of our positionality as anti-racism researchers, but also acknowledged the influential roles Black Lives Matter activists and protests played in shifting public conversations toward structural forces in the lives of People of Color at the time of data collection. A CRP analysis orients us toward a critical tempering of describing these findings as racial progress given that depending on how these brief structural accounts of disparities are deployed (i.e., with or without sufficient context), they can serve to reproduce and reinforce stereotypes about Black and Latinx communities as outlined in our analysis.

## Important Considerations and Future Directions

One important consideration is that our qualitative data come from a larger quantitative research project. The positivist methods used (e.g., large sample sizes, random assignment) do not necessarily align with constructivist approaches. However, our research question and philosophical assumptions were aligned with perspectives arguing for surfacing hidden meanings through interactive dialogue (Ponterotto, 2005). There are limitations to our approach (e.g., we could not probe participant responses; the format likely prompted short responses), but the heterogeneity of responses, iterative process of reflexive thematic analysis, and our collaborative coding approach facilitated a different sort of interactive dialogue within our coding pairs, during team analysis meetings, and within participant responses that considered one's own and others' beliefs.

Because of the prompt, participants varied on whether they claimed beliefs as their own, positioned them as others' beliefs, or did not say. While "others might say" was an initial subcode, it was not extracted as a salient pattern in the data by our team; but it is an interesting dimension to consider in future research. For our purposes, this prompt allowed participants to share possibly unfavorable beliefs and/or attributions they may have heard but disagreed with, providing a wider picture of the explanations for health disparities that exist in the US cultural milieu. Our goal was not to determine the most popular lay-theories, who might be most likely to produce different lay-theories, nor whether individuals are racist or not in their lay-theories. Our goal was to describe different ways people explain COVID disparities and examine what kinds of racialized discourse shows up in those explanations. While lay-theories may traditionally be thought of as individual-level mental processes and are typically studied in ways that prioritize methodological individualism (Adams & Stocks, 2008), our approach positioned lay theories as socially and culturally co-created. Although responses were brief, they corroborate, in participants' own words, different ways people make sense of health disparities.

Another consideration is that the prompt presented Black and Latinx communities separately when more than 1.3 million people in the U.S. identify as both. Future research could examine related lay-theories in Afro-Latinx communities or other minoritized communities. COVID-19's negative impact on Asian American communities health-wise—in addition to the racism—was largely ignored (Yee, 2021) and Native Americans also experienced high incidence rates (Hatcher et al., 2020). When, how, and whose lay-theories are represented in psychological research is an important conversation in epistemic exclusion (Fryberg & Eason, 2017; Settles et al., 2020). Approximately 73% of our sample identified as White, and all of our participants were U.S. citizens with English as a first language. Identifying counter-narratives would benefit from analyzing lay-theories among different groups, and across multiple waves of the pandemic.

Finally, in the early waves of the pandemic, U.S. news outlets were generally focused on why People of Color were hit harder by the pandemic than White communities. The larger project associated with this study was designed to have

a similar framing as these impactful news stories. Alternative approaches could have focused on explanations of why White Americans were faring better, likely producing differently racialized explanations (Powell et al., 2005).

## Why Racialized Lay-Theories Matter

Lay-theories are helpful tools for examining “mind-in-context” because they are both shaped by culture and have the power to shape culture (Salter et al., 2018). Studying the lay-theories individuals generate helps us understand conceptions of health disparities on a cultural level. Rather than treat the reasons generated by participants as a sample of individual beliefs, we consider these reasons as a sample of available narratives about racial health disparities in COVID-19 present within the US.

Lay-theories can feed into institutionalized public narratives and can sustain support for policies that either maintain or remedy racial injustice. They are entangled with the institutional practices and cultural narratives that are contributing to, if not causing, health inequalities themselves (Hook & Markus, 2020). While popular accounts described the ongoing global pandemic as “unprecedented,” the factors that contributed to the occurrence of COVID-19 disparities, and the racism-relevant attributions that people shared, were not “unprecedented” at all. There is a long history of systemic racism in healthcare and our analysis simply underscores the intersections of race, racism, and health during the pandemic.

A critical direction for researchers and practitioners who want to promote equity in healthcare is to address the questions of how individuals, groups, and societies explain the causes of health disparities. Understanding perceived causes provides much needed insight on the cultural ideas about Black and Latinx communities that may continue to function as barriers to equitable treatment. For example, if people believe COVID impacts Black and Brown “bodies differently than other races”, then it likely reduces the perceived need for systemic intervention or structural solutions. Some responses conveyed understandable frustration with the entanglement of employment, healthcare, and racial disparities. However, when does such frustration facilitate endorsing policy reform (e.g., universalizing healthcare) versus resigned acceptance in a culture of personal responsibility (i.e., work hard to get good jobs and health insurance)? As demonstrated by Senator Cassidy in the [opening section](#) of this paper, “experts” and policy makers are not immune to holding such theories (Leeman et al., 2011). It is crucial for scholars and practitioners to understand the lay-theories that they may need to challenge to mobilize resources for addressing racism as a barrier to equitable health outcomes.

Lay-explanations represent and reproduce narratives and explanations of COVID-19 disparities that are—at the very least—culturally and cognitively available among participants. Our qualitative approach highlights the utility of using critical, race-conscious approaches in psychological research. Without it, one could miss the ways in which lay-theories about COVID-19, and health disparities more broadly, resonate with existing racial frames and rhetoric. When viewed through a race-conscious lens, lay-theories become an important source of discussion for how racism is reflected and reproduced in everyday beliefs about health.

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**Funding:** A Psychology Department Summer Research Fellowship from Davidson College supported Ciara Coger’s participation in this research.

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**Acknowledgments:** The authors have no additional (i.e., non-financial) support to report.

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**Competing Interests:** The authors have declared that no competing interests exist.

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**Author Contributions:** Grace N. Rivera and Phia S. Salter contributed equally to this work. Jaren Crist and Michael Perez contributed equally to this work. Masi Noor and Rebecca J. Schlegel contributed equally to this work. Within these equal contribution pairings, authors were listed alphabetically.

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**Data Availability:** The research data for the study is publicly available (see Rivera et al., 2025S).

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## Supplementary Materials

The Supplementary Materials include the full text of the open-ended responses (see Rivera et al., 2025S).

### Index of Supplementary Materials

Rivera, G. N., Salter, P. S., Crist, J., Perez, M., Noor, M., Schlegel, R. J., & Cogger, C. (2025S). *Lay-theories reflect, reproduce, deny, and acknowledge racism: Explaining COVID-19 racial health disparities in the United States* [Research data]. OSF. <https://osf.io/qcevw/>

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