Unpacking Our History Article Packet

Slavery's Legacy in Health and Medicine
Legacies of Trauma

March 14, 2024

7:00 – 8:30 PM

Zoom ID: 823 648 5349 | Password: 691353

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May 9: State of Minority Mental Health

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Family & Children's Trust Fund OF VIRGINIA

SYSTEMS OF TRAUMA | Racial Trauma

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This issue brief will explore how racial trauma intersects and exacerbates trauma caused by family violence. In order to do so effectively, the brief will review issues of structurally embedded inequalities, individual actions that cause racial trauma, the effects of racial trauma on communities of color, and strategies for individuals, communities, professionals and organizations to prevent and mitigate race-based traumatic stress. Accompanying resources for this issue brief are available at www.fact.virginia.gov/systems-of-trauma

What is Racial Trauma?

Racial trauma, also known as race-based traumatic stress, refers to the stressful impact or emotional pain of one's experience with racism and discrimination. Common traumatic stress reactions that reflect racial trauma include increased vigilance and suspicion, increased sensitivity to threat, sense of a foreshortened future, and maladaptive responses to stress such as aggression or substance use. Further, racial trauma can have a negative impact on individuals' physical and mental health, including negative mood and depressive symptoms, and hypertension and coronary heart disease.[1]

Stress is the body's physiological and cognitive response to situations perceived as threats or challenges. It is a normal and natural response. Most stress individuals encounter on a day-to-day basis is tolerable, because individuals have coping skills and supportive relationships to help them endure it. However, exposure to stressful and adverse experiences over a long period without positive mitigating factors can become toxic.[2]

When an individual hears or sees a threat, the brain's limbic system, or "survival brain", sends out a red alert signal that releases stress hormones. This response is the normal physiological reaction that keeps humans and animals alive; however, when individuals experience toxic stress, there is a constant stream of stress hormones to remain hyper-vigilant to their unpredictable and sometimes dangerous environment.[3] Because of the prevalence of racial discrimination, being a racial minority generally leads to greater stress. Further, simply anticipating racist events will switch on the body's stress response systems. Systemic racism, everyday racial discrimination, and the fear of racist events can cause people of color to live in a constant state of red alert. This toxic stress increases wear and tear on the body--the sustained release of stress hormones can lead to multiple health issues including high blood pressure, high glucose levels and a weakened heart and circulatory system.[4,5,6]

Many researchers have noted the link between racism and trauma.[7] For example, Comas-Diaz and Jacobsen (2001) state, "Exposure to racism can result in psychological affliction, behavioral exhaustion and physiological distress."[8] Scurfield and Mackey (2001) argued "Exposure to race-related trauma, in and of itself, may be the primary etiology factor in the development of an adjustment or stress disorder."[9] Racial trauma does not occur in a vacuum and therefore is worsened by the cumulative impact of multiple traumas, such as community violence, victimization, and combat. For example, a study of PTSD among Asian veterans found that race-related stress was a strong and significant predictor of PTSD and stated that "the stressful effects of exposure to combat and racism could be additive and that cumulative racism can be experienced as traumatic."[10]

Racism and the trauma that results from racism exist at interpersonal, environmental, institutional, and cultural levels, thus affecting the physical, social and psychological health of individuals and communities.[11] Eliminating racism and racial trauma will require interventions at all levels, from individuals

to the family, community and nation. It is important for practitioners to understand how racial trauma affects their clients and use that as a lens for trauma-informed practice; however, it is also crucial to implement policy changes that work towards ending structural racism in our communities. The following sections specify some structurally embedded inequalities and individual inequalities that cause racial trauma.

Historical Trauma

Historical trauma is a form of trauma that affects entire communities. It refers to cumulative emotional and psychological harm, as a result of group traumatic experiences, transmitted across generations within communities and families. Racial and ethnic population groups that have suffered major losses and assaults on their culture and well-being experience historical trauma. For example, the legacies from the enslavement of African Americans, displacement and murder of American Indians, and devastation and decimation of Jews in the Holocaust have been transferred to current descendants of these groups and others.[1,12]

Historical trauma is constructively viewed from a public health perspective, as it has implications for the physical, psychological and social health of individuals and communities. Patterns of managing stressful life events are highly influenced by the environment that shapes individuals, families and communities. When caregivers' environments have been shaped by perceived and actual threats to their safety due to past traumatic experiences perpetrated against members of their community, they transmit implicit and explicit social messages to their children in an attempt to ensure their safety. Social messages imparted range from preparing children for discriminatory experiences to bolstering their pride in their ethnic/racial identity.[1]

Furthermore, experiences of historical trauma within a community, coupled with individual traumatic experiences can contribute to survival strategies that both reflect a community's resilience in the face of continued difficult life circumstances and heightened risks for experiencing community-level stressors (such as community violence).[1] For example, the adaptive and flexible nature of African American family structures (i.e., extended family and kinship networks) that emerged out of chattel slavery was (and remains) essential for survival during times of adversity. Conversely, the same close-knit extended family structure promotes a sharing of income that can mitigate African American professionals' ability to save and build generational wealth. Tech professional Sheena Allen coined this the "Black Tax" when she tweeted: "Many Blacks in my peer group are making good money but because they're the first person in their family to "make it", they are still living paycheck-to-paycheck because their money isn't just their money. Their money is mom's light bill money, little bro's football money, etc."[13] Historical trauma provides a context for understanding some of the stress responses that individuals from historically oppressed communities use to cope with difficult situations.

Historical Trauma in the United States

The United States is among the most diverse democracies in the world.[14,15] However, much of its history includes systems of violence and discrimination that have not only had traumatic consequences for those directly affected, but affect future generations and communities. The following section highlights just a few examples of communities that experience historic trauma in the United States. Further reading can be found at www.fact.virginia.gov/systems-of-trauma/

American Indians

The colonization of the Americas introduced a chain reaction of incidents that had traumatic consequences for American Indians for generations, some of which are outlined in the paragraphs below.

Treaty promises, made by the United States government, were broken by deceptive language designed to extricate valuable lands from American Indians. Aggression and violence often accompanied the rapid expansion of colonization. Calculated introduction of alcohol and disease, together with the slaughter and abuse of innocent individuals, caused deep and lasting traumatic wounds to American Indian individuals and families and allowed no time for the necessary mourning, regrouping, and restructuring of American Indian societies. American Indians were relegated to reservations, restrictive environments that destroyed many aspects of societal health that had been supported through intra- and intertribal relations.[16,17, 18, 19]

One example of an institutional governmental tool of racism is the initial creation of the Bureau of Indian Affairs (BIA), that was established as a subdivision of the Department of War in 1824. This

agency was given the task of controlling American Indians. A primary role of the BIA was to provide education for American Indians with the ultimate goal of "civilizing" them according to the prevailing standards of European American culture (BIA, n.d.).

A key strategy to doing so was the establishment of BIA-operated Indian schools that were reservation-based day schools. However, it rapidly became apparent that attempts at assimilating native children to European American culture were impeded by parental influence. Therefore, in 1876, the federal government decreed that all American Indian children must be removed from their families and confined in boarding schools. This legislation mandated that children be forcibly, if not voluntarily, removed from the care of their own relatives to be brought up within the confines of boarding schools. In 1892, the Commissioner of Indian Affairs, Thomas Jefferson Morgan, called for coercive enforcement of mandatory boarding school attendance through the restriction of food to those "barbarians and semi-savages" (parents) who were discovered to be in contempt.[17]

Between the late 1800s and mid-1900s, the United States government mandated that all American Indian children between the ages of 5 and 18 attend boarding school. By severing children from the nurturing and protection of their parents, school authorities were implicitly granted license to use and abuse children according to whatever exploitive, punitive, and perverse treatment they deemed advantageous to their fundamental mission of stripping the children of their natural beliefs and attachments.[17]

Consequences of Historical Trauma on American Indians

The current social-environmental, psychological and physiological distress in American Indian communities is a result of the historical losses this population has suffered over time. For example, the removal of American Indian children into boarding schools left generations of American Indians subjected to prolonged institutionalization, void of positive models of family life and family discipline and disconnected from the aspects of their culture that were critical for resiliency. Those factors can have a significant effect on individuals' ability to function as parents and partners within families. To that end, domestic violence and physical and sexual assault in American Indian communities are 3.5 times higher than the national average. However, the actual number may be higher, as many assaults are not reported. Further, American Indian children are one of the most overrepresented groups in the foster care system.[17,20,21]

Federal and state efforts to increase recognition of tribal sovereignty and acknowledgment of historical trauma are widely seen as positive efforts to increase healing and resiliency. On individual and community levels, American Indians have shown to be resilient to historical and current trauma especially when focusing on cultural practices. For example, among American Indian youth living in urban areas, gathering with other American Indians, learning about their history and reconnecting with their tribal culture helped decrease alcohol and other substance use and misuse, as well as depression, anxiety, suicidality and feelings of hopelessness.[22,23]

African Americans

Slavery in the United States spanned from the 1600s to the mid 1800s. It is estimated that six to seven million enslaved Africans were imported to the United States during the 18th century alone. The rapid expansion of the cotton industry in the late 1700s and early 1800s made Southern States dependent on slavery for their economy.[19, 24] Virginia was the second largest state for the importation of enslaved Africans and the number one state for the domestic slave trade, and, Richmond, Virginia was the epicenter of that trade. Richmond's economic success int he antebellum is largly due to the impact of the slave trade as a commercial enterprise. In fact, "In the 1850s, Richmond's biggest business by dollar volume was not tobacco, flour, or iron, but slaves."[27,28]

Enslaved individuals were denied the opportunity to learn to read or write and were prohibited from associating in groups (with the exception--in some cases--of religious meetings). Beatings and murder of enslaved persons were allowable if the enslaved person was "resisting" or if done "under moderate correction." Rape and sexual abuse of enslaved women were common, and families were regularly separated when children and spouses were sold.[19,24]

Although chattel slavery in the United States created horrific intergenerational trauma in and of itself, it was followed by a series of laws and policies that

supported the powerlessness of African Americans and expanded the legacy of historic traumas against African Americans in the United States. One example of such legacies is the Jim Crow Era, which spanned from the 1880's to 1965, post emancipation in the American South. Jim Crow laws supported race-based segregation and resource attainment in public and private domains. This formal codified system of racial apartheid affected almost every aspect of African Americans' daily life, mandating segregation of schools, parks, libraries, drinking fountains, restrooms, buses, trains, housing and restaurants. "Whites Only" and "Colored" signs were constant reminders of the enforced racial order.[19,24,25] Civil Rights activist Diane Nash stated: "Travel in the segregated South for Black people was humiliating. The very fact that there were separate facilities was to say to Black people and White people that Blacks were so subhuman and so inferior that we could not even use the public facilities that White people used." Diane Nash was a member of the Freedom Riders, a group of civil rights activists who rode interstate buses in the south to challenge bus segregation. It took several decades of direct action such as the Freedom Riders Movement, as well as legal action, to end Jim Crow Laws in the American South.[25]

> "Systemic racism has roots in historic racism; however, it is reinforced by contemporary environmental, institutional, and cultural structures."

Consequences of Historical Trauma on African Americans

For African Americans who are descendants of enslaved Africans, the dynamics of slavery itself; the institutionalized segregation and violence that followed emancipation, and ongoing struggles for racial justice continue to have a multi-faceted impact on African American Life.[24]

After studying PTSD in African Americans, Joy DeGruy, PhD, developed the theory of post traumatic slave syndrome which takes into account the development of survival adaptations necessary for enduring the hostile slavery environment, and how these adaptations, both positive and negative, continue to be reflected in African Americans' behaviors and beliefs. Dr. DeGruy theorizes that some of the violence in African American communities as well as patterns of behavior such as vacant self-esteem, ever-present anger and racist socialization are born out of a very violent past--specifically the unresolved and unaddressed trauma from slavery. Dr. DeGruy's theory also acknowledges the resilience and resourcefulness that made it possible for individuals and families to survive slavery, such as strong family relationships, community, and faith within African American communities.[26]

Current Systems of Racism

Policies and practices entrenched in established institutions that harm certain racial groups, and help others create systemic racism. Systemic racism has roots in historic racism; however, it is reinforced by contemporary environmental, institutional, and cultural structures. The following section outlines several examples of current systems of racial oppression that can cause and add to racial trauma.

Nationally, people of color are more likely to live in poverty than their White peers. Eight percent of White Americans live in poverty, while 20% of Black, 16% of Latino, and 22% of American Indian and Alaska Natives live in poverty.[29] Families of color are also between two and four times more likely than white families to live in areas of concentrated poverty, exacerbating the effects of poverty and impeding access to opportunity.[30] This wealth gap can be attributed to a myriad of societal structures, one of which is racial

discrimination in mortgage lending.

Racial discrimination in mortgage lending in the 1930s shaped the demographic and wealth patterns seen in American communities today. The federal Home Owners' Loan Corp (HOLC) created maps in which neighborhoods were graded based on their credit risk and ethnic demographics. Neighborhoods predominately made of African Americans, as well as Catholics, Jews, and immigrants from Asia and southern Europe were deemed undesirable to lend to and marked on HOLC maps with a red outline. Loans in redlined neighborhoods were unavailable or very expensive, making it more difficult for low-income minorities to buy homes and setting the stage for the United States' persistent racial wealth gap. Three out of four neighborhoods "redlined" on government maps 80 years ago continue to struggle economically today.[31,32]

Furthermore, African Americans are incarcerated at more than five times the rate of Whites. Though African Americans and Latinos make up approximately 32% of the United States population they comprised 56% of all incarcerated people in 2015. More African American adults are under correctional control today—in prison or jail, on probation or parole—than were enslaved in 1850, a decade before the Civil War began. The mass incarceration of people of color is a big part of the reason that African American children born today are less likely to be raised by both parents than African American children born into slavery. One in nine African American children has a parent in prison, against one in 56 White children. These stark racial disparities cannot be explained by rates of drug crime; studies show that people of all colors use and sell illegal drugs at remarkably similar rates.[33]

Beyond the separation of families, the over incarceration of African Americans has negative economic impact on families and communities of color. Over-criminalization substantially reduces an individuals' chance of reaching middle class status by middle age and men who have been imprisoned are significantly less upwardly mobile than those who have not.[34]

> "Policies and practices entrenched in established in-stituitons that harm certain racial groups, and help others, create systemic racism."

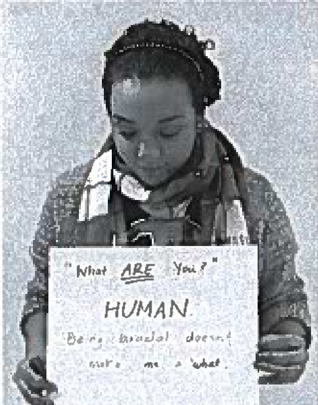
Xenophobia

The United States has been known throughout its history as a nation of immigrants; however, the United States also has a long history of xenophobia, or the dislike, prejudice and/or intolerance of immigrants. Today in the United States, immigration has become a focal point of heated national debates. Immigrants are repeatedly and incorrectly associated with the declining economy, overpopulation, pollution, increased violence, depleted social resources, erosion of cultural values, and terrorism; and immigrants are often portrayed as criminal, poor, violent, and uneducated.[35]

White western Europeans, who colonized the Americas, as well as individuals from many other nations, moved to the United States relatively freely and in great numbers until the early 1900s. In 1921, the United States Congress passed the Quota Act, which established a new system of national origin restrictions, favoring northern European immigrants over those from other regions of the world. In 1924, the Johnson-Reed Act further reduced the quota and created the United States Border Patrol. Subsequent immigration policies continued to be guided by race and social class-based policies (e.g., Chinese Exclusionary Act, the Alien Land Act, the McCarran-

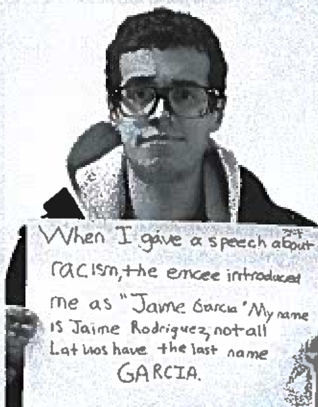
Examples of Microaggressions

Photographer Kiyun Kim asked her friends at Fordham University to "write down an instance of racial microaggression they have faced", all photos can be found on Kim's website, nortonism.tumblr.com:[43]



Cesca - "'What are you?' Human. Being biracial doesn't make me a 'what'."

Courtney - "'Courtney I never see you as a Black girl' #swerve #OPENYOUREYES!"



Jaime-"When I gave a speech about racism, the emcee introduced me as 'Jaime Garcia.' My name is Jaime Rodriguez; not all Latinos have the last name Garcia."

Walter Act) that denied entry or the right to citizenship to non-White immigrants. Non-White immigrants were first able to become naturalized citizens only in 1952, whereas this privilege had been granted to the majority of White immigrants since 1790.[36,37] In 1965, the Immigration and Nationality Act abolished quotas that favored Europeans. This policy resulted in significant demographic shifts in the immigrant population, with nearly 50% of documented immigrants entering the United States from Latin America and the Caribbean, 25% from Asia, and less than 15% from Europe by the year 2000.[36,38]

Even greater diversity resulted from the ratification of the U.S. Refugee Act in 1980, which opened borders to several million refugees who then resettled across the country.[36,39] In the late 1990s, the number of resettled refugees approached 130,000 a year. Recently refugee resettlement has been restricted by the United States government based in part on the inaccurate fear that refugee status would be used as a basis for entrance by criminals and terrorists.[36,40]

As this brief history reveals, immigrants coming to the United States have often been met by discriminatory policies coupled with prejudice and distrust from their host communities. Restrictive and punitive immigration measures have specifically targeted immigrants because of their race and social class. Because of xenophobia, many immigrants experience the interpersonal racism and racial trauma outlined in the sections below.[36]

Interpersonal Racism

Events that cause racial trauma occur in many different forms, and may be direct or subtle and ambiguous. Although most racial encounters occur on an interpersonal level, they are usually the effect of structural or systemic racism like the examples listed above. Examples of interpersonal racism include (but are not limited to) physical and verbal assaults against a person of color, treating a person of color as a stereotype, such as assuming a person of color is criminal or dangerous.[41,42]

Microaggressions

Psychiatrist and Harvard University Professor Chester M. Pierce first proposed the term racial microaggressions in the 1970s, to describe insults and dismissals which he regularly witnessed non-Black Americans inflicting on African Americans. Since Dr. Pierce's work, many psychiatrists and social scientists have advanced the concept. For example, Stanford University psychology professor Claude Steele conducted a study that found that African American women performed worse on academic tests when primed with stereotypes about race or gender. Additionally, several studies have demonstrated that many well-intentioned Whites who consciously believe in and profess equality unconsciously act in a racist manner, particularly in ambiguous circumstances. In experimental job interviews, for example, Whites tend not to discriminate against Black

candidates when their qualifications are as strong or as weak as Whites'. However, when candidates' qualifications are similarly ambiguous, Whites tend to favor White over Black candidates.[44]

Microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color. While individuals may not openly discriminate against people of color, they may engage in microaggressions such as avoiding eye contact on the street or making assumptions about someone's intelligence or mental state. Microaggressions are sometimes conscious and intentional, however on many occasions, the perpetrator may not be aware of the harmful effects of their behavior. Research on microaggressions provides strong evidence that these small slights accumulate over time and negatively affect people of color's mental and physical health such as elevated levels of depression, trauma and heart disease. Additionally, the ambiguous and subtle nature of microaggressions makes them especially frustrating for victims, since they may be unsure how to respond.[42]

How does racial trauma affect individuals?

Although not everyone who experiences racism and discrimination will develop symptoms of race-based trauma, individuals experience and react to racial trauma in a myriad of different ways. Repeated exposure may lead to the following symptoms according to a report on *The Impact of Racial Trauma on African Americans* by Dr. Walter Smith:[45]

- **Increased vigilance and suspicion** – Suspicion of social institutions (schools, agencies, government), avoiding eye contact, only trusting persons within our social and family relationship networks
- **Increased sensitivity to threat** – Defensive postures, avoiding new situations, heightened sensitivity to being disrespected and shamed, and avoid taking risks
- **Increased psychological and physiological symptoms** – Unresolved traumas increase chronic stress and decrease immune system functioning, shift brains to limbic system dominance, increase risks for depression and anxiety disorders, and disrupt child development and quality of emotional attachment in family and social relationships
- **Increased alcohol and drug usage** – Drugs and alcohol are initially useful (real and perceived) in managing the pain and danger of unresolved traumas but become their own disease processes when dependency occurs
- **Increased aggression** – Street gangs, domestic violence, defiant behavior, and appearing tough and impenetrable are ways of coping with danger by attempting to control our physical and social environment
- **Narrowing sense of time** – Persons living in a chronic state of danger do not develop a sense of future; do not have long-term goals, and frequently view dying as an expected outcome

Family Violence and Racial Trauma

The following examples identify and illustrate how racism and racial trauma impact human service systems that address family violence.

Child Welfare System

Research has shown that some children are disproportionately likely to become engaged with child welfare services based on their racial identity. A 2014 study found African American youth were overrepresented in foster care at a rate 1.8 times their rate in the general population in the United States—whereas White children where underrepresented in foster care at 0.8 times the rate in the general population.[46] Furthermore, racial disparities exist at various decision points in the child welfare involvement process. Compared to White and Asian children, African American and multiracial children are more likely to be removed from their homes, spend longer time in foster care, and are less likely to be adopted or reunited with their families before aging out of care compared to other racial groups. African American boys in particular are more likely to be placed in institutional settings; experience more placement moves; and are more likely to age out of care compared to the general population of children.[47,48]

Not only are children of color overrepresented in child welfare, but they also experience inequity in the quality of care provided. Contact with child protective services has been described by families of color as invasive, disruptive, unjust, and unsafe. For many families, this may lead to a general distrust of child welfare services, which limits collaboration between families and communities to promote the safety of all children.[49,50]

Domestic Violence System

Domestic Violence occurs among all races, ethnicities and socio-economic classes; however, for women of color, high rates of poverty, poor education, limited job resources, language barriers, and fear of deportation increase their difficulty finding help and support services. Although there are unique circumstances within the context of a particular community of color, common factors and considerations exist which may account for the under-reporting of domestic violence and failure to seek appropriate help services by this group. Some commonalities include:[51]

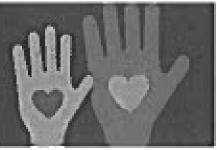
- Patriarchal elements to familial structure (e.g. women's role as wife, mother and homemaker)
- Fear of isolation and alienation
- A strong loyalty to both immediate and extended family
- Distrust of law enforcement and fear of police brutality and violence
- Skepticism that shelter and services are culturally and linguistically competent

Some reasons for not reporting domestic violence are more specific to individual communities. For example, as a result of historical and present-day racism, African American women may be less likely to report their abuser or seek help because of African American men's vulnerability to police violence. African American victims may want the abuse to stop, however they may be hesitant or unwilling to call the police because they don't want their partner to be killed. Similarly, immigrant and undocumented women may not seek help due to fear of their or their partner's deportation and/or separation from children.[51]

Implications for Practice

With increasing recognition of trauma-informed care across social systems and raised awareness of the historic and contemporary structural racism across the United States, it is imperative that sensitivity to racial trauma be included in all trauma-informed strategies. Trauma-informed care involves understanding, anticipating, and responding to the impact that trauma can have and increasing awareness about how to address existing trauma and prevent re-traumatization.[52] When applied to racial trauma, the overarching tenets of trauma-informed care remain the same.[53] However, individuals, communities, professionals and organizations must also consider the tenets through a lens of racial equity informed by historic and contemporary systems of oppression. The following section outlines the tenets of trauma-informed care through a lens that is sensitive to racial trauma.

- **Trauma Awareness:** An understanding of trauma including the types of trauma endured and how it affects a person's physical and mental health. Trauma awareness when addressing racial trauma may include:
  - **Education**- Learning about the impacts of systemic racism and white supremacy and how it causes racial trauma provides context when working with people of color with trauma symptoms.[1]
- **Safety:** Trauma survivors often feel unsafe and may be in danger (e.g. victims of racial violence). A trauma-informed approach works towards building physical and emotional safety. Safety when addressing racial trauma may include:
  - **Physical Safety**- create and support environments where people of color feel safe. Consider and acknowledge how those environments may be different to people of different races and cultures (e.g. police presence in an organization may provoke a trauma response in populations who disproportionately experience police brutality.)[1]
  - **Emotional Safety**- create and support environments where people feel safe to discuss emotionally charged issues such as racism and white supremacy.[1]
- **Respect**- People of color are often stigmatized and disrespected due to racism. It is therefore crucial to uphold the trauma-informed tenet of respect. Respect when addressing racial trauma may include:
  - **Authenticity**- it is natural to worry whether you are saying "the right thing," but respectful authenticity is the cornerstone of honest, albeit hard, conversations about racism.[1]
  - **Difference**- honor and respect differences in perspectives and emotional responses.[1]
  - **Empathy**- offer empathy and understanding to people who express distrust or distress as these emotions are key to acknowledging past hurt.[1]
  - **Validation**- validate and honor people's experiences and emotions rather than trying to convince them that they no longer have a rational reason to feel that way.[1]
- **Control & Choice**- Because control is often taken away in traumatic situations, and because racism is disempowering in and of itself, it is important to honor people of color's control and choice. Control & Choice when addressing



racial trauma may include:

  - **Avoid prescriptive solutions**- Ask individuals what they need to solve or improve their problem instead of relying on a prescriptive solution that may center the dominant culture.[1]
- **Strengths-based approach**- Trauma-informed care is strengths based rather than deficit oriented. Rather than focusing on real or imagined limitations, a trauma informed approach focuses on skills building and resilience.
  - **Re-channel emotion**- Support activities and organizations that foster leadership skills through action and activism. Make sure activities are truly led by people of color and offer space, resources and/or support.[1]
  - **Representation** – Recognize that no one is more of an expert on racial trauma than those affected by it and intentionally hire people of color, listening and looking to them for their expertise.[1]

Spotlight: Southside Trauma-Informed Community Network

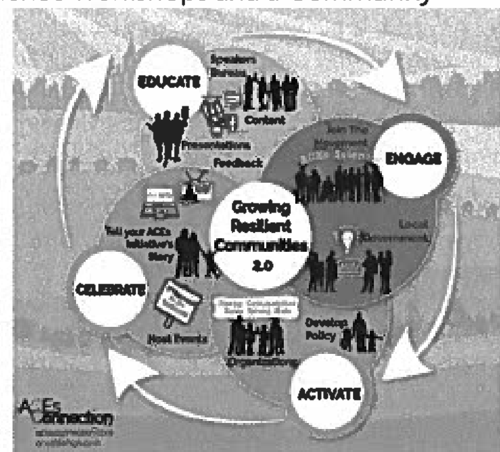
Petersburg, Colonial Heights, Hopewell, Emporia, Dinnwiddie, Prince George, Surry, Greensville and Sussex

The Southside Trauma-Informed Community Network (STICN) is a multi-agency and multi-disciplinary group of organizations and individuals working together to collaborate in creating a more trauma-informed and resilient Southside region. The STICN serves the cities of Petersburg, Colonial Heights, Hopewell, and Emporia and the counties of Dinnwiddie, Prince George, Surry, Greensville and Sussex.

The communities the STICN serves have unique sets of challenges rooted in historic and systemic injustices. For example, when Petersburg's largest industry and employer Brown and Williamson left the city nearly 30 years ago, access to jobs and opportunity drastically decreased, forcing many individuals and families to leave the city along with deterring new residents from moving there. Since then, Petersburg has experienced significant economic decline, which coupled with substantial turnover in city government has made it hard for the city to bounce back. Further, the Southside Regional Dump, which happens to be one of the city's largest employers, stands larger than most buildings in Petersburg creating unpleasant smells and unhealthy pollution from methane gas.

With the Crater Health District as a Backbone and administrative support from the United Way, the STICN employs ACEs Connection's Building Community Resilience 2.0 Model (illustrated below).

The STICN **educates** through ACEs, Trauma-Informed Care and Resilience Workshops and a Community Learning Collaborative. The STICN **engages** through regular community network meetings where members are encouraged to use their lived experience and expertise to inform the larger network on the unique issues affecting their communities. The STICN **activates** by working with Voices for Virginia's Children to inform trauma-informed policy and amplify their efforts through train-the-trainer workshops on ACEs and trauma-informed care. Finally, the STICN **celebrates** through an annual Beyond ACEs, Building Community Resilience Summit that focuses on the impact of race, culture and poverty on Adverse Childhood Experiences as well as a Healing Arts Program, which uses art to help youth overcome obstacles and adversities.



The STICN consists of a diverse group of people coming from nine localities, with members that are grandmothers, political officials, clinicians, ministers, counselors, educators, and other community members. Typical meetings start in a circle process where members of each community share the challenges affecting their area. Because the STICN covers a large area and members come from many different professions, races, ethnicities, and walks of life the STICN strives to gain insight from all of the unique backgrounds of STICN members and to be multicultural in their approach to educating members on trauma.

Spotlight: Just Neighbors
Northern Virginia, the Virginia Eastern Shore and parts of the I-81 corridor

Immigrants may be more vulnerable to domestic violence because they are often isolated due to language barriers and remoteness from family and friends. They may also come from countries where there are no laws or no enforcement of laws against domestic abuse. For some, the cultural norms for their home country don't protect victims from this type of abuse. The abusers often hold the survivors' dependence on the marriage for immigration status as tool of power and control.

Just Neighbors provides immigration legal services to low-income immigrants and refugees of all faiths and nationalities, especially those who are most vulnerable. In 2018, 34% of Just Neighbors clients were domestic violence survivors whose abusers where their avenue to obtaining legal residency. The Violence Against Women Act (VAWA) allows domestic violence survivors to file separate conditional status for residency from the dependence on their marriage (with some conditions).

Just Neighbors' staff and volunteer force has representation and speak the languages from many of the countries of origin of the immigrants they serve. They also have access to interpreter services for all client interactions if needed. This representation coupled with training gives staff context for cultural differences around domestic violence in many of their clients' country of origin. For example, clients coming from South America are often leaving countries where domestic violence is very common due to a culture of machismo (strong or aggressive masculine pride), and a lack of enforcement or protection against domestic violence.

Conclusion
Individual and systemic racism is woven into the customs, laws and traditions of the United States and continues to be endemic in all aspects of American life. As such, people experience the effects of racism in every social, professional and political realm of their lives. Experiencing racism across the spectrum, from frequent ambiguous microaggressions to blatant hate crimes can cause racial trauma, which can have a profound impact on an individual's mental and physical health.

Despite these injustices, people of color have consistently and continually shown resilience in the face of racial trauma. Strong community and familial bonds and cultural identity and pride not only increase people of color's protective factors against the negative outcomes of racial traumatic stress, but also empower communities of color to advocate against the systemic injustices affecting them. Human service professionals have the opportunity and responsibility to foster the resilience of individuals and families of color by infusing racial equity informed by historic and contemporary systems of oppression in all of their trauma-informed work.

Resources

Additional Information
Links to resources accompanying each section of this brief are available at www.fact.virginia.gov/systems-of-trauma

Facebook
Keep up with new information related to trauma and family violence on FACT's Facebook page: www.facebook.com/FACTVA/.

How 'Weathering' Contributes to Racial Health Disparities

When Dr. Arline Geronimus first introduced the theory in 1990, her ideas were derided and largely ignored. Now, people are starting to listen.

By Alisha Haridasani Gupta

Published April 12, 2023

For Arline Geronimus, avoiding the limelight had become a way of life.

Three decades ago, she put forward an idea that was unconventional for the time: that the constant stress of living within a racist society could lead to poor health for marginalized groups.

Dr. Geronimus, then a 32-year-old public health researcher at the University of Michigan, had spent three years gathering data on more than 300,000 pregnant women, in search of an explanation for the vast racial disparities in infant mortality rates. At the time, Black babies died more than twice as often as white babies in their first year of life. It was widely assumed that high rates of teen pregnancy among Black women were to blame.

Dr. Geronimus's research showed otherwise: The babies of Black teens were healthier than the babies of Black women in their 20s and older. These younger women, she posited, had endured fewer years of racism-induced stress, and therefore had given birth to more robust children.

She called this particular form of chronic stress "weathering," evoking a rock being eroded by constant exposure to the elements. She first presented her findings and the outlines of her hypothesis at the annual conference of the American Association for the Advancement of Science in 1990.

The backlash was immediate, and ran the ideological gamut. The Children's Defense Fund, a progressive organization that had knowledge about her talk ahead of time, set up a table outside to express outrage because they thought Dr. Geronimus's conclusion was that teen pregnancy was not entirely bad. "The policy implications of her arguments are perverse," a CDF representative told The New York Times a few weeks after her speech. A columnist at the Washington Times, a conservative paper, wrote "As Marie Antoinette might put it: Let them have babies." Michigan alumni pressured the university's president to fire her. She received death threats at home from anonymous callers.

"I was pretty traumatized," said Dr. Geronimus, now 66, over coffee at the New York Public Library in March. "So I kind of retreated into my work."

In the years that followed, Dr. Geronimus largely stopped going to conferences and rarely talked to reporters (she admitted that this interview was nerve-racking for her). But, with the University of Michigan's continued support, she has published more than 130 papers, expanding and bolstering the evidence for weathering well beyond Black mothers. She has studied Latina

mothers, Mexican immigrants and white people in Appalachian Kentucky, among other groups, repeatedly showing that people experiencing high levels of chronic stress as a result of their identities and circumstances have poorer health outcomes. Simultaneously, researchers across disciplines have linked the relentless strain of discrimination to premature aging and dysfunction of the immune, cardiovascular, metabolic and endocrine systems.

That body of evidence, which Dr. Geronimus describes in her new book, "Weathering: The Extraordinary Stress of Ordinary Life in an Unjust Society," has turned her into an "icon" and provided a framework for understanding health inequities that goes deeper than blaming poor health on lifestyle choices or flawed genetics, said Dr. Marcella Nunez-Smith, a professor at Yale School of Medicine who chaired the White House Covid-19 health equity task force

"There's a solid line from her work on weathering to what we now call social determinants of health," Dr. Nunez-Smith said. Weathering was the foundation of many of the task force's policy decisions during the height of the pandemic, which focused on reducing the excess stresses of the pandemic on people of color and low-income groups — like funding non-English speaking workers to help reach vulnerable populations for contact tracing, and switching from drive-through testing sites, which excluded those without cars, to walk-in options.

Covid is, in large part, why Dr. Geronimus, after years of turning down offers from agents, decided to re-enter the fray with her first book. In a grim affirmation of her work, the pandemic — with its disproportionately high numbers of deaths among people of color — has become one of the starkest examples yet of the effects of weathering.

The pandemic also presented an opportunity for structural change, she said, which would help address health disparities that have only gotten worse since she published her first paper back in 1986.

The Trap of Chronic Stress

When the body is exposed to stressors, it goes into fight-or-flight mode, said Elizabeth Brondolo, a psychology professor at St. John's University who studies the psychophysiology of discrimination. Breathing, heart rate and blood pressure shoot up and the bloodstream is flooded with glucose and fatty acids to fuel the large muscles.

Over time, if the sympathetic nervous system reaction remains activated, it can erode internal systems, Dr. Brondolo said. Chronically elevated blood pressure can damage arteries and veins, which can lead to hypertension, for example. A constant stream of cortisol — known as the stress hormone — can create insulin resistance, leading to diabetes. Research has suggested that chronic stress can damage DNA and even alter brain structure.

Though many people feel stress on a day-to-day basis, surveys have repeatedly found that people of color and those with lower socioeconomic status report more severe and more frequent rates of stress. Research shows that these same groups often can't escape their stressors because they face a higher likelihood of violence, job instability and discrimination while lacking social or material support.

There's also a physically potent and persistent quality to race-based stress. In a series of studies between 1999 and 2009 and in clinical sessions, Dr. Brondolo and her colleagues examined the physiological impact of racist behavior, finding that the body and mind can't easily shake off its

effects. In one study, for instance, participants who reported being on the receiving end of racist behavior experienced elevated blood pressure for an extended period, even while they were asleep. "That's really the key to what Dr. Geronimus is talking about — there was no recovery," Dr. Brondolo said.

Dr. Geronimus's research has found that upward mobility and wealth aren't antidotes for weathering. In one 2006 study, she analyzed the health data — including blood pressure, cortisol levels, liver function and cholesterol — of over 1,500 survey respondents and found that high-income Black women had worse health outcomes than low-income white women.

In a related case, when researchers from Ohio State University examined Black students who attended historically Black colleges and universities, they determined that those years of being "sheltered, at least somewhat, from racial discrimination," as they put it, put participants at a lower risk of health problems later on, compared with their peers who had attended predominantly white institutions.

One explanation for these findings is found in the stress a person experiences when they try to thrive in an environment where their identity or circumstances are in the minority — what psychologists call "high-effort coping." "The actual physiological energy it takes to succeed against all kinds of structural headwinds and barriers itself is weathering," Dr. Geronimus said. It is one of the reasons Black maternal mortality rates remain stubbornly high, she said, even among high-income families — and even as Black teenage pregnancies have plummeted in the decades since her first study.

The Challenges and Critiques

A caveat for much of public health research is that it's observational; it can identify links and associations but cannot prove causation, said Robert Kaestner, a professor at the University of Chicago Harris School of Public Policy who worked with Dr. Geronimus on a 2009 study on Mexican immigrants. When it comes to weathering, he said, not only is it "a difficult empirical task" to measure discrimination, it is also difficult to rule out other environmental stressors.

Despite his skepticism regarding its ability to be measured, Dr. Kaestner described weathering as "intuitive," "plausible" and "consistent with biological processes."

The intersection of health and racism is also a fraught research area that raises challenging questions about privilege and bias. That Dr. Geronimus is a white woman might have afforded her some credibility in that context, said Dr. Camara Jones, an epidemiologist at Rollins School of Public Health at Emory University, who served as a medical officer at the Centers for Disease Control and Prevention from 2000 to 2014.

"White people, in general, are given more credit when they're naming racism," she said. "When people of color do that, we are seen as having a chip on our shoulder or being subjective."

In 1992, Dr. Jones had also shown a link between racism and accelerated aging in a study on blood pressure disparities. But she didn't pursue this line of research for very long, in part because one of her advisers told her that she didn't want to be "known as 'the racism lady,'" she said. "Even when I was writing grant proposals, people would call me and say 'Camara, can you just change the word racism to discrimination?'"

But Dr. Geronimus's race doesn't negate the importance of her research, Dr. Jones said.

"I'm grateful for her work because now the knowledge is out there."

Putting Weathering Research to Use

In March 2020, an immigration lawyer named Kari Hong contacted Dr. Geronimus with a question: Could her research help get detained immigrants out of confinement?

Ms. Hong was worried about her clients' exposure to Covid-19 in the close quarters of detention centers in California and Arizona, where they were being held. "One judge had said people who are uniquely vulnerable to Covid-19 should be able to get out," Ms. Hong said. "So then the question became, 'Well, who's uniquely vulnerable?'"

It was clear that older detainees and those with underlying health conditions would fall into that category. But for her middle-aged clients, the health risks were less clear.

Dr. Geronimus agreed to help. She wrote up legal declarations for seven different cases. "It is my expert opinion that detainees younger than 65 who are Black or have been subjected to trauma and other forms of stress-mediated wear and tear based on their social identity or circumstances are biologically older than their chronological ages," she wrote, "and are more susceptible to experiencing Covid-19 infection in its most severe forms."

All seven detainees were released.

"Without Dr. Geronimus I wouldn't have had an argument at all," Ms. Hong said.

In "Weathering," Dr. Geronimus proposes other reforms that would decrease stress levels for people at risk, though she acknowledges some feel more realistic than others. These include deploying doulas to help reduce Black maternal mortality rates (a tactic that's already shown success in a few local programs across the country) and reinstating the Biden administration's expanded Child Tax Credits, which for many families reduced the hardship of making ends meet (Congress ended the program at the end of 2021).

The idea, Dr. Geronimus said, is to consider health equity even when developing policies "that do not, at first blush, appear health related."

"It does sound intractable at first — I've certainly had my periods of hopelessness over what can be done," she said. "But since these weathering stressors surround us, that means there are so many leverage points. You just have to be committed."

Black communities endured wave of excess deaths in past 2 decades, studies find

The loss of life came at a staggering cost, medically and economically

By Akilah Johnson Washington Post May 16, 2023 at 11:00 a.m. EDT

The reasons for the excess deaths and resulting economic toll are many, including mass incarceration, but the root is the same, according to the reports published Tuesday in the influential medical journal JAMA: the unequal nature of how American society is structured.

That includes access to quality schools, jobs with a living wage, housing in safe neighborhoods, health insurance and medical care — all of which affect health and well-being. For centuries, Black people were legally deprived of these benefits, and researchers said we have yet to fully ameliorate the effects.

"Just to illustrate the issue, one of the clearest examples of structural racism was in 1935 when the Social Security Act was passed," said Thomas LaVeist, dean of the Tulane University School of Public Health and Tropical Medicine and the lead author of the study on the economic implications of health disparities. "They intentionally left out domestic workers and farmworkers who were disproportionately Black. That hasn't been fully unraveled."

America's Black communities experienced an excess 1.6 million deaths compared with the White population during the past two decades, a staggering loss that comes at a cost of hundreds of billions of dollars, according to two new studies that build on a generation of research into health disparities and inequity.

In one study, researchers conclude that the gap in health outcomes translated into 80 million years of potential life lost — years of life that could have been preserved if the gap between Black and White mortality rates had been eliminated. The second report determined the price society pays for failing to achieve health equity and allowing Black people to die prematurely: $238 billion in 2018 alone.

"This is our collective challenge as a country because it hurts all of us deeply," said Marcella Nunez-Smith, associate dean for health equity research at Yale University and co-author of the study on excess deaths and years of life lost. "All of the potential.

Which one of those people whose life was cut short was on the way to some scientific discovery that would transform all of our lives or create beautiful art and music? Who among them was going to be a spiritual or religious leader? Not to mention the economic impact."

And the shorter life expectancy of Black Americans means they do not derive what they have invested in Social Security. People born in 1960 can start receiving their full Social Security benefits at age 67, but according to the Centers for Disease Control and Prevention, Black men born that year had an average life expectancy of just 61 years.
Not only is that person paying into a system they are not fully benefiting from but society is also losing "because that person isn't there as part of the economy," LaVeist said. "We've paid for schooling for this person, who gets a job and pays taxes and dies prematurely. The investment in that person is never recovered by society."
That comes at a significant cost in military readiness, in workforce fitness, in dollars and cents.

Researchers explored the economic burden caused by health inequities when someone dies prematurely or must pay out-of-pocket costs and third-party payments to health-care providers for emergency room visits, ambulance services, or vision and dental care.

They also calculated the economic toll when people can't work because they or relatives are sick, or when employees show up to work but are less productive because they're not well.

Expanding their analysis to a broader population, the researchers concluded that the failure to achieve health equity in 2018 cost the nation $1.03 trillion. That price tag includes the burden experienced by American adults older than 25 who do not have a college degree and by Native American, Asian, Black, Latino and Pacific Islander people.

More than two-thirds of the economic burden experienced by communities of color was attributed to premature deaths, with most of those untimely deaths coming from the Black community. Meanwhile, "adults with a 4-year-college degree had zero premature death costs," the report said.

For nearly 40 years, study after study examining disparate health outcomes in the Black community have started by referencing a landmark study on Black and minority health that came to be known as the "Heckler Report," so named because it was written when Margaret Heckler was President Ronald Reagan's health secretary. The two studies released Tuesday are no exception in citing that report, which attributed 60,000 excess deaths a year to health disparities as it became a clarion call to the nation.

"It's not just the '85 report, it's going back to 'The Philadelphia Negro' with W.E.B. Du Bois," which was published 124 years ago and was the first ethnography to outline problems faced by the Black community, said Darrell Hudson, who researches health disparities at Washington University in St. Louis. "The outcome is not new. Our understanding of the mechanisms, policies and practices have evolved."

In the decades since, modern medicine has witnessed major scientific discoveries and technological breakthroughs, but those advances haven't benefited everyone equally.

When taken together, researchers say, the reports released Tuesday dispel several myths about how society has — and has not — responded to the alarm sounded more than a generation ago.

"We tend to have this idea as we move through time, we're constantly improving," said Jessica Owens-Young, an assistant professor in the Department of Health Studies at American University, where she researches health equity. But, she said, "we can't always assume that as we continue to innovate that is going to promote and protect people's health."
Nunez-Smith, who was chair of President Biden's Covid-19 Health Equity Task Force, said the report on excess deaths dispenses with the notion that the root causes of racial health disparities reflect "some deterministic factor that race is biological."

Nunez-Smith and the other researchers analyzed death certificates from 1999 through 2020 to reach their conclusions about excess deaths — the observed number of deaths vs. what would be expected if Black and White death rates were the same.

From 1999 to the early 2010s, the report found that the gap in excess deaths narrowed, dropping by about 48 percent for Black men and about 61 percent for Black women compared with their

White counterparts. But then progress plateaued, the excess burden of death stubbornly persisting until it ballooned in 2020.

Excess mortality during the first year of the coronavirus pandemic, the report said, exceeded that of any previous year of the study.

Infants bore the brunt of excess deaths and years of life lost along with adults older than 50. The death gap between men and women widened sharply, according to the report.
The leading causes of excess death and years of life lost, according to the study, include infant mortality, heart disease and cancer.

"These findings indicate that current efforts to curb or eliminate mortality disparities have been minimally effective, and progress, when made, has been fragile," the report concluded.

The numbers represent something else, said Harlan Krumholz, a cardiologist at the Yale School of Medicine and co-author of the excess death study: a greater need to recognize "where we're failing and the magnitude of the problem."

"Why don't we accept that this is really racism as cause of death?" Krumholz asked. "What other health problem has created that kind of loss?"

The study shows that, except for ages 1 to 10, Black males experienced the highest rates of excess death and years of life lost, a finding that Derek Griffith, director of Georgetown University's Center for Men's Health Equity in the Racial Justice Institute, said reinforces the need to consider the ways "anti-Black racism is gendered and use that as foundation for how we need to intervene."

Griffith said the report mentions "structural racism, but it's too blunt of an instrument. Anti-Black racism manifests in stereotypes and tropes. It's that cultural narrative that shapes why it makes it okay for us to have these patterns."

Many of those stereotypes are viewed through a gender lens, he said.

Research shows Black boys are often viewed as older, stronger and less innocent than their peers. Black men are seen as criminals, intellectually inferior, "deadbeat dads." Black women are reduced to racist caricatures of lasciviousness, aggressiveness, the "welfare queen."

"We don't tend to think about the structural drivers of racial inequity in a way that is precise enough," Griffith said. He noted that talking about Black men's poor health outcomes often "gets uncomfortable. We try to deal with this as a race pattern without dealing with the gender pattern."

Those differences are evident in how men are socialized to handle stress and their health. Also, researchers said, many government and health programs tend to be geared toward helping single mothers, but those same services aren't available for men and single fathers.

"Over time, we find that socioeconomic status doesn't protect in the same way it does for other people, especially for Black men who report more discrimination the more income and education they have," Hudson, of Washington University, said.

Often, to seek out upward mobility, Black people have to cross boundaries, navigating mostly White spaces to get an education, earn a living, take out a loan, raise a child. That can prove caustic, Hudson said, because if someone is constantly crossing boundaries, they are constantly experiencing stress — or anticipating it.

Stress is a physiological reaction, hard-wired. At the first sign of danger, the brain sounds an alarm, setting off a torrent of neurological and hormonal signals that flood the bloodstream. Overexposure to those hormones wears down the body, causing it to become sicker and age quicker, or "weather."

While weathering isn't specific to race, it is believed to take a particular toll on Black people because of the unique, unrelenting stress caused by racism. Research shows Black people have much higher rates of hypertension, obesity, diabetes and strokes than White people do, and they develop those chronic conditions up to 10 years earlier.

"Our bodies are not sophisticated enough to discern that this is not a lion on the savanna but someone who just looked at you funny," said Hudson, who calls it "the cost of upward social mobility."

But there is reason for hope, and it can be found in the period during the coronavirus pandemic when the gap between Black and White death rates began to shrink and even flip. In 2021, White people had the second-biggest drop in life expectancy, losing a full year while Black people lost 0.7 years, according to the CDC.

"And why was that happening?" asked Reed Tuckson, co-founder of the Black Coalition Against Covid. There are two reasons, he said. "One, of course, was the destructive messaging that came from many White political leaders but also the impact of the mobilization of Black faith and community-based organizations and social and fraternal organizations."

Tuckson, an internist and former D.C. public health commissioner, said the herculean efforts by the Black community "to fight for our lives" despite having meager resources show that it is past time for the federal government "to find a way to create sustainable, predictable funding at scale to support the Black community and its institutions."
"We have shown that we can catch up despite running a race with an anvil on our backs," he said.

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The Impact of Racism, Class, and Criminal Justice on Women's Distress and Health: A Reinforcing Cycle of Social Disadvantage

Abenaa A. Jones, PhD, and Alexis R. Santos-Lozada, PhD

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See also Alang et al., p. S29.

The intersection of racism, classism, gender discrimination, and criminal justice involvement in the United States continues to manifest syndemic inequalities. In their work, Alang et al. (p. S29) describe police brutality and the adverse outcomes produced in women's lives over time. Drawing on seminal work on intersectionality and public health,[1,2] Alang et al. argue for in-depth consideration of how gender and racism influence police brutality and the impact of interactions with the police on the health and well-being of racialized women. Personal and vicarious witnessing of police brutality and other adverse criminal justice contacts has been shown to affect women and Black individuals.[3,4] Moreover, Black and Latina women are significantly more likely to fear police brutality than White women, and this anticipatory fear is linked with depressed moods.[5] Furthermore, evidence suggests that even having a family member incarcerated during a woman's childhood is associated with a higher likelihood of depressed mood in adulthood.[5]

The interaction between the criminal justice system and racial minority status is complex, as evidenced by results on the impact of a partner's incarceration on racially minoritized women and consequences for their own life. In the case of Black women, evidence suggests that partner incarceration is linked with substance use.[6] Although the mechanisms through which partner incarceration leads to drug use need further exploration, the knitted relationship between gender and race can lead to heightened vulnerability and inequality.[6] Moreover, fear of harassment from police reduces access to syringe service programs and other harm reduction programs among racialized people who use drugs and may contribute to rising overdoses and fear of overdoses among minoritized groups, contributing to health disparities.[7–9]

Although minoritization based on race and sex complicates health and social equity, the impact of adverse criminal justice contacts on women receives less attention than the impact on racialized men, eliciting calls for gender-inclusive racial justice initiatives.[1] Notwithstanding criminal justice–related cases of physical and sexual exploitation of women, few studies have quantified the prevalence and magnitude of such incidents.

Research by Cottler et al.[10] showed that among a sample of 318 women involved in the criminal justice system, 25% reported police sexual misconduct. Of these women, 96% reported having sex with an on-duty officer, 77% reported repeated exchanges, and 31% reported being raped by police.[10] In a study by Stringer et al., a smaller yet sizable percentage of women involved in the criminal justice system (14%) reported police sexual misconduct, significantly increasing depression and posttraumatic stress disorder among victims.[11] An especially vulnerable group of women are those who engage in sex work, have a history of multiple arrests, and are affected by the syndemic nature of substance use and poverty, as they may be coerced into sexual activities in exchange for favors from police officers.[10–12] The few studies quantifying adverse criminal justice outcomes and participant insights gain validation with US Department of Justice reports and the never-ending stream of media stories.[13,14]

The lack of measurement of these issues in large, representative samples limits our understanding of the impact of adverse criminal justice contacts on women's health. In a brief descriptive analysis, we used data from the 2016 to 2019 National Survey on Drug Use and Health (n = 65 184) to further highlight the effects of racism, gender, class, and criminal justice on women's health and well-being. We explored the impact of ever being booked in prison (a measure of criminal justice involvement)

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among White and Black women and how the disparities observed in the initial measure transformed when poverty status (a proxy for social class) was incorporated into the analysis.

Panel A of Figure 1 shows that Black women who had been booked in prison reported worse health than any other group. They were followed by White women who had been booked and Black women who had never been booked. Interestingly, White women who had contact with the criminal justice system reported poor or fair self-reported health at levels closer to those of Black women who did not have contact with the criminal justice system than White women who reported no contact. The patterns observed in Figure 1 underscore how racial minority status and criminal justice involvement adversely affect health. White women who had never been booked in prison reported lower levels of poor or fair self-reported health than the other groups included in the analysis.

We also explored the association between self-reported health and racial minority status, class, and criminal justice involvement categories (Figure A, available as a supplement to the online version of this article at https://ajph.org). Disparities in self-reported health status were more evident and magnified when income level was considered. We acknowledge the various measurement issues arising from self-reported health, but it is still one of the most widely collected and used health outcomes and is associated with physiological dysregulation, other adverse health outcomes, and mortality.[15,16]

Panel B of Figure 1 shows corresponding trends for serious psychological distress. The descriptive analysis showed that White women who had been booked in prison reported worse serious psychological distress than the other groups. They were followed by Black women who had been booked in prison and White women who had not been booked. Black women who had never been booked in prison reported serious psychological distress at lower levels than the other groups assessed included in the study. When income level was considered, this pattern shifted. The odds of meeting the threshold for serious psychological distress were lower among White women who had never been booked and who lived above the poverty threshold than among most of the other groups. The only exception

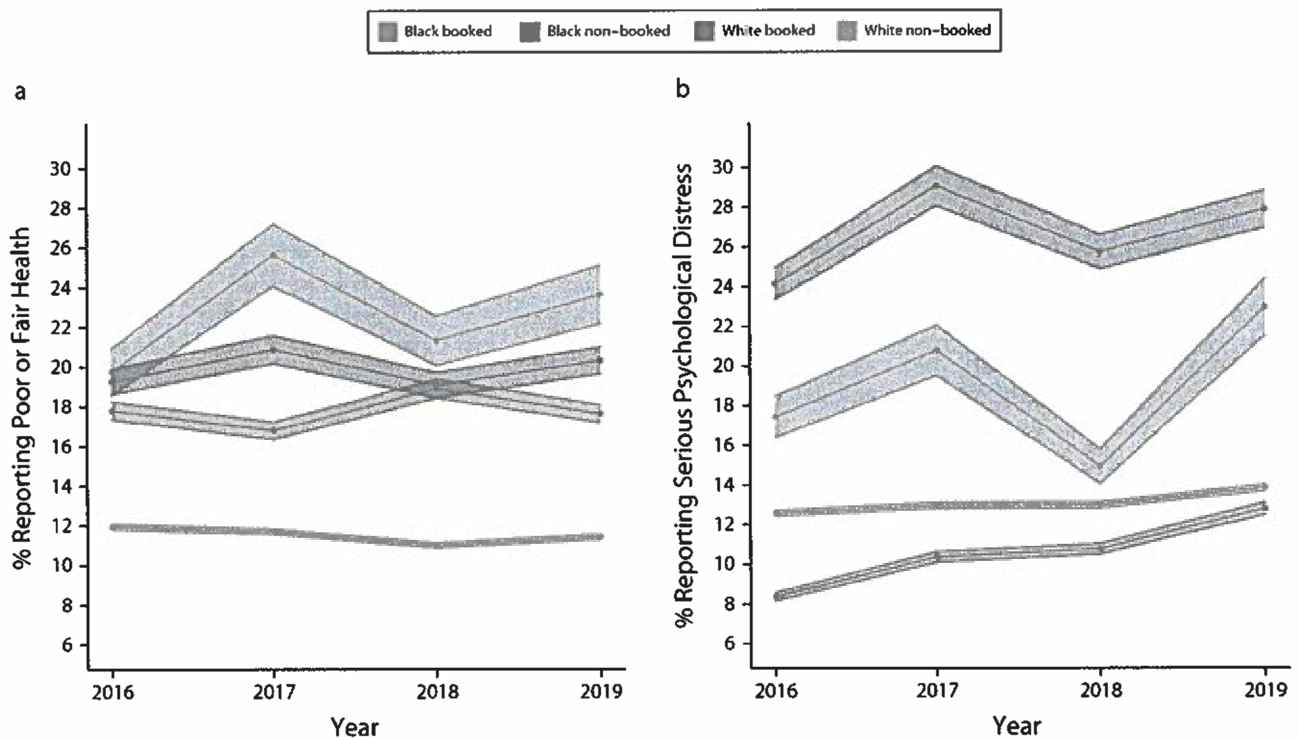

FIGURE 1— Differences in (a) Poor or Fair Health and (b) Serious Psychological Distress Between White and Black Women According to Whether They Had Ever Been Booked in Prison: United States, 2016–2019

Note. The analysis evaluated women aged 18 years or older.
Source. National Survey of Drug Use and Health, 2016–2019.

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was Black women who had not been booked and lived above the poverty threshold (Figure A).

These results add quantification to some of Alang et al.'s arguments and corroborate previous research on the negative impact of adverse criminal justice contacts on psychological health.[5] Mattingly et al.[3] found that, among a large sample of racially/ethnically diverse young adults in California, distress regarding police brutality rose from 2017 to 2020, with Hispanic and Black individuals having the highest distress. Distress over police brutality was linked with substance use in racialized groups. Overall, the constant exposure to police brutality on media channels and physical witnessing of these incidents by racialized communities, along with personal police contact, produce vicarious and collective trauma.[4,17] There is a disproportionate police presence in racialized communities, making anticipatory fear of adverse criminal justice contacts pronounced.[4,5]

In recent years, the constant stream of media stories and videos of police brutality victims and adverse criminal justice outcomes has illuminated pervasive racism in the United States, leading to calls for reformation within the criminal justice system. Research by Reingle et al.[18] showed that every increase in police academy graduating class size was linked with a 9% increase in the odds of discharge for police sexual misconduct, and having a graduating class above 35 was associated with more than four times the odds of discharges than smaller classes. These results imply that solutions to adverse criminal justice contacts may include limiting police academy class sizes and instituting steady hiring practices, rather than intensive hiring periods, to ensure proper training of all members. Alang et al. note that "power and the benefits of power are what keep oppressive systems in place." Acknowledging and addressing the effects of these intersectional social factors will be key to improving women's health. AJPH

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A. A. Jones conceptualized the study, advised on the operationalization of measures, and wrote the article. A. R. Santos-Lozada performed the data analysis, produced the data visualizations, and assisted in the writing process.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

REFERENCES

1. Crenshaw K, Ritchie A, Anspach R, Gilmer R, Harris L. Say her name: resisting police brutality against black women. Available at: https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=4235&context=faculty_scholarship. Accessed August 20, 2022.
2. Bowleg L. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *Am J Public Health*. 2012;102(7):1267–1273. https://doi.org/10.2105/AJPH.2012.300750
3. Mattingly DT, Howard LC, Krueger EA, Fleischer NL, Hughes-Halbert C, Leventhal AM. Change in distress about police brutality and substance use among young people, 2017–2020. *Drug Alcohol Depend*. 2022;237:109530. https://doi.org/10.1016/j.drugalcdep.2022.109530
4. Turney K. Depressive symptoms among adolescents exposed to personal and vicarious police contact. *Soc Ment Health*. 2021;11(2):113–133. https://doi.org/10.1177/2156869320923095
5. Alang S, Haile R, Mitsdarffer ML, VanHook C. Inequities in anticipatory stress of police brutality and depressed mood among women. *J Racial Ethn Health Disparities*. 2022 [Epub ahead of print]. https://doi.org/10.1007/s40615-022-01390-8
6. Bruns A, Lee H. Partner incarceration and women's substance use. *J Marriage Fam*. 2020;82(4):1178–1196. https://doi.org/10.1111/jomf.12659
7. Jones AA, Schneider KE, Mahlobo CT, et al. Fentanyl overdose concerns among people who inject drugs: the role of sex, racial minority status, and overdose prevention efforts. *Psychol Addict Behav*. 2022 [Epub ahead of print]. https://doi.org/10.1037/adb0000834
8. Jones AA, Park JN, Allen ST, et al. Racial differences in overdose training, naloxone possession, and naloxone administration among clients and nonclients of a syringe services program. *J Subst Abuse Treat*. 2021;129:108412. https://doi.org/10.1016/j.jsat.2021.108412
9. Strathdee SA, Beletsky L, Kerr T. HIV, drugs and the legal environment. *Int J Drug Policy*. 2015; 26(suppl 1):S27–S32. https://doi.org/10.1016/j.drugpo.2014.09.001
10. Cottler LB, O'Leary CC, Nickel KB, Reingle JM, Isom D. Breaking the blue wall of silence: risk factors for experiencing police sexual misconduct among female offenders. *Am J Public Health*. 2014;104(2):338–344. https://doi.org/10.2105/AJPH.2013.301513
11. Stringer KL, Marotta P, Goddard-Eckrich D, et al. Mental health consequences of sexual misconduct by law enforcement and criminal justice personnel among black drug-involved women in community corrections. *J Urban Health*. 2020;97(1):148–157. https://doi.org/10.1007/s11524-019-00394-w
12. Jones AA, Dyer TV, Das A, Lasopa SO, Striley CW, Cottler LB. Risky sexual behaviors, substance use, and perceptions of risky behaviors among criminal justice involved women who trade sex. *J Drug Issues*. 2019;49(1):15–27. https://doi.org/10.1177/0022042618795141
13. Jones AA, O'Leary CC, Striley CW, et al. Substance use, victimization, HIV/AIDS risk, and recidivism among females in a therapeutic justice program. *J Subst Use*. 2018;23(4):415–421. https://doi.org/10.1080/14659891.2018.1436604
14. US Department of Justice. Investigation of the Ferguson Police. Available at: https://www.justice.gov/sites/default/files/opa/press-releases/attachments/2015/03/04/ferguson_police_department_report.pdf. Accessed August 20, 2022.
15. Santos-Lozada AR, Howard JT. Using allostatic load to validate self-rated health for racial/ethnic groups in the United States. *Biodemography Soc Biol*. 2018;64(1):1–14. https://doi.org/10.1080/19485565.2018.1429891
16. Jylhä M. What is self-rated health and why does it predict mortality? Towards a unified conceptual model. *Soc Sci Med*. 2009;69(3):307–316. https://doi.org/10.1016/j.socscimed.2009.05.013
17. Herschlag G, Kang HS, Luo J, et al. Quantifying gerrymandering in North Carolina. Available at: http://arxiv.org/abs/1801.03783. Accessed August 20, 2022.
18. Reingle Gonzalez JM, Bishopp SA, Jetelina KK. Rethinking police training policies: large class sizes increase risk of police sexual misconduct. *J Public Health (Oxf)*. 2016;38(3):614–620. https://doi.org/10.1093/pubmed/fdv113

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