

COMMENTARY

Commentary on the special issue on disproportionate exposure to trauma: Trauma, stress, and adversities and health disparities among disenfranchised groups globally during the COVID pandemic

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Abstract

The papers in this *Journal of Traumatic Stress* special issue on disproportionate adversity cover the gamut of discrimination traumas and stressors, including microaggressions, a more insidious forms of discrimination, and their often-devastating and wide-ranging mental health sequelae, in disproportionately affected disenfranchised groups. Discrimination based on race, ethnicity, gender, and sexual orientation commonly confers cumulative and chronic effects. In the field of traumatic stress studies, several types of identity-linked traumatic events have been identified and empirically investigated as posttraumatic stress disorder (PTSD)–producing experiences. Collectively, the 13 papers included in this special issue raise questions about the definition, conceptualization, and categorization of various forms of explicit and implicit identity-linked trauma. These papers highlight the need for acceptance of a shared nomenclature and better differentiation of both causal and correlational associations with acute and chronic PTSD, depression, suicide risk, alcohol misuse, and other mental health outcomes. In this commentary, the discussion is extended to COVID-19, a disease that has been globally devastating for many. On multiple levels (i.e., physical, mental, emotional, economic, and social), COVID-19 has magnified the prepandemic fault lines of race, ethnicity, gender, gender identity, and sexual orientation. Applying a syndemic framework to the health impact of COVID-19 and, arguably, the most pervasive identity linked epidemic worldwide—systemic racism—brings perspective to the biological and social forces that are likely to be driving the convergence of COVID-19, systemic racism, and chronic health inequities, and may be informative in guiding evidence-based strategies for managing racial trauma in the context of COVID-19.

This thought-provoking and rich ensemble of empirical studies calls to attention the pervasive mental health impact of traumatic events, extreme adversities, and severe stressors that disenfranchised populations and subpopulations around the world experience. The 13 studies add to the extant global discourse on discrimination stressors and provide unique insights on a spectrum of health disparities. Although none of the studies specifically examine discrimination during the COVID-19 era, their findings raise essential questions for research, clinical practice, and policy in the complex context of what has become a prolonged pandemic.

Currently, the deleterious effects of identity-linked exposures (i.e., discrete and nondiscrete, within and across generations) on health, functioning, and social relationships have rapidly been shaped by the cumulative impact of a severe, unpredictable, and prolonged global trauma that is continuing to inflict much physical, mental, and economic suffering. With COVID-19 at the forefront and its impact wide-reaching, some questions arise for disenfranchised groups: What are the associations among identity-linked trauma, adversity, and chronic stress and differential COVID-19 disease exposure, disease susceptibility, and health outcomes? What are the explanatory processes and interactions that are at play?

It is fair to say that COVID-19 has magnified the prepandemic fault lines of race, ethnicity, gender, gender identity, and sexual orientation rather than becoming the global “equalizer” disease it was projected to be. Marginalized populations have experienced significant disadvantage with respect to COVID-19 exposure, susceptibility, and treatment access, as well as in the psychosocial effects of the pandemic (Diaz et al., 2021; Ruprecht et al., 2021). Biomedical factors and social determinants of health are proposed to underpin these health disparities, which hold up even after factoring in sociodemographic and comorbidity confounds.

In the United States, COVID-19 has revealed serious disparities in disease outcomes among African American and Latinx individuals (Kullar et al., 2020), with a disproportionately high rate of COVID-19 mortality among these groups (Webb Hooper et al., 2020). Similarly, drawing on data from the UK Biobank, a prospective cohort study found that Black individuals in the United Kingdom had over a 4-fold increased risk of COVID-19 infection and Asian individuals a doubling of the risk compared with White individuals; these increased risks were only partially attenuated after adjusting for putative explanatory socioeconomic, lifestyle, and mental- and physical health-related factors (i.e., 33% for Blacks, 52% for Asians; Lassale et al., 2020). Disaggregated patterns by race and sex show a similar patterning, with the highest COVID-19 mortality rates occurring in Black men compared to Black women as well

as in men and women of races other than White (Griffith et al., 2021).

Perceived discrimination may further contribute to the exacerbation of COVID-19 health risks in disenfranchised populations. Recent data show that the frequency and stress of experiences of discrimination predict an increase in both COVID-19 illness severity and the number of persistent symptoms, even after controlling for sociodemographic factors and mental and physical health comorbidities (Thomason et al., 2021). The impact of discrimination on mental health during the pandemic, as well as the increase in mental health problems such as anxiety, depression, and psychosis, extends to other marginalized ethnic and indigenous groups, such as the Kashmiri Indians (Mukherjee, 2020) and Aboriginal and Torres Strait Islander populations in Australia (Newby et al., 2020).

Discrimination stressors in sexual and gender minorities (i.e., lesbian, gay, bisexual, transgender, two-spirit, queer, questioning, intersex, and asexual [LGBT2SQIA+] individuals) are similarly of concern. In these minorities, COVID-19 has magnified prepandemic inequities, such as finances, access to employment, health care, stigma, and transphobic violence, adding to the preexisting mental health burden in this population (e.g., PTSD, anxiety, depression, suicidality) and to overall lower levels of well-being (Buspavanich et al., 2021; Diaz et al., 2021; Gibb et al., 2020; Krause, 2021; Salerno et al., 2020). Corroborating this, the authors of a study in an LGBT+ community in Hong Kong found that sexual minority-specific COVID-19-related stressors explained significantly more of the variance in depressive and anxiety symptoms above and beyond other COVID-19-related stressors (Suen et al., 2021).

A SYNDEMIC OF SYSTEMIC RACISM AND DISCRIMINATION, COVID-19, AND HEALTH

Several months into the pandemic, Clarence Gravlee (2020), an anthropologist, warned that systemic racism, chronic health inequities, and COVID-19 were a “syndemic” in the making. Racism and discrimination are chronic stressors that have demonstrated a longstanding and significant association with poorer mental and physical health (Paradies et al., 2015); however, COVID-19 has amplified the associations among structural racism, social risk factors, and health (Egede et al., 2020). The term syndemic, coined by Singer (1996), was originally used to denote the disproportionate converging impacts of the AIDS epidemic, violence and drug use, and other noxious social factors, on American Black and Latinx communities. A syndemic refers to the presence of two or more epidemics

interacting synergistically in ways that exacerbate health consequences because of their interactions. These synergistic interactions are strongly influenced and sustained by a wider set of political, economic, and social factors (Singer, 1996; Singer & Clair, 2003). A syndemic, therefore, is buttressed on disease concentration (i.e., the co-occurrence of two or more epidemics), disease interaction (i.e., the synergistic effects of overlapping epidemics in exacerbating health outcomes) and large-scale structural and social forces that, over time, “result in deep-seated social, economic, and power inequities” (Gravlee, 2020). The study by Mootz and colleagues (2021) in this special issue extends the concept of syndemics (the interacting epidemics of HIV and interpersonal violence) from individuals to couples, showing that the adverse impact of exposure to interpersonal violence on couples living in Uganda was most severe when they lived in a war-torn area and the male partner was HIV-positive or had an unknown HIV status. Further research is needed to determine how syndemic exposure affects not only individuals and couples but also extended families in different settings.

In the context of COVID-19, complex, bidirectional biological and social processes are likely to be driving the disease to converge with systemic racism and chronic health inequities. For example, systemic racism and social inequities (e.g., poverty, poor nutrition, overcrowding, violence, pollutants) may be increasing the risk for COVID-19 through various behavioral and physiological pathways, including inflammation and cardiometabolic status (e.g., hypertension and diabetes; Gravlee, 2020). Conversely, COVID-19 has been deepening preexisting social inequities and further worsening health, with job and income losses and access to health care inordinately affecting Black communities and other people of color. Besides the disproportionate burden of underlying comorbidities, exposure to health-damaging neighborhood conditions, reduced access to protective resources, home and employment circumstances that preclude staying at home and socially distancing, and biological and genetic factors, may predispose disenfranchised groups not only to more severe disease and increased COVID-19-related mortality but also to stress-related psychopathology, anxiety, and depression (Webb Hooper et al., 2020).

COVID-19 AND DISCRIMINATION AND OPPRESSION AS TRAUMATIC STRESSORS

There is mounting evidence that discrimination and other insidious forms of oppression are potentially traumatic experiences that give rise to trauma-related symptoms and posttraumatic stress disorder (PTSD), although these types of exposure are not recognized in the *Diagnostic and Sta-*

tistical Manual of Mental Disorders (fifth ed.; DSM-5) as PTSD-inducing (i.e., Criterion A) events (Holmes et al., 2016; Kira et al., 2019). There are also striking similarities in the stress neurobiology stemming from discrimination (e.g., hormonal and neural effects) and other PTSD Criterion A traumatic events (Berger & Sarnyai, 2015). The study by Bird and colleagues (2021) in this special issue supports this premise and is important insofar as it provides evidence for the predictive utility of racial discrimination on PTSD severity. In their prospective study of African Americans, the authors report that past racial discrimination experiences were significantly associated with more severe posttraumatic stress symptoms in the early aftermath (i.e., within 2 weeks) of a traumatic injury and further predictive of more severe PTSD symptoms at 6-month follow-up. Limitations of the study are the retrospective measurement of discriminatory experiences and lifetime trauma exposure as well as the assessment of these experiences in relation to the traumatic injury, which was anchored as the index trauma, which precludes direct causal examination of the PTSD-producing effects of current racial discrimination. The authors make a poignant observation that “naming racial discrimination as traumatic and recognizing the mental health effects of these experiences may be validating for many” (Bird et al., 2021).

Their proposition about racial discrimination as traumatic is supported by the findings reported by Estrada and colleagues (2021), whose paper on intersectional discrimination and traumatic stress in multiminoritized groups of individuals is a welcome addition to the issue. In Latinx, gender- and sexual-minority immigrants, the authors report a positive association between posttraumatic symptoms and experiences of intersectional discrimination (i.e., based on race and sexual orientation) and acculturative stress—an association that was sustained both independently and across varying levels of perceived social support. The cross-sectional design and lack of determination of a clinical PTSD diagnosis did not permit the ascertainment of intersectional discrimination as a direct antecedent to PTSD. These studies underscore the value of carefully anchoring PTSD symptoms and diagnosis to different forms of oppression and adversity.

Addressing a different form of adversity that is often underappreciated in PTSD research, material hardship, Holmes et al. (2021) examined a sample of Black women, who are disproportionately burdened by both poverty and PTSD symptoms. Unsurprisingly, material hardship was positively associated with PTSD in this group. The authors highlight that the findings may be better explained by other constructs, such as racism and sexism, which were not measured in the study. Two lessons can be drawn: First, unmeasured variables of intersectional discrimination and other forms of oppression could be driving explanatory

associations with PTSD symptoms and diagnosis and should be considered; second, indicators of poverty, such as material hardship, should be included in trauma and PTSD research, assessment, and treatment. In addition, attention to the cyclic and ongoing nature of oppression and adversity in these populations cannot be overemphasized. This is the focus of a mixed-method study in this issue by Potluri and Patel (2021). The authors applied a continuous traumatic stress (CTS) framework to characterize past, current, and future perceptions and experiences of ongoing adversity, documenting their related mental health impact among Indian women from slums who are exposed to the intersectional effects of poverty and gender-based violence.

Questions have been raised as to whether specific race-related traumatic experiences that are more pervasive, routine, and constant, such as microaggressions, give rise to more unique posttraumatic stress reactions that are not a consistent match with the *DSM-5* construct of PTSD (Comas-Díaz et al., 2019). In another paper in this issue, by Auguste et al. (2021), it is notable that Black, Indigenous, and people of color in the United States did not report high levels of stress due to microaggressions. However, microaggressions were uniquely associated with depressive symptoms, whereas posttraumatic stress symptom severity partially mediated this association. Higher levels of lifetime trauma exposure in the sample did not account for the association between microaggressions and posttraumatic stress symptoms, suggesting that microaggressions may contribute to posttraumatic stress independently of other trauma exposure. This was a cross-sectional study, however, and parsing out the directional and mediation effects will require longitudinal assessment.

Although neither discrimination and oppression nor COVID-19 are currently recognized as *DSM-5* Criterion A events, there is emerging evidence that the consequences of the combined exposure may be profound. COVID-19 has been suggested as a “new type of traumatic stress that is multilayered, continuous, and has profound social status adverse effects” (Kira, Shuwiekh, Alhuwailah, et al., 2021; Kira, Shuwiekh, Rice, et al., 2021). In this regard, the authors of a study across seven Arab countries (i.e., Egypt, Kuwait, Saudi Arabia, Jordan, Algeria, Iraq, and Palestine) found that COVID-19–related traumatic stress, when coupled with collective identity trauma—namely, discrimination due to ethnicity, race, culture, religion, national origin, and sexual preferences, as well as torture due to political affiliation or history of oppression, being discriminated against, or being threatened by genocide—contributed significantly to existential and death-related anxiety; higher levels of PTSD, anxiety, and depression; and reduced perceived social status and well-being (Kira, Shuwiekh, Alhuwailah, et al., 2021). These associations were found to be invariant across gender and different countries.

THE BIOLOGICAL EMBEDDING EFFECTS OF ADVERSITY AND TRAUMA

The biological embedding of the stress of racism and discrimination has been widely documented. Everyday discrimination experiences have consistently been linked to hypothalamic–pituitary–adrenal axis dysregulation (i.e., increased glucocorticoids), proinflammatory cytokines, other inflammatory markers, and poorer mental health (Borrell et al., 2013; Williams, 2018). In addition, there is evidence of an association between a higher allostatic load, a composite measure of multisystem dysregulation, and consistently elevated levels of perceived racial discrimination among African American adolescents, the latter only ameliorated by the receipt of high levels of emotional support (Brody et al., 2014). Finally, using recent methods designed to examine biomarkers of “weathering” or aging, some studies have demonstrated that African American youth and adults show accelerated physiologic weathering through telomere attrition with associated health declines across age and sex (Chae et al., 2020; S. Y. Liu & Kawachi, 2017; Pantesco et al., 2018; Rewak et al., 2014) as well as DNA methylation patterns indicative of biological aging (Brody et al., 2016). The effects are notably cumulative, with a positive association reported between a higher lifetime burden of racial or gender discrimination and shorter telomere length (Pantesco et al., 2018). The adverse impact of living in communities in which violence is endemic on both physical and psychological health may begin early in life, as illustrated by the finding reported by Stewart and colleagues (2021) in this special issue that Salvadoran schoolchildren exposed to such conditions were at risk for both medical problems and elevated posttraumatic stress symptoms.

Cumulative and chronic experiences of discrimination have also been linked to elevated blood pressure (Bron-dolo et al., 2008), increased heart rate, and an increased risk of cardiovascular disease (Borrell et al., 2006). With COVID-19, the disparities in COVID-19 risk and health outcomes may, to some extent, reflect the effects of systemic racism on biological alterations secondary to stress, as previously indicated (i.e., HPA and immune dysfunction, metabolic aberrations that contribute to medical comorbidities including Type 2 diabetes, hypertension, and asthma), all of which may contribute to an increased risk of contracting COVID-19 (Ajilore & Thames, 2020). The findings reported by Holmes and colleagues (2020) in this special issue suggest a need to investigate the added burden of material hardships, such as poverty, homelessness, and limited or no access to health care, on medical problems in marginalized populations that result from the allostatic load caused by the posttraumatic stress symptoms that can develop in the wake of such hardships.

Further, racism and discrimination may alter host innate immunity to promote abnormal inflammatory responses and increase the risk of contracting COVID-19 and consequent adverse psychiatric, neuropsychiatric, and physical health outcomes. First, racial differences in the regulation of the renin–angiotensin system and, in particular, the angiotensin-converting enzyme 2 (ACE 2), the entry receptor utilized by COVID-19, which is also implicated in racial differences in hypertension, may account for the disproportionate risk of severe COVID-19 outcomes in African Americans. Second, marginalized groups may be at an increased of depression, anxiety, trauma-related disorders, and neurological complications, indirectly through previously mentioned social determinant factors or more directly through stress-induced inflammatory factors and a SARS-CoV-2-virus-induced “cytokine storm” mechanism. Third, and drawing on the field of social genomics, gene expression may be altered by a diverse array of social adversity conditions, including racism and discrimination, through a common gene expression patterning system that is known as conserved transcriptional response to adversity (CTRA; Ajilore & Thames, 2020). This system is triggered by chronic low-grade activation of the sympathetic nervous system and is characterized by increased expression of proinflammatory genes and decreased expression of genes involved in innate antiviral responses, antibody synthesis, and gene expression (Cole, 2013, 2014). These changes are relevant to COVID-19. With regard to CTRA, it is relevant to note that experiences of racial discrimination have been found to explain more than 50% of Black–White differences in CTRA profiles, particularly in genes that promote inflammation (Thames et al., 2019). This is a putative mechanism that may underlie the differential vulnerability to and outcomes of COVID-19.

NAVIGATING THE PANDEMIC AND BEYOND

Public health initiatives throughout this global pandemic have largely centered on flattening the COVID-19 infection and mortality curves. To confront both the crisis and the raging disparities head-on, public health initiatives must be more inclusive of intensive efforts to flatten the curve of health and mental disparities by addressing the social determinants that are both common and unique to disenfranchised groups. Mobilizing the strengths and resources already present within vulnerable communities may be a powerful tool for mitigating the negative effects of adversity during the COVID-19 era. Community-based organizations can be used to address basic needs, disseminate public health and medical information, facilitate access to and encourage the use of mental health services, and help

to break through some of the cultural barriers to uptake. In the modern internet era, access to media and technology that are liberatory may be a crucial protective factor for young adults of color, as demonstrated by the finding reported by Volpe and colleagues (2021) in this special issue that access to media that represents people of color in a positive manner was associated with lower levels of trauma exposure and posttraumatic stress symptoms among a sample of young adults of color who completed an online survey.

At an individual level, S. R. Liu and Modir (2020) have identified several evidence-based strategies that mental health providers can employ to manage racial trauma in the context of COVID-19. These strategies can be adapted for other identity-linked traumatic experiences and entail: (a) focusing on cultural identity in clinical care by enhancing inherent strengths and leveraging past experiences of resiliency, (b) addressing “racial socialization” in treatment to help patients deal with the realities of racism and equip them with the skills to cope and be resilient, (c) encouraging and assisting patients to connect with social support, (d) assessing for exposure to racial trauma that may have emerged or been exacerbated during the COVID-19 pandemic, and (e) adopting a culturally informed trauma approach in individuals who are exposed to racial trauma and other health disparities during the pandemic.

As we continue to navigate the devastation and suffering wrought by the pandemic, it will be important, especially in low-resource contexts, to develop the capacity within our systems of care and in our communities to serve the most disenfranchised—capacity that is sustainable in the aftermath of the pandemic and beyond.

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