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Editorial

And how are the Children? Establishing Historical Trauma as an Intersectional Social Determinant of Health for Vulnerable Populations

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EDITORIAL

Primary care providers should consider historical trauma as a part of their overall approach to patient care. Descending from an earlier description of the experience of children of the Holocaust, historical trauma prompts a traditional question of Massai warriors "And how are the children?" or Kasserian Ingera [1]. This question reflects the extension of historical trauma to inform the plight of other populations like African American descendants of slaves, and individuals involved in the juvenile/criminal justice system. By definition, historical trauma refers to a complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance [2]. Of greatest relevance to providers, populations (African Americans) previously subjected to historical traumas like slavery exhibit a higher prevalence of disease even several generations after the original trauma commenced [3]. It has also been established that mass incarceration in the US is at heightened proportions, and African Americans are overrepresented in these systems. In addition, there is a high prevalence of trauma histories among those incarcerated suggesting a need to improve access to services, as well as service provision as they re-enter community-based treatment settings [4].

Race-related historical trauma has measurable and distinct outcomes, including links to health disparities [3]. Racial and ethnic minority populations continue to lag behind Whites with a quality of life diminished by illness from preventable chronic diseases and a life span cut short by premature death [5]. The World Health Organization's (WHO) Commission on social determinants of health (SDH) highlighted health disparities through a framework that emphasizes structural (socioeconomic and political contexts – public policies and culture and societal values) and intermediary determinants (health system) of health [6]. The juvenile/criminal system could also be included as an intermediary determinant of health since people of color disproportionately bear the burden of mass incarceration in the US [4,7]. Consequently, youth and adults involved in the juvenile justice system comprise a uniquely vulnerable population [20]. Structural and intermediary determinants directly impact one's health and well-being. Arguably, a case can be made for situating historical trauma in the structural and intermediary aspects of the SDH framework. In terms of African American descendants of slavery, historical trauma reflects the governance, policies, and cultural and societal values of its time; a legacy that persists today. The 246 years of slavery relegated African Americans to a legacy of debt – pain – and trauma [1]. Moreover, the growth of the US penal system with its overrepresentation of African Americans constitutes a new form of Jim Crow [8]. Consequently, the intersections of race, class, gender, etc. suggest a greater focus on the cumulative affects associated with the health of vulnerable populations. Moreover, recognizing historical trauma as an intersectional social determinant of physical and mental health for African Americans is necessary for primary care providers to ensure more comprehensive service delivery and improve their health outcomes.

Previous studies have used SDH as a conceptual framework to investigate approaches to emphasize individual, household- and community- factors like psychological distress (mental health problems and substance use), violence and education [9,10]. Some scholars have focused on intersectionality to increase awareness of identity characteristics like race, gender (including transgender), and sexual orientation, and the privileges or oppression these characteristics can incur [11]. Specifically, scholars have conducted studies that focus on intersectional social determinants of health with HIV infected populations, including intimate partner violence and other forms of abuse that were associated with pre –and –post HIV diagnosis [12]. Stevens and colleagues noted that women identified being diagnosed with HIV as a 'traumatic event' that resulted in numerous changes, including severe misery, substance misuse, depression, suicidal behavior, etc. [13]. Among low-income women in Baltimore, MD, a relationship was noted between homelessness, incarceration, low-income, and HIV-related risk behaviors [14]. Future research

should include mixed methodology and focus on intersectional SDH associated with health outcomes, especially with justice-involved African American youth re-entering their communities.

Reframing the problem of racism and the role of slavery is significant for providers to understand the cumulative impact of historical trauma on African Americans' health and well-being [8,15]. This reframing is critical to respond to the question about how our children are doing. We need to focus on both addressing historical trauma at the individual and structural level to improve the health of the most vulnerable individuals. This will require institutional transformation through policy development to promote trauma-informed care, especially with people of color [11]. Consequently, pathways within institutions like the health and juvenile/criminal justice systems need to be created, so the care delivery of practices consider the impact of trauma on individuals' lives [16]. For example, city policies are quite important to health equity as they have the potential to reduce health disparities [17]. In a study of 535 mayors and health commissioners of cities throughout the US, it was noted that many mayors and some commissioners were unaware of the potential of city policies to reduce health disparities. Also, liberal respondents were more likely than conservatives to strongly agree that disparities existed. Information about health disparities, and ways to reduce them must be more effectively communicated to city policymakers [18]. The ability to translate research about health disparities into effective public policies requires that the public and policymakers are knowledgeable about disparities and their causes [19]. Primary care providers also need to be knowledgeable about health disparities, as well as the role of historical trauma and how this information would be useful for understanding patterns of care and subsequent physical and psychological health outcomes of those with the greatest needs.

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