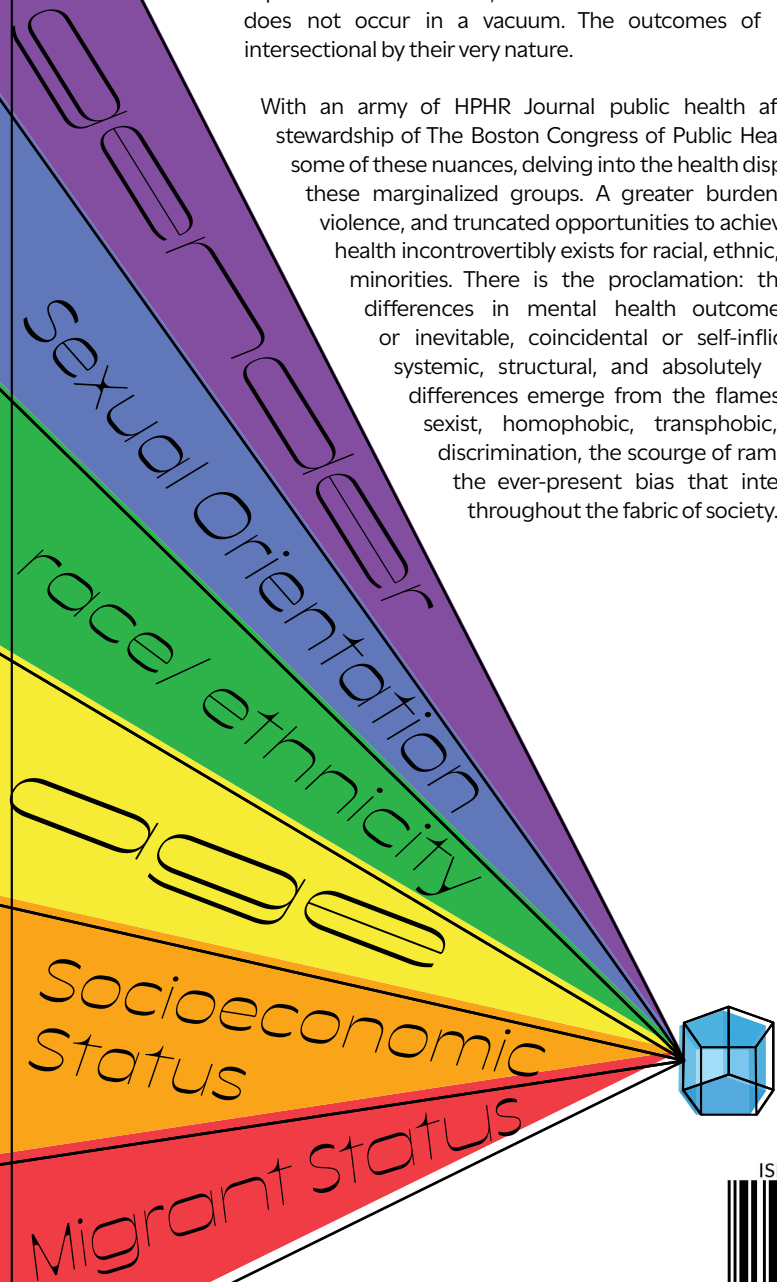


In the anthology PRISM: Mental Health Through the Lens of Difference, Krista L. R. Cezair utilizes a unique approach to examining mental health at the intersection of gender, sexual orientation, race and ethnicity, age, socioeconomic status, and migrant status. How do women, members of the LGBTQ+ communities and immigrant/refugee communities, Black and Brown groups, and economically and politically disenfranchised peoples experience mental health, or the lack thereof? In other words, mental health does not occur in a vacuum. The outcomes of mental health are intersectional by their very nature.

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PRISM

*Mental Health Through
the Lens of Difference*

Edited by
Krista L.R. Cezair, J.D., M.P.H.
and Dr. Candice Carpenter

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Table Of Contents

Foreword • • • • • 4
 Health is Wealth • • • • • 6
 Introduction • • • • • 8
 The Ethics of Mental Hospitals • • • • • 10
 Everything Between Us • • • • • 16

Gender • • • • • 21

How Mandated Paid Family and Medical Leave
 Can Reduce Disparities in Mental Health for Black Women • • • • • 22
 "I want people to have more grace,":
 Learning from the Intersection of Mental Illness and
 Gender Minority, an Interview with Kirabo Katami • • • • • 26
 The Road to Rock Bottom • • • • • 31
 A Patient's Perceived Effect of the "No Visitor Policy"
 Implemented During COVID on Their Overall Mental
 and Physical Health: A Retrospective, Observational Study • • • • • 32
 A Strong Black Woman Finally Lies Down • • • • • 50

Sexual Orientation • • • • 53

The Prison Rape Elimination Act and
 Other Protections for LGBTQ+ Incarcerated Populations • • • • • 54
 Mental Health for One is Mental Health for All • • • • • 59
 Rainbow Magic • • • • • 63
 An Overlooked Minority: the Mental Health of Bisexual People • • • • • 65

Race and Ethnicity • • • • 71

Racial Disparities in Schizophrenia Diagnosis and
 Treatment: Their Effect on Black Americans • • • • • 72
 BPD • • • • • 77
 Cutting Cane: A Cultural Studies Informed
 Approach to Trauma and Cultural Competence • • • • • 78
 My Therapist Told Me • • • • • 83
 Maladaptive • • • • • 84
 The Mental Health Impact of Police Violence
 Among Black Americans in the United States: A Review • • • • • 85
 Ashes • • • • • 95
 After Danez Smith • • • • • 95
 To Save Black Mental Health, We Must Destroy Racial Capitalism • • • • • 96
 To the Blacker Berry and the Sweeter Juice • • • • • 100

Age • • • • • 103

Adding Mental Health Counselors and Mental Health Curriculum in Public Schools to Reduce Mental Health Disparities • • • • 104

Swimming Through Rainbows • • • • • 109

“...there’s room for optimism as science, medicine, and society advance.”: Interview with a Schizophrenia Success Story, Carlos A. Larrauri, MSN • • • • • 112

A Grade of F • • • • • 118

Amplifying the Promise of Digital Mental Health Interventions for BIPOC and LGBTQ+ Youth Through FDA Regulatory Reform • • • • • 120

The Impact of Exercise on Organizational Empathy • • • • • 127

Socioeconomic Status • 135

Essential and Underserved: The Mental Health Needs of Migrant Farmworkers • • • • • 136

“Mental illness’ is a way that the body is just trying to get some extra support.”: An Interview with Judy Hu, LMHC and Boundary Coach • • • • 141

Community Care • • • • • 147

Employee Engagement Policy Recommendations For Sustaining Wellbeing Of A Diverse Workforce In A Hybrid Setup –Based On Learnings From Adverse Impact Of Middle-Income Employees In The Service Industry • • • • • 148

Migrant Status • • • • • 157

Immigrants with Mental Illness and the Immigration and Nationality Act • • • • • 158

A Preliminary Report of Trauma Impact on Language Skills in Bilingual Adults: A Case for Trauma-Informed Services • • • • • 163

A Trini Asks Answers of Her Ancestors • • • • • 170

Conclusion • • • • • 173

About the Lead Author and Editor • • • • • 176

Anthology Contributor • • • • • 178

About The Boston Congress of Public Health and HPHR Journal • • • • • 179

Glossary • • • • • 180

Appendix • • • • • 200

Foreword

By Dr. Candice Carpenter

In the anthology PRISM: Mental Health Through the Lens of Difference, Krista L. R. Cezair utilizes a unique approach to examining mental health at the intersection of gender, sexual orientation, race and ethnicity, age, socioeconomic status, and migrant status. How do women, members of the LGBTQ+ communities and immigrant/refugee communities, Black and Brown groups, and economically and politically disenfranchised peoples experience mental health, or the lack thereof? In other words, mental health does not occur in a vacuum. The outcomes of mental health are intersectional by their very nature.

With an army of HPHR Journal public health aficionados and the stewardship of The Boston Congress of Public Health, PRISM explores some of these nuances, delving into the health disparities that exist for these marginalized groups. A greater burden of disease, injury, violence, and truncated opportunities to achieve the apotheosis of health incontrovertibly exists for racial, ethnic, sexual, and gender minorities. There is the proclamation: these often-negative differences in mental health outcomes are not innate or inevitable, coincidental or self-inflicted – but rather systemic, structural, and absolutely preventable. These differences emerge from the flames of ongoing racist, sexist, homophobic, transphobic, and xenophobic discrimination, the scourge of rampant prejudice, and the ever-present bias that intercalate themselves throughout the fabric of society.

Cezair intertwines a tantalizing intellectual tapestry of writing media – from qualitative and quantitative research, in-depth interviews and exposes to poetic pieces and quenchable quotes. As readers, we are but passengers on Cezair's meditative walk. Alongside her, we ferociously muse: How can we expunge with the ingrained ableism within American society? How might we explore the interconnections between cultural and genetic heritage on one's experience of health and disability? How do we begin to tackle the social, environmental, and political problems of marginalized groups, especially given the backdrop of white supremacy, heterosexism, cissexism, racial capitalism, and nationalist hegemony? A high order indeed, but a worthwhile one if someone is committed to the challenge.

By defining mental health broadly from the outset—as the inclusion of emotional, psychological, and social well-being — Cezair articulates how to prioritize the mental health of these vulnerable communities with a policy cookbook of sorts: (a) by decreasing the incidence of traumatic events that propagate mental health disorders; (b) by reducing in the incidence of adverse childhood experiences, (c) by strategically and intentionally modifying the built environment; (d) by minimizing the financial and housing insecurities that exist; and (e) by obliterating the structural stigma targeted to people experiencing mental illnesses at the intersection of multiple, marginalized identities.

In the gender section, PRISM explores how Black women's mental health can be significantly improved with the expansion of family and medical leave. PRISM traces how transgender and non-binary individuals struggle against the double threat of both physical and psychological violence related to their non-dominant identity. Cezair forces us to interrogate: how do pernicious and overbearing expectations placed on Black women contribute to the manifestation of their depression, and leave them besieged by their illnesses?

In the sexual orientation section, PRISM articulates the limitation of the Prison Rape Elimination Act (PREA) in protecting incarcerated individuals of the LGBTQ+ community. It presses for expansion of gender-affirming caregivers and support groups for these niche marginalized communities, both while they are incarcerated and upon their reentry into society. Additionally, it forces us to look at the plight of bisexual people, as they are embattled against both structural and interpersonal biphobia and bi-erasure, which can catapult individuals into loneliness, depression, and other adverse mental health outcomes.

Throughout the race and ethnicity section of the anthology, PRISM shows us how stigmatization of mental health disorders can alienate and devastate Black, Latino, and other ethnic and immigrant communities, to the point of reduced job prospects, imperiled economic power, and increased risk for substance use disorders. PRISM further delineates the multi-level impact of police violence on public health outcomes of Black Americans in particular. So when is there a heightened and deepened probability of mental health crises in Black, Brown, Indigenous communities? When the elements of poverty, unemployment, housing instability, and incarceration collide in devastatingly compounding ways.

Illuminating the perils surrounding mental health disorders in youth, the age section of PRISM dives into the often complicated, fractionated, and unforgiving mental health system of the United States. However, this section also offers a ray of light, as research into family support, proper sleep and nutrition, and consistent exercise displays these factors as protective for mental health illnesses and crises.

Finally, in PRISM's sections on socioeconomic status and migrant status, we see how migrant workers face the brunt of multiple factors that threaten and lay waste to their mental health: physically demanding and traumatic work conditions, a dearth of social and political support, precarious citizenship status and looming deportation risks, along with virtually non-existent healthcare access. And what about those immigrant populations, asylum seekers, refugees, and survivors of forced displacements? These populations are doubly and triply jeopardized as well, often to the point of posing a danger to themselves vis-a-vis suicidal ideation or suicidal attempts. Cezair concludes this section with a call to action for more culturally responsive and trauma-informed care. And I second her on that, as a reimagined and reconfigured U.S. healthcare system – invested in cultural sensitivity and accountability – is what we need now more than ever.

Health is Wealth

By Krista L. R. Cezair

If health is wealth,
Consider me bankrupt
Disability, a thief in the night,
Comes for my silver spoons
Replaces them with pills
Crammed down my throat

If health is wealth,
Know that I live paycheck to paycheck
When I am feeling healthier,
I know it's only a matter of time
Usually a fortnight, biweekly,
Until I don't or can't or won't

If health is wealth
My family hasn't passed on any assets
But the debts remain
All my ancestors left me was a (loan)
Too much trauma,
Too much anxiety,
Too many emotions in the blood

If health is wealth,
Truly,
Then what do I have to show
For a life lived
From psychiatrist visit to
Therapist visit to
Hospital ward, over and over again?

Artist Statement

I implore you to examine the ingrained ableism within yourself and American society as evidenced, in part, by the common use of phrases like the one that is the subject of this piece. Also of interest are the lines exploring how my cultural and genetic heritage have had an impact on my experience of health and disability as a person diagnosed with bipolar I disorder, a mood disorder characterized by dramatic swings in mood and energy that can last for weeks and months at a time causing hospitalization and major life disruption.

Introduction

By Krista L. R. Cezair

What is mental illness and how does it differ from mental health? I learned this lesson firsthand several years ago when I was diagnosed with bipolar disorder type II, a form of bipolar disorder that includes mood swings and changes in energy from longer and deeper bouts of depression to less serious hypomania as opposed to the mania of bipolar disorder type I. What I failed to learn then, I learned when I was diagnosed a few years later with severe bipolar I disorder that included depression and full-blown mania: periods of high energy and sometimes mood that include psychotic features which are sometimes serious enough to warrant hospitalization.

The National Institute of Mental Health offers a few definitions:

"Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below).

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI."¹

By contrast, mental health is a much broader concept. "Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices."² Some factors that can affect our mental health include biological factors like brain chemistry, family history of mental health problems, and life experiences like trauma or abuse.²

It is this last category, life experiences, that can explain how marginalized groups tend to share some commonalities in the presentation of their mental illness. Different communities share certain life experiences as a group, most of all the experience of marginalization itself, that can affect their mental wellbeing. Those who experience marginalization because of their gender, sexual orientation, race and ethnicity, age, socioeconomic status, and migrant status are the subject of this anthology. These experiences are referred to as disparities and inequities in mental health.

"Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."³ These are referred to as inequities, rather than inequalities, because these differences are due to unfair treatment. For example, you will read about how bisexual people face worse mental health outcomes than people who are lesbian, gay, or heterosexual, in part because of how they are treated due to their sexuality. Disparities and inequities in mental health are the result of discrimination, prejudice, and bias. They are not natural differences between marginalized populations, and it is not a coincidence that marginalized populations bear the brunt of these differences.

Although mental illness is often framed as an individualized phenomenon, I believe mental health disparities and inequities cannot be addressed unless a public health lens is used to view the problem of mental health differences between demographic groups. Rather than focusing on individual-level risk factors, population mental health brings attention to macrosocial factors that affect whole groups. By addressing these macrosocial factors, especially through nonclinical and public policy approaches, we can improve mental health at the population level.⁴ One study offered the following general public policy priorities to facilitate better mental health across communities:

“Reduce the incidence of traumatic events.”

“Reduce the incidence of adverse childhood experiences.”

“Modify the built environment.”

“Reduce financial and housing insecurity.”

“Reduce structural stigma toward people with mental illness and members of other social groups.”⁵ [emphasis added]

It is easy to see how the social, environmental, and political problems these policies tackle disproportionately affect marginalized groups, especially given the United States’ history of white, heterosexist, cissexist, patriarchal, capitalist, and nationalist hegemony. Making the proposed changes requires an interdisciplinary approach. Many disparate people will need to be brought together to achieve this common goal. That is why this anthology is addressed to anyone who comes across it. To help enable understanding, policy essays and academic essays have been included to instruct, poetry added to help readers feel the emotions of people who experience these disparities, interviews interspersed among the works representing guided conversations with clinicians and patients alike, and finally, quotes sprinkled throughout to reflect on the perspectives of distinguished writers. After reading this anthology, I hope you learn, I hope you feel something, I hope you teach someone else, but most of all, I hope you act.

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The Ethics of Mental Hospitals

By Justice Gordon Goodman

I shall be obliged to speak with great plainness, and to reveal many things revolting to the taste.... But truth is the highest consideration. I tell what I have seen—painful and as shocking as the details often are—that from them you may feel more deeply the imperative obligation which lies upon you to prevent the possibility of a repetition or continuance of such outrages upon humanity. If I inflict pain upon you, and move you to horror, it is to acquaint you with suffering which you have the power to alleviate....

*Excerpt from Dorothea Dix's Memorial to the Legislature of Massachusetts (1843)*¹

Introduction

After studying the treatment of the mentally ill in England during the 1830s, Dorothea Dix returned to the United States where she conducted a series of investigative studies and reports on the care for the mentally ill, which she presented as “memorials” to state legislatures—first in Massachusetts (1843), followed by New Jersey (1845), Illinois (1847), North Carolina (1848), and Pennsylvania (1853).² Her remarkable efforts ultimately lead to passage by Congress of the “Bill for the Benefit of the Indigent Insane” in 1854, which would have funded construction and maintenance of asylums for the mentally ill across the United States from sale of federal land.

If this bill had been adopted and implemented, our federal government's ultimate responsibility for the care of the mentally ill would have become an integral part of the American experience starting in the mid-19th century. Unfortunately, President Franklin Pierce vetoed the bill, arguing that social welfare was the responsibility of the states. Subsequently, Dorothea Dix was appointed the Superintendent of Army Nurses by the Union Army during the Civil War.

I propose today, in 2022, that the federal government assume the responsibility of caring for the “indigent insane” that Dorothea Dix first proposed, and Congress first approved, in 1854.

Discussion

A Brief History of Mental Hospitals in the United States

In her "History of Psychiatric Hospitals,"³ Professor Patricia D'Antonio, Mental Health Nursing Chair at the University of Pennsylvania School of Nursing, describes the transition from almshouses and private hospitals in the 18th century, to the development of public and charitable asylums that adopted a "moral treatment" program for the mentally ill first developed in Europe in the 19th century. This moral treatment discontinued use of harsh restraints and long periods of isolation. It relied upon construction of mental hospitals in secluded, country settings that provided opportunities for work and recreation. Privileges and rewards were granted for the exhibition of rational behaviors, and less painful restraints were adopted for short periods.

An early example of this system was built by Philadelphia's Quaker community in 1814, known as the Friends Asylum. Similar mental hospitals that adopted the moral treatment program included the McLean Hospital built by Massachusetts General Hospital in 1811, the Bloomingdale Insane Asylum built by New York Hospital in 1816, and later the Institute of the Pennsylvania Hospital in 1841 (the Institute). Thomas Kirkbride was the first superintendent of the Institute, and he designed what became known as the "Kirkbride Plan," which was the prototype for many subsequent mental hospitals built in the United States. Almost all states funded one or more of these institutions during the latter part of the 19th century.

In the 1890s, as life expectancies increased, local and municipal governments started to shift the cost of caring for the elderly by redefining the concept of senility into a psychiatric problem, and then transferring many elderly patients to state funded mental hospitals. The resulting increase of patients in state mental hospitals forced doctors and nurses to confront the limitations of trying to provide psychiatric treatment to large numbers of elderly patients suffering from dementia.

Many of these state mental hospitals have now closed due to the deinstitutionalization process described below, but I note that both my parents who are now deceased (Dr. Melvin Goodman and Shirley Goodman, M.S.W.) worked at two of the remaining Texas state mental hospitals (North Texas State Hospital in Vernon and Rusk State Hospital). They also worked at two of Texas' community mental health facilities which are called MHMRs (the MHMR in Temple, TX, and the MHMR in Odessa, TX). Nothing in this article should be considered as a criticism of the noble men and women like my parents who dedicated their lives to caring for the least among us, often working in the harshest of circumstances, and this article is dedicated to their memory.

Professor D'Antonio concludes her survey of U.S. mental hospitals with the following thoughts:

Today, only a small number of the historic public and private psychiatric hospitals exist. Psychiatric care and treatment are now delivered through a web of services.... The quality and availability of these outpatient services vary widely, leading some historians and policy experts to wonder if "asylums," in the true sense of the word, might be still needed for the most vulnerable individuals who need supportive living environments.

The Seeds of Deinstitutionalization: Neglect, Budget Constraints, Pharmacology, and Civil Rights

Overcrowding and deteriorating conditions in state-run mental hospitals was exacerbated by the economic depression of the 1930's followed by the widespread reallocation of medical personnel caused by World War II. In partial response to these problems, the Mental Hygiene Movement arose during the early 20th century⁴ that proposed creating more outpatient clinics (like the MHMRs mentioned above) to provide mental health treatment away from the traditional confines of mental hospitals. Also, during the 1930s and 1940s, psychiatrists began experimenting with new types of therapies (some of which were later criticized and discontinued) including insulin and electric shock, psychosurgery, and different medications.

Despite these problems and worsening conditions, the United States reached its peak number of mental hospital beds in 1955, almost all of which were in state-run facilities. At that time, there were over 500,000 available psychiatric beds (compared with just over 50,000 as of 2014 — a ninety percent reduction during this six-decade period).⁵

The 1950's brought major pharmacological changes to the field of psychiatry with development of chlorpromazine and other anti-psychotic medicines, which offered the hope of treating some of the most severe and debilitating psychiatric problems like psychosis and schizophrenia (i.e., the serious or severe mental illnesses or SMI). Though some members of the SMI population responded positively to these new medicines, many continued to need long term custodial care.

One of the researchers into these new drug treatments was Dr. Nathan S. Kline,⁶ a professional colleague of my late father Dr. Melvin Goodman. In 1952, Dr. Kline created a research unit at Rockland State Hospital in New York, where he investigated the use of reserpine as a possible treatment for schizophrenia. He also promoted the use of iproniazid, an anti-depressant for the treatment of severe depression. (As a child, I accompanied my family on a vacation to Haiti where we visited the Mars and Kline Psychiatric Institute, which was co-founded by Dr. Kline.)

All these changes led to the deinstitutionalization movement that started in the 1960s. Within the judiciary, courts responded to real civil rights concerns by creating increasingly stringent rules for making commitments into mental hospitals starting with the case of *Lake v. Cameron*,⁷ which introduced the concept of "least restrictive setting." In 1975, the U.S. Supreme Court found in *O'Connor v. Donaldson*⁸ that a person had to be a danger to him- or herself or to others for confinement in a mental hospital to be constitutional. Finally, in 1999 the U.S. Supreme Court in *Olmstead v. L.C.*⁹ determined that mental illness was a disability under the Americans with Disabilities Act,¹⁰ and as such "reasonable accommodations" had to be made to move people from mental hospitals into community-based treatment facilities.

As noted by Dr. Daniel Yohanna, Chair of the Department of Psychiatry at the University of Chicago Pritzker School of Medicine, in his 2013 comprehensive review of these events in the *AMA Journal of Ethics*,¹¹ these judicial constraints on

the commitment process were instituted at about the same time that Congress passed the “Community Mental Health Construction Act,” in 1963, which made federal grants available to states for establishing local community health centers in anticipation of closing the state-run mental hospitals.

But the most significant change in federal law was the introduction of Medicaid, which shifted funding for people with SMI from a state-run program into a shared partnership with the federal government. This created a perverse incentive for states to close the facilities that they funded on their own (i.e., the state mental hospitals) and move those patients into community mental health facilities and nursing homes partially paid for by the federal government through Medicaid.

The deinstitutionalization process continued in 1981 with the “Omnibus Budget Reconciliation Act,”¹² which ended federal funding for community-based nursing homes that primarily treated patients with mental health problems and required states to return to funding non-nursing homes (many of which were private and for-profit) for the long-term care of people with SMI within the community.

The resulting confusion and disruption caused by these well intentioned judicial and legislative initiatives, and their unintended consequences, are apparent in every city around the United States. The resulting plague of unhoused and unsheltered individuals living on our city streets suffering from SMI, and even more distressingly the use of jails and prisons as default long-term residential facilities for some individuals with SMI, are outrageous. And yet, as Dorothea Dix observed so many years ago, we have the power to alleviate this suffering.

A Possible Solution: A Renewed and Repurposed Marine Hospital Service (The U.S. Public Health Service Hospital System)

The Marine Hospital Service was established by Congress in 1798 through passage of “An Act for the Relief of Sick and Disabled Seamen.”¹³ It was the first federal health law, and it led to creation of a wide network of hospitals along the U.S. coasts and inland waterways—Marine Service Hospitals were ultimately established in Boston, Norfolk, Staten Island, Charleston, Mobile, Lahaina (Hawaii), Key West, New Orleans, Natchez, Louisville, Cleveland, Chicago, Paducah, San Francisco, Detroit, St. Louis, Portland (Maine), Cincinnati, Galena, Vineyard Haven, Port Townsend, Memphis, Cairo, Baltimore, Evansville, Fort Stanton, Wilmington (North Carolina), Ellis Island, Savannah, Pittsburgh, and Buffalo. In 1902, the Marine Hospital Service was renamed the Public Health and Marine-Hospital Service, and in 1912 it was again renamed the Public Health Service (Division of Hospitals). This system of federal hospitals reached a peak of 30 hospitals in 1943, and then began to decline through a series of closures—first during the period 1944-1953 and another series of closures in 1965-1970. The system’s remaining eight general hospitals were finally closed or transferred to other groups in 1981.

There are also several federal hospital facilities specifically dedicated to mental health care including St. Elizabeth’s Hospital in Washington, D.C., which is now administered by the District of Columbia Department of Mental Health, and two Federal Medical Center facilities (FMC Devens in Massachusetts and FMC Lexington in Kentucky) that are now operated by the Federal Bureau of Prisons.

Conclusion

Congress should consider taking the following steps:

Re-establish the Marine Hospital Service under the direction of the U.S. Public Health Service;

Authorize the Marine Hospital Service to re-acquire the hospital facilities it closed or transferred (if possible), renovate them, and re-open them as hospitals dedicated to serving the SMI population;

Authorize the Marine Hospital Service to acquire existing and closed state-run mental hospitals (if possible), renovate them, and re-open them as hospitals dedicated to serving the SMI population; and

Authorize payment, where appropriate, from all existing federal funding sources now dedicated to providing mental health resources (including Medicaid) to the new Marine Hospital Service for the treatment and residential care of individuals with SMI.

Dr. Yohanna found in 2013 that there were approximately 378,00 incarcerated individuals with SMI and many times that number of individuals suffering from SMI who were not incarcerated, including a significant portion of the unhoused and the unsheltered living on our city streets. The new and re-purposed Marine Hospital Service should aim to establish and maintain a minimum of 300,000 safe and sanitary psychiatric beds located in every state throughout the U.S., and to offer scientific and moral treatment to all individuals suffering from SMI.

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About the author

Justice Gordon Goodman was elected to the First Texas Court of Appeals in 2018. He is a member of the Texas State Bar, Pennsylvania Bar, and Energy Bar Associations. Before serving on the bench, he started his career with the Whittenburg Law Firm in Amarillo, TX, where he focused on civil trials, appellate work, oil & gas law, banking law, and general practice. He subsequently served in senior positions for the Howell Corporation; E.I. DuPont de Nemours & Co.; Conoco, Inc.; Occidental Petroleum Corporation; and most recently with NRG Energy. He earned his BA degree Magna Cum Laude from the University of Pennsylvania and his JD degree from the University of Pennsylvania Law School both in Philadelphia. He received his high school degree from the Horace Mann School in the Bronx, NY.

Everything Between Us

By Jonathan Abram, Rahsaan V. Garland,
Racheli Glasser, and Jessica Honig

You wrestle with the situation you were born into.

Cornfields
Categories
Street corners
Codes

Trying to do the work of reduce and reimagine, from here.

You never fit in
You will never fit in
You don't want to fit in

Into their boxes.

What's happening has happened before.

What's happening has happened before.

Self-sabotaging your future is a mental bad habit!

You didn't light the match.

But you're the one burning,
Internalized hate.

Let go of things that are unnecessary, that you've outgrown.
Let go of what was never yours to hold onto.
Walk (don't run), influence (can't control) your path to greatness!

Greatness, be, as simply as discovering the lightness of being.

FLOAT

FLOW
(get distracted by a few million microaggressions)

FLOAT

FLOW
(bump)

FLOAT

FLOW

Emotional beings, predictable dynamics.
This world has rules.
Discover them.
Apply them.

Then decondition,
Mirrored by nature:

fluidity.

Infinite gradients along the continuum of molecular

You've studied the human condition, for a reason.
You needed to understand how you came to be...

Broken.

You reflect, here now, with the wounded others —
The skin they are in or culture or coming of age variance resembles your own.

The haunting whispers sound similar.

Stop holding their hand.
They will think you are.

I am.

Straighten your hair.
You look too...

I am.

Somewhere in between,
You float. You are learning how to float.

Miss Mister Thang Therapist says, "It's okay to speak up here. Your voice
matters."

A good therapist is comparable to a compass;
Always helping you find your true north whenever you get off track.

Outside the office, unexpected stimuli (haven't you, yet, prevented all blindsiding?);
Anger turns onto the street of RAGE.

And you have to make decisions,
Less reactive ones than that time and the other one and the other
one.

You grow wiser; evolving skills, devolving memories,

most of the time.

Floating isn't easy.

You're trained to make anger look different (keeps you safeish).

BUDDHA-LIKE

WHITEWASHED

RAGE FLOATING TOWARD INFINITESIMAL NOTHINGNESS

You show up to Thang's office.

You show up, again and again.

As often as you are able, you show up.

Hope comes along, shoved into your little-overstuffed bag.

You play the best role suited for you.

You long to try on other roles.

From the beginning,

You were typecasted.

#tokenmascot

You deserve an Oscar as someone capable of letting go and mentoring others to do the same.

Hey, over here, don't forget.

Don't you ever forget what really happened.

Maybe anger is malleable, a mirage like all the other feeling states.

Float.

Baby.

Float.

Float back to the essence.

Empty it all out.

Sit in that office. Or Zoom. Or Tele 21st Century Ways.

Learn how to be. Be. Just be, as you are.

Good enough.

Outside the nest, the safe space you have constructed, how to move forward?

Keep moving forward.

Keep moving forward.

I'm just trying to find my way into this moment.

Pause.

Pausing is a bold action.

Shhhooooooooosh, quiet, stay a little while.

You can afford a while longer.
You cannot afford anything less.

Breathe.
Stretch.
Love ya'self.

Good enough, just as you are.

Then head back to your family of origin and school, sourcing the bigotry.

Tidal pool;
what you were born into.

i was never born at all,

until—maybe—now.

Hello World.

This is me.

Artist Statement

This work is composed of original content expressed by a clinician and clients, as a collective—wounded healers affected by systemic, complex relational trauma.

Authors/Artists List

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Gender

By Krista L. R. Cezair

The gender section covers issues that are unique to diverse genders, including all those who do not identify as cisgender men. Although there are mental health issues that disproportionately affect men (e.g., completed suicides¹ and people who die by suicide using guns²), the point of each category is to highlight groups that are marginalized because of their defining characteristic from that category.

In this category, Black people who are not men are represented very strongly, there is a poem from a woman's point of view, and there is discussion about a policy that disproportionately affected the mental health of women.

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How Mandated Paid Family and Medical Leave Can Reduce Disparities in Mental Health for Black Women

By Krista L. R. Cezair

Abstract

Federally mandated paid family and medical leave would be a boon to all wage earners, but the policy has the potential to correct the specific disadvantage Black women experience when their mental health is considered. Because Black women are particularly sensitive to economic and family stress, serving simultaneously as primary breadwinners and primary caretakers, paid family and medical leave have the unique ability to relieve this stress and improve their mental health.

Introduction

Due to many factors, including systemic historic and continuing discrimination, Black women bear a disproportionate burden of economic stress. Black women participate in the labor force at higher rates than other women and more frequently serve as heads of household.^{1,2} The stress of serving as the main breadwinner and caregiver for their families often leaves Black women at higher risk for mental health challenges. These mental health challenges can go undiagnosed and under- or untreated. However, paid family and medical leave could reduce the strain Black women feel and give them an opportunity to receive treatment for their mental health and to attend to their families without the economic burden of lost wages. This policy, though helpful to all people who work, would have a distinguishable positive effect on the mental health of Black women distinctive to that population.

Discussion

Black Women and Economic Stress

Black women are uniquely positioned to bear a particularly heavy burden of economic stress. They disproportionately participate in the labor force where they face institutional and interpersonal racism, sexism, and the intersection of both systems of oppression at once, misogynoir. Most often, they are occupied in the lowest paid jobs with the paltriest benefits. In addition, Black women are more likely to head their households, acting as the main financial and familial support to the rest of their families.²

The “Strong Black Woman” (SBW) stereotype has others look to Black women for an abundance of unreciprocated support, care, resources, and strength, leaving Black women with no one to turn to themselves.³ Monetarily, Black women are more likely to support relatives with lower income than theirs, siphoning off their own discretionary income.⁴

The Women’s Bureau at the Department of Labor reports that although down from an all-time high of 63.5% in 1999, 58.8% of Black women participated in the labor force in 2021.¹ The participation rates of Asian, Hispanic, and white women are clustered together around 55%.¹ The difference is indicative of the greater expectation for Black women to play a more supportive role for their families. Results from the 2010 Census show that 43% of Black women live in female-headed family households.⁵ More current estimates from the American Community Survey put that number at around 60%.² All of this extra responsibility translates to extra mental strain and worse mental health.

Even in the face of palpable discrimination, Black women are expected to overperform. This is in large part due to the Strong Black Woman cultural schema that places outsized expectations on the actions of Black women. Socialized by media, their families, their jobs, and other social institutions, Black women are expected to display “unyielding strength, [the] assumption of multiple roles, and caring for others.”³ Taken together, the financial and supportive expectations placed on Black women disproportionately relegate them to the unenviable position of experiencing a greater economic burden.

Economic Stress and Mental Health

Economic stress and lower socioeconomic status, which is disproportionately experienced by households headed by Black women, is directly correlated with greater mental strain and the risk and prevalence of mental health challenges. A systematic review of studies about financial stress and depression found a positive association between financial stress and depression.⁶ The association is even stronger among populations with lower incomes.⁷ In the United Kingdom, a reduction in housing benefits increased the prevalence of depression in a population receiving government assistance.⁶ Whether a person possesses assets and material wealth can also act as a significant predictor of depression with the association being stronger for individuals with lower levels of assets.⁶

Evidence from economic crises highlights this point. The World Health Organization notes that both mental health problems and suicides increase in number during economic downturns.⁷ Studies also indicate that the personal economic effects of economic crises, like unemployment, increased workload, and lower wages can cause stress that has a deleterious effect on mental health.⁸ Depression is most often experienced because of these economic conditions.⁸ Poor family relationships are associated with high suicide rates during these times.⁹ This could be attributed to the fact that lack of social, familial support to, perhaps, care for children or tend to oneself when sick and attempting to avoid losing wages increases the financial burden and mental strain.

Paid Family and Medical Leave

The Family and Medical Leave Act (FMLA) of 1993 “entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.”⁹

This is a vital policy for American workers, and it surely is a relief for workers to know that their jobs are protected while they tend to family emergencies; however, under FMLA, a leave from work is hamstrung by a major barrier to access, namely that it is unpaid. Also of note are its onerous eligibility stipulations that require a person to have worked only for a “covered” employer for 1,250 hours during the 12 months prior to the start of leave.⁹

A Black woman who is the head of her household simply cannot afford to take unpaid leave. For this reason, the act should be amended or a new act passed to mandate paid medical and family leave for all employees regardless of tenure. To ensure that the benefits accrue to Black women, those most in need, there should be an educational campaign that increases awareness about the new policy in culturally competent ways and specifically encourages Black women to use it. These promotional materials should also include information for filing a complaint to report when an employer has violated an employee’s rights under the act. There are already 200 offices of the Wage and Hour Division of the Department of Labor ready to investigate and prosecute these violations.¹⁰ Black women’s exposure to sexism and racism could make them likely targets for violations.

It is important to note that this policy is credible and feasible. For example, during the COVID-19 pandemic, an FMLA amendment was passed that extended paid sick leave for two weeks due to illness and quarantine related to the pandemic.¹¹ This policy shows that paid leave can be mandated for American workers. It would just need to be expanded and made accessible for all. Several states, including, California, the District of Columbia, New York, Massachusetts, and Washington, offer paid family and/or medical leaves.¹²⁻¹⁷

Conclusion

Because Black women are uniquely poised to bear a disproportionate amount of economic and caregiving stress, they are uniquely poised to benefit from an accessible paid family and medical leave program. The relief of this mental strain would absolutely improve scores of Black women’s mental health so long as they can safely take this leave, and their rights are not violated.

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“I want people to have more grace,”: Learning from the Intersection of Mental Illness and Gender Minority, an Interview with Kirabo Katami

By Krista L. R. Cezair

Lead author and editor of this anthology, Krista L. R. Cezair, interviewed contributing author, *Kirabo Katami, who is a non-binary person being treated for borderline personality disorder (BPD). Borderline personality disorder is indicated by a cluster of behaviors that reveal severe emotional dysregulation and impulsivity, impacting one's feelings about oneself and one's relationships, which are often fractured.¹ As a non-binary person, Kirabo does not identify with the gender identity of solely either man or woman and uses they/them pronouns.

Krista L. R. Cezair

Help us understand how you came to be diagnosed with borderline personality disorder (BPD).

Kirabo Katami

I was never actually formally diagnosed. In the United Kingdom, it's really hard to get diagnosed because it's so stigmatized that the doctors try to avoid giving people the diagnosis. But when I was an undergrad, I was doing university counseling. The general practice is that they give patients six sessions and then they sort of let you go. But after the six sessions, my counselor was like, "Let's give you six more." Then after those six, she recommended a clinical psychologist who's more specialized and able to help me deal with my stuff. So, I ended up in dialectical behavioral therapy (DBT) and in group therapy and also in individual therapy. For a couple of years, I was doing two to three different types of therapeutic work, and it was geared towards people who exhibited the traits of BPD. But from the beginning, the psychologist avoided labeling us, insisting that there are multiple ways to think about the reasons behind our poor emotional regulation and behaviors. He pointed out that stigmatizing diagnosis of BPD can be a smokescreen or mask for complex trauma or for a collection of maladaptive coping mechanisms that people develop in order to survive in the world.

Cezair

And how important or effective do you think self-diagnosis is, and is it more important for marginalized groups?

Katami

I think about diagnoses as maps or frameworks for trying to understand oneself and for trying to understand what therapeutic measures might help you. I think it's important for marginalized people to have access to the information that diagnoses can give you, and I think self-diagnosis is a really powerful way to give a language and a voice to what it is that you're going through. I also think, as I've already mentioned, diagnosis can also be very stigmatizing. I understand why people are afraid of diagnoses, whether from external parties or from themselves, and resist having labels put on them. It can affect future care that they receive, and it can affect the way that they are treated by the police and by healthcare systems.

Cezair

Thank you. How or why has your gender identity journey impacted your mental health journey?

Katami

When you don't have good mental health, you're constantly questioning your sense of reality, and when other people are aware of your mental health, it also gives them leeway and scope to question your sense of reality, and so, when you add a marginalized gender on top of that, it means that you're constantly fighting externally. You're fighting other people to recognize who you are and to recognize your reality, but you're also fighting yourself, because there are so many things that are telling you that, what you think and what you feel aren't real. A symptom that's commonly associated with BPD is an unsteady sense of self and so that again adds to the sense of, "What is real?" So, it's a constant process of almost forgetting oneself and then relearning and forgetting and relearning and having to be very conscious of both. You know, I identified as a woman for most of my life, and then I actually realized that I have always felt a bit different. And so, not being attached to a steady sense of self has been helpful too. It's allowed me to kind of shed previous expectations of my gender presentation in a way that maybe I wouldn't have if I didn't have that aspect of my personality.

Cezair

So, the labels for your identity are kind of comparable to the function you believe diagnoses for mental illness serve?

Katami

Yeah, they're less about giving a concrete and permanent idea of who I am, and they're more about giving me a map. A way to understand my experience and a way to articulate it to kind of give it a commonly understood language. People may not always understand the various ways that you want to articulate your interiority and so, sometimes, it's useful to have a shorthand, and I think that's what an identity label and the diagnosis can be.

Cezair

We know that people who are transgender and/or non-binary face more mental health challenges than others. Why do you think this might be based on your own experience?

Katami

I think there's this combination of the threat or actual occurrence of physical violence, as well as a kind of psychological violence, of being told who you should be, what you should look like. And then, when you try to express who you actually are, being told that that's disgusting or unwanted or wrong or criminal. That is not a recipe for mental wellness.

I say all of this as someone who has largely been protected from physical danger, but I come from a country where queer communities are highly scapegoated. At various times, people have tried to create legislation to kill queer people, they've imprisoned them on the basis of unrelated criminal legislation, or they have acted extrajudicially and killed queer people without facing any consequences. There's a very present sense of danger, which takes a toll. Often the consequence of mental illness is that you don't feel safe—not in your body, not in your mind, not in your surroundings. When you add a layer of very real and present danger, it can be hard to get to a place of mental wellness.

Cezair

How have you balanced accepting two very stigmatized identities and folding them into your sense of self?

Katami

It's still a work in progress. There are definitely days when I don't think I balance them that well at all. On the days when I feel most like I'm able to accept all aspects of myself and especially my identities which are more stigmatized, it's because I've found people and art that helped me to trust in the beauty of who I am as I am. I have friends and some family members who are really accepting and open, and my therapist has been helpful. On top of that, the writing of Akwaeke Emezi [a non-binary Nigerian multidisciplinary artist and storyteller] played a role in helping me to accept who I am, and helped me to see myself from a lens that's removed from a Western mental health paradigm, which, don't get me wrong, I still very much use, but it was helpful to acknowledge that there are other ways of thinking about queerness, there are other ways of thinking about how my brain works and what form my body can take in the world.

There's this poem by Mary Oliver, which is very frequently quoted where she says, "You do not have to be good..You only have to let the soft animal of your body love what it loves." On the days when I feel the worst about myself, I just remember that. So, yeah, still a work in progress. Especially being Black and African, community is important to us, so I have to navigate the complex cultural influences involved with that. I have a tendency to second guess myself because I sometimes get stuck in the "what would so-and-so think?" about my situation. Figuring out for oneself what feels safe to share and what doesn't—especially when there's a risk that you could be ostracized by your community—is important and a part of the process too.

Cezair

How have the other parts of your identity helped you with this process of balancing your gender identity and illness that we were speaking about? You brought up the fact that you're Black and African, and I assume an immigrant if you're in the United Kingdom. So those are actually all marginalizing categories in this anthology, race and ethnicity, migrant status, and your age, because you're young. How do you use those identities to help you support yourself with your mental illness and your gender identity?

Katami

Finding other Black queer people has been really important for me in understanding my place in the world and in accepting myself, because I've met people, younger than me and many generations above me, who have been through similar things to me. They've experienced these things in Uganda and Kenya and Nigeria and Jamaica and Barbados and the United States and Canada and the United Kingdom. I think having connections to people from different generations who are Black and have had mental health experiences and/or experiences with their queerness that are similar to my own, reminds me that what I've been through is particular to me but at the same time, I'm not alone in it, and I never have been. Having a multigenerational community of Black queer people reminds me that our struggles are survivable and there are people who can love me through all of that. And if they can love me through all that, then I can also love me and others through all of that. And it's made me realize community is so important and integral to survival and to creating a life you love. At least to me, community and connection are so important.

Cezair

And it's important to note that, at least in America, Black people have a lower incidence of mental illness than white people, even though we experience the added mental strain and difficulty of racism. Part of the reason for that is the protective factor of social support, where we have greater community with one another, so I think you're onto something.² What is something you want people to understand about your gender identity and about borderline personality disorder?

Katami

I want people to have more grace, I think. A big part of my personal journey is finding a way to balance grace and boundaries. Those are two key things. First, I'll speak to people who do experience BPD and who are queer and non-binary and say I think we need to have grace for ourselves, because the world is very hard. If available, find supportive communities, accept the grace they give you and give grace to them too. For people who aren't non-binary and who don't have BPD, check out resources like this book and do research to understand people's mental health and queerness journeys. Ask questions if the person you're asking is genuinely receptive to it. And for everyone, figure out which boundaries you need to set in order to be well, and honor the boundaries that others set.

Cezair

Wow, grace for ourselves and grace for each other. I love it. Thank you so much.

Interviewee Bio

Kirabo Katami is a pseudonym for the author, a 25-year-old Black non-binary person of recent African heritage, who is a writer and lawyer based in the United Kingdom.

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The Road to Rock Bottom

Gender

By Racheli Glasser

The road to rock bottom is actually quite pleasant and the scenery is rather serene.

Beautiful overlooks, down memory lane, reminders of the turns we could have taken.

Wondering what would the scene have looked like from there?

The dining of delicacies that were suddenly desirable.
The options that make you forget, about the chances long gone.
The comradeship of peers that were traveling your way.
The ones that understand the heartbreak of the journey.

As you get closer the lanes become slimmer; the exits further and far between.
As you get closer the air gets smoggier, making it harder to breathe and claw your way.

That's how you know you're getting closer. Closer to rock bottom.

When I arrived, it was a relief, as the arduous journey was through. I checked into the pitch black hotel and laid my head on the ice cold floor. It was dark, no bright lights shining. The pain, a lifetime away. Rock bottom was my new home.

I spent a few months there in rock bottom. Enjoying an oasis from the pain. But then I found myself missing; even longing for the bright sunshine. I tried to reach out. I tried to scream but I couldn't. What if no one remembered me? Even worse, what if no one even wanted to?

Slow and steady, I encouraged myself,
You can climb your way out.
[] I knew it was me.
I knew I was the one.
The only one,
That could set my soul free.

So I made the call that changed my future.
To the one that gave me the key to break out on my own.
From the brass iron chains of my beliefs.

It's her voice in my psyche whispering words of encouragement
When the downward spiral begins,
My compass to calm.

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A Patient’s Perceived Effect of the “No Visitor Policy” Implemented During COVID on Their Overall Mental and Physical Health: A Retrospective, Observational Study

By Eman Al Haddad, Brent Hill, Kristina Grant, Sabrina Henri, Hugh Giffords, Dr. Melchor L Bareng

Abstract

Background

A social support system has proven to improve patient outcomes; thus, we are proposing that with the implementation of the “No Visitor Policy” during COVID that there was an effect on the patient’s overall physical and mental health. Because this is a retrospective, observational study we assess the patient’s perceived level of effect that this “No Visitor Policy” had on their overall physical and mental health via a Likert-style survey.

Methods

We conducted a retrospective, observational survey study in which we selected 538 participants in a random fashion via survey administration on social media. The inclusion criteria were as follows: each participant must have been hospitalized with COVID during the pandemic as defined by the World Health Organization (WHO) as well as be located within the Windsor, Ontario, Canada area. Our primary outcome measurement is to determine whether the “No Visitor Policy” implemented during COVID impacted the patient’s overall physical and mental health.

Results

The model consisted of 2 major themes; 57.81% of respondents indicating no perceived negative physical impact and 29.37% showing a minor negative physical impact, while 94.42% of the respondents perceived that their mental health was negatively impacted, with the majority of respondents,

32.16% indicating they felt the visitor restrictions had a major negative impact on their mental health. ANOVA statistical method identified a significant difference in perceived physical health between gender and whether their physical health was impacted; females ($M=1.68, SD=.894$) agree more than males ($M=1.52, SD=.832$) that their physical health was impacted. $F(1, 536) = 3.452, p=0.032$. Furthermore, females ($M=3.92, SD=1.079$) agree more than males ($M=3.47, SD=1.163$) that their mental health was impacted $F(1,536) = 0.748, p<0.001$.

Conclusion

We believe this is an important research topic to further investigate because patient outcomes and compliance are so closely tied with patient social support.

Introduction

During times of illnesses, acute or chronic, patients' mental wellbeing and recovery are imperative. In addition to the prescribed medical treatment and its implementation tasked to various health care professionals, many factors impact the progression and overall recovery outcomes. A social support system is essential and regularly compliments the medical treatment plan.

A social support system is a multidimensional concept that includes, but is not limited to, emotional support, informational support, tangible support, and social interaction.¹⁵ Emotional support includes being present to offer compassion, reassurance, and encouragement. The presence of a trusted person can alleviate anxiety and fear. Family engagement may affect the healthcare outcome. One study reported that longer visiting hours in the intensive care unit were linked to reducing cardiovascular complications, possibly through patients' reduced anxiety and better hormonal profiles.⁹

As described by the World Health Organization (WHO), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Good mental health allows you to feel, think and act in ways that help you enjoy life and cope with its challenges.⁵ Therefore, during challenges like acute illness hospitalizations, the social support system has been proven to benefit the patient's mental health.

On March 11, 2020, the World Health Organization (WHO) declared COVID-19 a worldwide pandemic, and hospitals and healthcare systems worldwide quickly implemented changes to all aspects of their procedures to combat the spread of the virus effectively. Restriction of companions in emergency rooms, surgeries, ICU and hospital wards were one of the first to be impacted by the new changes designed to help stop the spread of COVID-19. To better understand the effects of these restrictions on patients, this observational study will focus on the regulations implemented in Windsor, Ontario, Canada. On December 2nd, 2020, all hospitals in the region implemented a "No Visitor Policy" across the board. This policy was instituted until April 17, 2021, for a total of 136 days. This observational study will survey adult (18+) patients that were hospitalized due to acute illnesses during this period to determine the impact it had on their physical health and mental health.

Multiple evidence-based studies prove that allowing visitation for recovering patients leads to decreased anxiety and increased satisfaction for both the patient and the companions.¹⁴ A literature review indicated that open visitation policies enhance patient and family satisfaction, while a survey of patients, families, and health care team members revealed a desire for a more open visitation policy.¹⁹ When companions are allowed to visit and spend time with a patient, they provide a social support system for the patient. This includes emotional support, informational support, tangible support, and social interaction.¹⁵ This social support system supplements the treatment plan for the patient by having positive impacts on recovery and their mental wellbeing—furthermore, the mental well-being of their companions, including family members and friends.

The COVID-19 pandemic took the world by storm. Due to the many unknowns the virus brought with it, hospitals around the globe quickly implemented protocols to eliminate the spread and manage the affected patients. Almost every aspect of the healthcare system across North America was involved, including, but not limited to, cancellations of elective surgeries and routine visits, shifting to telemedicine appointments, and prohibition of visitations or companions for inpatients. Although these changes were undertaken to prevent the spread of coronavirus, the effects of their imposition have negatively impacted many people's lives.

The elimination of visitation and the prohibition of allowing companions or visitors with patients, regardless of a COVID-19 diagnosis, greatly impacted both the patient and their loved ones. A study conducted to evaluate what parents were experiencing with NICU visit restrictions due to the COVID-19 pandemic stated parents expressed dysphoric emotions, sadness, and anger. The study confirmed that restrictions accentuated the emotional suffering of parents whose infants were in the NICU and that the distress may interfere with the baby's development.¹⁴

These findings echoed in every ward in the hospital and other health care institutions. From pregnant women delivering unaccompanied to emergency room patients brought in alone to nursing home patients denied interaction with the general public devastating stories have been documented across North America due to the restrictions that have been imposed.⁴

Moreover, for patients who expired without family members or companions by their side, the mental anguish of the bereaving individuals has been compounded. Many families have reported being denied opportunities to say goodbye before a death.³ These circumstances have negatively impacted the normal grieving process and the mental health of the bereaving surviving loved ones.

This study assessed the level of physical and mental health of the "No Visitor Policy" as perceived by patients in Windsor, Ontario, Canada. Specifically, it sought to answer the profile of the respondent based on age and gender, the level of physical and mental health of the respondents, the difference in the level of physical and mental health of the respondents when grouped according to age and gender and the relationship between the profile variables and the levels of physical and mental health of the respondents.

The null hypothesis states there is no difference in the level of physical and mental health of the respondents when grouped according to age and gender and there is no relationship between the profile variables and the levels of physical and mental health of the respondents.

Methods

Using an observational retrospective design, qualifying participants completed a survey with a series of questions to assess the impact of the “No Visitor Policy” on their physical and mental health. Respondents were categorized using standardized age groups used by the census in Canada.

This study was conducted using the outlined survey (Appendix-I) using Survey Monkey via public local city pages (Windsor, Ontario, Canada) on social media outlets.

The population targeted patients over 18 years old hospitalized due to an acute illness in Windsor, Ontario, Canada, during December 2nd, 2020, and April 17th, 2021 (136 days). This geographical location was chosen due to its uniform hospital visitor restriction policies across all local hospitals, population size, and convenience of reach.

Using Slovin’s formula, the researchers estimated the number of respondents based on the population and statistical data regarding hospitalizations per month (Appendix-VI). Windsor, Ontario, Canada’s population and acute illness admission statistics, given the outlined timelines and a 95% confidence level and a 5% margin of error, a total of 362 respondents were necessary.

A structured questionnaire was the primary tool in gathering data from the respondents. The first portion includes the demographic profile of the respondents, while the second portion includes the respondents’ experiences concerning their physical health and mental health. “No negative impact” will be categorized into “no impact group” and “Minor negative impact,” “Moderate negative impact,” “Major negative impact,” and “Severe negative impact” will be grouped into “impacted group.

Descriptive statistics was used to analyze the profile and impact of physical health and mental health as perceived by the patients over the age of 18 who were hospitalized due to an acute illness in Windsor, Ontario, Canada during December 2nd, 2020, and April 17th, 2021 (136 days).

Analysis of variance (ANOVA) was used to determine the differences in the level of physical and mental health when grouped according to profile variables at 0.05 level of significance.

Pearson Product Moment of Correlation was used to determine the relationship between the age variable and levels of physical health and mental health of the respondents at 0.05 level of significance. A Chi-square test will be used to determine the relationship between the gender variable and levels of physical health and mental health of the respondents at a 0.05 level of significance. Any respondent that did not meet the participation criteria, time, or geographical location criteria and any respondent that did not fully complete the survey questions were excluded.

Results

The power for this research project indicated that 362 surveys would be required for the results to be statistically significant. There was a total of 547 respondents that completed the survey. Of those 547 respondents, 9 were excluded because they did not meet the inclusion criteria or did not complete the survey correctly, leaving 538 respondent participants. The respondents were relatively diverse, with participants ranging from 18 to over 65 years. The majority of the respondents were between 50 and 65 years and older (285, 53.98%, see Table 1). Additionally, the respondents had equal representation regarding gender, with slightly more female respondents than male (Females 283, 52.60% and male 255, 41.40%, see Table 2).

The patient's experience during hospitalization has been a point of refinement for health services improvement. A likert-style survey was utilized and a model representing the patient's perceived physical health impact emerged from the analysis (see Figure 3). The model consisted of 2 major themes (see Table 3), with approximately 57.81% of respondents indicating no perceived negative physical impact and 29.37% showing a minor negative physical impact.

ANOVA statistical method identified a significant difference in perceived physical health between gender and whether their physical health was impacted (see Table 4, Appendix II). Females ($M=1.68$, $SD=.894$) agree more than males ($M=1.52$, $SD=.832$) that their physical health was impacted. $F(1, 536) = 3.452$, $p = 0.032$. As the P-value is less than 0.05, this indicates the statistical significance and gives evidence against the null hypothesis. There is less than a 5% probability the null hypothesis is correct as of the result of randomization. Thus, we reject the null hypothesis. This finding indicates a definite and consequential relation between gender and perceived physical impact when visitors were limited, where females perceived more physical health impact than males. The overall results reveal that approximately 57.81% of respondents indicate no physical impact. In comparison, 42.19% of respondents indicate minor to severe negative impact, with only 1.67% of respondents indicating a severe negative physical impact. This was further analyzed (see Appendix IV) with 133 females indicating some form of perceived negative physical health impact, while only 94 males reported a negative physical health impact.

Additionally, statistical analysis was performed to evaluate the difference between age groups, and their perceived physical health was impacted (see Table 5, Appendix III). The ANOVA statistical method identified a highly significant difference between age and physical health impact. Those in the age groups from 18 to 19 years old ($M=2.17$, $SD = 1.193$) agree more than those from 30 to 34 years old ($M=1.39$, $SD=0.629$). According to data collected, the order of age and physical impact from age groups with highest perceived physical impact to least perceived physical impact is as follows: 18 to 19 years old ($M=2.17$, $SD = 1.193$) with highest perceived physical impact, 20 to 24 years old ($M=2.00$, $SD=1.044$), 65 years and older ($M=1.83$, $SD=1.106$), 35 to 39 years old ($M=1.70$, $SD= 0.832$), 25 to 29 years old ($M=1.63$, $SD= 0.833$), 40 to 44 years old ($M=1.54$, $SD= 0.830$), 60 to 64 years old ($M= 1.53$, $SD= 0.700$), 45 to 49 years old ($M = 1.50$, $SD= 0.754$), 55 to 59 years old ($M= 1.49$, $SD= 0.778$), 50 to 54 years old ($M=1.45$, $SD=0.810$), 30 to 34 years old ($M=1.39$, $SD=0.629$) with least perceived physical impact. $F(10,527) = 2.722$, $p < .01$. According to the p-value, we can reject the null hypothesis. The

results provide support indicating a definite and consequential relationship between age group and perceived physical impact.

The ANOVA statistical method identified a significant difference in mental health between gender and whether their mental health was impacted (see Appendix II). Females ($M=3.92$, $SD=1.079$) agree more than males ($M=3.47$, $SD=1.163$) that their mental health was impacted. $F(1,536) = 0.748$, $p < 0.001$. According to the p-value, the researchers can reject the null hypothesis. Our results provide support indicating there is a definite and consequential relationship between gender and mental health impact. According to the data (see Table 6), approximately 94.42% of the respondents perceived that their mental health was negatively impacted, with the majority of respondents, 32.16% indicating they felt the visitor restrictions had a major negative impact on their mental health.

Statistical analysis was performed to evaluate the difference between age groups and their perceived mental health impact. Those in 20 to 24 years old ($M=4.22$, $SD= 0.951$) agree more than any other age group that their mental health was impacted. Those in the age groups from 30 to 34 ($M=3.39$, $SD=1.286$) agree that their mental health was impacted. $F(10,527) = 1.648$, $p > .05$. One Way ANOVA data indicates no statistical difference between age groups and perceived mental health impact. Thus, for this relationship we fail to reject the null hypothesis.

A Pearson correlation was used to express how the two variables, age, and perceived physical impact, are linearly related (See Table 9). The data indicates no correlation between age and physical health, $r(538) = -0.076$, $p > 0.05$. However, the data is not statistically significant. Additionally, the correlation between age and mental health was also measured. The data indicates no correlation between age groups and perceived mental health impact, $r(538) = 0.016$, $p > .05$. The data is also not statistically significant. Thus, we fail to reject the null hypothesis for both a correlation between age and physical health and for age and mental health. The lack of evidence doesn't prove that an effect does not exist.

A Chi-Square test was used to examine whether a statistically significant relationship exists between nominal and ordinal variables to determine whether two variables are independent of one another. We looked at whether gender and perceived physical health are independent or not (see Table 10, Appendix IV). The data indicates no relationship between gender and perceived physical health $\chi^2(4, N=538) = 6.541$, $p > .05$. There was no association between gender and perceived physical health. Thus, we fail to reject the null hypothesis, and our data did not provide sufficient evidence to conclude that an effect exists. We also examined the statistically significant relationship between gender and mental health (see Table 11, Appendix V). The data indicates, there is a significant relationship between gender and mental health $\chi^2(4, N=538) = 29.299$, $p < .01$. Thus, we reject the null hypothesis, indicating a relationship between gender and mental health.

Discussion

The respondent age profile is outlined in Figure 1 and Table 1. Furthermore, the age distribution is outlined in Figure 2 and Table 2, with 47.4% (255) of respondents being male patients and 52.60% (283) female patients.

On the provided scale of 1-5, 1 being no negative impact on physical health and 5 indicating a severe negative impact on physical health, 57.81% (311) of respondents answered that they experienced no negative impact as a result of the "No Visitor Policy" which were put in place due to COVID-19 in Windsor, Ontario. 42.19% (227) reported negative impact; with 29.37% (158) minor negative impact and 1.67% (9) severe negative impact (see Figure 3 & Table 3).

Although more than 57% of the respondents answered, they experienced no physically negative impact, 43% of people did share some type of negative impact regarding their physical health and social isolation. Studies have shown that people with depression have worse outcomes in physical recovery.²⁰

Furthermore, with regards to mental health, the provided scale of 1-5, 1 being no negative impact and 5 being severe negative impact; 94.43% (508) were impacted; with 8.47% (47) with minor impact and 29.18% (157) being severely impacted (see Figure 4 and Table 4). Several studies have described mental health consequences in prior lockdowns, such as increased depression, stress, or insomnia.¹⁷ What was unknown was the mental state and capacity of the individuals that completed the survey for the study.

Zavaleta et al. (2017) defined social isolation as "inadequate quality and quantity of social relations with other people at the individual, group, community, and larger social environment levels where human interaction takes place."²² Policymakers and practitioners have realized the role those social relationships play with individuals. Structures through social connections can influence health.²⁰ People with mental illness may have a more significant negative experience with isolation than the general population.

According to the results, there was a difference between gender and physical health. More females were impacted in their physical health than males; being a female was considered a risk factor.¹⁷

All age groups were negatively impacted in their physical health; however, the 18-19-year-old group was most affected. To isolate these young adults from their families and peers could introduce forms of depression and anxiety.¹

There was a difference between gender and mental health, with women being more affected than men. Study results from China and Italy suggest that women are more vulnerable to stress than men.¹

There is a difference in the relationship between females and physical and mental health. More females were negatively impacted in these categories than males. Women and young adults are more likely to experience depression and anxiety than other groups.⁸ One study found that at the beginning of lockdown, younger adults and women, and people with pre-existing mental health conditions reported higher levels of depression and stress.⁸

Biological processes in gender differences are not fully understood; however, some evidence shows that the changing hormones in women may be responsible for sensitivity to emotional stimuli.¹ Along with greater brainstem activation in women and greater hippocampal activation in men may enhance their capacity to conceptualize fear.

This study aimed to understand the patient experience, paying particular attention to aspects of hospitalization visitation policy during COVID restrictions. Policy and practice related to visiting hours are of pressing concern and will continue to be an ever-changing aspect of medical healthcare, specifically when the fear of an epidemic or pandemic is of genuine concern. Following the reactions to Coronavirus of 2019, policies and practices related to visiting hours in healthcare settings have become pressing, with no evidence-based guideline to inform decision-makers regarding the best available method. These findings provide insight for leaders and hospital policy makers into patients' perceived physical and mental health impact during a time of hospital stays. The challenge presented is to maintain positive health outcomes, especially when faced with the challenge of minimizing the spread of infections. It is best to be proactive. This study provides insight into the importance of patients' perception of physical health and mental health to better implement policies that decrease negative impact while increasing positive effect on patients.

Quarantines should be as short as possible to minimize the stress and negative impact physically and mentally.¹⁷ Some recommendations to help with social isolation would be to strengthen social connection and cognitive stimulation.¹⁷

Limitations

Due to the nature of this retrospective observational study and the limited resources, this study will not capture respondents who expired during their hospitalization. Further limitations in the study include the possibility of recall bias and selection bias. Efforts were made to decrease confounders within the study by formatting the survey in the form of scales and prolonged time collecting data for three months, thus allowing for a larger sample size. However, human memory is imperfect; the participants were asked to recall specific details to collect dates, thus introducing "recall bias" as patients may not remember the facts accurately. Furthermore, the study subjects may not be representative of the population as participants who chose to answer the survey may be different from those who decided not to answer.

Furthermore, there were no clear-cut quantitative definitions of no impact to severe impact. Each individual participant has an internal gauge of this definition and so there is not really any standard to assess what is considered no impact for one patient and what is considered severe impact for another patient. To combat this the data separated the groups into no impact and impact thereby alleviating some of that statistical discrepancy.

Conclusion

In summary this study has determined that during times of acute illness a patient's mental and physical health are needed for recovery. According to this preliminary data, when hospital visitations are restricted, interventions should be considered to minimize the impact on physical and mental health. Moreover, the findings should be extrapolated and considered by healthcare professionals in the future when formulating response plans to confront future catastrophic and/or pandemic-like events.

Many studies have indicated patient outcomes are directly linked to the patient's social support. We believe that our data warrants further investigation into other patient populations in order to determine if there is a link between the "No Visitor Policy" implemented during COVID and a patient's perceived mental and physical health. We also believe that more data could prove beneficial in the future with regards to policy implementation changes.

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About the Authors

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I am a current second year medical student at Saint James School Of Medicine Anguilla. I received a Bachelor of Science from the University of Windsor. I completed training in Medical Laboratory Science from St. Clair College. I not only manage the daily life of a medical student but am also able to continue my work as a Medical Technologist at the Children's Hospital of Michigan. I have worked as a Medical Technologist for the last seven years with a specialized focus in blood transfusion medicine. I am a current member of the American Medical Student Association. I look forward to advancing the field of medicine through innovation and research.

Brent Hill

I am a current second year medical student at Saint James School Of Medicine Anguilla. I have had the opportunity to be involved in Hyperbaric Oxygen Therapy (HBOT) for over 15 years and have special interest in the promising effects of HBOT management of patients with Traumatic Brain Injuries (TBI). I hope to complete my residency in either Emergency Medicine (EM) or Internal Medicine (IM) with possible fellowship in HBOT. I have a special interest in research and hope to continue to find projects that will promote excellence and advancement within the medical community.

Kristina Grant

I am a current medical student at Saint James School Of Medicine Anguilla. I am concurrently completing a dual doctorate pathway which I will complete a Doctorate in Public Health along with my Medical Doctorate. I joined the United States Army at the age of 17 and served in Iraq. I served a total of 10 years in the United States Army. I am currently involved in the Student National Medical Association, Inc. (SNMA) where I am serve as the Diversity Research Chair. As the Diversity Research Chair for SNMA, our committees role is to focus on promoting support through investments and improving the amount and quality of research in those underrepresented minority areas through the eyes of those minority medical students. SNMA also focuses on promoting racial equality within the physician medical profession.

Sabrina Henri

I am a current second year medical student at Saint James School Of Medicine Anguilla. I received a Bachelor of Science degree in Biology and Nursing. I also received a Master's degree from Indiana University of Pennsylvania in Health Service Administration. I have always wanted to pursue a career in the medical field. I initially thought about applying to Dental school but after being exposed as an Emergency Room Nurse during the Pandemic, I felt a calling to apply to medical school. I received my Bachelor's degree of Nursing from Mount Aloysius College and believe that because of that strong base in education, faith and learning I am better equipped and more well rounded as a physician in training during this pandemic and as a future practicing physician. I am also very interested in providing access to quality mental health care that respects people's human rights and implementation of Emergency Medical Services to help health equity, while decreasing the existing health disparities.

Hugh Giffords

I am a current medical student at Saint James School Of Medicine Anguilla. I currently practice Veterinary Medicine in Phoenix, Arizona. I received my Doctorate of Veterinary Medicine (DVM) from Iowa State University College of Veterinary Medicine. I have had the opportunity to experience the healthcare profession from a variety of different perspectives as I previously worked as a police officer for the NYPD and as a first responder firefighter with the New York Fire Department. On September 11th, 2001 I was part of the New York Fire Department first responders on scene. Those brave men and women will never be forgotten. Being there when the North Tower fell and observing the bravery of average everyday men and women is something that I will remember for a lifetime. I have continued a life of service both in Veterinarian Medicine and now as a medical student at Saint James School Of Medicine. I hope that everyone will remember all those great guys that lost their lives during 9/11 and that the path I have chosen will make them proud.

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Dr. Melchor L Bareng is the current Dean of Student Affairs at Saint James School Of Medicine at the Anguilla campus. Dr. Melchor L Bareng has received two Master degrees as well as a PhD degree. Dr. Melchor L Bareng has a Master in Public Health – Infectious Diseases from James Lind Institute and a Master of Science in Public Health from Università Telematica Internazionale UNINETTUNO. Dr. Bareng also has a Master of Science degree in Human Biology for which he graduated in 2008 from Cagayan State University. Dr. Bareng received his Doctor of Philosophy in 2012 from Cagayan State University. He also completed Post Graduate Course in Occupational Health and Safety at the University of the Philippines. He is currently an Associate Professor of Medicine at Saint James School of Medicine. His subject area of focus is Histology. He currently teaches Histology. Dr. Melchor L Bareng is also an instructor of research, statistics and methodology. He mentors current medical students and is a co-author on our current research project focusing on how the "No Visitor Policies" implemented during COVID have impacted the individual patient's mental and physical health.

Figure 1: Age Profile of Respondents Sample, n=538.
Age Profile

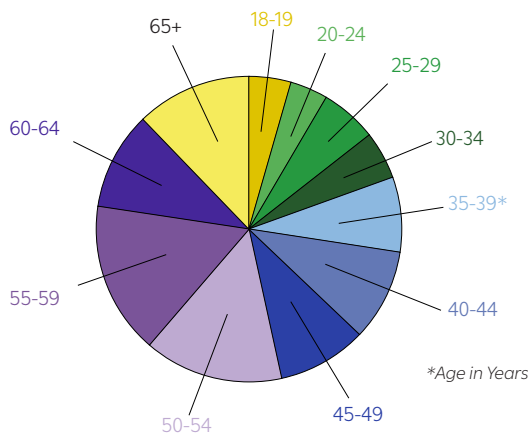


Table 1: Demographic Characteristics of Age Profile for Respondents Sample, n=538.

Age Groups	Frequency	Percentage
18 to 19 years	23	4.28%
20 to 24 years	23	4.28%
25 to 29 years	32	5.95%
30 to 34 years	28	5.20%
35 to 39 years	43	7.99%
40 to 44 years	52	9.67%
45 to 49 years	52	9.67%
50 to 54 years	75	14.94%
55 to 59 years	86	15.99%
60 to 65 years	60	11.15%
65 years and older	64	11.90%
Total	538	100%

Figure 2: Gender Profile of Respondents Sample, n=538

Gender

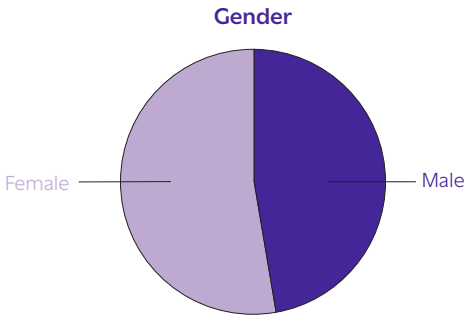


Table 2: Demographic Characteristics of Gender Profile for Respondents Sample, n=538

Gender	Frequency	Percentage
Male	255	47.40%
Female	238	52.60%
Total	538	100%

Figure 3: Results of Perceived Physical Health Impact on Respondents.

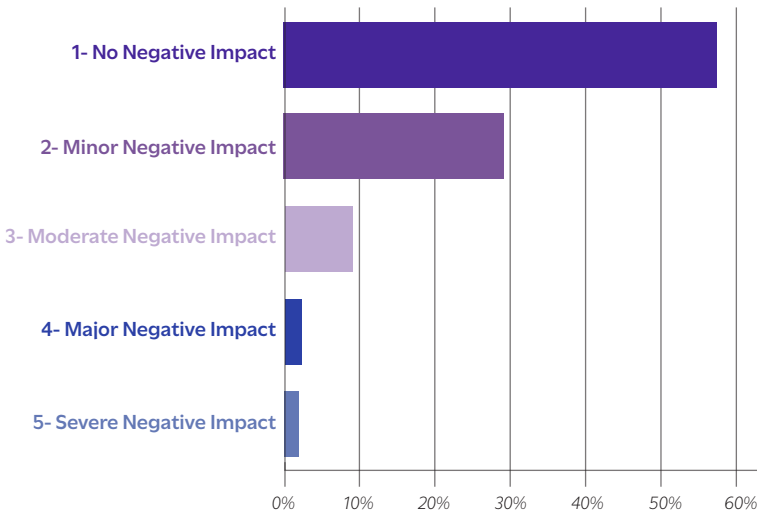


Table 3: Characteristics of Perceived Physical Health Impact on Respondents.

Description	Frequency	Percentage
1- No Negative Impact	311	57.81%
2- Minor Negative	158	29.37%
3- Moderate Negative Impact	48	8.92%
4- Major Negative Impact	12	2.23%
5- Severe Negative Impact	9	1.67%
Total	538	100%

Table 4: One-Way Analysis of Variance for Perceived Physical Health Impact by Genders

Sources	df	SS	MS	F	P
Between Groups	1	3.452	3.452	4.612	0.32*
Within Groups	536	401.009	.748		
Total	537	401.461			

Note: * Significant at 0.05

Table 5: One-Way Analysis of Variance for Perceived Physical Health Impact by Age

Sources	df	SS	MS	F	P
Between Groups	10	19.865	1.987	2.72	0.003**
Within Groups	527	384.594	.730		
Total	537	401.461			

Note: ** Highly Significant at 0.01

Figure 4: Results of Perceived Mental Health Impact on Respondents.

Gender

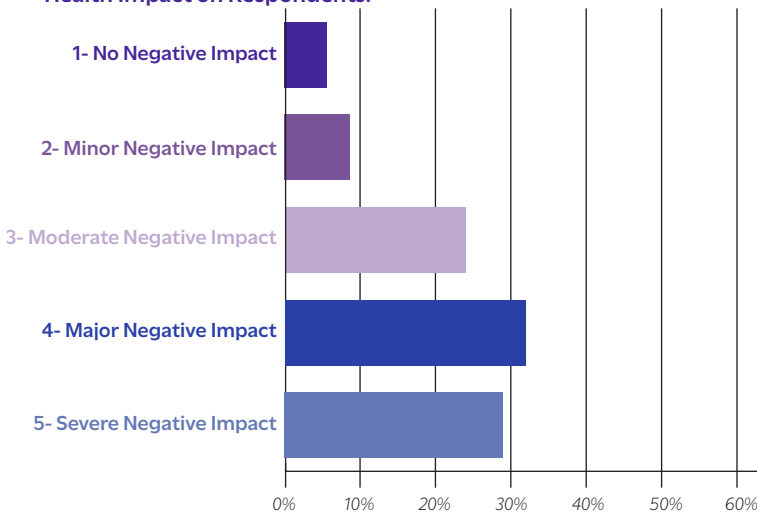


Table 6: Characteristics of Perceived Mental Health Impact on Respondents.

Description	Frequency	Percentage
1- No Negative Impact	30	5.58%
2- Minor Negative	47	8.74%
3- Moderate Negative Impact	131	24.35%
4- Major Negative Impact	173	32.16%
5- Severe Negative Impact	157	29.18%
Total	538	100%

Table 7: One-Way Analysis of Variance for Perceived Mental Health Impact by Genders

Sources	df	SS	MS	F	P
Between Groups	10	27.842	27.842	22.214	0.000**
Within Groups	527	671.756	1.253		
Total	537	699.599			

Note: ** Highly Significant at 0.01

Table 8: One-Way Analysis of Variance for Perceived Mental Health Impact by Age

Sources	df	SS	MS	F	P
Between Groups	10	21.209	2.121	1.648	0.90 ^{NS}
Within Groups	527	678.389	1.287		
Total	537	699.599			

Note: NS not significant

Table 9: Correlations Between Perceived Physical Health, Mental Health and Age Table

Variable	Age	Physical Health	Mental Health
Pearson Correlation	1	-0.076	-0.016
Sig. (2-tailed)		0.080 ^{NS}	0.716 ^{NS}

Note: NS not significant

10: Chi-Square Tests: Relationship between Gender and Physical Health Table

	Value	Df	Asymptomatic Significance (2-Sided)
Person Chi-Square	6.541	4	0.16

Note: NS not significant

11: Chi-Square Tests: Relationship between Gender and Mental Health

	Value	Df	Asymptomatic Significance (2-Sided)
Person Chi-Square	29.299	4	0.000**

Note: ** Highly Significant at 0.01

A Strong Black Woman Finally Lies Down

By Krista L. R. Cezair

But

Sleep evades.

Instead, I'm a weeping willow

As my head hits the pillow,

Feeling pain so deep it bellows.

I hear cellos.

Then hands on my head,

Touching knees to elbows,

Hunched over

As emotion cascades right over these cold shoulders.

Both are completely frozen

With ice chips big enough to bring down titans

And stop men in their tracks.

I know that my stay in this inhospitable place

Will be lengthy.

Since rest is no longer an option,

What to do?

All there is:

Pluck my brain from its stem,

Examine

Examine

Examine

Despair,

Decry the discoveries.

No one hears.

Concealed by the mask y'all require I wear.

Soaked, nay steeped, barreled, and fermented
In the bitter, acrid liquid of self-loathing,
I've learned to breathe with no air.
I'm still mourning the morning me.
Y'all can't see that this
Wonder Woman warrior is wounded?

This life, a golden cage,
Marred, scarred, barred
By expectations galore

Yours,
And even more,
Mine.

Artist Statement

The myth of the “Strong Black Woman” is a cultural force with all too real effects on the lived experience and mental health of Black women. This view of Black women as untiring caretakers capable of managing it all can lead to self-silencing behavior within Black women that has us avoid seeking mental health treatment.¹ In addition, women experience depression at higher rates than men.² This poem reflects a Black woman with depression interrogating the expectations of those around her and of herself that make her feel trapped in her illness. The title indicates that even though she finally has a chance to rest, her mental anguish prevents her from doing so.

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SEXUAL ORIENTATION

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Sexual Orientation

By Krista L. R. Cezair

The sexual orientation section covers mental health issues that pertain to people who do not identify as heterosexual. There are higher levels of mental illness in this population and even between those with different sexualities, in part due to the extra stress that comes from minority status—a concept known as the minority stress model.¹ The goal of this section is to illuminate those differences.

The content of this section reflects the unique challenges of bisexual people as opposed to monosexual people like lesbian, gay, or heterosexual people, of incarcerated people who are members of the LGBTQ+ community, youth who are sexual minorities, and quotes and a poem that express the richness of experience for members of this community.

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The Prison Rape Elimination Act and Other Protections for LGBTQ+ Incarcerated Populations

By Krista L. R. Cezair

Abstract

Members of sexual minorities and diverse gender identities face unique challenges in their interactions with the carceral system in the United States. Members of this population are overcriminalized and then mistreated within the system. The Prison Rape Elimination Act (PREA) introduced some protections but does not provide nearly enough relief in implementation. This article advocates for specific changes to the treatment of incarcerated Lesbian, Gay, Bisexual, Transgender, Queer, and more (LGBTQ+) community members to safeguard and improve their mental health.

Introduction

Members of the LGBTQ+ community are overcriminalized. LGBTQ+ youth and especially youth of color within this community are introduced to the juvenile justice system at much higher rates than their heterosexual, cisgender, and white counterparts. Within the juvenile justice system, the proportion of the population that identifies as LGBTQ+ is double that of the LGBTQ+ proportion in the general adolescent population.¹ Also, 40 percent of girls who are incarcerated report same-sex attraction or identification as LGB.¹ Further, it is estimated that 85 to 90 percent of the LGBTQ+ youth who are incarcerated are of an ethnically or racially minoritized group.¹ This is important because youth who experience detention face a cascading series of risk factors for incarceration across the lifespan, including dropping out of school, experiencing homelessness, and performing high-risk survival behavior.¹ These disparities mean that LGBTQ+ people are more likely to experience both the social determinants of health—i.e., environmental factors—that contribute to mental health problems and incredibly traumatizing incarceration.

While in prison, LGBTQ+ people face specific dangers, especially to their mental health. The danger of incarceration to the community's mental health is on top of mental health disparities that members of the general LGBTQ+ community already face. "LGBTQ+ individuals experience higher rates of depressive and anxiety symptoms, thoughts and attempts of suicide, and substance use" than heterosexual and cisgender populations regularly.² They also face more violence and trauma, like hate crimes, harassment, and discrimination.² All of these inequities are compounded by any time spent in prison.

That is why lack of access to mental healthcare in prison disproportionately affects LGBTQ+ people. The community is also vulnerable to psychological, physical, and sexual violence in prison from other incarcerated people and from prison staff alike. While there have been sweeping protections enacted through the Prison Rape Elimination Act (PREA), which has specific provisions for protecting the LGBTQ+ population, some argue that these protections do not go far enough and should be updated.³ The effects of PREA and potential improvements will be explored.

Discussion

PREA was passed in 2003 but implemented in 2012 after nearly a decade of study and review.⁴ It set up standards for the response to sexual abuse by prison facilities. The act carves out specific protections for sexual minorities and transgender and gender diverse people. The Bureau of Prisons (BOP) requires specific training for employees to exhibit professionalism in managing and communicating with LGBTQ+ people who are incarcerated.⁵ In reviews of abuse incidents and screening for signs of abuse, employees must consider a person's LGBTQ+ status or perceived status.⁵ The BOP is also prevented from segregating LGBTQ+ people in separate or solitary housing simply because of their LGBTQ+ status.⁵ The PREA standards insist that housing decisions for transgender and intersex people be made on a case-by-case basis.⁵ This population must also be allowed to shower separately, and their own perceptions of their safety must be considered for their housing decisions.⁵ Housing decisions must be reviewed twice a year.⁵ Finally, BOP employees are forbidden from searching a transgender or intersex person to find out the status of their genitals.⁵ Although, the standards do allow a medical professional to conduct an exam to find out this information, which could still be intrusive and distressing.⁵

According to some formerly incarcerated LGBTQ+ people, the protections are not enough and are sometimes even used as tools to discriminate against themselves. For example, one transgender woman who had been incarcerated explained that prison administrators use the rule that forbids segregating LGBTQ+ people to deny requests by those incarcerated to be moved to cells where they would feel safer.³ Also, sexual orientation, gender identity, and expression (SOGIE) policies in prison facilities, including juvenile justice systems, are notoriously varied and inconsistent because PREA standards give wide latitude to individual facilities to interpret and implement the standards. This is dangerous for the LGBTQ+ juveniles and adults unfortunate enough to be sent to incarceration at a facility with outdated practices or outright discrimination. To improve PREA, the woman mentioned earlier, Patricia Elane Trimble, suggested that incarcerated people who are members of the LGBTQ+ community be interviewed for their recommendations on implementing PREA.³ The goal would be to brainstorm ways to make it harder for administrators to use the standards to discriminate and force the interpretation of the standards in a way that is consistent with the stated purpose of supporting the community.³

Improvements to reduce prison rape would help protect vulnerable LGBTQ+ populations from further trauma, but these populations also face a dearth of care for their current mental health problems. Often, LGBTQ+ people lack access to services that would support their mental health while incarcerated.

For example, interruptions in hormone therapy or failure to start it can exacerbate gender dysphoria and rob transgender and gender diverse people of the gender affirmation they need to maintain emotional and mental health.¹ There is strong evidence that gender-affirming care positively impacts mental health.¹ Given that LGBTQ+ people tend to have worse mental health outcomes especially in the absence of needed mental and gender-affirming care, it is alarming that one study showed that prison staff have low mental health literacy and stigmatized views of those who require mental health care.² This makes for a particularly unsafe environment for the emotional and mental health of LGBTQ+ people who are incarcerated. Intentional discrimination against LGBTQ+ people because of their status, their race and ethnicity, and mental or physical disability makes it likely that they will not receive mental health support while incarcerated.²

It is essential that this community is given access to the health care they need while incarcerated. The Supreme Court has ruled that indifference to medical needs in correctional settings amounts to cruel and unusual punishment which is forbidden under the 8th Amendment.⁶ Some courts have found that care for gender dysphoria is necessary and cannot be treated with indifference by prison officials.⁶ However, other courts, like the U.S. District Court for the Western District of Texas, have found that an incarcerated person is not entitled to hormone therapy regardless of the person's diagnosed gender identity disorder.⁶ This is unacceptable. Gender-affirming care and mental health care must be made available to vulnerable LGBTQ+ populations.

Conclusion

LGBTQ+ people who are incarcerated face unique traumas, stressors, violence, and mental health issues because of their time spent under carceral control. With PREA, an attempt was made to address these inequities, but it remains an imperfect solution. Policymakers should look toward the affected communities for suggestions for improvement. Also, there is a gap in mental health care for LGBTQ+ populations that must be filled. Support groups, counselors, and gender-affirming care should be made available to this community while they are incarcerated to maintain or improve their mental health and to help make their reentry into society more successful.

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**“If I didn’t
define myself
for myself,
I would be
crunched into
other people’s
fantasies for me
and eaten alive”**

By Audre Lorde

Mental Health for One is Mental Health for All

Sexual
Orientation

By Carly Ferre and Arielle Melen, MS

Abstract

Just as patients face abounding barriers to accessing mental healthcare, primary care providers struggle to recommend quality, affordable, and practical mental health resources to their patients. Keeping track of mental health providers and their services can seem insurmountable, especially when patients require personalized resources to meet unique social and financial needs. As medical students, we see how these barriers impact patient care and outcomes. Bearing witness to these shortcomings inspired our local resource mapping project involvement. The AAP Advocacy Training Grant-funded project aggregated mental health resources available to youth in Utah. Mental healthcare access affects communities and requires a community-derived and integrated solution. We hope this database will be an asset to healthcare providers and school districts in Utah to provide more personalized mental health recommendations. In addition, the newly created resource will broaden access to mental health support services covered by patients' insurance, located within their zip code, available in their preferred language, and comfortable working with their specific needs. We share this process in hopes of reflecting on how communities and healthcare providers can unite to break down barriers to mental healthcare access and inspire other organizations to take on resource mapping projects within their communities to increase mental healthcare accessibility.

Introduction

Luis's voice receded, he nervously glanced at the door as if his mother, who had accompanied him to his adolescent well-child visit, could burst in at any moment. "I think I'm gay," he exclaimed, sounding anxious but hopeful we could provide support. As medical student volunteers accompanying a resident physician at a community clinic, we were eager to help our patient, but unsure where to start. Luis explained that he came from a Hispanic Catholic household and could not disclose his sexuality to his family. It became clear that he needed more than a 15-minute appointment. Without a clear handle on what resources were available and accessible for a Medicaid-insured teenager without transportation, we left the exam room to brainstorm. Our team considered some mental health providers for Luis. However, we were unsure if they took new patients, accepted Medicaid, provided LGBTQ+-inclusive care, or could provide care in Luis's preferred language of Spanish. Finally, we scribbled a phone number on a sticky note and passed it to Luis. Leaving the exam room, we wished we could have done more.

Discussion

Later that week, our inboxes pinged with the medical school weekly newsletter. The words, “medical students needed to participate in a resource mapping project,” jumped off the page as Luis’s face flashed into our minds. The Granite School District (GSD) Resource Mapping Project, funded by an Advocacy Training Grant from the Utah Chapter of the American Academy of Pediatrics (AAP), is a collaboration between the University of Utah Pediatrics Residency based at Primary Children’s Hospital (PCH) and the GSD. The GSD serves children throughout the Salt Lake Valley, more than 54% of whom live at or below the poverty line.¹ Inspired by a similar project at the Children’s Hospital of Pennsylvania, we collaborated with medical students, residents, and physicians to assemble a list of zip code-specific resources addressing the district’s student and family needs.² We gathered mental health resources with our patient Luis in mind, knowing the challenges he was facing were not unique. In 2019, 60% of Utah’s youth with depression, ages 12-17, received no treatment for their depression.³ We hope our work will enable healthcare providers and school district employees to connect children with mental health resources aligned with their specific needs, location, insurance, and background.

In October 2021, the AAP declared a national state of emergency regarding children’s mental health.⁴ Their declaration urged increasing access to mental health resources, especially for under-resourced populations. Since 2018, suicide has been the second leading cause of death for 10-24-year-olds in the United States.⁴ Children from communities of color and LGBTQ+ youth are disproportionately impacted.^{5,6} Hispanic adolescents, especially females, report higher levels of depression and anxiety than other racial/ethnic groups in the United States.⁷ Data suggests that children like Luis are four times more likely to attempt suicide than their non-LGBTQ+ peers.^{5,6} Growing research highlights how multidimensional social identities compound experiences of oppression.⁸ This presents distinct stressors for a child like Luis, who identifies as gay and Latino. The context of Luis’ story motivated us to take action and improve mental health access for vulnerable patients.

In a recent study, more than 60% of parents surveyed reported that the most significant barrier to seeking mental health resources for their child was not having information about where to find help.⁹ Our resource mapping project addressed this main patient-reported tension point by providing a zip code-specific database of mental health providers within patients’ communities. With this goal in mind, we utilized internet searches and cold calls to gather information about local pediatric mental health providers and services within the GSD catchment area. We aggregated services offered, telehealth availability, referral processes, and current waiting times. Notably, we included information about the types of Medicaid accepted by the providers, the availability of fee waivers, the costs of sliding-scale services, and languages spoken.

Language barriers between provider and patient in psychiatric care can lead to miscommunication and distortion, especially when interpreters are not utilized.¹⁰ Within the GSD, students speak 106 unique languages and dialects.¹ It was essential to include languages spoken by mental health providers in our database to serve the GSD’s diverse student population and patients like Luis.

As other communities consider taking on a resource mapping project, we believe it is crucial to work with the populations physicians intend to serve to ensure that the information they gather has utility and applicability to their specific patient population.

Exploring the gaps in our community's mental health resources was an immersive learning experience. Even after extensive searches, some zip codes within the GSD housed no mental health resources. For a family already facing economic, social, and cultural barriers to accessing mental health care, adding the burden of transportation and time could make seeking help nearly impossible. This realization was jarring, though essential, as future community healthcare providers. Awareness of the barriers patients face is vital to providing empathic and practical recommendations for our patients.

Conclusion

Counselors within the GSD and healthcare providers at PCH look forward to utilizing our database as a more centralized access-point to mental health resources personalizable to individual patient and family needs. We envision this project as a stepping stone to advancing mental health resource access in zip codes across Utah. A comprehensive and up-to-date database for the state would benefit health care providers, school districts, foster homes, and juvenile facilities. We hope this work will not only encompass the state of Utah but that similar projects may take hold in other communities.

Luis left our clinic with a handwritten phone number scribbled onto a sticky note. We are not sure if he ever was connected to a mental health provider and, if so, whether they accepted Medicaid, if the provider was close to his home, spoke his preferred language, or provided him with the support he needed. The creation of our resource database will empower patients like Luis to leave our community clinics and hospitals armed with options for accessing quality mental health care without placing undue burden on their layered lives.

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Rainbow Magic

By Krista L. R. Cezair

*Sexual
Orientation*

Sometimes

I walk past mirrors on my own
And they don't offer a reflection
But that's to be expected

At times

A Black woman is a big black hole
Greedy gobbling light
Swallowing every hue in sight

After

Hiding in plain sight, eaten up and unknown
Prismatic insides
Are turned out with pride

See

I managed to cajole
Myself into being my self's bride
Never to leave my own side

Surely

This love of self is gold
As I move through the world
Queer flag unfurled

I

Gorge myself on color, bold
And brash, out loud, undimmed
Taking up space, un-slimmed, untrimmed

From

My brown skin's copper undertones
To my brown eyes' sultry glimmer
I transmute light into glitter and shimmer

Magic

Through time and space untold
Black holes never get their fill, still
Of the wavelengths and strengths of the Black woman that spill

Over

But as I look again to the mirror's hold
I admire what I see, truth be told
Beauty too vibrant to behold

Artist Statement

This poem follows the journey of a queer Black woman who experiences the mental turmoil of failing to live authentically as represented by the pitch blackness swallowing her. That turmoil gives way to kaleidoscopic, colorful pride through self-love, healing, and recovery..

An Overlooked Minority: the Mental Health of Bisexual People

By Krista L. R. Cezair

Abstract

Bisexuality is an often-misunderstood sexual orientation, which contributes greatly to the disparity in mental health faced by the people who identify as bisexual. Bisexual people experience sexual or romantic attraction to more than one gender or sex, in contrast to monosexual identities like gay, lesbian, or heterosexual. And although bisexual people make up the largest share of the sexual minority (lesbian, gay, bisexual, or queer) community—more than half (54.6%) reported bisexuality in 2020—they face unique stigma and mental stressors because of their plural sexuality.^{1,2} This article aims to describe these inequities and discuss ideas for reducing them.

Introduction

An Explanation of the Disparities in Mental Health Faced by Bisexual People

Bisexual people experience higher rates of poor mental health outcomes than monosexual people.³ The trend is so steadfast that a meta-analysis of studies found that bisexual people experienced higher rates of depression and anxiety than all heterosexual people studied and as high or higher rates of anxiety and depression than their lesbian and gay counterparts.³ Across a range of studies from Australia, America, Japan, and Canada, greater percentages of bisexual men reported suicidality, including suicide attempts and suicidal ideation, than both gay and heterosexual men.⁴ In the American study, more bisexual men than heterosexual or homosexual men reported active suicidal ideation, indicating that they had developed a specific plan to die by suicide.⁴ Higher percentages of bisexual American women have reported suicide attempts than both lesbians and heterosexual women.⁴

This phenomenon holds true for bisexual youth as well. One meta-analysis found a similar conclusion, that bisexual youth reported more suicidality than lesbian and gay youth.⁵ Even the COVID-19 pandemic had a disproportionate impact, with bisexual adults' self-reported wellbeing experiencing the most consistent and robust downward trends from before the pandemic when compared to their heterosexual counterparts' self-reported wellbeing.⁶ The difference in the effect of the pandemic on bisexual people from heterosexual people is attenuated by the fact that bisexual participants in the survey were younger, on the whole, than other cohorts. The young age of bisexual people has been confirmed by several surveys.

In the most recent of which, a Gallup survey from 2020, the vast majority (72%) of the 15.9% of adults born from 1997-2002 (Generation Z) identified as bisexual.¹ These younger people were particularly vulnerable during the pandemic to economic stressors like inadequate health coverage and job insecurity making their age a confounding factor in understanding the effect of bisexuality on mental health.⁶ This is why it is important to have a solid grasp of the reasons for these disparities between bisexual and monosexual people.

Discussion

Why Do These Disparities Exist?

These disparities exist because bisexual people face mental stressors that are unique to the positioning of their identity in the world. Largely, bisexuality remains marginalized by a monosexual culture that fails to view plural sexuality as legitimate. Structurally and interpersonally, bisexual people are erased, made invisible, and invalidated. One example is in scientific research itself. Few journal articles focus solely on bisexual people although their increased risk for negative mental health outcomes more than warrants attention. A meta-analysis cited earlier had to reject over 500 articles under consideration because the data was not separated to distinguish bisexual populations from other sexual minorities.³ This represents structural bi erasure, a process by which the existence or legitimacy of bisexuality is denied outright.⁷

There is also interpersonal bi erasure and discrimination, which people experience on a person-to-person level. Perhaps surprisingly, bisexual people experience this stigma from gay and lesbian people and from heterosexual people, creating what has been called the “double closet.”⁸ These forces, in turn, cause bisexual people to engage in identity concealment because they lack the safety to “come out” and identify themselves as bisexual. This quote from a qualitative study typifies the issue, “I still haven’t told my lesbian friends. I’m scared they’ll reject me because they don’t really like bi women. (Peta, 25).”⁸ So, unable to turn to the lesbian and gay community or to the heterosexual community, bisexual people lack a place to receive support and social resources affirmative of their identity. Loneliness and social isolation result, leading to poor mental health.⁹

Ways to Address These Disparities

First, more mental health research must be done on bisexual populations with an aim of identifying population-specific prevention and intervention methods. This is especially important in a funding climate where strong scientific evidence is needed to secure interventions for specific groups.³ This evidence base could form the foundation of an education campaign put on by the Department of Health and Human Services in partnership with state public health departments and nonprofits like The Trevor Project, a suicide prevention and crisis intervention organization for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) youth.¹⁰ The campaign’s materials should be developed with the input of bisexual people with first-hand experiences of mental health issues and could be held during Bisexual Awareness Week in September.¹¹

Therapeutic modalities that affirm the sexual orientation of bisexual people are more helpful on an interpersonal level. There are ways of performing cognitive behavioral therapy (CBT) that are tailored to an individual's struggles with their sexuality that have shown to be more effective than regular CBT for sexual minorities.¹² These therapies should focus on making bisexual people feel seen and validated, which is missing from their experience outside of the therapists' office. It is important to note that providers may harbor implicit or other bias against bisexual clients too, so individuals in healthcare settings themselves must ensure that they are not perpetuating societal prejudice.

Bisexual youth have unique needs that warrant intervention, centering around their need to belong in their family units, schools, and communities. So long as biphobia (discrimination based on bisexuality), bi erasure, and stigma are as strong as they are within our society, young people will fear coming out of the "double closet" to their families and friends. This fear leads to higher levels of depression and anxiety.⁵ These cultural attitudes toward bisexual people must change to make our communities a safer place for bisexual youth. Also important is the early identification of risk factors that would indicate mental health issues, including experiences of stigma, discrimination, family rejection, family conflict, and bias-based bullying.⁵ This is important for all youth, but it is essential for youth vulnerable to mental health issues like bisexual youth.

Conclusion

Bisexual people experience worse mental health than either lesbian and gay or heterosexual people. They are at greater risk for mood disorders, like depression, and anxiety disorders. Reasons why include structural and interpersonal biphobia and bi erasure that cause loneliness and poor mental health. More research should be done to uncover novel, effective methods to combat this discrimination and to find new ways to encourage protective factors for mental health like social support.

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“Every woman I have ever loved has left her print upon me, where I loved some invaluable piece of myself apart from me—so different that I had to stretch and grow in order to recognize her. And in that growing, we came to separation, that place where work begins.”

- Zami A New Spelling of My Name

By Audre Lorde



Race and Ethnicity

By Krista L. R. Cezair

The race and ethnicity section covers disparities experienced primarily by members of marginalized racial and ethnic groups, including Black, Indigenous, and People of Color (BIPOC) who do not identify as non-Hispanic white, who are also subject to the extra stress and mental strain that comes with being a minoritized group in the United States.

The section contains works that describe inequities experienced by Black Americans due to the medical system, capitalism, and police brutality. It also features poems by Black people with serious mental illness (SMI). A piece on the experience of a Cuban American with schizophrenia also elucidates the role of ethnicity on mental health.

Racial Disparities in Schizophrenia Diagnosis and Treatment: Their Effect on Black Americans

By Krista L. R. Cezair

Abstract

Schizophrenia is chronically over diagnosed in Black populations by mainly white clinicians. The brain disorder is heavily stigmatized, and misdiagnosis exposes Black people to a slew of lasting negative consequences. Reasons for this phenomenon range from outright bias to cultural incompetence and overidentification with white cultural hegemony. The article concludes with advocacy for further areas of research and professional shifts to address this disparity.

Introduction

The study and practice of psychology has long been haunted by the specter of racism. Both interpersonal and structural or institutional racism have had a serious deleterious effect on Black people and their engagement with the field. Like similar medical disciplines, the “science” of psychology, especially at its inception, was harnessed to uphold racial hegemony and white supremacy. It is unsurprising then, that there are racial and ethnic disparities in the diagnosis, treatment, and outcomes for mental health conditions. There is thought to be an overdiagnosis of schizophrenia in Black patients who present symptoms that could be interpreted in different ways to arrive at a different conclusion¹—compounded by the prescription of higher doses of and more antipsychotic medicines for Black patients.²

Discussion:

Schizophrenia is a chronic brain disorder characterized by three main types of symptoms: positive symptoms are the abnormal presence of psychosis, like hallucinations, delusions, and paranoia; negative symptoms are the abnormal absence of affect and abilities, like a loss of or decrease in the ability to speak, express emotions, or make plans; and disorganized symptoms are those like disorganized or confusing speech, bizarre behaviors, and difficulty with logical thinking.³ The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) lists schizophrenia as belonging to a spectrum of psychotic disorders, giving healthcare providers latitude in making diagnoses.⁴ Schizophrenia is a chronic disease with no cure, but it is treated with antipsychotic medication and psychological interventions, like psychotherapy, in order to reduce the reoccurrence of acute episodes.³

Crucially, people with schizophrenia are at a greater risk for substance misuse and often require treatment for a double diagnosis of schizophrenia and substance use disorder.³ Schizophrenia is also a highly stigmatized mental illness. Stigma includes stereotypes about those with schizophrenia that are defined by ignorance, negative attitudes, prejudice, and discrimination. There is evidence that the chronic environmental stigma endured by people experiencing schizophrenia contributes to high rates of social anxiety and substance misuse.⁵

Perhaps it should come as no surprise that Black people in America—a group of people who are already heavily marginalized—would be overrepresented in the diagnosis of such a stigmatized disorder. In fact, this effect has been observed so often that the abstract of a meta-analysis of the racial disparity in diagnosis published in 2017 began as follows: “Researchers have repeatedly observed that clinicians diagnose Black individuals with schizophrenia at greater rates than white individuals.”⁶ Black patients are diagnosed with psychotic disorders at a rate three to four times the rate at which white patients are diagnosed.¹ The diagnostic excess persists even though there is no genetic difference in prevalence between Black and white people,¹ which is exactly what would be expected given that there are no significant genetic differences between members of different races and that race is an entirely social concept. Black people are also less likely to be diagnosed with mood disorders that may explain symptoms that can be mistaken for schizophrenia than white people are.⁷

As a result of this phenomenon and for reasons that will be explained in further detail below, the treatment of schizophrenia in Black people is also highly racialized. Black people are more likely to be exposed to heavy antipsychotic drugs while in an inpatient hospital setting.⁷ They are also more often prescribed “long-acting injectable formulations” and older antipsychotics as well.⁷ These differences in pharmacological treatment are compounded as those people who have been hospitalized in the past are given even higher doses of medication still upon their return.⁷ Black people are then more likely to be diagnosed with schizophrenia, more likely to be prescribed older and heavier doses of medication with unpleasant side effects, and more likely to receive stronger pharmaceuticals upon reentry to an inpatient hospital setting.

This problem has several implications for Black people who incorrectly overidentify with the schizophrenic label. As discussed earlier, schizophrenia is one of the most stigmatizing mental illnesses. Having a diagnosis of schizophrenia may contribute to a toxic and unhealthy relationship with a person’s social environment, which then becomes a factor in the development of social anxiety and substance misuse that are even further stigmatizing.⁵ It is particularly important to consider this stigma because environmental factors are thought to help bring about disordered symptoms and can trigger development of a psychotic disorder in the first place.⁵ Stigma also exists at the intersection of different marginalized identities, where it is added to the harmful discrimination already perpetuated daily against Black people in America.

Both forms of negative attitudes toward these groups operate at the interpersonal and structural levels as well. The racial disparity in medication prescription within hospitals is evidence of discrimination at the institutional level.

This over-prescription is dangerous because it exposes Black people to unnecessary side effects of powerful medication that may affect their wellbeing. On the individual level, interpersonal racism, stigmatization, cultural ignorance, and discrimination play a part in the different rates of schizophrenia diagnosis.

Stigma from mental illness in general, and schizophrenia in particular, is so debilitating that one psychiatrist referred to it in print as a “second illness” that must be dealt with just as sincerely as the first illness of the mental health condition.⁸ There is also a socioeconomic angle to consider. Because of the stigma associated with schizophrenia, many people with the disorder are, often illegally, discriminated against in the hiring process. One study found that only 32.7% of a sample of people who had experienced psychosis had been in paid employment in the past 12 months.⁹ This percentage is far lower than the entire population. Even mental health professionals doubt the employability of their patients who have experienced psychosis.⁹ All of this external stigma can cause self-stigmatization, when a person internalizes stigma and comes to incorporate the negative beliefs about themselves that they encounter in the world into their sense of self.⁹ Self-stigmatization is bad enough, but to have the experience of being demoralized and hamstrung in that way based on a diagnosis that is not accurate is a tragic inequity and failure of the mental health care system.

Diagnosis of any mental illness is notoriously difficult. For schizophrenia, which is experienced by an estimated 0.25% to 0.64% of the American population, misdiagnosis may be even more common due to the rarity of the condition.¹⁰ Even still, Black people are misdiagnosed at higher rates than white people. For example, one study found that Black nursing home residents were more likely to have their Alzheimer’s or dementia misdiagnosed as schizophrenia first.¹¹ There is also a pattern where Latino Americans are diagnosed with schizophrenia at rates three times higher than white Americans.¹ Further, a similar international pattern exists of overdiagnosis of schizophrenia in ethnic minority immigrant groups.¹ In Portugal, Black immigrants were significantly more likely to receive a diagnosis of schizophrenia upon admittance to an inpatient hospital setting.¹ In the Netherlands, Black and minority ethnic groups and white immigrants from other countries were equally likely to be recommended for involuntary hospital admissions at rates over twice that of Dutch natives.¹ A few studies have suggested that structured assessments would help improve this disparity by narrowing the provider’s discretion in diagnosis, forcing them to stick to the DSM-5 or other criteria. Although this seems effective in theory, a study was done that showed racial differences in schizophrenia diagnosis persisted despite the use of structured assessments.⁶

There are a few theories that have been advanced to account for the origin of this disparity. One study noted that unconscious bias on the part of clinicians is a plausible rationale for the systematic overdiagnosis of schizophrenia in Black patients and systematic under-diagnosis of affective disorders—mood disorders like major depressive disorder, bipolar disorder, and generalized anxiety disorder—in the population.¹ Diagnosticians may hold beliefs based on stereotypes around who they expect to have low incomes, to be unhoused, or to have a substance use disorder that may be affecting their diagnosis of schizophrenia because the disorder is highly correlated with these conditions. The groups are all highly stigmatized and face structural and interpersonal discrimination.

This theory is closely related to the hypothesis that beyond bias, clinicians may simply be culturally incompetent. Rather than clinicians associating a stigmatizing disorder with a marginalized group, they might have difficulty interpreting the gestures, language, and affect of people from different cultures.¹ The international pattern of overdiagnosis supports this theory. Clinicians from the dominant domestic ethnic group fail to accurately identify symptoms in patients from different backgrounds, and so, more members of the group are misdiagnosed. Although, in Canada, patients can be referred to a cultural consultation service that is intended to make up for this deficiency, diagnoses of psychotic disorders are still harder to shake for immigrant and ethnic minority populations. Of the patients who received no change in their psychotic disorder diagnosis, 44% were Black.¹ This is compared to the 5% of people with nonpsychotic diagnoses who received a concluding diagnosis of a psychotic disorder.¹ The discrepancy shows that a diagnosis of schizophrenia or similar psychotic disorders is strongly associated with Black patients regardless of cultural competence, assuming the cultural consultation service is effective.

Conclusion

The implications of overdiagnosis of this stigmatizing disorder are devastating for the Black, Latino, and other racial, ethnic, and immigrant communities it affects. Anything from reduced job prospects and loss of economic power to increased risk for substance use disorder is possible and could be avoided. More training is needed for clinicians so that they can overcome their biases in diagnosis and prescribe medication as it is intended. Also, further research could use larger datasets of patient information to associate a greater number of characteristics more closely with the diagnostic trends. This research would provide a clearer picture of the characteristics that are associated with legitimate diagnoses of schizophrenia and offer clinicians more information to use in drawing conclusions around the proper diagnosis of this serious illness.

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BPD

Race
/Ethnicity

By Kirabo Katami

To be skinless.

To be flayed by your own barbed whip.

To know the song of the sirens so intimately,

it is as though you have sung the words onto their tongues.

To crave the sickly sweetness of infinity,

to have cavities from the taste.

To live by ritual: your thighs a canvas of survival's scarification.

To unmake life's softer treasures and try to stitch a life together from everything that unmakes you.

To be the residue of a life not quite extinguished

And to forge a path in the waning light.

Artist statement

The poetry details the quotidian emotions and thoughts that I have experienced while navigating my mental health journey as a Black nonbinary person. It is about the daily reminders and promises that one has to make to oneself in order to navigate the highs and lows of a condition like BPD. Each day of surviving this condition brings new meaning to the adage "trust the process" - it is not always joyful, pretty or pleasant, but every act of love shown towards oneself and others is proof that we have the capacity to survive and create lives filled with meaning and tenderness.

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Cutting Cane: A Cultural Studies Informed Approach to Trauma and Cultural Competence

By Carlos A. Larrauri, MSN and Natalie Catasús, MA, MFA

Abstract

Cultural studies can provide a window into understanding the transmission of trauma between generations of racial and ethnic minority groups. By engaging theories from cultural studies in examining the experience of a Cuban American family (one of the co-authors' own) seeking mental health care, we see how shared cultural identities between patients and providers do not necessarily translate into culturally competent care. Cultural studies-informed analysis could help us critique and improve our understanding of care for Cuban Americans and, similarly, be applied to improve the care of other racial and ethnic minority groups.

Introduction

"A él lo que le conviene es mandarlo a cortar caña." The psychiatrist's words pierced through the dialogue between Carlos (the co-author) and his mother, imbued with historical implications yet trivializing a severe medical crisis. Carlos had become increasingly psychotic when his mother Ana took him to a Miami psychiatrist who, after a brief 15-minute interview, opined, "It is in his best interest to send him to cut cane." In Cuba, employing "volunteers" in gathering sugar crops began soon after the revolution in 1959.^{1,2} Many Cuban exiles would later arrive in Florida to find that the first job available to them was in the agricultural industry—cutting sugarcane.

Nevertheless, there was Carlos, a young adult in his early 20's, in the private practice office of a Cuban-born, yet U.S.-trained physician, when the psychiatrist offered little more than a dismissive, if not negligent, assessment of his mental health. The doctor's words spoke volumes about his own cultural and generational attitudes and yet said nothing about Carlos as his patient or as a person. Fortunately, Ana continued seeking mental health professionals, who diagnosed Carlos with adult-onset schizophrenia and provided much-needed specialized care.

As second-generation Cuban Americans who now work in the fields of mental health and the humanities, the scene we have just described raises several questions for the authors: how do the traumas of Cuban exiles continue to influence the lives of later generations of Cuban Americans?³ And how might a public health approach that engages with cultural studies—a broad humanistic field including the study of literature, media, politics, and history—contribute to culturally competent care for Cuban Americans and other racial and ethnic minority groups?^{4,5}

Discussion

More than a single case study is needed to understand these complex dynamics fully; nevertheless, this anecdote speaks to broader issues arising from cultural differences between the exile generation who arrived to the United States in the 1960s and their children's generation—Cuban American millennials whose coming of age has coincided with a gradual de-stigmatization and more open attitudes towards seeking mental healthcare.^{6,7}

Here, the interdisciplinary field of memory studies, a branch of cultural studies that seeks to understand “the ways we draw on, shape, and are shaped by the past,” offers a potential framework for understanding how unprocessed trauma can be transmitted intergenerationally through coded language.⁸ Psychoanalysts have suggested that trauma is passed from one generation to the next through the repetition of linguistic forms, such as metaphors, that mask the source of trauma with a more palatable image.⁹ In this framework, we might understand “cutting cane” as a prescription in which an easily visualizable action stands in for a more abstract source of psychiatric distress.

Historical studies of Havana's psychiatric asylums offer further examples of how a generalized language of mental health provides a vehicle for articulating the trauma of exile in a manner that can obscure the nuances of an individual's psychiatric condition. Historians suggest that the popular ideas of *locura* (madness) and *nervios* or *nerviosismo* (nerves or nervousness) become metaphors that blanket political and psychiatric complexities in Cuban society.¹⁰

In particular, anthropologists have found that *nervios* “represented an extraordinarily flexible diagnosis” and could “refer to a wide array of mental and spiritual disturbances, including schizophrenia, bipolar disease, hypochondria and even perturbations provoked by the deceased, saints or orixas [sic].”¹¹ These assessments suggest that the pervasive “diagnosis” of *nervios* and other generalized language has so firmly settled into vernacular use that the Cuban-American community may overlook severe conditions needing precise diagnosis and specialized treatment, as was the case with Carlos.^{12,13}

Moreover, the concept of postmemory offers a way to understand how the second generation constructs their own “memories” of an inherited past mediated by the “stories, images, and behaviors among which they grew up.”¹⁴ Several literary scholars have mobilized this theory to show how “[f]or Cuban Americans who lack first-hand experience of the island or the historical events that have defined their communities, postmemory is a fundamental part of their sense of self.”¹⁵

Some scholars suggest that the second generation is perhaps better equipped to acknowledge the nuances of the past and address the limitations of the dominant narratives because of their distance from the actual traumatic events. They observe the second generation exercising postmemory to interrogate the stereotypes that have been passed down about Cuban exile. In doing so, “they reframe, revise, and re-voice the history, stories, and memories of Cuba in the diasporic present.”¹⁶

What struck us about Carlos’s experience is that the shared culture between the provider and the patient not only failed to produce culturally competent care but may have also contributed to the dismissal of his mental state. Whether the psychiatrist’s remarks alluded to trauma from Cuban exile—“you don’t know had bad you could have it”—or the deeply ingrained American ethos that hard work is the means for decency and upward mobility—“you need to pull yourself up by your bootstraps”—it was neither diagnostic nor therapeutic. He overlooked the need for urgent intervention by projecting cultural and generational norms onto his patient.

Implicit in our analysis is the presumption that culturally competent care includes working cross-culturally and intra-culturally. Consequently, healthcare providers must not overlook intra-cultural differences between them and their patients; shared cultural identities are not enough to ensure cultural competence. Healthcare providers should also be sensitive to intra-cultural differences when working with patients from different generations. Additionally, second-generation minority patients and their providers would benefit from critically examining how their mediated relationships to a traumatic past have shaped themselves and their community, especially when seeking or delivering mental healthcare.

Though the exact social, cultural, and biological mechanisms behind intergenerational trauma are a source of ongoing and lively debate, there is increasing consensus within the medical scholarship that parental and communal trauma exposure can impact subsequent generations, and that pairing trauma-informed care with cultural learning on the part of healthcare providers can help them better support the intersectional challenges faced by their patients.^{17,18,19}

As such, we suggest further cultural studies examining the experience of minority patients and families seeking care to advance our understanding of intergenerational trauma mediated by socio-cultural mechanisms and contribute to a more nuanced discussion of cultural competence.

Conclusion

In sum, Carlos’s family’s experience seeking mental healthcare provides a microcosm for exploring larger issues affecting the Cuban American community. We hope that learning from cultural studies-related fields such as the growing interdisciplinary field of Narrative Medicine can inform future understanding of the transmission of intergenerational trauma and, in this way, help us better understand what constitutes culturally competent care for Cuban Americans and other racial and ethnic minority groups.²⁰

We intend this piece only to start the conversation, and we need much more discussion exploring the intersection of cultural studies and public health to improve care in the long term.

Race
/Ethnicity

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My Therapist Told Me

Race
/Ethnicity

By Kirabo Katami

Remember how fragile these bodies are.
These acts of survival do not have to be beautiful,
they are wrought from the impossibility of a
life that continues
in spite of its own
better judgement,
against its own nature.

Every day that you make it is another battle won.
It's the knowledge that you tried
and you're trying.

That might be your path to freedom.

Artist statement

The poetry details the quotidian emotions and thoughts that I have experienced while navigating my mental health journey as a Black nonbinary person. It is about the daily reminders and promises that one has to make to oneself in order to navigate the highs and lows of a condition like BPD. Each day of surviving this condition brings new meaning to the adage "trust the process" - it is not always joyful, pretty or pleasant, but every act of love shown towards oneself and others is proof that we have the capacity to survive and create lives filled with meaning and tenderness.

Author biography

Kirabo Katami is a writer and lawyer based in the United Kingdom.

Maladaptive

By Kirabo Katami

Sadness like a lukewarm bath.
Edged with a gossamer film of the day's sediment,
The week's,
The year's,
A genealogy's.

And so familiar.
A tepid embrace, an enfolding,
only leave it when you need to work
or to make them love you.

But remember it's yours.
Return and sink in.
Hold your breath down under.
Know it so well that if the stone around your neck is heavy enough
it will feel like going home.

Artist statement

The poetry details the quotidian emotions and thoughts that I have experienced while navigating my mental health journey as a Black nonbinary person. It is about the daily reminders and promises that one has to make to oneself in order to navigate the highs and lows of a condition like BPD. Each day of surviving this condition brings new meaning to the adage "trust the process" - it is not always joyful, pretty or pleasant, but every act of love shown towards oneself and others is proof that we have the capacity to survive and create lives filled with meaning and tenderness.

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The Mental Health Impact of Police Violence Among Black Americans in the United States: A Review

By Dr. Harun Khan

Abstract

Although it is a global phenomenon, there is a growing consensus that the level of police violence in the U.S. constitutes a national public health crisis. In 2022, there were already over 280 civilian killings by police by the end of August – the majority of whom were Black people and people of color. Although police violence related mortality has received significant media coverage, less emphasis has been placed on the impact of police violence on morbidity outcomes, particularly chronic outcomes relating to mental health. Thus, this paper will explore the multi-level impact of police violence on the public health outcomes of Black Americans, with mental health as its principal focus. It will also propose three strategies that can be employed to decrease the incidence of racialized police violence moving forward.

Introduction

Amidst the rise of the Black Lives Matter movement in the United States (U.S.), mainstream public support has been galvanized to tackle the crisis of police violence and its disproportionate burden on communities of color.¹ Police violence describes the use of excessive force (physical and sexual and/or psychological) by police officers² and may constitute violence at the interpersonal level, community, or population levels. Such acts of violence range from the police killings of individual civilians to the misuse of crowd-control weapons during mass protests; importantly, it can also include police inaction such as neglect.³ Although it is a global phenomenon,^{4,5} there is a growing consensus that the level of police violence in the U.S. constitutes a public health crisis. Given the significant mental health impact of police violence and its propensity to further exacerbate well-established racialized health inequities, this paper will describe the multi-level impact of police violence on the mental health outcomes of Black Americans and the strategies that public health practitioners can employ to decrease its incidence moving forward.

Discussion

An Overview of Police Violence and Public Health

Police violence has a cyclical and compounding effect on the public health of communities of color.⁶ Black Americans, in particular, are disproportionately burdened with more frequent exposures to multi-level police violence throughout the life course, which may adversely impact their health outcomes. This inordinate exposure to police violence even persists when controlling for crime rates based on race and are only partially explained by social factors like median income and the demographic make-up of one's neighborhood.⁷ The mechanisms by which police violence impacts health are multiple, and their magnitude is beyond the scope of this paper, although they may include direct physical and mental health harm secondary to abuse as well as adverse physiological responses relating to coping with chronic stress. The type of hypervigilance that has commonly been developed as a coping mechanism to such harm has been described as a type of "coping fatigue."⁸ As such, police violence is an everyday health stressor for some minoritized groups, most notably for Black Americans.⁹ For the purpose of this paper, we will focus on the adverse impact of police violence on mental health at the population level.

Police Violence and Physical Health (Mortality & Chronic Health)

There is a growing body of evidence that clearly links exposure to police violence with adverse physical health outcomes among Black Americans at the individual and population levels. Most public health research thus far has focused on:

- 1) mortality (i.e., police killings) and;
- 2) the link between community-policing and chronic health conditions. In the U.S., there were only 15 days in 2021 where someone was not killed by the police¹⁰—making up 8% of annual homicide deaths.¹¹ In 2022, there were over 280 civilian killings by police by the end of August 10. When stratified by race, Black American adults are 3 times more likely to be killed by a police shooting than white Americans (see appendix – figure 1); this increases to 21 times when only reviewing deaths among teenagers.¹² The principal limitation behind these statistics is that they have been aggregated from independent data sources, such as the Guardian U.S.'s The Counted program, a database that recorded police killings in 2015/1613 and the Mapping Police Violence Project.¹⁰

These independent databases exist to overcome the absence of national standards for the reporting of police killings and the lack of a national database that records homicides secondary to police violence. There have also been additional calls for police killings to be considered a notifiable illness, as with many infectious diseases,¹⁴ which may improve national data collection. Despite the obvious data gap, it is still well-established that police killings in the U.S. are more prevalent per person of the population than any other high-income country in the world.¹⁵ This still does not account for non-fatal injuries secondary to police violence, that are far numerous, which may mean that current estimates of overall police violence have been vastly undercounted.

Moreover, ecological and cross-sectional data has primarily been used to study the deleterious effects of community-level policing – mass surveillance, stop-and-frisk encounters and traffic stops – on chronic health conditions.

Approximately, 21% of Americans who are over 16 years old have had contact with the police. The most common type of police contact refers to traffic or street stops; these are most common among Black Americans who are also more likely to feel that they were treated with excessive force or were threatened during a stop.¹⁶ Current evidence suggests that a strong link between everyday stressors relating to policing and the development of chronic health conditions is likely. For example, in a cross-sectional study of 36,188 participants in New York City (NYC) between 2009 and 2012, those who lived in communities where police stops were more likely self-reported more new diagnoses of diabetes mellitus, hypertension, acute asthma exacerbations and an increase in body weight; these findings persisted after controlling for crime.⁹ When stratifying by race, Black people fared worse than their white counterparts across all health outcomes apart from diabetes mellitus and outcomes were worse among Black people who resided in white majority neighbourhoods.¹⁷ Links between police encounters and poor sleep among at-risk Black youth have also been replicated in multiple studies; this further compounds the well-documented harms of poor sleep that co-exist with mood disorders that are of increased prevalence among this subgroup.^{18,19}

Another cross-sectional study of 1,059 birthing people showed that those who lived in neighborhoods with an increased police presence were more likely to deliver pre-term babies; the effect was again worse among Black birthing people.²⁰ This complements finding on chronic stress and birthing outcomes in other studies. For example, Arab American women in California experienced a higher relative risk of adverse birthing outcomes during the 6 month period after the September 11th attacks [compared to 6 months before] – this finding was not significant for any other historically excluded groups including Native American and Indigenous people and African Americans.²¹ Although cross-sectional studies like these cannot establish causality, results like these warrants strong speculation regarding the role of racialized stressors and adverse health, including birthing, outcomes. Further funding is required to investigate the impact of racialized stressors, like policing, across the life course. In addition to physical health outcomes, there is a clear association between exposure to police violence and impaired mental health outcomes including depression, post-traumatic stress disorder and subclinical psychotic symptoms, which disproportionately impacts Black Americans and will be the focus of the remainder of the paper.⁶

Police Violence and Mental Health

The deleterious effects of policing on mental health are well-summarized by a recent systematic review which showed that Black Americans with more frequent police encounters experienced higher levels of PTSD, suicidal ideation, and depression. Of the 11 studies in the review, 9 were cross-sectional by design, 10 used self-reported data and 3 limited their study population to Black participants only.¹² In one study of 1,000 participants in Baltimore and NYC, those victim to sexual violence and physical violence with a weapon, in particular, reported the most significant mental health harms.²² Although cross-sectional designs, again, are unable to establish causality, reverse causality is unlikely as 4 of 11 studies stratified their results by previous mental health history of participants. Even among those with mental health disorders, Black Americans are more likely to be met with police violence after which their mental health symptoms are often worse.²³

As well as direct police violence impairing one's mental health, studies have found that police violence may impact the mental health of Black Americans through vicarious means, i.e., those who are not personally connected with the victim may still be impacted. Multiple theories have been posed to explain this phenomenon including the possibility of shared mental trauma through a process of "communal bereavement". In a quasi-experimental study of 103,710 Black Americans—38,993 of whom were exposed to at least 1 police killing in their state up to 3 months prior to the survey—1 killing of an unarmed Black American was associated with respondents experiencing 0.14 additional days where their mental health was "not good."²⁴ At the population level, this accounts for 55 million extra days where Black American adults would self-report a "poor mental health day"²⁴ above a regular baseline.

Although this study is limited by factors like unmeasured confounders or the reliance on self-report data – "not good" mental health may be interpreted differently by participants, for example – it clearly demonstrates the vicarious impacts of police violence on public health that extends to community-level impacts. This theory has been supported by two recent studies as well. Most notably, a 3-year longitudinal study across 5 U.S. states that showed that police killings of unarmed Black Americans were associated with an 11% increase in emergency department presentations for depressive symptoms.²⁵ This was complimented by the findings of a qualitative study where Black participants shared the distress that they experienced merely viewing images of police violence – this manifested as a persistent fear of death, as well as hypervigilance among some and may continue to have long term impacts.²⁶

Strategies to Tackle Police Violence

Given the increasing momentum to combat the immense level of police violence in the U.S., there are a variety of strategies – ranging from legal to political – that have the capacity to decrease its incidence. In this section, I will discuss three options that are particularly relevant to the current U.S. context that employ legal, medical and research methods to combat police violence.

Politico-Legal Strategy – End Qualified Immunity

One strategy to tackle police violence is to introduce or tighten measures that hold police accountable for misconduct, such as ending the legal doctrine of "qualified immunity" in the U.S.. Qualified immunity is a type of legal immunity that protects government officials, including police officers, from personal liability in federal lawsuits unless the violation of federal law was "clearly established."^{27,28} It was first introduced by the Supreme Court in 1967 to protect law enforcement officials from unsubstantiated civil suits and financial liability for court cases. Since its passing, this legal doctrine has been used by police officers to circumvent both the costs of a trial and personal liability in cases of police misconduct, such as police killings.²⁸ In order to file a lawsuit against police officers for misconduct, qualified immunity places the onus on the victim to find an almost identical prior legal case, where a victim's civil rights were violated in the same way under the law, to prove that their constitutional rights were violated.^{28,29} as such, as reported by Reuters, qualified immunity is a "nearly failsafe tool to let police brutality go unpunished."³⁰

There has been growing political support to end qualified immunity, as critics argue that its elimination will incentivize the police to respond with more appropriate force – with hopes of police violence decreasing as a result.³¹ The End Qualified Immunity Act was thus proposed in 2020 by congress persons Ayanna Pressley and Justin Amash. Although at least 20 states are considering bills to end qualified immunity in state courts,²⁹ opposition to the bill from the political right has acted as a barrier to its passing at the state level. Critics have undermined calls to end qualified immunity by arguing that, like the introduction of bodycams for police officers, ending qualified immunity will not alter police behavior nor decrease levels of police violence – both a review of 70 studies and a 2020 systematic review showed that body cameras did not reduce levels of misconduct, nor increase police convictions³² or decrease the police officer’s use of force.³³ However, proponents of the bill, including the American Civil Liberties Union, claim that ending qualified immunity is one of the most impactful strategies in the fight to ensure police accountability.²⁹ To date, qualified immunity has been ended completely in Colorado and New Mexico and only partially suspended in New York; there is no evidence currently that demonstrates whether this has led to a decrease in police violence in these states.

Medico-Legal Strategy – Debunk “Excited Delirium”

Another approach to combat police violence is to outlaw the use of unproven “medical disorders” that have been used, and arguably designed, to justify racism in the form of police killings. Many consider “excited delirium syndrome” (EDS) – a syndrome that is widely regarded as unsubstantiated in clinical medicine – as a modern-day example of medicalized racism that has been used frequently in fraudulent forensic reports to justify in-custody deaths of racial minority men in particular.³⁴ It was a term first used in 1985 in the U.S. to describe a syndrome (a collection of symptoms) that acutely develops in cases where one is physically restrained and may make someone “irrationally combative and dangerous.”³⁴

As such, it has been cited in several cases which led to the otherwise unexplained deaths of Black and brown men who were restrained by officers including incarcerated individuals.^{35,36} Although it is not a recognized medical diagnosis – merely a descriptor of a range of symptoms – there is no mechanism that results from excited delirium to death directly, nor are there any autopsy findings associated with EDS,³⁷ forensic pathologists have still commonly cited it as a cause of death in the U.S. to justify police killings.³⁶ This makes EDS the only primary cause of death on a death certificate that has no evidenced medical explanation. Most recently, it was used to explain the murder of Angelo Quinto, a Filipino American, died moments after police officers were kneeling on his neck.³⁸

As of today, EDS is not an accepted medical diagnosis recognized by the World Health Organization, the American Medical Association or the American Psychiatric Association. To the dismay of health and human rights groups who maintain that it is a “baseless medical diagnosis,”³⁸ it is accepted by The American College of Emergency Physicians (ACEP). “Excited delirium” is receiving growing criticism, as the term EDS is being slowly exported elsewhere in the world to justify excessive policing.³⁸

For many, EDS is reminiscent of the U.S.' history of scientific racism,³⁹ such as the disorder "drapetomania" – a false psychiatric disorder that was designed to retrospectively pathologize enslaved people who wanted to run away from their captors. Given that it has not been medically established, there is no theoretical need to debunk EDS. However, an increasing movement within the medical and legal professions are required to outlaw EDS once-and-for-all instead of, once again, weaponizing medicine to justify racism.

Research Strategy – Improving Non-Fatal Injury Data

Another option to strengthen the movement against excessive policing is through the availability of police violence data. Given the disproportionate focus on police killings, the burden of non-fatal injuries (NFI) from police violence, which are harder to delineate but likely larger in number, have been long neglected. The Global Burden of Disease study on police violence in the U.S. has already confirmed that over half of police deaths are underestimated in the USA National Vital Statistics System.⁴⁰ Due to the paucity of NFI data, police violence as a whole is likely severely undercounted; this may contribute to its poor prioritization as a policy issue at the local, state and federal levels. It is arguable that the under-estimation of police violence in the U.S. is the reason behind the lack of mainstream support for policy related to police violence – much like ending qualified immunity which has only been passed by 3 states.^{28,31} Data on NFI from police violence is also inextricably linked to economic and social outcomes. For example, victims of police harm may be subject to exorbitant medical costs and time away from work due to ill-health – exacerbating the vicious cycle of poverty and poor health outcomes.⁴¹ This underlines the tremendous need to improve data on NFIs in order to promote health equity.

One way to gather NFI data could be to cooperate with local injury prevention programs or emergency medicine departments in secondary care hospitals. A simple, yet effective, initial study proposal could focus on emergency room patients who have presented with NFI relating to police taser use. Informal studies on NFIs have been conducted by human rights groups; for example, Physicians for Human Rights (PHR) conducted an informal mixed methods study in the aftermath of the Mott Haven protests in the Bronx, New York, which erupted after the murder of George Floyd. Here, PHR documented instances of police violence including the blockage of urgent medical assistance to protesters and the use of disproportionate force against protestors including crowd-control weapons, like teargas, and crowd control methods, such as "kettling."⁴² These findings will be used to support legal proceedings, such as those aiming to limit the use of militarized weapons by law enforcement; this is a great example of how higher quality NFI data could be used to support political and legal advocacy efforts to dismantle structures that promote police violence in the U.S.

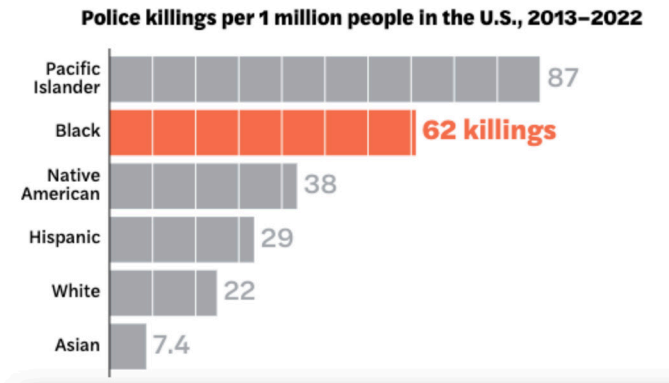
Conclusion

In summary, police violence serves a health stressor that has a tremendous influence on the public health outcomes of Black Americans in the U.S. across their lifespan. There are a number of strategies that one can employ to join the fight to tackle police violence. Although the public health world has finally awoken to seeing police violence as a public health crisis, we will only be able to attain a true state of health equity through tangible action, such as funding for NFI research and political support behind outlawing EDS and qualified immunity.

Author Bio

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Figure 1 – Police killings per 1 million people in the U.S. between 2013 to 2022 stratified by ethnicity. Credit: MappingViolence.org



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Ashes

After Danez Smith

By Kirabo Katami

There will be days when you must
wrest your life from the grasp
of your own tightening fist
and fight for yourself with tenderness.

Remember that survival is configured by the pulsing mundane:
The nights when you let those cleansing drops tattle,
revealing what threatens to silence you;
The mornings when you hear the latent peal of birdsong
and wait for the dappled fragments of that emerging star
to spin silver from the ash on your skin.

Loosen your fist. Stretch your fingers.
Learn, as often as you need to,
how to survive.
Trace the silver-spun paths on your parched expanses:
all roads lead to you.

Artist statement

The poetry details the quotidian emotions and thoughts that I have experienced while navigating my mental health journey as a Black nonbinary person. It is about the daily reminders and promises that one has to make to oneself in order to navigate the highs and lows of a condition like BPD. Each day of surviving this condition brings new meaning to the adage "trust the process" - it is not always joyful, pretty or pleasant, but every act of love shown towards oneself and others is proof that we have the capacity to survive and create lives filled with meaning and tenderness.

Author biography

Kirabo Katami is a writer and lawyer based in the United Kingdom.

To Save Black Mental Health, We Must Destroy Racial Capitalism

By *Matthew Thompson*

Abstract

This essay examines the roles of racism and capitalism in shaping the mental health outcomes of Black Americans. Racial capitalism has played a critical role throughout U.S. history to create the socioeconomic landscape we see today, in which Black people are subject to race-based discrimination and live in poverty at disproportionate rates compared to their white counterparts. Poor socioeconomic outcomes then correlate negatively with mental health. Policy reforms have provided relief to some individuals but have not tackled root causes. To create a state of mass wellbeing, I argue for the creation of vast grassroots networks of mutual care, and for a social revolution.

Introduction

"Amerika trips me and proceeds to ask me how I fell; whips me, then asks me how to stop the bleeding."

There is no conversation about the state of mental health in Amerika's Black communities without discussing the violence wrought on them by racial capitalism—a term coined by Cedric Robinson. Robinson, a pioneer in the study of the Black Radical Tradition, argued that the "development, organization and expansion of capitalist society pursued essentially racial directions."¹ It is this pursuit that has helped shape many of today's societal ills, including poor rates of Black mental health.

Discussion

Historical oppression, including slavery, sharecropping, and race-based exclusion from health, educational, social, and economic resources has translated into the socioeconomic disparities faced by Black people, today.² In turn, socioeconomic status correlates with positive and negative mental health. Studies have long shown that conditions, including poverty, unemployment, housing instability, and incarceration all increase one's risk of mental illness and psychiatric hospitalization,³ Black people score the worst in all these categories.^{4,5,6,7,8} This demographic is also subject to the mental health effects of ongoing racial terror, as evidenced by continued police-involved killings, such as that of Jaylan Walker—shot at over 90 times and hit more than 60—and by acts of mass violence, including the shootings targeting Black victims in Buffalo, New York and in Charleston, South Carolina.^{9,10,11} Acts like these impose collective trauma on Black people, who are expected to carry on functioning normally in their wake.

Black adults are more likely to have feelings of sadness, hopelessness, and worthlessness than white adults.² Sixteen percent (4.8 million) of Black Americans reported having a mental illness, and 22.4 percent of those (1.1 million) reported a serious mental illness over the past year.¹² Black Americans living below poverty are twice as likely to report serious psychological distress than those living over two times the poverty level, according to Mental Health America.² Black people have experienced disproportionate trauma and psychological distress resulting from COVID-19, even if they were not personally infected.¹² We also have an issue with the criminalization of mental illness, where Black people with mental health conditions, especially those involving psychosis, are more likely to be in jail or prison than people of other races.¹²

Is it a mistake that the people who need mental health resources the most have the least access to it? This phenomenon cannot be when 63 percent of Americans support single-payer healthcare.¹³ Living wages, universal college, debt forgiveness—all policies that most Americans support and would disproportionately benefit the most materially deprived, including Black people, indigenous people, and other marginalized groups, thereby improving their socioeconomic conditions and their overall positive mental health rates. When a flower does not bloom, we do not blame the flower; we look to its environment to add the elements it needs to thrive.

So, what is preventing these policies that would drastically improve both people's material lives and mental health on a massive scale from passing our legislatures? Capitalism. Our politicians are more interested in receiving big money donations from lobbyists to back policies that maintain and exacerbate inequity, than in championing policies that would disrupt the status quo. The advocates that do exist in these bodies are so few that they are virtually powerless to disturb the system in a way that would make a material difference in the lives of the masses. How, then, with a government committed to capitalist ideals can we ever expect to seriously address mental health? The answer is grassroots organizing and social movement.

Capitalism has conditioned us to think as individuals in a "survival of the fittest" mentality. Matters that communal society members would work to resolve through mutual aid are now outsourced in the West by those who can afford it—childcare, eldercare, cooking, cleaning, etc., can be purchased as services to lessen one's own burden, thereby reducing mental stress. If you are poor, you do not have this luxury. We must organize communities to share and tap into each other's resources, so they may help everyone meet their needs and build community resilience. Moreover, this should be combined with advocacy training to build the movement necessary to effect material change in society. We must build a movement so powerful and organized that its demands cannot be ignored by the state.

Conclusion

Increasing access to counseling and therapeutic services is a good thing, but only benefits a minority of the individuals who need them. Moreover, such services are often necessary because of the trauma that poverty breeds. To save the mental health of the Black masses we need something more. We need a social revolution.

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Author biography

Matthew Thompson is a revolutionary organizer from and living in Brooklyn, NY. He holds an MPA from CUNY John Jay College of Criminal Justice, and a BBA from Howard University. Matthew is the Senior Policy Associate at Legal Action Center, where he advocates for equity on behalf of people living with mental illness, substance use disorder, and/or criminal records.

To the Blacker Berry and the Sweeter Juice

By Krista L. R. Cezair

They swear it's a liability,
Our skin with its fidelity
To the Blacker berry and the sweeter juice.
Well, that perspective is obtuse.
Because it's the Black community
That offers the opportunity
For protective factors
Against mental detractors.
Yes, studies show,
Despite stigma bestowed,
That there are lower rates
Of mental illness straits
Amongst non-Hispanic Black people
Than non-Hispanic white people,
And it can partly be attributed
To the widely distributed
Love for one another
Between the sistas and brothas.
Social and emotional support
Does the work to thwart
The onset of mental illness
Or suicide with its stillness.
Further, pride in the Black identity
Makes for more serenity.
See, even though we struggle
And discrimination we juggle
Among the many other pains
That make daily life a strain,
Together, we care for each other
Paying dividends, one after another.

Artist Statement

In writing this ode to the Black community, I wanted to get across the point that being Black is not all pain and suffering, that there are incredibly positive effects of our community and that I am lucky to be a part of it. As far as mental health goes, in 2020, the prevalence of mental illness in Black people was 5.3% lower than in white people.¹ This is despite the additional burden of race-related stressors. Belonging to the Black community, having a strong sense of Black identity, and receiving sufficient social and emotional support are all protective factors that help prevent suicide among Black people.²

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Age

By Krista L. R. Cezair

The age section covers the mental health experiences of people in particular age groups because members of all age groups face their own mental health challenges. Young people, especially youth of color, face worse mental health outcomes that have been characterized by the federal government as the “youth mental health crisis.”¹

The unique experiences and concerns of today’s youth and people in middle age are explored in depth through essays, verse, and an interview.

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Adding Mental Health Counselors and Mental Health Curriculum in Public Schools to Reduce Mental Health Disparities

By Krista L. R. Cezair

Abstract

There is currently a great need for mental health services for young people. A “national mental health crisis”¹ means that new solutions must be presented to meet this need. The mental health structures in place are not enough. With youth from backgrounds that are marginalized, like different racial and ethnic groups and lower socioeconomic statuses, there is an even greater need for services that they are not accessing at the rates of their white, wealthy peers. Interventions in public schools can begin to address these disparities.

Introduction

In announcing the allocation of nearly \$35 million to strengthen support for the mental health of children and young adults, the Department of Health and Human Services frequently referred to a “national mental health crisis.”¹ The federal government recognizes that this problem is having a disproportionate impact on the youth of this nation, with over half of all parents expressing concern regarding the mental wellbeing of their children.² The COVID-19 pandemic has introduced loss of family members and relationships, disruption in daily routines, increased social isolation and anxiety, and learning loss to the lives of young people.² On top of the particular stressors of the pandemic, young people generally experience a time of precarious mental health—fifty percent of mental illnesses begin by age 14, and three-quarters begin by age 24.³ Intervention at the earliest stages of mental illness could prevent more serious illness later on; however most kids do not currently have access to mental health care.⁴ Mental healthcare interventions should be destigmatized and offered in public schools to democratize access to mental health care.

Discussion

The need for youth mental health services is greater than the current supply. Among adolescents in the United States aged 13 to 18 years old, 49.5 percent are estimated to have had a mental health disorder at some point in their lives.⁵ Of this percentage, a further 22 percent are estimated to have severe impairment due to their mental health disorder according to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria.⁵

Young adults aged 18 to 25 years old were the highest proportion of adults over 18 to have either any mental illness (AMI), 30.6 percent, or serious mental illness (SMI), 9.7 percent. This psychopathology is increased among youth and young adults who are also members of intersectional marginalized groups.

Youth who come from households with lower socioeconomic status are at a higher risk for mental illness.⁶ About half of children in the child welfare system have mental disorders.⁶ Children living in foster care often encounter traumatic events, like adverse childhood experiences (ACEs) including experiencing abuse and neglect, witnessing the injury or death of another, or feeling their safety otherwise seriously threatened.⁶ Among children ages 6 to 17 years old, those who had been discriminated against based on their race or ethnicity had a higher prevalence of one or more mental disorders.⁷ In addition, almost 70 percent of youth in the juvenile justice system have mental disorder that can be diagnosed.⁶ Youth who are members of a sexual minority group (lesbian, gay, bisexual, or more groups that are not heterosexual) “are at greater risk of experiencing mental health issues, including feeling sad or hopeless, seriously considering attempting suicide, making a suicide plan, attempting suicide, and being injured in a suicide attempt.”⁸

These mental health challenges can represent the early age of onset of lifelong AMI or SMI. Onset of these illnesses in adolescence is also associated with more severe, chronic, and disabling conditions across the life course.⁹ There is also a strong indication of homotypic and heterotypic continuity with several studies showing that mental disorders in adults are preceded by adolescent conditions of either the same (homotypic) type or a different (heterotypic) type.⁹ Since psychopathology is continual in nature, early prevention and intervention among adolescents and young adults are incredibly important to minimize more debilitating mental health problems in adults. Investment in treating people this age will pay dividends in reducing suffering among the youth being treated and among the adults they become.

Unfortunately, most children currently do not have access to the mental health care they need. The average time it takes between age of onset of mental illness symptoms and the start of treatment is an astounding 11 years.¹⁰ Further, only an abysmally low 20 percent of children with mental, emotional, or behavioral disorders receive health care from a specialized mental health care provider.⁴ There is even more unmet need once the data is stratified by race and ethnicity: 31 percent of white children and youth access mental health services in contrast with 13 percent of children and youth of color.⁶

One way to address this need is to embed mental health professionals in public schools. On March 1, 2022, President Biden issued an executive order that committed relief funds, including \$160 billion from the America Rescue Plan, to support school districts, colleges, and universities in doubling the number of mental health professionals based in schools.² This increase in mental health professionals is sorely needed. Although 96 percent of public schools reported providing what they considered mental health services to schoolchildren during the 2021-2022 school year, 88 percent of public schools did not strongly agree that they could provide mental health services to all who needed them.¹¹ It is also important to note that these services varied widely, from one-on-one counseling to case management coordinating mental health support to outside referrals.¹¹

The most common limitations identified by the schools were an insufficient number of mental health providers to meet the needs of the school's caseload, especially due to inadequate access, and inadequate funding.¹¹ The additional relief funds should help to address this need for mental health professionals in public schools. Extra funds should also be redirected from the employment of school resource officers (SROs), police officers who operate in a school setting, to licensed mental health professionals for schools. The Office of Community Oriented Policing Services within the Department of Justice indicates that of four roles, SROs are expected to function as "informal counselors" and "educators" regarding positive student behavior.¹² These roles are better served by mental health professionals who are the experts where student behavior is concerned.

Finally, mental health literacy programs using a social and emotional learning (SEL) approach should become a requirement for all children and adolescents in public schools. "The SEL approach integrates competence promotion and youth development frameworks for reducing risk factors and fostering protective mechanisms for positive adjustment."¹³ One aspect of SEL is self-regulation. This concept includes competencies such as the ability to regulate one's emotions, the capacity to have positive interactions with others, the ability to refrain from aggressive or inappropriate actions, and the capacity to conduct self-directed learning.¹⁴ One study showed that curriculum-based interventions focused on self-regulation with teachers as the main intervention providers for kindergarten through 12th grade (K-12) students resulted in 76 percent of interventions reporting consistent improvements in self-regulation.¹⁴ This is important because it translated to improvements in academic achievement, social skills, conduct, and behavioral problems.¹⁴ Also, a report from the National Academy of Medicine (formerly the Institute of Medicine) from as far back as 2009 recommended that promotion of the behaviors and competencies emphasized by SEL can serve as the basis for prevention and treatment of mental, emotional, and behavioral disorders.¹³

Conclusion

These public school-based interventions, curricular changes and the addition of more mental health professionals, will reduce disparities by giving more children access to mental health promotion and treatment. The Academic, Social, and Emotional Learning Act introduced in 2009 sought to support SEL in elementary and secondary schools, prioritizing schools with high percentages of students from families with low incomes and schools that need improvement.¹³ Especially given that the COVID-19 pandemic has resulted in learning loss and the reduced emotional maturation of students, SEL and access to mental health professionals are needed more than ever to help address the mental health needs of K-12 students in public schools.² There is already funding being set aside to increase the number of mental health professionals in public schools. For a greater impact, federal funds should be set aside to train teachers to deliver the SEL curriculum promoting mental health, and like the previous bill, the funds should be prioritized to be delivered to schools that have the highest need as measured by proportions of children coming from households with low incomes and high percentages of children of color.

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Swimming Through Rainbows

Age

By Ms. Gloria Harding Mills, M.Ed

Beloved,
May I stretch my own memories
beyond the binds of time?
May I reference recollections
as historical happenings?
My perspective be more relatable than race,
more common than the golden fibers etched into dreams.
I can't choose one shade to be favored.
For I am certain of one thing and one thing only: all life exists in the middle of spectrums.

The space between,
that's where I was born.
Hidden amongst hues of vast variance,
that's where I learned:
a chameleon is not bound to one color.
Survival is not bound to one modality.

On the bridge between life and death,
that is where I came to blossom.
I drowned
trying to cling too closely to any(one) thing.
Like a child
lovingly squeezing the life from fireflies,
admiring the fractured light too closely,
holding on too tight
taints the tinted night.

And then there was no light.
That
chilling, child-like fear
greeted even the most certain person
in the dark.
In the realm of shadows,
misty memories bend

like caricatures of joy.
There is no shimmer
when
one's internal light is altered to survive,
tuned to fit the whims of others.
When brilliance is tampered with,
it dons another moniker
and
shadows rise from the shattered fragments of internal thunder.

Not all thunderstorms birth rainbows.
Some personify gloom.
And when there is no light, the shadow is formed.
How old were you when
dusk settled around your soul's prism?
Did you feel it? The moment your sparkle grew dull?
The heaviness,
did your arms grow weary swimming through the dense fog,
the weighted memories?

I almost drowned.
I swam from one end of the spectrum to the other
trying to mirror the caricatures of joy in my vision's field.
Like distorted rays
siphoned
through a prism,
my light source fractured into pieces.
You always thought my soul was more beautiful broken,
split between the tethered ends of reality.
Instead of admiring my natural tinge,
you preferred to imbue me with imbalance,
mixed me until my blood turned muddy.
And the moment I realized
it was my own hand who handed you the spoon
to
stir my bucketed heart like painters blending the perfect lacquer,
I was met with a second certainty: relationships are reflections.

The truth of who I am emerged from your pupils.
How can you see my depth with eyes closed, beloved?
Color exists between the fullness of light

and
the hovering darkness,
the physical evidence of many expressions generated from one source.
We see color how we see each other,
a portion of the whole,
swimming through rainbows,
through spectrums,
somewhere between realms,
a mere reminder of our existence in the middle.

Not all thunderstorms are deadly.
Even lightening holds fast to the smallest charge,
navigating nature's shadows with knowing,
A reminder of my final certainty:
great light begets great shadows.
And thus, we swim through both.

Artist Statement

The former archetypical middle-aged experience has always been linked to the phenomenon identified as a “middle-age crisis.” This creative work is based on empirical evidence linking this crisis to the realization of underlying mental health conditions.

About the Author

Ms. Gloria Harding Mills is a STEM Education Professional in Washington, D.C. She specializes in using research-based practices to transpose math and science content and data into multiple formats for varying audiences.

“...there’s room for optimism as science, medicine, and society advance.”: Interview with a Schizophrenia Success Story, Carlos A. Larrauri, MSN

By Krista L. R. Cezair

Lead author and editor of this anthology, Krista L. R. Cezair, interviewed contributing author, Carlos A. Larrauri, who was diagnosed with schizophrenia as a young adult in his early twenties. Schizophrenia is a disorder causing psychosis and the abnormal perception of reality that impairs a person’s thoughts, feelings, and behaviors.¹

Krista L. R. Cezair

How did you come to be diagnosed with schizophrenia?

Carlos A. Larrauri

I came to be diagnosed with schizophrenia mainly due to the efforts of my family, who advocated for me. One of the unusual things about schizophrenia is that the term “psychotic break” is actually a misnomer. It usually doesn’t happen where you just snap one day. You may have some self-awareness in the beginning that something’s off and may have trouble functioning in school or work. For example, I knew I felt off, and I went to see my school psychologist to seek help for my mental health.

However, if left untreated, the fog of psychosis settles in and becomes so dense that it obfuscates your mind so that you no longer objectively see what’s happening. So, even though I initially sought care on my own, I became so ill that, ultimately, I needed friends and family to advocate to get the care I needed. This illness is such that you may initially have some insight, but then the fog rolls in, and you may no longer fully appreciate that you are unwell. There are moments punctuated by insight and self-awareness; however, the disease slowly robs you of that, so you become dependent on having a community of friends and family to navigate the mental health system to get care.

In my case, my mom took me to see several mental health professionals. We got every diagnosis from schizoid or schizotypal personality disorder to a psychiatrist saying, “He needs to cortar caña,” which is cut sugar cane — a form of hard manual labor in Cuba.

That was his professional opinion, which was clearly negligent and projected his own cultural machismo and generational trauma, as I discuss in my article for this anthology. In any event, it took my mother advocating for me to get care multiple times to ultimately get the appropriate diagnosis of schizophrenia and access the medication I needed. With treatment, I could realize this was something that I needed to take seriously and manage if I wanted to recover and achieve the goals and quality of life I desired.

Cezair

How did you know that schizophrenia was the right diagnosis?

Larrauri

After all those different ones? That's an excellent question. I struggled with the diagnosis of schizophrenia for some time because, obviously, it's loaded with stigma. And for myself, I had my own internalized prejudices of what it meant to be someone with schizophrenia. I thought I would smoke cigarettes and stare at the television all day, not work or live independently. So, it took me a long time to come to terms with the diagnosis. I think what helped most was being curious. I looked at the doctors' evaluations and records and read their rationale. Most of them agreed that it was something psychotic and probably schizophrenia.

Given that I had once been high achieving and then, a few years later, unable to do my schoolwork, hold down employment, and sustain personal relationships with friends and family, these impairments were a strong indicator of severe illness. By all accounts, my life had seriously deteriorated, yet I had poor self-awareness of what was going on.

However, by taking medication, I could start to see what was happening. After reading the paperwork for my evaluation and arming myself with psychoeducation by reading a lot of books — even *Schizophrenia for Dummies* — I started to realize this diagnosis makes sense, and this helps me understand my experience. Maybe the television talking to me is not normal. It was undoubtedly normal in the throes of psychosis; it just felt like my reality.

Nonetheless, I've come to own my diagnosis in the sense that people recognize what I add has a particular value because of my skill set, knowledge, and lived experience. I've achieved so much because I approach my mental health advocacy and work with high intrinsic motivation and find a deep sense of purpose in it.

Cezair

That's inspiring. Thank you for that answer. So, how or why has your age impacted your mental health at the time you were diagnosed?

Larrauri

I was around twenty-two or twenty-three when I was diagnosed with adult-onset schizophrenia. So, on the one hand, I had pursued higher education and was completing my bachelor's degree, and I believe education is a protective factor for living with psychosis or schizophrenia. But it was also challenging because my life was sidetracked as a young adult in a formative phase. My peers were going on to graduate school, forming relationships with partners, and starting families. It felt like I was being left behind, and it would take additional time and effort to catch up if given the opportunity.

One way I frame it is if you were in a car accident and suffered physical trauma, it would take weeks or months to rehabilitate your body. It's the same thing with your mind and your brain, except it may take years, and you're rehabilitating the behavioral aspects of yourself: how to think and behave appropriately, how to socially engage, how to do cognitive, demanding work, and how to handle stress and pressure. All these higher-order tasks are refined over normal development, but you must almost re-learn them.

After my episode, I started taking a couple of credits at community college, flipping burgers and waiting tables. There's no shame, dishonor, or indignity in that; however, I was hoping to be at a different place. Given that I was already twenty-three and completing my education, and those were jobs I had done when I was younger as part-time work, I was hoping to be farther along in my career and studies. But I had to start at square one again, which was fine. It took a while before I could get to where I'm today as a clinician, law student at Michigan, and graduate student at Harvard.

One of the most challenging parts of being diagnosed at that age is that it's right as you're forming your identity as an adult. So, you're figuring out who you are. You're finally kind of independent from your parents. You're working towards becoming your own person when you get side-swiped with this trauma and label that could easily become your whole identity. You must redefine your identity in a new way, in that I think you accept and integrate the disorder. But it doesn't have to be the totality or sum of your experiences.

Cezair

I think your answer ties into my next question, which is that we know most people are diagnosed with or show symptoms of mental illness by age twenty-four, and you were diagnosed around twenty-two or twenty-three, so right before that age. How does that statistic compare with your experience with others with mental illness or your clinical understanding of mental illness in general?

Larrauri

In terms of my understanding of mental illness, it returns to the idea that mental illnesses are more like a slow boil. They don't suddenly appear overnight. I think of it like dementia, where the pathological processes happen years earlier before the symptomatic or clinical manifestations.

In schizophrenia, you have this prodrome where a person is in a high-risk state. They have awry developmental biological processes like excessive synaptic pruning or may have environmental conditions like adverse childhood experiences. Still, it could take several years before clinical manifestations like psychosis occur. This delay makes it challenging to identify early, I think, because the warning signals may not necessarily be overt symptoms or crises. There can be excessive marijuana use, poor academic functioning, mood changes, disrupted sleep patterns, or inappropriate behavior. Still, nobody wants to conclude that a severe mental illness like schizophrenia is developing when they see these behavioral issues.

So, I think that's what makes it particularly challenging in the context of age and in a teenager's development, and it also speaks to the need for biomarkers and better diagnostics that can catch people early.

Otherwise, we often intervene during a florid psychotic break, equivalent to waiting for someone to have a heart attack or metastasis before getting help. We generally don't do that with medical care. We try to catch people with high cholesterol or hypertension or screen them for cancer to identify it early. But with psychosis or schizophrenia, we are mostly identifying and treating patients when they're already in stage 4.

Cezair

Absolutely, I definitely agree with that. And I'm wondering, have you thought about ways that we can monitor younger people for symptoms, or is there a way a primary care physician can put together those symptoms and recognize that they might indicate a mental illness?

Larrauri

Well, I hate to sound self-interested, but I'm going to plug my work with the Accelerated Medicines Partnership® program - Schizophrenia, through which I serve as the Co-Chair of the Steering Committee. It's a large public-private partnership with several government agencies, including the National Institute of Mental Health (NIMH), and industry partners, nonprofits, and other organizations. It's working to develop new biomarkers for identifying people in the clinical high-risk state, this kind of prodrome period before they convert to psychosis or other serious manifestations. We are trying to better identify people in this group and potential treatments for them.

There's exciting science on the horizon, and we're enrolling people in the study. I hope that a combination of biomarkers, cognitive tests, digital measures, or other assessments will lead to earlier identification and intervention. Digital measures result from interfacing with smart technology to passively or actively collect data about us that could help us identify and even anticipate mental health episodes. I'm hopeful that some combination of these inputs will lead to developing an algorithm or clinical tool that can guide clinical decision-making in a much more objective and informed way.

But the issue of how primary care interfaces with patients, I think, is crucial because primary care is often the first place people go to seek help. More people go to primary care doctors to get mental health help than see psychiatrists, and there's less stigma associated with it. With respect to psychosis and identifying people earlier, we must better educate and train primary care providers. It's easy to tell when someone's fully in an episode of schizophrenia or mania, but it's much harder to tell when they're leading up to it. We must also better train nurse practitioners and physician assistants, especially because they are increasingly primary care providers and can refer patients to more specialized psychiatric care.

It's also critical to empower communities and patients' support networks to help identify, provide resources, and facilitate connection to clinical services when needed. It was certainly the case in my episode where it wasn't a clinician who recognized it; instead, it was a family friend who had known me for over a decade and knew that my issues were not just marijuana or stress related.

Cezair

Your work is inspiring, and I want to commend you. And the perspective that you have on the community, I think, is something that not a lot of clinicians and people within the formal mental health community understand. That's where having that lived experience really comes into play.

Larrauri

Absolutely. For example, many communities have National Alliance on Mental Illness (NAMI) chapters that offer family and peer support groups where people can learn from each other's experiences living with mental illness. Expanding access to community support services and educating the public is just as vital as training more psychiatrists or achieving insurance parity. I think you're right. My lived experience led me to this insight, not necessarily my clinical training

Cezair

Switching gears a little bit, how have you worked to accept your diagnosis with one of the most stigmatized disorders and fold it into your sense of self? You talked about it a little bit. But I want to hear more about that.

Larrauri

I have to give credit to my mom. She said you know, you got to own this, which means attending support groups and connecting with peers and role models with a shared lived experience. Seeing is believing, as they say, and after meeting others surviving and thriving with this diagnosis, I thought I could do it as well. Meeting peers in my age group going through the same developmental challenges and mental health issues helped me feel like I was not alone.

Writing and creating have been helpful too. I've written about my lived experience in op-eds in the Miami Herald and peer-reviewed publications [like in this anthology]. I make music drawn from my lived experience. It's just as important. I think art is another way to express your voice and to share a story, and I think, in many ways, it's a very emboldening way of doing so because you have a lot more creativity and control over how you frame your narrative. Much of the music I write is Americana music, drawing from influences like blues, rock, and gospel. And I think, in those genres, there are stories of overcoming adversity and empowerment. People can experience post-traumatic growth, and you can grow into a better person because of or despite these experiences.

I still choose to self-disclose judiciously because there's stigma and people may discriminate, but others will "get it" and value and dignify our lived experiences. And again, there is that capacity for post-traumatic growth, which people don't often think about. But people often do experience profound adversities and yet grow stronger.

Cezair

I can relate to everything you just said with my journey with bipolar disorder. I'm absolutely doing things that I never expected to do, and I have surprised myself with what I'm capable of now that I have been through my episodes. Post-traumatic growth, I like that. I now have a word for it.

Larrauri

There you go! As you said, we're incredibly resilient and can surprise ourselves. I mean, that's assuming we're fortunate enough to have the right resources and supports, but often there's a depth of resilience that we're unaware of, and we just don't know we have access to it until we're pushed. My life's harder with schizophrenia than without it, but, in some ways, I'm grateful for it because I think I have grown more mature and well-adjusted.

Cezair

So that brings me to my final question: what is something you want to leave young people with an understanding of schizophrenia?

Larrauri

Well, I want to leave people with hope. I want to let others going through similar experiences, especially youth, know that they're not alone and it does get better. Psychotic experiences are relatively common, and schizophrenia alone affects one percent of the population. And usually, the hardest part is during the first episode. I think that's the case because that's when you see the highest rates of suicide. But it often improves with the right resources, treatments, and support.

I want others like me to know that they can still live the life they want to live. You might need more steps or time to get there. You might need accommodations or to learn new skill sets or coping mechanisms. Nevertheless, in many cases, it's still possible to live a fulfilling, purpose-filled life with love, work, and friendships.

Don't let the shame or self-doubt get you down. Living with this illness is more challenging than it needs to be because of the stigma associated with it. Still, I think about how many people were institutionalized two or three generations ago and how I'm fortunate to have a better life as a person with schizophrenia than people did in the recent past. Likewise, I think it will be better for people with psychosis in the near future. I mean, we still have a long way to go. But I think there's room for optimism as science, medicine, and society advance.

Cezair

That's a fantastic note to end on. Thank you. Thank you for the hope. Thank you for the optimism. And hopefully, things will keep getting better.

Interviewee Bio

Carlos A. Larrauri is a JD/MPA candidate at the University of Michigan Law School and Harvard Kennedy School, where he is a Zuckerman Fellow at Harvard's Center for Public Leadership. He aspires to interface clinical practice, health policy, and research to reduce health inequities for people living with mental illness.

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A Grade of F

By Krista L. R. Cezair

Young people have their entire lives ahead
of them. But what is there
to do when that life seems
painfully short and utterly bleak?

For a Black trans teenager whose family rejects her, you can *promise* it gets better, but that still assumes there'll be a future.

And who knows if that'll happen, considering:

Climate change and

Gun violence and

Armed conflict on the geopolitical stage and

Income inequality and

Pandemics,

Including the youth mental health crisis.

Which reminds me, did you know that for Black, Indigenous, and people of color, more suicides are clustered before age 30, while for non-Hispanic whites, the greatest risk period is from age 50 to 65 (a problem in and of itself)?¹ Can you blame them? The young ones?

Also, according to one highly cited study, “[f]irst onset of mental disorders usually occurs in childhood or adolescence, although treatment typically does not occur until a number of years later.”²

What an impressively unimpassioned way to say

that we are failing

our

youth.

Artist Statement

This poem represents the paucity of hope that our young people feel in the face of what seems like insurmountable odds. It is therefore understandable that their mental health is in such dire straits. The statistics are truly desolate and may leave us in despair, but the first step to solving any problem is to learn just how bad it is, and this poem aims to illustrate that.

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Amplifying the Promise of Digital Mental Health Interventions for BIPOC and LGBTQ+ Youth Through FDA Regulatory Reform

By Krista L. R. Cezair and Nathaniel Z. Counts, JD

Abstract

Often referred to as a crisis, youth mental health in America is undeniably of great concern. Black, Indigenous, and People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) youth face even greater threats to their mental health than their white counterparts while accessing fewer high quality mental health interventions. Digital mental health interventions offer a chance to help address these inequities; however, this opportunity will not be realized unless targeted action is taken to incentivize the developers of these technologies to consider the needs of these populations in production. This article proposes regulatory incentives.

Introduction

Adolescent mental health has declined in the United States over the past decade, with growing inequity. The overall prevalence of past-year major depressive episode (MDE) doubled between 2009 and 2019, and notable disparities emerged among Black, Indigenous, and People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) youth. In 2019, 25.5 percent of American Indian or Alaskan Native youth, 11.8 percent of Black youth, and 8.9 percent of Hispanic youth reported attempting suicide in the past year, compared to only 7.9 percent of white youth.¹ 46.8 percent of youth who identify as LGB reported seriously considering suicide—more than three times the rate of youth identifying as heterosexual.¹ This is especially concerning as BIPOC and LGBTQ+ youth are the least likely to have access to traditional mental health services due to racial and ethnic cultural differences, urban versus rural environments, and socioeconomic status.^{2,3} While 50.3% of white youth with past year MDE received mental health services in 2019, only 35.6% of Black and 36.8% of Hispanic youth with past year MDE received mental health treatment in 2019.⁴

Given that current and future adolescents are digital natives, there is an enormous opportunity to improve access to effective mental health care with technology. In 2018, 95% of teens aged 13 to 17 in America reported they have a smartphone or access to one.⁵ BIPOC youth show similar rates of smartphone ownership with white youth and are far more likely to use the devices to access information about health conditions than their white counterparts.^{5,6} This indicates that digital mental health interventions (DMHIs), technologies that purport to treat mental health conditions, host a great deal of potential for use with adolescents and may improve mental health equity.⁷ If effective, these web- and computer-based programs or mobile applications (apps) that help to diagnose, prevent, and treat mental health conditions could improve access to culturally and linguistically appropriate mental health care for BIPOC and LGBTQ+ youth. With widespread adoption, these technologies could also reduce stigma and potentially strengthen young patients' engagement in their own treatment.⁷ If these technologies become a regular part of young people's lives, mental health care would become normalized, and young people would be more involved in care. DMHIs may also be lower cost than expanding access to traditional providers, creating new opportunities for access for youth in middle- and low-income regions and countries. Eventually, DMHIs can go beyond simply replicating the effects of current in-person interventions and potentially serve people in a better, more comprehensive way. Youth themselves report attitudes ranging from neutral to positive regarding DMHIs, reflecting their own desire for these products and their eager anticipation to use them.⁷

We must take great care to ensure that we do not miss the chance to take advantage of this opportunity. This article will explore the current state of the regulatory landscape for DMHIs for BIPOC and LGBTQ+ youth, determine whether DMHIs have been developed for BIPOC and LGBTQ+ youth and their efficacy, and offer policy recommendations in one area that will support and incentivize the inclusion of these populations in the construction of DMHIs—the U.S. Food and Drug Administration (FDA) Software Precertification (Pre-Cert) Program.

Discussion

Current Incentives and Regulations Regarding Producers of DMHIs

DMHIs can be guided or unguided, where users are either accompanied by a person in using the intervention or use the product alone. Most DMHIs follow established therapeutic models, such as cognitive behavioral therapy (CBT), although some have begun to pioneer new approaches that are made feasible by the technology. DMHIs are sometimes distinguished from “wellness apps,” which may have mental health benefits but do not claim to diagnose, prevent, and treat mental health conditions. As opposed to wellness apps, which are largely unregulated, the development of DMHIs is more reminiscent of the research and development process of pharmaceutical drugs with the inclusion of clinical trials and medical providers and the goal of regulatory approval through the Food and Drug Administration (FDA) and insurance coverage.

The current regulatory framework within FDA that governs DMHIs is in a state of flux. FDA regulates DMHIs through the Center for Devices and Radiological Health (CDRH) where the products are designated as Software as a Medical Device (SaMD).⁸ Starting in 2019, FDA developed and began testing the Software Precertification (Pre-Cert) Program, a regulatory model intended to streamline FDA evaluation and approval of the developers of these technologies while delivering safe and effective technological solutions to the hands of patients more quickly.⁸ In this model, more emphasis is placed on the appraisal of organizations that produce SaMD rather than on the products themselves. This approach is based on the major difference between SaMD and traditional medical devices: software can be modified easily in response to safety and effectiveness concerns. Therefore, it is more important that offerings come from a source that can be trusted to adapt the product to meet patients' needs than it is to evaluate any given product. The Pre-Cert Program seeks to whitelist SaMD development companies that meet five excellence principles—Patient Safety, Product Quality, Clinical Responsibility, Cybersecurity Responsibility, and Proactive Culture.⁸ The documentation of the working model of the Pre-Cert Program identifies twelve organizational domains that demonstrate the excellence principles.⁸

Once FDA pre-certifies a company that has released a product, the program then calls for an evaluation of its real-world performance. These real-world performance analytics for product monitoring do measure user feedback using response rates by demographic and response rates by feedback channel to ensure that user feedback is representative of the full user population. During this time, companies can begin to market their DMHIs without threat of FDA enforcement against them, as long as the company maintains its pre-certification status or does not otherwise violate existing law.

The market for DMHIs is rapidly evolving, but currently DMHIs are primarily accessible through unsubsidized private markets—i.e., as employer benefits, add-ons to commercial health insurance, or as apps for consumers. Ironically, producers of DMHIs are currently incentivized to create products that meet the needs of those with the most access to traditional mental healthcare. People with access to employer benefits and generous health insurance coverage are not the most in need of alternative solutions to traditional mental healthcare, yet this is the largest market for DMHIs and, as a consequence, the population to which most DMHIs are geared. Enough research simply has not been completed on marginalized populations to determine what DMHIs would be effective for them. There are some DMHIs that are offered direct to consumer (D2C) in app stores or online; however, these solutions can have costly subscription fees. Also, there are thousands of DMHIs of varying levels of efficacy marketed D2C, as wellness apps blended with DMHIs that have greater evidence in app stores. Most D2C apps do not have the scientific backing of rigorous evidence or peer-reviewed studies to substantiate claims about effectiveness.

Misalignment with the Needs of BIPOC and LGBTQ+ Youth

As investment in digital-health startups reaches a record high, the current market and regulatory incentives disfavor making DMHIs effective for or accessible to BIPOC and LGBTQ+ youth. As noted, corporate benefits executives are the main customers for digital-health startups, and companies

are incentivized to produce DMHIs for this target market. Youth are not likely to be employed in jobs offering DMHIs as benefits and, to the extent that they have family members who are, corporate benefits executives are less likely to know or consider the mental health needs of dependents unless it results in high-cost spending. In general, young adults are one of the demographic groups with the least access to employer-sponsored health insurance and most likely to be uninsured. Medicaid is a major payer for much BIPOC and LGBTQ+ youth healthcare, and there is currently no policy in place supporting coverage of DMHIs. Further, the DMHIs that obtain FDA approval and will be most likely to be covered in the future may require a prescription for use. Depending on the accessibility of prescribers who feel comfortable with DMHIs, this may also keep these technologies out of reach of those with limited insurance or that are not connected with a potential prescriber. Also as noted, high costs may make DMHIs marketed direct to consumer prohibitively expensive for BIPOC and LGBTQ+ youth. These difficulties can, in turn, reinforce the historical inequities in access to mental healthcare that keep it out of the reach of BIPOC and LGBTQ+ youth.

When entering the market, the Pre-Cert program creates little incentives for companies to serve BIPOC and LGBTQ+ youth. Among the five excellence principles of the Pre-Cert—Patient Safety, Product Quality, Clinical Responsibility, Cybersecurity Responsibility, and Proactive Culture—no mention is made of the company's commitment to the inclusion of diverse or underrepresented perspectives. Under the Design and Development organizational domain that maps to the five excellence principles, consideration is given to incorporating user experience in partnership with patients and caregivers; however, there is nothing to ensure that BIPOC and LGBTQ+ youth are included. The argument here is that companies should, for the greater good, undertake the production of youth-focused products as well as those focused on adults. The result is that a DMHI company that is seeking precertification by the FDA is not incentivized to regularly include BIPOC and LGBTQ+ youth in the design and development of their products. The evaluation of real-world performance does include information on diversity but having demographic information relegated to the late stage of user feedback on a fully built product is a major problem as it can turn the process of soliciting user input into a box-ticking exercise that does not substantially alter the product. Though this may be true for all users, it is especially true for historically marginalized users who are most likely to be left out of efficacious DMHIs.

Likely as a result of these misaligned incentives, evidence indicates that DMHIs developed to date might not be effective for BIPOC and LGBTQ+ youth. Although some randomized controlled trials of DMHIs in youth find evidence of effectiveness, often the effects become non-significant effects when compared to active controls.⁷⁹ It may be that designing DMHIs is a more difficult research and discovery process than designing DMHIs for adults, but prevailing consensus in the literature is that the problem more likely stems from producers of these technologies failing to adequately adapt DMHIs to the cognitive and developmental needs of youth.⁹ In fact, one analysis of web- and phone-based digital health interventions found that existing interventions did not just fail to produce results, they actively harmed members of the LGBTQ+ community by promoting heteronormativity and further marginalizing the group.¹¹

If DMHIs were adapted from use with adults or newly developed for BIPOC and LGBTQ+ youth with the influence and equitable partnership of the ultimate end users – youth with lived experience themselves – then developers may be able to build and market DMHIs that realize the potential for technology to improve mental health equity. Participatory technology design, in which the technology's design is co-lead with members of the community it will serve, directly addresses adaptability issues by sourcing information from the population of youth who will be using the end product. Effective participatory design could lead to products that effectively reach, engage, empower, and address the needs of BIPOC and LGBTQ+ youth.^{12,13,14} Leaving youth out of the design process and study of DMHIs would result in a huge missed opportunity to create products that are effective for these vulnerable groups with specialized needs.

Recommendations for Pre-Certification Program

A range of federal and state policy changes will be necessary to better align incentives for DMHIs to serve BIPOC and LGBTQ+ youth. We focus here on opportunities with the FDA Pre-Cert Program as an early policy change that can begin a shift toward greater reform. While FDA's Pre-Cert Program is a useful way to speed up the market implementation of DMHIs in a safe manner and almost all companies that manufacture DMHIs go through the Pre-Cert Program, its lack of accountability for companies' commitment to diversity and inclusion means that there will be a gap between the products that are offered and the needs of the most vulnerable populations. The demands and results of current products show that without an explicit incentive to create and adapt products for these groups, companies that produce DMHIs will not meet their needs. To ensure that developers will prioritize the inclusion of these groups in their design, FDA must require that companies that move through the Pre-Cert Program engage in participatory technology design and co-design with vulnerable groups.

BIPOC and LGBTQ+ youth must be included in the upstream development of DMHIs to ensure that the products work for them. This inclusion should be encouraged in the Pre-Cert Program, either as a whole new excellence principle for companies to meet or as part of the Design and Development domain. Companies that then measure demographic information for the patients and caregivers included in the development of their products and seek to actively increase the number of people from vulnerable populations would be more trusted and rewarded with higher levels of certification, fewer regulatory hurdles to market, and speedier approval from insurance payers and, potentially, the Centers for Medicare and Medicaid Services (CMS). After the product has launched, developers would be responsible for collecting and using demographic data about users to increase BIPOC and LGBTQ+ users and for incorporating feedback from those populations into future updates and iterations of the products.

Conclusion

FDA concluded the Pre-Cert Pilot program in September 2022 and reported out several findings.⁸ Most relevant for the major suggestion of this paper is that organization-level appraisal was not found to be a good substitute for device-level appraisal.⁸ However, to remedy this, organizations can be whitelisted or prequalified through some form of the Pre-Cert Program, which earns their

devices a quicker, though not immediate, pass through the approval process. Higher-risk and novel devices would be subject to longer review. This would serve to triage devices so that less risky devices can be approved more quickly. Unfortunately, FDA found that it does not have the statutory authority to enact the Pre-Cert Program as imagined.⁸ It is important to note that the regulatory foundation for FDA's ability to control medical devices is from 1976.⁸ This legal framework needs to be updated considering new medical technology and modern ways of producing medical technology, including SaMD that can be developed and updated so quickly.

DMHIs consisting of FDA-designated SaMD have enormous potential to radically change access to mental healthcare for millions of young Americans who are currently going without the care they need. To ensure that the needs of this vulnerable population are met, the government must provide an incentive to developers to create for them because current DMHIs are not being developed with BIPOC and LGBTQ+ youth in mind. FDA's Pre-Cert Program should form the model for a new regulatory framework that would reward companies with a commitment to early-stage inclusion of these voices in the development of their products. Creating for the most vulnerable groups tends to result in products that are better and more accessible for all. There is a duty and an opportunity here for FDA and developers of DMHIs to cast a wide net, seeking to improve mental healthcare for as many people who need it.

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The Impact of Exercise on Organizational Empathy

Age

By James D. Davis, Ed.M., MA

Abstract

Countless strategies in the broader field of social emotional learning have been shown to benefit individuals and organizations alike. Capacities like empathy can improve interactions and have been recommended as a necessary skill. Such psychological capacities are heavily influenced by physiological states. Research supporting this alignment continues to grow. This article examines the role of emotional granularity in empathy, and the impact of exercise on that process. All components of an organization's environment should be deliberately crafted. Individuals and organizations hoping to improve social emotional learning should also uphold healthy standards for sleep, nutrition, and exercise. It would be a costly mistake to misunderstand the connection of body and mind. Performance, and public health at large, depend on it.

Discussion

What do office buildings, schools, and Zoom meetings have in common? An unhealthy amount of sedentariness.

This is not a matter of opinion or personal preference, sedentariness has been linked to increases in "all-cause mortality, CVD mortality, cancer risk, risks for metabolic diseases such as DM, HTN, dyslipidemia, and musculoskeletal diseases such as knee pain and osteoporosis," among countless reports of decreased productivity and mental health. In one of the most decisive and declarative reviews of the adverse effects of a sedentary lifestyle, Jung Ha Park and team claim that "it is indisputable that the negative health impacts intensify with increases in the total daily sedentary times,"¹⁰.

On the other hand, exercise can improve mood, focus, and sense of calm⁵ alongside a general state of health and wellness¹¹. Organizations should encourage healthy, mobile workplaces for the benefit of their employees. Even if employee health is not a primary concern (sure hope that's not the case), organizations might want to examine the benefits of a mobile workforce for the positive impact on culture.

The positive impact of exercise extends beyond the individual and may contribute to overall organizational health. Improvements in mood influence the way one understands and relates to others. Turns out, the extension of this impact is profound.

Exercise and Emotion Recognition

In 2016, a group of researchers in Belgium found that the ability to differentiate between emotions led to “higher levels of empathic accuracy,”⁶. The more specific and granular one can be in their identification of emotions (a concept referred to as emotional granularity), the greater their ability to be successfully empathetic.

‘Successfully empathetic’ is an intriguing term. Leaders regularly hear that empathy is good, that we should have more of it. As we have previously discussed, empathy takes work, it requires perspective-taking, it is often an intentional construction⁴. If that construction is not accurate, empathy falters.

An increasing number of leaders have incorporated the teaching of emotional granularity into their list of SEL necessities (added to the SEL toolbox, just beside emotion regulation). Wilson-Mendenhall and Dunne at the University of Wisconsin-Madison advocate for cultivating emotional granularity, calling it an “important skill,”¹⁵. Tan, Wachsmuth, and Tugade of Vassar agree, suggesting that emotional granularity elicits more “informational value than that provided by global mood,”¹⁴. If everyone within an organization were to improve their ability to recognize emotion in others – to improve their empathy – the health of the entire organization would improve.

Psychological skills are often impacted by physiological states – sleep, exercise, and nutrition can all impact mood and cognition. Which is why, during a recent round of field research, we asked the question, can exercise influence the way we perceive emotion in others?

To address this question, we brought together a group of educators to conduct field research, preapproved by a school’s internal research committee and in alignment with the standard school day. We conducted a cross-sectional study which collected ninety-two (92) total responses from two groups of forty-six (46) participants. Both groups engaged in an emotion identification survey, described below. Group A engaged with the survey after 20 minutes of standard Health Education curriculum (sedentary group); while Group B engaged with the survey after exercising for 20 minutes (active group).

Participants completed a pen and paper quiz which asked them to name the emotions being displayed on the faces of professional actors, which were projected onto a screen. On each new slide, there was an image of an actor displaying an “emotion” using only their facial expression. A version of this method of measuring emotion recognition (by the interpretation of facial configurations) was developed by Dr. Lisa Feldman Barrett at the Interdisciplinary Affective Science Lab of Northeastern University. The facial configuration images are from a deck used in previous studies. Much of our understanding of the science of emotion has come from Dr. Barrett’s work^{1,2,7}.

We collected the surveys and examined the responses for two key variables: missed responses and adjective variety. We were interested in missed responses based on the notion that exercise could increase select neurotransmitters associated with focus and cognition³. We were interested in adjective variety for a more complex and, arguably, more important reason.

The term 'adjective variety' refers to the number of different adjectives participants used to describe emotions during the survey. We believe that adjective variety is a good indicator of emotional granularity. For example, one student in our group responded to a series of four faces with the adjectives "mad, mad, happy, happy," while another responded to the same four faces with "angry, frustrated, pleased with himself, proud". While it is important to note that there is no right or wrong answer to the survey responses – the cards depict the faces of actors, there is no true emotion to be read, if that were even possible – the second student has greater adjective variety. She seems to be able to interpret the nuanced difference between 'pleased with himself' and 'proud', in reference to two smiling faces. That degree of intuition should positively equate to emotional granularity.

We believe that exercise might be a positive addition to the emotion recognition equation for several reasons, but mainly for the power of exercise to increase the production of dopamine in the brain⁸. Moreover, regular exercise has been shown to improve dopamine receptor availability over time¹². Dr. Pilar Salgado-Pineda, researcher at the Spanish Lab FIDMAG Hermanas Hospitalarias Research Foundation, suggests that dopamine is directly connected to emotional responses¹³.

If exercise can increase dopamine production and dopamine is essential to emotion recognition, we believe that the exercised group (Group B) will outperform the sedentary group (Group A) in tests of emotion recognition.

Notable Impact

Exercise had a positive impact on participant errors (in the form of missed responses) and adjective variety.

Missed responses came in the form of an empty response field or one that was crossed out. This was a user-friendly survey so there were not many total errors. Follow-up conversations with participants indicate that these missed responses occurred because the participant "got messed up on which number [they were] on" or "couldn't think of [an adjective] for that one."

While all participants did well, Group A (sedentary group) made errors on an average of .40 questions out of a possible 18; Group B (active group) made errors on .24 questions. While the total number of errors remained low, it accounts for a 40% difference. That is, the group who exercised before taking the survey committed 40% fewer errors than their sedentary peers.

We saw a similarly positive impact on adjective variety. Once again, this intelligent group of participants performed well across the board. Group A (sedentary group) used an average of 10.34 adjectives to label 18 face cards. Group B (active group) used an average of 11.73 adjectives. The adjective variety in the exercised group was 13.44% higher than their sedentary peers.

Figure 1

	Sedentary	Exercised	Difference	%Diff
Missed Responses	0.40	0.24	-0.16	40%
Adjective Variety	10.34	11.73	1.39	12.44%

40% decrease in missed responses and a 13.44% improvement in adjective variety. Exercise is creating some powerful changes.

IMPORTANT: this is not 'proof' that exercise improves emotional granularity. It is more likely that, in a post-exercise state, the level of engagement with the task deepened. Participants, experiencing the neurochemical cocktail inspired by the exercise routine, had improved focus (allowing them to deeply engage with the task) and improved cognition (allowing them access more to deeper reaches of personal vocabulary).

As emotional granularity builds within individuals and empathy builds within the culture, the health of the entire organization can flourish. No one would suggest that exercise will absolutely improve empathy, but the results we found were intriguing. Can we expect this effect to apply to more typical social interactions? Perhaps, but we should not count on it.

Moving Forward

It is possible that, in a post-exercise state, one would more deeply engage with the people around them, with access to enhanced emotional granularity. But with so many other factors at play – namely, complex social situations and pressures inherent in any given day – improvements would be difficult to guarantee. That does not mean we should not try.

In pursuit of a healthier organization, leaders should create a space where physical health is valued and opportunities to exercise are not severely limited. Business expert Peter Lencioni believes that “organizational health trumps everything”⁹. While Lencioni refers to healthy communication and other necessary group dynamics, a growing body of research suggests that physical health should be prioritized right alongside psychological and culture-building skills.

Empathy is good. Exercise can make it better. Emotion regulation is good. Healthy sleep can make it easier. Maintaining wakefulness down the back stretch of the day is ideal – nutrition should enter the conversation.

Organizational health is a measure of body, mind, and interaction – these three components work together, always. Physical health belongs in this conversation. Individuals and organizations hoping to improve social emotional learning should uphold healthy standards for sleep, nutrition, and exercise as well. Hopefully, acknowledging the connection between exercise and empathy will encourage leaders everywhere to get up and get moving in the right direction.

Disclosure Statement

Age

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About the Author

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James (Jim) Davis is a graduate of the Human Development and Psychology program at Harvard University. His research areas include public health, the relationship between physical and psychological wellness, and leadership development. He has also received degrees from Northwestern University and Knox College. He presents across the country (and overseas) in the areas of health, wellness, and leadership. For his work, he has been recognized with the US Marine Corps' Excellence in Leadership Award as well as multiple coach/educator of the year awards. Contact him through his nonprofit organization, the Good Athlete Project: @goodathleteproject

Socioeconomic Status

By Krista L. R. Cezair

The socioeconomic status section explores the mental health challenges of people with low and middle incomes. This includes social determinants of health—“the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks”¹—particularly environmental factors that affect mental health.

The mental health of migrant farmworkers, those in poverty, those with middle incomes, and the uninsured and underinsured are discussed.

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Essential and Underserved: The Mental Health Needs of Migrant Farmworkers

By Krista L. R. Cezair

Abstract

Migrant farmworkers, upon whom we rely for our food supply, often toil in obscurity, their needs swept under the rug by a system that treats them as disposable. Facing poverty, physically demanding and traumatic work, lack of social and political support, precarious citizenship status, and practically nonexistent healthcare, migrant farmworkers must also contend with the extra risk of developing serious mental health conditions. Diverting federal funds to treating these essential workers is not only the ethical choice to address health inequities between groups for their own sake, but also represents an investment in assuring a consistent supply of food to feed the nation.

Introduction

A little over one third of farmworkers earn annual incomes below the federal poverty line,¹ which is \$27,750 for a family of four.² This percent jumps to 44 when the field is narrowed to migrant and seasonal farmworkers¹, half of whom earn less than \$7,500 in an entire year.³ This extreme poverty accompanies a host of psychosocial stressors that make migrant farmworkers particularly susceptible to developing mental health problems. The stressors only seem to increase for these workers who are primarily Hispanic or Latino and may not be documented—national surveys indicate that only about 56 percent of migrant farmworkers have authorization to live and work in the United States.¹ What is life like for these migrant farmworkers and their families, and how can we improve their mental health when they have such little access to resources?

Discussion

The Demographics of Migrant and Seasonal Farmworkers

The following statistics are gathered from the 2019-2020 National Agricultural Workers Survey (NAWS), which is limited by excluding crop workers with H-2A visas (a temporary visa for international agricultural workers), excluding other farmworkers who do not work on crops, and excluding crop workers who have been out of work for over a year.⁴ There is also a non-response bias and the inability to verify self-reporting.⁵

Of all farmworkers, migrant and seasonal farmworkers (those who travel from farm to farm in search of work, sometimes following a seasonal crop tending pattern) make up 15 percent¹ and represent the most at-risk for several health issues, including mental health problems, “occupational injuries, chronic pain, heart disease, cancer, and conditions related to pesticide exposure.”³ Migrant farmworkers are defined by NAWS as having traveled at least 75 miles between jobs in a 12-month period.¹ A small majority of migrant farmworkers are domestic or newcomers to the United States (52 percent).¹ The rest are international migrants.¹ Migrant and seasonal farmworkers are primarily Hispanic or Latino with 78 percent of all farmworkers belonging to the ethnic group and 63 percent hailing from Mexico alone.¹ Most farmworkers have work authorization, but a large percentage, 44 percent, do not have authorization to live and work in the United States, making their living situation precarious.¹

Migrant farmworkers often live separately from their families, with 43 percent of migrant parents living away from their children and 69 percent of migrant farmworkers living away from all nuclear family.¹ Migrant farmworkers are also more likely to live in employer-provided housing that is often substandard.^{1,6} There are federal and state regulations of this housing, but analyses of compliance with these regulations have found it lacking.⁶ Among this housing, a greater percentage of migrant farmworkers live in crowded spaces, where more than one person lives in one room.¹ Migrant farmworkers are also less likely to have health insurance, with 41 percent reporting that they had coverage.¹ Given their propensity for health problems, this deficiency is significant. Another risk factor is that 82% of migrant farmworkers in one study reported food insecurity, which has been associated with mental disorders.⁷ Most migrant farmworkers, 57 percent, plan to work as migrant farmworkers for over five more years or as long as they are able.¹

The Mental Health of Migrant Farmworkers

These demographic challenges translate to psychosocial stressors that place a great deal of pressure on the mental health of migrant farmworkers. First there is the discrimination and acculturative stress faced by minoritized Hispanic and Latino groups in America who may have entered the country as immigrants. Most farmworkers were born in Mexico, so they necessarily arrived in the United States at some point having to become accustomed to a different land with a different language.¹ This causes acculturative stress, which immigrants experience as they acculturate or adapt to American culture. This stress can usually be offset by the social support of immigrant communities; however, migrant farmworkers often migrate alone, without their families.¹ Depression was reported in a qualitative study of stress and coping mechanisms among migrant farmworkers.³ A common reason cited was persistent sadness because of separation from their families.³

This social isolation is magnified by the inability to access suitable housing. In one North Carolina study, two thirds of migrant farmworkers lived in a crowded space with more than three people to a room.⁶ This significantly cuts down on security, privacy, and basic dignity. Over half of the study participants lacked even a key to the exterior doors of their dwelling.⁶ Substandard housing has been proven to affect health, including mental health, and these housing conditions are no different, especially since all the housing in the study violated state and federal regulations.⁶

Crowding of the homes was strongly associated with depression and anxiety with more study participants who slept in rooms of five people or more reporting significant depression and anxiety scores on validated scales.⁶ Elevated depression symptoms were also found among migrant farmworkers who lived in barracks or dormitory style housing, probably due to crowding.⁸

Lack of access to resources is a substantial concern that contributes to mental strain for migrant farmworkers. These worries include not having a consistent or regular job, savings, or the ability to send money back to their families in different countries.³ One study participant was quoted as follows, "I don't have enough money to pay the bills. Makes me feel hopeless and want to cry."³ In response to low pay, one study found that migrant farmworkers must request assistance from nonprofit organizations and charities, limit all discretionary spending, and borrow money.⁹ This is because despite high levels of poverty, most migrant farmworkers are not eligible for social services or able to access worker's compensation or disability benefits.¹⁰ Low family income and living in poverty were associated with high levels of depressive symptoms.⁹ Families' economic stress is most strongly associated with depression and anxiety in children of migrant farmworkers according to one study, which noted this finding's consistency with another study that found that economic hardship was the most salient predictor of depressive symptoms in of migrant farmworker mothers.¹⁰

Conclusion

The mental health problems, especially depression, experienced by migrant farmworkers put them at risk for occupational accidents or unintentional injury in addition to the strain of enduring the conditions.⁸ Migrant farmworkers need better access to healthcare to maintain their physical and mental health. There are currently about 2,480 federally funded health centers operated by 177 grantees¹¹ to service an estimated 3 million migrant farmworkers.¹⁰ This number of centers is simply not enough to meet the demand of this many people who are at such high risk for healthcare utilization. More federal funding should go into creating these health centers with community partner organizations.

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“The distribution of sadness ... by this I mean the overrepresentation of Mexican-origin populations in the bilges of poverty, and among the undereducated, underemployed, and underrepresented who suffer from poor mental and physical health and lack protection. They are also overrepresented in penal institutions and as war casualties.”

–Malinowski Award Lecture, 2003: Regions of Refuge in the United States: Issues, Problems, and Concerns for the Future of Mexican-Origin Populations in the United States

By Carlos G. Vélez-Ibáñez

“‘Mental illness’ is a way that the body is just trying to get some extra support,”: An Interview with Judy Hu, LMHC and Boundary Coach

By Krista L. R. Cezair

Lead author and editor of this anthology, Krista L. R. Cezair, interviewed Judy Hu, a Licensed Mental Health Counselor turned Boundary Coach, about how she dispenses emotional health help to people of all socioeconomic levels trapped in a system of capitalism that she believes harms us all.

Krista L. R. Cezair

Tell us about your journey becoming a licensed mental health clinician after growing up as a first-generation, Chinese American in a working-class immigrant family in a white neighborhood.

Judy Hu

Both of my parents were born and raised in China, and then during the Communist takeover, fled to Taiwan and then the U.S. They grew up around people who looked like them. Their racial identity development was never at play like it was for me, as the first American born Chinese. Another context that is important is that they were very poor and subsequently uneducated. When they came over to the U.S., it was with very few means and no connections, including language, so that informed how they parented.

Growing up in a white community in Colorado, we owned a Chinese restaurant. My family didn't have a lot of emotional capacity to check in on me or understand the challenges that I was having specifically around racism. It was all very confusing. And because they didn't have a lot of emotional capacity, they parented me through, what I understand now as, control. Basically, I grew up adhering to every single rule that they had, working really hard, being the best student, all of those model minority myths that I didn't realize I was playing into.

And then cut to, "What am I doing for my profession?" I thought I was going to be a teacher because the educational system is what saved me. Since no one was home, I often stayed at school as late as possible. School was where I felt community and connection. And so, I thought, "Oh, I'll do that as a teacher." Thankfully, I earned a very prestigious and generous scholarship to attend any university in Colorado. During my first week on campus, I tried to return my scholarship because I felt like a complete fraud. That's when I started therapy, and that was the start of my journey.

When I began teaching I learned it was not for me. Shortly after “failing” that profession, I realized that becoming a mental health clinician would be a better fit since I was actively trying to heal myself.

Cezair

Well, thank you for your story. That’s really empowering to realize that you could come from that background where, amongst your family, there’s no understanding of mental health and how important it is and then help other people with their mental health. What barriers did you face in becoming a clinician because of your working-class background?

Hu

When I was living it, instead of barriers, I believed them to be personal deficits. I couldn’t discern the impact of class or culture, because I internalized that something was wrong with me. Specifically for clinical training, I remember sitting on the outskirts. When I studied expressive arts therapies, I would sit in the background in awe at how talented and embodied my peers were and felt like a complete fraud. Only after having my own children do I now understand that my clinical peers were talented and well-rounded due to access to enrichment classes as children. While they had time and funds to go to classes, I spent my childhood working.

Work was the only thing I could connect to as I was learning to be a clinician. A rookie mistake is working harder in the room than the client. I was totally codependent: if my clients got better, that meant I was a good clinician, which just fed into the oppressive systems.

Cezair

Could you speak more about how that fed into oppressive systems?

Hu

We’re taught as clinicians to be a blank slate. Let the person offload, and then guide them to their truth. But the thing is, we are all raised in capitalism, patriarchy, and white body supremacy, so what feels like truth is actually the toxin that makes us feel awful. The very nature of being a mental health clinician in the ways that I was taught was just continuing to perpetuate the system. Justifying treatment for insurance companies was “How do I get you well enough to get back to work?”

Everything in our society is coded in the sense of “if I make enough money, if I buy a home, if my car looks like this, my body looks like that, my kids look like this, then I’m a good valuable person, right?” That’s all codependent, and what we don’t understand is that we’re human beings that are meant to be diverse, imperfect, and interdependent. We see this in climate change. “Take, take, take, take what I want!” versus “What do I need? How do I give to the community?” This interdependence is what I think is healthy.

In my viewpoint, capitalism came out of trauma of colonialism. How do these people in poverty raise themselves up to wealth like the royalty? But it actually just perpetuated the system of colonialism where only a few people had money, and everyone else worked to increase their wealth.

Cezair

I feel like I'm learning so much. I did want to talk about one point you made about getting people back to work. Because that, I think, is such a terrible way of thinking. And you see it with COVID-19, where it was like, "How can we get people back to work as fast as we can?" That is evidence of capitalism's influence. And it's something that harms our mental health.

Hu

So, part of the getting back to work might be to meet your basic needs, especially if you're responsible for children who cannot provide those things, so I don't want to minimize the desire to get back to work, but what I want to highlight is the desire to get back to work to be a worthy human being. Many of our systems fuel that belief: you are only as valuable as what you produce. To equate productivity with your value is at the root of capitalism, which is based on free labor of enslaved people.

Resmaa Menakem, the author of *My Grandmother's Hands* and one of my teachers, says trauma decontextualized in a person looks like personality. Okay, so trauma decontextualized in me looks like anxiety and perfectionism, because if I made a mistake, I would be harmed. But now it looks like personality, because I'm not out of the context of my parental trauma, which when decontextualized in a family, looks like family traits. So, if working is the priority, then hard work becomes the family trait, but that level of grind was needed to survive. Having that trauma decontextualized in a people looks like culture. As a society, we prioritize productivity and profit over people.

Bringing someone back home to them selves by re-memembering their sense of Self is what I do now. You are a human being. You are a gift on this planet, because there is no one else like you. Your job is not to produce well for me or the system. Your job is to figure out what you bring to this world.

Cezair

That is something that I had not heard about. The decontextualization of trauma theory is going to stick with me for a while. It makes sense. It just explains so much.

Hu

There is the context of all of the wars and the lack of space or resources to process all of this collective trauma, so we just absorb it. Right now, I'm watching people present with hypochondria, social anxiety from all the racialized violence that's decontextualized. So, when I go out and I'm noticing my social anxiety, other people are like, "Are you okay?" And I'm like, "Well, we did just get out of COVID. There are still people dying due to the color of their skin. I'm responding appropriately." And then they can see the context of my anxiety. I think it's fascinating.

Cezair

Yeah, and another thing that I think happens is that it's individualized, so that we think, "Oh, well, there's just something wrong with you. There's just something wrong with that person or that family, or something like that. There's nothing wrong with the entire culture. There's nothing wrong with the economic system. There's nothing wrong with the political system."

Hu

I'll give you an example. I'm very active in the parent teacher organization at the elementary school that my kids went to, and I saw that they were putting out these questionnaires about mental health that the government provided to schools around the nation to administer in order to receive funds. The language was literally, "Do you worry about getting sick? Do you worry about your family dying?" And then you had to rate it on the scale. One, the language was wrong. You were already putting them up for worry because you queued that word up in their mind.

I know the intention was good, but it was created in the system that is already so toxic. Sixty to eighty percent of the students who took the test had the test reveal some level of PTSD or anxiety. What was their solution? Support groups during the school day. Sixty to eighty percent of the kids tested in, but only twenty percent of the kids opted in to the support groups. And the school administrators asked, "Why is that?" And I found it obvious: mental health is still stigmatized. To pull just a few kids out of class implies that this is an issue for only a few, which is not right.

I suggested they change this process, but they couldn't due to the guidelines of the funding. I suggested they preface the questionnaire with "Everyone is experiencing high stress because of the pandemic. No one has been untouched. This survey is to see which levels of support every single one of you need. So, this is not showing there's anything wrong with you. This is for us to gather data about the impact that everyone has experienced." Context would have made a huge difference. Unfortunately, they didn't make the change. And I can see the behavioral outcomes of that decision.

It's all intertwined, right? We need the financial resources to provide to the schools and to our neighborhoods, but we don't necessarily need the approach that the people who are in charge of this funding espouse.

Cezair

If you think about public school kids, this might be their only experience with mental health care.

Hu

I know. I went to public school. I didn't do anything related to mental health until I was in my twenties. Mental health in school is primarily for kids with behavioral issues, the ones who are acting out. The ones who are most missed, whom I'm most worried about, are the quiet ones who just disappear, who just check out, dissociate, who just kind of go under the radar, because those are the ones who internalize, and that internalization goes into depression. So mental health support in schools is focused more about ending behavioral issues to get them back to work.

Cezair

What effect do you believe capitalism has on the mental health of your clients who have low socioeconomic status?

Hu

My perspective is most of the mental health issues are because of our oppressive systems. Going back to capitalism, more equals more value, more love. I think that gets really internalized for all of my clients, regardless of socioeconomic status. It's more so, though, in lower socioeconomic status, because from my perspective, it's the always looking up to. "Oh, it would be great to have a house like that, or it would be great to have all those toys, or it would be great to have those experiences." That adoration makes it really hard to also just focus on who I am, what my gifts are, because if I'm always so deficient, then I am always looking externally for happiness.

The therapy model is actually really hard to use to help people to get out of it is because it's trying to get you good enough to be okay in the system that's actually killing you. So, I'm shifting from therapy now to coaching. I always bring in the context of capitalism, patriarchy, and white body supremacy because that's exactly why my clients are feeling so bad about themselves.

My lesson that I've learned through traditional mental health care is that it often perpetuates the harm that oppressive systems, like capitalism, are producing. There are clinicians who are taught in anti-racism but there's not a lot of us.

Cezair

So, what do you think is the alternative? How does this become different?

Hu

The pandemic was hard, but it was also very rich for me in learning. I never thought remote, telehealth sessions were going to be good. They're fine. They're incredibly accessible for people who have kids who then, if they had sessions, they could only go during the school days, or if they had work and kids, they could only do it if they got a babysitter. Whereas, now I can see people anywhere: in their office, on a walk, or in their car. Their kids are watching TV in the other room. It's even accessible for folks with disabilities. People of all socioeconomic statuses.

The other change I made was that I started running groups. Any profession like any labor around care or nurturing, is not paid as much as other professions that focus around making more money or making people more productive, and so creating groups allowed me to see more people from different professions. And then spreading the cost through the group members so that the groups can be more accessible for them, and much more possible for me than other alternatives.

Cezair

The last question that I have is are there any policy solutions or regulations you would change or introduce to expand low earners' access to positive mental health?

Hu

I don't think this is anything new—there should be national health care. Then, we need to raise the minimum wage to a living wage. "Mental illness" is a way that the body is just trying to get some extra support, because the system, the context, is not working.

And underneath all of that is because, most important, humanity is not more important than the earth, not more important than other nations. Every human being is the same.

I use these circles in my therapy. So, there's three sizes, a small, medium, and large. Capitalism is like, if you earn more, you increase your value, you're worth more, and you're the large circle. If you're unhoused, or have a substance use disorder, or mental health issues, you're less worthy. You're the small circle. What I'm trying to say is, "No, you are worthy no matter what." Everyone is the same sized circle. Nothing can change your worthiness. Some people, due to power and privilege, feel like their circles are larger—they're entitled to take up more space. Which is wrong. We need to right size everyone.

Cezair

So, we as human beings, have our own inherent worth as human beings, and it's not greater or lesser than any other human being. What a wonderful place for us to end.

Interviewee Bio

Judy Hu is a seasoned Licensed Mental Health Counselor turned Boundary Coach. Developing her own Psychological Boundary Framework™, she helps Individuals, Couples, and Groups learn a new way of healthy embodiment that is grounded in equality, non-violence, freedom, social responsibility and interdependence.

Community Care

Socioeconomic
Status

By Krista L. R. Cezair

We have a health insurance system.
Not a healthcare system.
So my mental health needs go uncared for,
And the stress of working incessantly makes it
Worse.

In a country run by capital,
For want of wealth,
I can only hang my head,
Bank on spitting out the brokenness,
Replace it with the requisite gaping need.

I don't know where or when this will end.
If worse comes to worst,
And I end up in the emergency room in crisis,
Will I waste away from the illness or the bill?
It figures that figuring it out is above my pay grade.

But what if there was another way?
One grounded in gaining community?
One where we look out for one another?
And healthcare is health-forward and curative?
And meets us where we're at?

Dare we dream?
I fear that's all this kind of living has left us,
So let us.
Then we will roll up our sleeves
And make real this alternate reality.

We will fight.
We will slog.
(Look how hard it was to pass even obsequious Obamacare.)
But my mental health and yours
Depends on us, unencumbered, in unison.

Artist Statement

This poem directly confronts America's for-profit health system and its implications for underserved and under-resourced communities. It also presents a gesture at a way forward, indicating that the direction in which we should move is one where mental health care is accessible for all. The answer lies in all of us together as a community.

Employee Engagement Policy Recommendations For Sustaining Wellbeing Of A Diverse Workforce In A Hybrid Setup – Based On Learnings From Adverse Impact Of Middle-Income Employees In The Service Industry

By Farheen Neyaz, Dr. Nadeem Ahmed, and Idris Ameerah Titilayo

Abstract

This literature review explores the premise between employee wellbeing and organization policies. Aggravated by the sudden shift of dynamic work coerced by the pandemic, organizations were forced to act without forethought. It's imperative to introspect and relook at these policies that have been prevalent for the past two years and identify the scope for improvement. Employee wellbeing is attenuated by a lack of social interaction, prolonged working hours, continual contact, muddled work-family boundaries, and insufficient organizational assistance. Looking at what innovations have helped organizations wade through the transition without hampering employee wellbeing, the essay recommends significant policy changes in performance management, scheduling, and day-to-day functioning.

Introduction

Employee engagement continues to be sub-optimal, and in specific industries like the service sector, it is at an unprecedented low. The same is further catalyzed by the grey area created by the transition from fully remote work to hybrid working in which employees spend some portion of the workweek at home and the other in the office. A prime contributor to this is the one-size-fits-all policy, leading organizations to not only ignore the palpable disparity in challenges their workforce faces but also expose themselves to undue attrition.

The COVID-19 catastrophe essentially destroyed most of the planet's economies and social structures.¹ Leading to a dynamic shift to hybrid work, it demanded employees to adapt and maneuver accordingly. Almost 30 months hence, employees are still grappling with the sheer uncertainty of a hybrid work environment. The service sector (traditional and modern),² which thrives in middle-income countries owing to economic reforms,³ increased purchasing power parity,⁴ and cheaper labor,⁵ has been significantly affected. The effect is more pronounced by differences in age, marital status, employment history, and income amongst employees.⁶

An employee accustomed to a relatively stable organization, which predominantly strategizes to minimize uncertainty, will have trouble adapting to the unpredictability of schedules post-pandemic. The higher you go up the ladder, the more time is spent on collaborating and mentoring, and more uncertainty creeps in, leading to fatigue and stress amongst these employees. The imperative here is to formulate a strategy catering to the well-being of employees and the organization, to thrive in these times of rapid change.

Discussion

Owing to the disruption caused by the pandemic, employees were coerced to view their houses as their new workplaces. Promoting flexibility while simultaneously having myriad negative impacts on health, especially mental health, most organizations failed to realize that hybrid work was here to stay.⁷

Hybrid work has had a cascading effect on multiple facets of an employee's life.⁸ Triggered by issues such as a lack of social interaction, prolonged working hours, continual contact, muddled work-family boundaries, and insufficient organizational assistance, employees have been feeling less connected, and project completion times tend to be longer.⁹ The service industry is characterized by short project durations and high attrition of employees, with the remaining employees struggling with schedule instability and unpredictability. The traditional service sector has been rampant with precarious work, providing us with the premise of how exposure to variable work schedules affects attrition and the long-term impacts on attrition and employee earnings in the service sector.¹

It has been established from various surveys that the impact of working remotely differs amongst genders. Women's psychological wellbeing appears to have been significantly impacted by the epidemic.¹¹ With blurred boundaries between work and family life, 56% of working women have increasingly experienced acute stress balancing remote work with parental and caregiving duties.¹² The stringent and prolonged work hours, increased frequency of weekend collaborations, and scheduled evening meetings have escalated job losses for women as they have been unable to cope with the contiguous burnout. The cornerstone of organizational policies striving to tackle the looming issues of hybrid work should be the satisfaction derived from interpersonal interactions, ease of collaboration, and perceived meaningful work.

The crucial need is to construct policies that disintegrate the impediments to collaboration while measuring performance in a hybrid setup. Innovation is the key to overcoming disruptions such as the pandemic.

Microsoft adopted a data-driven approach to ensure that its employees were not stuck in back-to-back meetings and were given sufficient breaks, increasing their productivity and well-being.¹³

A case in point, Google is experimenting with the 'campfire' method, organizing meetings in a circular setting with virtual employees displayed on their respective screens.¹⁴ The intent was to drive equal participation and eventually tackle bias between on-site and virtual employees.

Hubspot has been a changemaker in this arena, having adopted a policy that considers employees' autonomy over their work mode and aids them in achieving productivity in both environments.¹⁵ Its office, flex, and home model caters to the diverse needs of employees and allows Hubspot to optimize its infrastructure and adopt 'hot-desking' as a policy.¹⁶

The policies we recommend need to tackle the cited obstacles striking a balance between objective and subjective measures in a hybrid setting.

To aid organizational productivity, the 'Breathe' practice is a viable approach. In the face of stressful situations and overwhelming schedules, this practice of an uninterrupted break between continuous meetings helps employees psychologically transition from one topic to another.¹⁷

Data analytics can be a fundamental tool to enhance employee experience quality. With the adoption of big data extensively, organizations can track end-to-end employee life cycle data and rely on multiple metrics like collaboration hours, 1:1 meetings with the manager, and long after-hours to gauge employee experience.¹⁸ It can aid in the identification of functions that are overworked and burnt out and eventually aspire for equitable workload distribution.

Figure 1: Employee experience over the employee life cycle
(Source: Author)



Data metrics like 1) 1:1 with the manager, 2) Schedule conflicts, 3) Multitasking, 4) All-hands presentations, 5) Increase in focus time, 6) Manager co-attendance, 7) All-hands meet, 8) Manager coaching, 9) Long after-hours, and 10) Redundant meetings can be sufficiently leveraged to enhance employee experience.

To increase employee well-being, weekends should be devoid of meetings and mail hours. Less collaboration time at the end of and beginning of each week helps employees transition. Businesses can adopt a 'no-meeting Friday' policy to prevent the expansion of work and overburdening employees during the time taken off on weekends. Managers can be torchbearers to institute this change. A significant correlation between focus hours and employee well-being dictates organizations to remove barriers for employees to seek focus hour blocks and evaluate meeting effectiveness over meeting time.¹⁹

Conclusion

The fragility of hybrid work policies lies in the unconscious bias that creeps in for on-site employees and eventually acts as a deterrent for those working virtually. It is at this point that objective parameters might aid decision-makers in formulating policies. Sacrosanct policies are not for the new-age organizations which operate in turbulent times and cater to dynamic change. Hence, the importance of flexible policies cannot be overemphasized, as this is vital in preventing burnout and improving employees' mental well-being. Data analytics aided with agile timelines together constitute an effective policy-making tool to objectively assess performance devoid of inherent biases. Decision-makers and organizational architects should wield these powerful policy-making tools to effectuate an empathetic culture for employee development that will have a cascading impact on organizational success.

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Migrant Status

By Krista L. R. Cezair

The migrant status section features mental health challenges faced by people who move between countries, including voluntary and involuntary migration. This section reflects immigrant populations, asylum-seekers, refugees, survivors of forced displacements, and unaccompanied minors.

The content of this section explores the feelings and trauma around migration and its effect on bilingual adults, federal immigration policy, quotes, and poetic works about the generational impact of migration.

Immigrants with Mental Illness and the Immigration and Nationality Act

By Krista L. R. Cezair

Abstract

Immigrants to the United States with mental disorders have an added hurdle to clear as they seek to become permanent residents. Their illnesses may make them inadmissible for entry if certain criteria are met. These criteria are stigmatizing and reify existing stereotypes, structural bias, and ableism around mental health conditions. Improvements to the language of the act authorizing this discrimination can maintain the act's goal of promoting safety while dismantling its prejudice.

Introduction

Immigrants applying to become permanent residents of the United States are required by law to have a medical examination prior to their application. This is because there are some medical conditions that make an applicant inadmissible for entry or subject to deportation. Mental illnesses that are not allowed belong to one of the three following criteria:

- **“Current physical or mental disorder with associated harmful behavior.**
- **Current physical or mental disorder with a history of associated harmful behavior if the harmful behavior is likely to recur or lead to other harmful behavior in the future.**
- **Drug (substance) abuse or addiction (medically identified as a ‘substance use disorder’) of any of the substances listed in Section 202 of the Controlled Substances Act.”^{1,2,3}**

This paper will explore the discriminatory effects of this policy and suggest improved language.

Discussion

Immigrant Applications and the Immigration and Nationality Act

The policy excluding certain people with mental illnesses is found in the Immigration and Nationality Act (INA) § 212(a)(1)(A)(iii).³ The language of this section was last updated in 1990 and applies to all immigrants seeking permanent residence in the United States, all immigrants living within the United States without lawful documentation status, and those applying for visas to live in the United States.⁴

The Department of Health and Human Services (HHS), namely the Centers for Disease Control and Prevention (CDC), is responsible for defining the words that make up the policy, including “mental disorder,” “harmful behavior,” “likely to recur,” and “drug abuse or addiction.” Mental disorders are defined as “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof),” with the Diagnostic and Statistical Manual of Mental Disorders (DSM) listed as the authoritative voice on the subject matter.¹ Substance use disorders are also diagnosed using the DSM.¹ Harmful behavior is defined as “[s]erious psychological or physical injury to the applicant or to others (e.g., a suicide attempt [emphasis added] or child abuse)” or a “[s]erious threat to health or safety (e.g., driving while intoxicated or verbally threatening to kill someone).”¹ The decision around whether the behavior is “likely to recur” is a subjective one made by the examining physician who must use clinical judgment.¹ The CDC lists a number of typical mental health conditions as “most commonly associated with harmful behavior,” including mood disorders like bipolar disorder and depression, anxiety disorders, personality disorders, and psychotic disorders. In fact, the listed categories represent almost half of the chapters of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).⁵

Effects of the INA

By casting such a wide net, the CDC’s guidance to physicians necessarily disadvantages those seeking to migrate to the United States who have any of the most common mental health conditions. This policy could be characterized as ableist, discriminating against those who have mental disorders by casting them as violent and dangerous. This also creates a perverse incentive for immigrants with mental health issues to avoid mental health treatment. After all, a person cannot be penalized for a mental illness that is not reported or documented. Elsewhere, HHS makes it clear that the vast majority of people with mental illness are not violent and people with serious mental illness (SMI) “are over 10 times more likely to be victims of violent crime than the general population.”⁶ It is also important to note that a previous suicide attempt is also grounds for inadmissibility. Although there is the additional condition that the behavior must be likely to recur, that judgment is highly subjective and could be vulnerable to bias or misunderstanding on the part of a culturally incompetent physician. The prohibition against anyone with substance use disorder could be characterized as outright discriminatory and inconsistent with a medical rather than criminal model of substance use disorder. Further, an understanding of the social determinants of health, the environmental and social conditions that affect health, could bring one to the conclusion that permanent residency, by providing stability and the ability to obtain better employment and housing, could assist in improving the mental condition or substance use disorder experienced by an immigrant.

Improvements to the INA

The point of this policy is to exclude immigrants based on a mental disorder that could endanger the immigrant or others, but as described above, the policy is overly broad and offers too much discretion to medical examiners.⁴ Inherent in these judgements are the characterizations of large groups of people as dangerous and threatening and the assumption that physicians can determine with certainty who will pose a threat to the safety and welfare of others in the future based on their health status.⁷

This concern is really more of a concern about crime or homeland security and should be treated as such.⁷ The language referencing “physical and mental disorder” should be taken out, and the policy regarding persons who are a danger to themselves and others should be relocated to a different section of the INA. Barring such an overhaul, the width of the net cast to prevent people with mental illnesses from entering could be reduced, either by forcing the government to reach a higher evidentiary standard or by giving less latitude to the physicians making these determinations.⁷ In that way, there could be more specific criteria for the definitions of “harmful behavior” and “likely to recur,” curbing physicians’ ability to use their own, perhaps flawed, judgment.

Conclusion

Immigrants with mental illnesses, even those with serious mental illness who may have at one point posed a danger to themselves through suicidal ideation or a suicide attempt, are valued members of our society. No one should be turned away from living in the United States due to a disability they have, including mental disabilities. INA § 212(a)(1)(A)(iii) and the CDC’s instructions to civil surgeons or physicians around it contain stigmatizing language that should be rewritten to remove references to medical disorders and simply retain the language regarding safety. People with mental illnesses do not pose a threat more significant than that posed by the general population and are oftentimes more likely to encounter violence against themselves.⁶ The INA is outdated in its treatment of people with mental conditions and must be updated to ensure that the United States does not discriminate against valuable additions to the country.

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**“No one leaves
home unless
home is the
mouth of a
shark.”**

**- Teaching My Mother
How to Give Birth**

By Warsan Shire

A Preliminary Report of Trauma Impact on Language Skills in Bilingual Adults: A Case for Trauma-Informed Services

*By Jennifer Rae Myers, PhD, MS, CCC-SLP and
Sulare Telford Rose, PhD, BA, CCC-SLP*

Abstract

This study explores the reported impact of trauma on language skills in bilingual adults and show language fluency in both languages spoken may be impacted by traumatic experiences including COVID-19.

Introduction

In her memoir, *I Know Why the Caged Bird Sings*, the author, poet, civil rights activist, and orator Maya Angelou recounts a profound childhood trauma that led to her selective mutism. The trauma Maya experienced so profoundly affected her physiology that she rendered herself incommunicable for five years. This illustration highlights the relationship between trauma and language. Trauma, defined as “exposure to a single or multiple events or experiences that overwhelm (overload) the brain, and includes the internalization of feelings of powerlessness, helplessness, and loss of safety,” can have detrimental impacts on one’s linguistic abilities⁷.

A burgeoning body of research supports that people who experience trauma are at higher risk for having communication disorders, smaller vocabularies, and poorer expressive, receptive, and socio-pragmatics language skills).^{6-9,14} Further, Busch & McNamara³ argue that trauma may limit one’s “inclination to learn languages, to use, retain, or abandon a particular language.” Specifically, the underlying processes that promote language skills such as memory, attention, executive functioning, linguistic processing, and other cognitive functions are often negatively impaired as a result of trauma^{5,14}. Consequently, the importance of trauma-informed services has garnered more attention in recent years, with COVID-19 serving as one of its catalysts for prominence. As our understanding of the relationship between trauma and cognitive- communication is evolving, it is crucial to explore how trauma can affect various populations we serve—particularly groups that have historically marginalized members, as they are at greater risk for cognitive-communication impairment and exposure to trauma.

The current descriptive study explores the perception of recent traumas on the bilingual abilities of simultaneous and sequential bilinguals with implications for culturally responsive transdisciplinary intervention.

Methods

Survey data on 212 Spanish-speaking bilingual adults (ages 21-60) was examined as part of a larger ongoing study examining posttraumatic stress, COVID-19, and cognitive-linguistic skills in Spanish-speaking bilinguals. The survey was developed based on questions from survey studies found to be effective in capturing meaningful bilingual-related information.⁵ Research has also shown self-reports of language fluency and usage among US Spanish/English bilingual adults are reliable indicators of language ability in this population.¹² Responses from demographic, cognitive-communication, and trauma-related questions were used to conduct a descriptive analysis concerning their current (within 5 years), most impactful trauma. Participants' characteristics are outlined in Table 1.

Table 1. Participant Characteristics

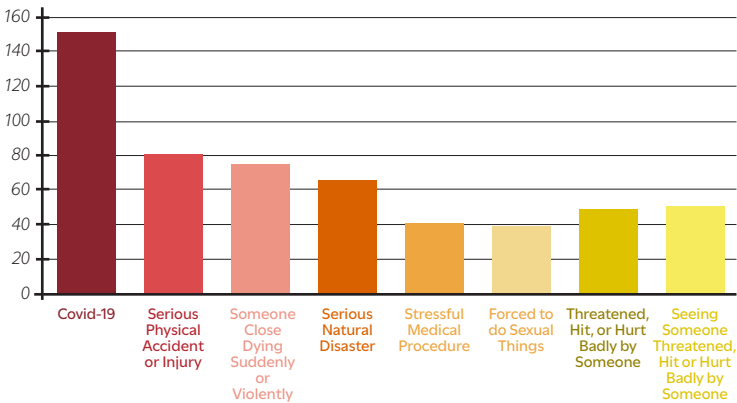
Characteristics	Participants (N = 212)
Age – M (SD)	34.94(6.72)
Gender – n (%)	
Men	119 (56)
Women	93 (44)
Hispanic Origin – n (%)	
Yes	111 (48)
No	102 (52)
Race – n (%)	
American Indian or Alaska Native	7 (3)
Asian	20 (9)
Black or African American	44 (21)
Native Hawaiian or Pacific Islander	7 (3)
White	103 (49)
Prefer not to say	31 (15)
Education – n (%)	
High School	6 (3)
Some High School	5 (2)
Bachelor's Degree	83 (37)
Master's Degree	81 (36)
PhD or higher	25 (11)
Associate's Degree	10 (4)
Trade School	1 (<1)
Prefer not to say	1 (<1)
Primary Language – n (%)	
English	161 (76)
Spanish	48 (23)
Both	2 (<1)
Other*	1 (<1)

The survey took approximately 20 minutes to complete and was provided in English and Spanish. Participants gave informed consent prior to completing the survey (also provided in English and Spanish). Upon successful completion of a survey, participants were compensated via a \$15 gift card. This study was reviewed and approved by the University of the District of Columbia's institutional review board.

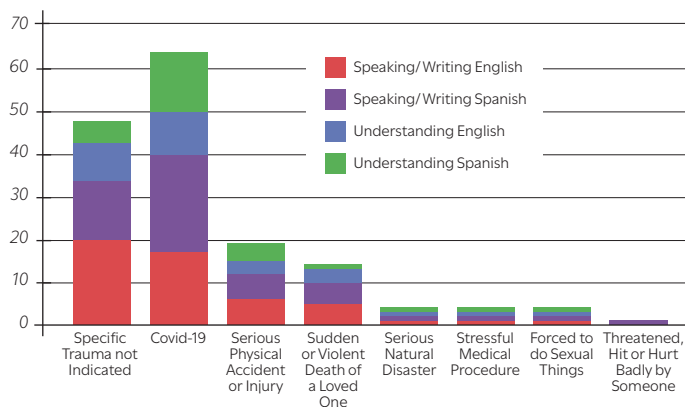
Results

Participants were asked to indicate if they “experienced mental, physical, or emotional trauma within the last 5 years” based on established traumatic stressors (e.g., “threatened, hit, or hurt badly by someone”) and COVID-19. Almost all the participants endorsed at least one traumatic experience (98%), with 56% of those participants experiencing multiple traumas. The percentages were reduced to 78% and 36%, respectively, when COVID-19 was removed. Thirty-three percent of participants indicated their traumatic experience was currently impacting their language skills, and of those experiences, 44% were attributed to COVID-19. Lastly language fluency (speaking/writing) in Spanish was the most reported language skill impacted (77%) closely followed by language fluency in English (76%). Figures 1 and 2 provide additional details regarding participants’ history of trauma and its impact on their language skills.

Figure 1. Reported Traumatic Experiences



N = 212; One reported traumatic experience , n = 92; more than one reported traumatic experience, n = 115; no reported traumatic experience, n = 5; Number of traumatic experiences reported in sample: COVID-19, 152; Serious physical accident or injury, 81; Someone close dying suddenly or violently, 75; Serious natural disaster, 66; Stressful medical procedure, 41; Forced to do sexual things, 39; Threatened, hit, or hurt badly by someone, 49; Seeing someone threatened, hit, or hurt badly by someone, 51.

Figure 2. Reported Trauma Currently Impacting Language Skills

N = 70; Trauma type: Specific trauma not indicated (n = 22); COVID-19 (n = 31); Serious physical accident or injury (n = 8); Someone close dying suddenly or violently (n = 5); Serious natural disaster (n = 1); Stressful medical procedure (n = 1); Forced to do sexual things (n = 1); Threatened, hit, or hurt badly by someone (n = 1). Not shown as n = 0, Seeing someone threatened, hit, or hurt badly by someone; Language skill impacted (% of participants): Speaking/writing English (76%), Speaking/writing Spanish (77%), Understanding English (41%), Understanding Spanish (40%).

Discussion

These preliminary research findings indicate that a staggering one-third of participants perceived that their recent traumas negatively impacted their speaking and writing ability in both languages. This finding supports the existing literature on trauma and language^{3,13}. In addition, the findings also demonstrate that an overwhelming majority whose linguistic skills were impacted found that both languages were impaired. Therefore, intervention in both languages may be optimal for remediation. As speech-language pathologists are specialists for individuals who have or are at risk for language disorders, a transdisciplinary approach with a team of other specialists such as psychologists, occupational therapists, and social workers is recommended to optimize the success of the clients/patients. Given the sensitive nature of trauma it is also pertinent that healthcare clinicians be culturally responsive and aware to address the unique needs of bilingual individuals and employ cultural and linguistic brokers when there is a mismatch between the client and clinician's language and culture¹⁰.

A transdisciplinary approach to intervention is optimal⁷. The envisioned transdisciplinary team would convene after the completion of a biopsychosocial evaluation by the psychologist. The rationale for establishing the team would be to ensure that all parties utilize the tools and expertise of each professional in a meaningful way to enhance their own discipline-specific work and provide holistic trauma-informed services to the client. A cultural and linguistic broker must serve on the team pre-evaluation to provide the clinicians with pertinent information regarding the client's specific language(s) and cultural norms that differ from the mainstream culture. The psychologists or trauma trained licensed social worker would inform the other clinicians on identifying "trauma responses," "building relationships of trust and safety," and reducing triggering repeated trauma with the specific client⁷. The speech-language pathologist would support the clinical social worker or psychologist by addressing needs for learning new vocabulary for expressing feelings, thoughts, and ideas or who have trauma-related socio-pragmatic communications challenges. In sum, the team would begin by sharing their roles and responsibilities for the client and then, as a team, construct an integrated plan for addressing the client's needs from a holistic perspective which may enhance overall treatment efficacies.

Conclusion

Ongoing research concerning culturally responsive and trauma-informed care for bilingual individuals who experience trauma is essential. As we learn more about the impact of trauma on language, it is important to understand the profiles of individuals with trauma in order to make meaningful strides in the field.

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Disclosure Statement

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be interpreted as a potential conflict of interest.

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About the Author

Jennifer Rae Myers, PhD, MS, CCC-SLP,

Jennifer Rae Myers is clinical research scientist at a digital health company. As a speech-language pathologist and neuropsychologist, her interests include the cognitive-communication impact of trauma, cognitive health disparities, and research inclusivity. In 2019, she founded a grassroots nonprofit, RB Foundation, that provides free expression-focused programs in underserved communities. Recently, she co-created 'Culturally S.M.A.R.T.', a program which provides culturally responsive training and research mentorship to underrepresented clinical graduate students.

Sulare Telford Rose, PhD, BA, CCC-SLP

Sulare Telford Rose is an assistant professor of speech-language pathology at the University of the District of Columbia. She serves as the professional development manager for the American Speech-Language-Hearing Association's Special Interest Group-17, Global Issues in Communication Sciences and Related Disorders, and serves on the board of directors for the National Black Association of Speech-Language and Hearing (NBASLH). Sulare is keenly interested in exploring culturally responsive assessment and intervention methods for addressing the needs of non-mainstream populations, particularly those from Spanish and Caribbean English Creole-speaking backgrounds. Her most recent research explores providing evidence-based trauma-informed care to bilingual clients. She is the co-creator of 'Culturally SMART,' a program that provides culturally responsive training and research mentorship to underrepresented graduate students in speech-language pathology and related disciplines.

A Trini Asks Answers of Her Ancestors

By Krista L. R. Cezair

Did you know?
Y'know, beforehand?
The very fact of our madness?
That it cycles like all natural things?
When did you learn that it was a part of you?
As real as our unattached earlobes, ocher skin, and corkscrew curls?
Did they whisper about it behind closed doors?
Or shout it from the streets downtown?
Send you away, up the hill, to St. Ann's Hospital?
Where they keep people like you?
Like us?

Did you know?
Y'know, beforehand?
That it would be passed down?
Through genes?
Through culture?
Through shared trauma?
That we'd face such discrimination in a new land?
That you traveled to in order to give us a better life?
That the sickness would take hold?
In more than half of your children's children's children?

Did you know?
Y'know, beforehand?
That you'd find the spectacle of it, the pathology, beautiful?
That I would, practically from birth?
Having been trained up in it?
At home amongst the internal chaos?
That I'd long to bear witness to it again and again?
But that no one else would?
That they'd stare in horror?
That others of your own family would be a g h a s t?
Despite the hushed history you and I know of...now?

Is there a way you could have let me know that I was to watch out?
But warily, so as not to be transfixed?

Y'know, beforehand?
When it mattered?

I just keep thinking
About how different it all

**“you broke the
ocean in half
to be here, only
to meet nothing
that wants you.
- immigrant”**

- salt

By Nayyirah Waheed

Conclusion

By Krista L. R. Cezair

Where do we go from here? It is vital that we require health equity in our health system, policies, and programs. Defined by the Centers for Disease Control and Prevention (CDC) as “the state in which everyone has a fair and just opportunity to attain their highest level of health,” health equity requires a full commitment by policymakers and other decision-makers with power over the social determinants of health (SDOH), which the preceding pages have shown are fundamental to good mental health and controlling of mental health disparities.¹ There is so much work to do as generational injustices must be corrected. First, discrimination against the six groups covered in this anthology must be rooted out and removed, root and branch, meaning that both the deep-seated origins of this discrimination and the ways that it manifests in people’s daily lives must be faced and rectified. Acknowledging, for example, that racism exists and impacts people of color in America at the structural or systemic, interpersonal, and internalized levels is a necessary beginning step.¹

Policies that make equitable access to social services—education, housing, transportation, child care—a reality for people who experience mental health inequities could go a long way toward improving their environments and, subsequently, their mental health.¹ Although not a perfect or by any means singular solution, the election and placing in power of people who belong to the communities that experience mental health disparities could improve the reach of people who care about these issues. Further, collecting data on the problems facing these groups and the magnitude of the disparities is critical. A problem that goes unmeasured goes unsolved.¹ The Administration of President Joseph Biden has committed a great deal of money and resources to try to address the mental health crisis in America. There is, of course, a long way to go and much to be done to heal the communities that face mental health inequities.

A sample of recent federal actions highlighted by the Administration that affect the communities of concern of this anthology follow:

Gender

In partnership with the RAISE Family Caregiving and Supporting Grandparents Raising Grandchildren Advisory Councils, The Department of Health and Human Services (HHS’s) Administration for Community Living will submit a National Caregiving Strategy to Congress outlining new recommendations for better supporting family caregivers, many of whom have been under great strain during the COVID-19 pandemic.

Sexual orientation

HHS’s Centers for Disease Control and Prevention announced new Comprehensive Suicide Prevention Program funding to support a comprehensive public health approach to suicide prevention with attention to disproportionately affected populations, such as veterans, rural communities, tribal, LGBTQ, and youth.

Race/ethnicity

The Department of Interior's Bureau of Indian Affairs Office of Justice Services is implementing a Mental Health Crisis Instructor Training Program and a Resiliency Initiative to train officers on coping with stress; managing anxiety; providing psychological first aid; and identifying substance use disorder, depression, and post-traumatic stress in themselves and in colleagues.

Enhance school-based supports in Native communities. The Department of Interior's Bureau of Indian Education is launching a Social and Emotional Learning Initiative for educators and staff, which will work to improve access to culturally relevant social and emotional learning supports at schools serving Native communities.

To reduce behavioral health-related disparities, HHS is announcing a nearly \$3.5 million, five-year grant opportunity to launch a new Asian American, Native Hawaiian, and Pacific Islander (AANHPI) Center of Excellence, which will promote culturally and linguistically appropriate behavioral health practices while providing training and technical assistance on addressing the mental health impacts of hate and unconscious bias against the AANHPI community.

Age

Bright Futures, a Health Resources and Services Administration (HRSA) partnership with the American Academy of Pediatrics, added universal screening for suicide risk to its national guidelines for individuals ages 12 to 21.

The Department of Education is issuing new guidance to colleges and universities on how to use American Rescue Plan (ARP) relief funds to provide mental health and substance use disorder services on campus, including by hiring mental health professionals, expanding virtual counseling support, offering stress-reduction activities, building peer support programs, and erecting student-staffed crisis hotlines.

ARP provided \$122 billion in relief funds for schools to help them reopen safely and address the social and emotional needs of students. As of April, the number of social workers in public schools has increased by 67 percent, and the number of counselors has increased by 18 percent, since the years before the pandemic.

HHS announced \$2 million in funding to establish the new Center of Excellence on Social Media and Mental Wellness, which will develop and disseminate information, guidance, and training on the impact of children and youth social media use, especially the potential risks social media platforms pose to mental health.

Socioeconomic status

HHS awarded \$250 million across 100 grants to increase access to Certified Community Behavioral Health Centers (CCBHCs), which provide 24/7, comprehensive primary and behavioral health care – including crisis care – to the most vulnerable Americans.

The United States Department of Agriculture (USDA) invested nearly \$25 million in the Farm and Ranch Stress Assistance Network projects which to strengthen programs that provide professional behavioral health counseling and other services to individuals in agricultural occupations.

Migrant status

The United States is announcing today nearly \$23 million in additional humanitarian assistance in Mexico and Central America. This new assistance will help governments in the region respond to the increased humanitarian and protection needs of migrants, refugees and other vulnerable populations in their care. Recognizing that no one country can respond to these needs alone, this assistance will help support shelter, health, legal assistance, mental health and psychosocial support, water, sanitation, hygiene products, gender-based violence response, livelihoods, other protection related activities, and capacity building for partners.

All

The Equal Employment Opportunity Commission (EEOC) has actively used its enforcement authority to combat unlawful disability discrimination against individuals based on their mental health conditions, their use of legally prescribed opioid medications, and their participation in substance use recovery programs. It has also conducted outreach and education programs for employers emphasizing their obligations to treat employees with mental health conditions the same as those with any other disabilities.

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About the Lead Author and Editor



Krista L. R. Cezair

Krista L.R. Cezair, J.D., M.P.H. is a writer, poet, and researcher concerned with mental health, particularly with disparities in mental health and mental illness among groups marginalized by characteristics like race, ethnicity, gender, sexual orientation, and more.

Drawing upon her lived experience, she works to communicate to these communities in a way that informs about mental health while reducing stigma around the topic to improve mental health outcomes. She has worked at the Berkman Klein Center for Internet & Society at Harvard University, at the O'Neill Institute for National and Global Health Law at Georgetown University Law Center, at the American Psychological Association, and at Mental Health America, a community-based nonprofit.

She is a recent graduate of Harvard Law School and the Harvard T.H. Chan School of Public Health, having completed concentrations in Health Policy and Population Mental Health while earning a joint Juris Doctor/Master of Public Health. Before matriculating at Harvard, she worked at Google. She also holds a Bachelor of Business Administration in Accounting from Howard University.

More of her work can be found **@klrcezair** and under her name, **Krista L.R. Cezair**, on Instagram, YouTube, and Medium.

About the Executive Editor



Dr. Candice Carpenter

Dr. Candice Carpenter is Co-Chief Executive Officer and Chief Strategy Officer of The Boston Congress of Public Health (BCPH). She co-founded BCPH in August 2021.

Dr. Carpenter also serves as the Co-Editor-in-Chief of Strategy and Innovation for The HPHR Journal. She is the Editor for the forthcoming publication, The Best of HPHR Journal 2014-2021. She is also Executive Producer of the Great Health Debates Season 1 through 3, Producer and Host of the BCPH 40 under 40 Public Health Catalyst Awards Program and Director of the BCPH Public Health Summer Institute and Pre-Medical Academy. She is a neurosurgeon-in-training, bio and social entrepreneur, educator, and social justice advocate.

She has received prestigious fellowships from the Congress of Neurological Surgeons Leadership Program, the Oxford's Women Leadership in Entrepreneurship Programme, Oxford's Social Impact Program, and Harvard Chan's Diversity, Equity, and Inclusion department. She will be joining the UCLA Biodesign and Clinical and Translational Institute as a Healthcare Technology Innovation Fellow in Summer 2023.

She holds an MPH in Public Health Leadership and Health & Social Behavior from the Harvard Chan School of Public Health, an M.B.A. from Oxford University Said Business School, an M.D. from the University of Cincinnati College of Medicine, an Ed.M. in Mind, Brain, Education from the Harvard Graduate School of Education, and a B.A. in Psychology from Yale University. She has done Neurosurgical Residency Training at The Ohio State University Wexner Academic Medical Center.

Anthology Contributors

Musa Isma'il

Musa Isma'il is a passionate and enthusiastic Medical Laboratory Scientist with special interest in Infectious Diseases and Public Health. He graduated from Bayero University Kano with Bachelor of Medical Laboratory Science Concentration in Medical Virology and Immunology, He is currently a Mdc Candidate in Public Health and will be pursuing a doctorate in public health policy in Fall 2023.

About The Boston Congress of Public Health and HPHR Journal

Established in August 2021 by Co-CEOs Dr. Candice Carpenter and Dr. Circe Gray Le Compte, BCPH's mission, vision, and activities were crystalized in Fall, 2021 by a cohort of public health advocates deeply passionate about public health, social justice, and health equity. Representing Harvard and Oxford alumni, physicians, scientists, researchers, consultants, and practitioners of public health, BCPH Founders included Penny Sun, Simon Morgan, Dr. Hannah Nazri, Dr. Isioma Okolo, Dr. Jessica Huang, Dr. Monty Ghosh, Kim Harmon, Brian Shim, and Alice Colescu.

The mission of BCPH is to democratize public health through the lens of social justice.

Democratize is defined as:

- **Equitable power amongst various stakeholders, productive partnerships, new school academia,**
- **Equitable voices,**
- **Equitable distribution of resources,**
- **Equitable pricing,**
- **Intersectional engagement – varying social class, nationality, disparity, sexuality, gender identity.**

Transcending the traditional boundaries of academia and medicine, the Boston Congress of Public Health (BCPH) supports emerging and established thought leaders, researchers, and advocates committed to social justice and health equity, and democratizes access to evidence-based public health thought.

Glossary

Ableism

Ableism is the discrimination or prejudice against people who have disabilities.
-Forbes

Prejudice and discrimination aimed at disabled people, often with a patronizing desire to “cure” their disability and make them “normal”—is one explanation.
-APA

Acculturative stress

The stress that emerges from conflicts when individuals must adjust to a new culture of the host society.
-NCBI

Adverse childhood experience (ACE)

Traumatic events that occur in childhood (0-17 years).
-CDC

Affect (noun)

An affect is a feeling or emotion. It is also an expressed or observed emotional response.
-wordreference

Alzheimer’s

Is a type of dementia that affects memory, thinking and behavior.
-Alzheimers

Analysis of variance (ANOVA)

ANOVA is essentially a procedure for testing the difference among different groups of data for homogeneity.
-Research Methodology C R Kothari

Analysis of variance (ANOVA) is a statistical technique that is used to check if the means of two or more groups are significantly different from each other.
-Analytics

Antidepressant

Antidepressants are a class of drugs that reduce symptoms of depressive disorders by correcting chemical imbalances of neurotransmitters in the brain.
-Rxlist

Antidepressants are a type of medicine used to treat clinical depression.
- NHS Mental Health

Antipsychotic

Antipsychotics are a type of psychiatric medication which are available on prescription to treat psychosis.

-MindUK

Anxiety Disorder

A condition in which a person has excessive worry and feelings of fear, dread, and uneasiness. Other symptoms may include sweating, restlessness, irritability, fatigue, poor concentration, trouble sleeping, trouble breathing, a fast heartbeat, and dizziness.

- NCI Dictionary of Cancer Terms

Any mental illness

Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder.

- Mental Health Information

Bi erasure

Is a pervasive problem in which the existence or legitimacy of bisexuality (either in general or in regard to an individual) is questioned or denied outright.

-GLAAD

Biopsychosocial evaluation

A biopsychosocial evaluation is an assessment typically conducted by therapists and counselors at the beginning of therapy. It assesses for biological, psychological, and social factors that can be contributing to a problem or problems with a client.

-IMP

Biphobia

Is fear, intolerance, or hatred towards bisexuals.

- Healthyplaces

Biphobia is a term used to describe the fear of or aversion to bisexuality, or discrimination against LGBT people who are bisexual or perceived to be bisexual.

- Brown

BIPOC

Stands for Black, Indigenous, and People of Color. This is a term specific to the United States, intended to center the experiences of Black and Indigenous groups and demonstrate solidarity between communities of color.

- YWCA Seattle

Bipolar I disorder

Bipolar I disorder is defined by manic episodes that last at least 7 days (most of the day, nearly every day) or by manic symptoms that are so severe that the person needs immediate hospital care.

- National Health Institute

Bipolar II disorder

Bipolar II disorder is when one has an experience of at least one major depressive episode and at least one hypomanic episode.

- American Psychiatry Association

Birthing people

Someone who gives birth, regardless of their gender identity, which may be female, male, nonbinary, or other.

- NICHQ

Bisexual

The term "bisexual" is used to describe a person who experiences emotional, romantic and/or sexual attractions to, or engages in romantic or sexual relationships with, more than one sex or gender.

- American Psychological Association

Borderline personality disorder

Borderline personality disorder is a mental illness that severely impacts a ones' ability to regulate their emotions. Signs and symptoms include: efforts to avoid real or perceived abandonment; a pattern of intense and unstable relationships with family, friends or loved ones; a distorted and unstable self-image; impulsive and dangerous behaviors, such as spending sprees, unsafe sex, substance abuse, and reckless driving; self-harming behavior; recurring thoughts of suicidal behaviors or threats; intense and highly variable moods; chronic feelings of emptiness.

- NIH Mental Health Information

Chi-square test

The Chi-Square Test of Independence determines whether there is an association between categorical variables (i.e., whether the variables are independent or related). It is a nonparametric test.

- Kent State

The Chi-Square statistic is commonly used for testing relationships on categorical variables and is most commonly used to evaluate tests of independence.

- Statistics solutions

Cisgender

Cisgender is a term that is used to describe people whose gender identity matches the sex they were assigned at birth.

- IAPAC

Cognitive behavioral therapy

Cognitive behavioral therapy (CBT) is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness.

- APA

Control (research)

Control groups are essential to experimental design. When researchers are interested in the impact of a new treatment, they randomly divide their study participants into at least two groups:

The treatment group (also called the experimental group) receives the treatment whose effect the researcher is interested in.

The control group receives either no treatment, a standard treatment whose effect is already known, or a placebo (a fake treatment to control for placebo effect).

- Control Groups

Cross-sectional study

A cross-sectional study is a type of observational study design. In a cross-sectional study, the investigator measures the outcome and the exposures in the study participants at the same time.

- NCBI

Culturally competent

Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.

nccc.georgetown

Deinstitutionalization

The policy of moving severely mentally ill people out of large state institutions and then closing part or all of those institutions.

- Frontline

Deinstitutionalization is the procedure of shifting the care and support from long-stay psychiatric hospitals to community mental health services for patients diagnosed with severe mental disorders.

-Frontiers in Psychiatry

Dementia

Dementia is a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities.

- CDC

Dialectical behavioral therapy

Dialectical behavior therapy (DBT) is a comprehensive, evidence-based treatment for borderline personality disorder (BPD).

- *Psychiatry (Edgmont)*

Digital mental health intervention (DMHI)

DMHI are technology-based interventions in the form of mobile apps, web-based programs, virtual reality (VR), wearable devices, or video games.

- *Curus*

Direct to consumer (D2C)

D2C is a type of business-to-consumer (B2C) retail sales strategy where a business will build, market, sell and ship a product directly to the customer.

- *TechTarget*

Dopamine

Dopamine is a neurotransmitter that is produced in the substantia nigra, ventral tegmental area, and hypothalamus of the brain.

- *Hindawi*

Dopamine is known as the 'feel-good' neurotransmitter—a chemical that ferries information between neurons.

- *Psychologytoday*

Double closet

The compounded difficulty faced by Arab Americans who self-identify as lesbian, gay, bisexual, or transgender (LGBT) who not only encounter racism and homophobia from society as a whole, but also racism from within the LGBT community as well as homophobia from within the Arab American community.

- *scholarworks*

Drapetomania

This is a term coined by Samuel Cartwright, MD (1793–1863), from the Greek drapetes, a runaway, and mania, madness. He defined it as a “mental illness” that caused African slaves in the U.S. to flee their captivity. Hektoen International

DSM-V

Stands for Diagnostic and Statistical Manual of Mental Disorders. is a reference book on mental health and brain-related disorders
-APA

Emotional granularity

This is the level of specificity that characterizes verbal representations of an affective experience.

-frontiers

It is the ability to put feelings into words with a high degree of specificity and precision.

- Northeastern

Excited delirium syndrome

Excited delirium syndrome is characterized by agitation, aggression, acute distress and sudden death, often in the pre-hospital care setting.

-NCBI

Excited delirium syndrome is an acute confused state marked by intense paranoia, hallucinations, and violence toward objects and people.

-ScienceDirect

Family and Medical Leave Act (FMLA)

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

-US Department of Labor

First Generation Immigrants

This category includes persons who were born outside a country. For the most part, these are people who are now, or once were, immigrants to a particular country.

-Statistic Canada

A person who is a first-generation immigrant is defined as one who is born outside of the United States.

- Harvard Immigration Initiative

Gender affirmation

Gender affirmation is an umbrella term for the range of actions and possibilities involved in living, surviving, and thriving as our authentic gendered selves.

-Transhub

Gender dysphoria

Gender dysphoria is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity.
-NHS

Gender identity

Gender identity is each person's internal and individual experience of gender. It is a person's sense of being a woman, a man, both, neither, or anywhere along the gender spectrum.
-Ontario Human Right Commission

Gender-affirming health care

Encompasses a range of social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with the gender they were assigned at birth.
-AAMC

Heteronormativity

Heteronormativity is defined as the belief that heterosexuality is the human default sexual orientation.
-F Ferrari

Heteronormativity describes the ways in which heterosexuality is normalized through myriad practices, so that it becomes naturalized as the only legitimate form of sexuality.
- ScienceDirect

Holistic health care

Holistic health care is an approach to life that considers multidimensional aspects of wellness. It encourages individuals to recognize the whole person: physical, mental, emotional, social, intellectual, and spiritual.
-WCSU

Hormone therapy for TGD people

Use of hormones in transgendered (TGD) to adjust their secondary sex characteristics to be more congruent with their experienced gender.
-BMJ

ICD-10

Stands for International Classification of Diseases. Serves a broad range of uses globally and provides critical knowledge on the extent, causes and consequences of human disease and death worldwide via data that is reported and coded with the ICD.
-WHO

Immigration and Nationality Act (INA)

A comprehensive federal law which deals with immigration, naturalization, and exclusion of non-native individuals who have immigrated to a country.

-*National*

Institutional racism

Institutional racism (or systemic racism) describes forms of racism which are structured into political and social institutions.

-*Racism No Way*

Intergenerational trauma

Intergenerational trauma is a concept developed to help explain years of generational challenges within families. It is the transmission (or sending down to younger generations) of the oppressive or traumatic effects of a historical event.

-*OIE*

Interpersonal racism

Interpersonal Racism is the biased response that occurs when individuals interact with others that are considered racially different than themselves.

-*Vanderbilt*

Intersex person

An intersex person is a person who is born with a combination of male and female biological traits.

-*Planned Parenthood*

Intersex people are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.

-*ohchr*

K-12

K-12 education is the foundation of a student's academic career. It provides the basic knowledge and skills necessary for success in college and the workplace.

-*Tech*

LGBTQ+

An acronym for "lesbian, gay, bisexual, transgender and queer" with a "+" sign to recognize the limitless sexual orientations and gender identities.

-*Human Right Campaign*

Literature review

A literature review is a piece of academic writing demonstrating knowledge and understanding of the academic literature on a specific topic placed in context.

-*Endinburgh*

A literature review is a search and evaluation of the available literature in your given subject or chosen topic area.

-*Royal Literary Fund*

Longitudinal study

In a longitudinal study, subjects are followed over time with continuous or repeated monitoring of risk factors, or health outcomes, or both.

-*BMJ*

It is a type of observational and correlational study that involves monitoring a population over an extended period of time.

-*Psychology*

Major depressive disorder/ episode (MDE)/depression

Major depressive episodes (MDE) include depressed mood and loss of interest or pleasure in activities (anhedonia), at least one of which must occur for at least two weeks.

-*Science Direct*

Marginalized

Marginalized populations are groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions.

-*National Collaborating Centre for Determinants of Health*

Medicaid

Medicaid is a program that provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements.

-*Medicaid*

Medicare

Medicare is federal health insurance for people 65 or older, some younger people with disabilities, people with End-Stage Renal Disease.

-*Medicare*

Mental health

A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.

-*sciencedirect Herrman et al., 2005*

Mental health literacy

Mental Health Literacy is the knowledge and understanding that helps us become responsible, effective and successful in living full and healthy lives.

-*Mental Health Literacy*

Mental illness

Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these).

-*Psychiatry*

Mental wellness

Mental wellness is a positive state of mental health. It is more than the absence of mental illness.

-*Sam Health*

Microaggression

Microaggressions are defined as the everyday, subtle, intentional — and oftentimes unintentional — interactions or behaviors that communicate some sort of bias toward historically marginalized groups.

-*NPR*

Minority stress model

Describes stress processes, including the experience of prejudice acts, expectations of rejection, suppressing feelings, concealing identities, and internalized homophobia.

-*Meyer, 2003*

Misogynoir

Misogynoir refers to the misogyny directed towards Black women where both race and gender intersect in forming a bias against them.

-*Feminism India*

Monosexual

A monosexual person is romantically, emotionally, and/or sexually attracted towards one gender only.

-*UNICORN*

Mood Disorder

Mood disorders are described by marked disruptions in emotions (severe lows called depression, or highs called hypomania or mania). Mood Disorder;

- *Sandeep Sekhon*

Mood disorders are mental health disorders that involve emotional disturbances consisting of long periods of excessive sadness (depression), excessive joyousness or elation (mania), or both. Depression and mania represent the two extremes, or poles, of mood disorders.

- *MSDManuals*

Mood stabilizer

Mood stabilizers are medications used in the treatment of bipolar disorder, where a person's mood changes from a depressed feeling to a high "manic" feeling or vice versa.

- *Centre for Addiction and Mental Health*

Mood stabilizers are a class of medications used in the management and treatment of bipolar disorder.

- *Mala Nath; Vikas Gupta*

Nonbinary

"Non-binary" is a general term that includes those whose identity falls outside of or between male and female identities; as a person who can experience both male and female, at different times, or someone who does not experience or want to have a gender identity at all.

- *International Journal of Transgenderism*

Observational study

Observational studies are ones where researchers observe the effect of a risk factor, diagnostic test, treatment or other intervention without trying to change who is or isn't exposed to it.

- *Institute of work and Health*

An observational study is when researchers are looking at the effect of some type of intervention, risk, a diagnostic test or treatment, without trying to manipulate who is, or who isn't, exposed to it.

- *Elsevier*

Participatory technology design

This is a democratic process for design (social and technological) of systems involving human work, based on the argument that users should be involved in designs they will be using, and that all stakeholders, including and especially users, have equal input into interaction design.

- *ScienceDirect*

Pearson correlation

The Pearson correlation is a measure of the strength of a linear association between two variables.

- *r. Laerd Statistics*

Pearson's correlation coefficient is the test statistics that measures the statistical relationship, or association, between two continuous variables.

- *Statistics Solution*

Plural sexuality

A person's sexual identity or self-identification as bisexual, straight, gay, pansexual etc.

- *merriam-webster*

Post-traumatic stress disorder (PTSD)

PTSD is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event.

- *NIMH*

PTSD is an anxiety disorder caused by very stressful, frightening, or distressing events.

- *NHS Mental Health*

Poverty line/level

A level of personal or family income below which one is classified as poor according to governmental standards.

- *merriam-webster*

It is an economic measure used to decide whether the income level of an individual or family qualifies them for certain federal benefits and program.

- *Investopedia*

Prison Rape Elimination Act (PREA)

PREA is a federal law that prohibits sexual misconduct in correctional settings such as prisons, jails, lockups, juvenile facilities, and Immigration Services/ICE detention facilities.

- *Washington State*

Prodrome

A period of time which begins with the first behavioral, cognitive and perceptual changes in a person and extends up to the development of the first psychotic symptoms.

- *Fusar-Poli et al., 2013*

Psychopathology

It is the scientific exploration of abnormal mental states that, for more than a century, has provided a Gestalt for psychiatric disorders and guided clinical as well as scientific progress in modern psychiatry.

- *Frontiers*

It is a term that encapsulates deviant, dysfunctional, or otherwise abnormal behavior and thought processes.

- *Springer*

Psychosis

Psychosis is when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions).

- *Mental health conditions*

Psychotherapy

Is a way to help people with a broad variety of mental illnesses and emotional difficulties.

- *psychiatry*

Psychotic disorder

Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions.

- *Medlineplus*

Quasi-experimental study

Quasi-experimental studies are studies that aim to evaluate interventions which do not use randomization to a treatment arm.

- *NCBI*

Racial capitalism

This is the process of deriving value from the racial identity of others, harms the individuals affected and society as a whole. For instance, racial capitalism can exist in a form when white individuals and predominantly white institutions use nonwhite people to acquire social and economic value.

- *Harvard Law Review*

Racial Hegemony

A system of dominance and exploitation based upon race.

- *scholarlycommon*

Schizophrenia

Schizophrenia is a serious mental illness that affects how a person thinks, feels, and behaves.

-*NIH Mental Health Information*

Schizophrenia is a serious mental disorder in which people interpret reality abnormally. Schizophrenia results in a combination of hallucinations, delusions, and extremely disordered thinking and behaviors that impairs daily functioning, and can be disabling.

- *Mayo Clinic*

School resource officer (SRO)

A sworn officer assigned to a school on a long-term basis trained to perform three major roles as a law enforcement officer, law-related counselor, and law-related educator.

-*Swanseal*

Second-generation immigrant

Second-generation immigrants are born in the United States but have parents who are born abroad.

-*Harvard Immigration Initiative*

Self-diagnosis

An effort of diagnosing medical conditions in oneself by using the resources on the internet or books or self-experience.

-*IGI Global*

Self-regulation (emotional)

The ability to act in your long-term best interest, consistent with your deepest values.

-*Stonsy, 2011*

Emotional self-regulation refers to the complex process of initiating, inhibiting, and modulating the conscious aspects of emotion to effectively achieve one's goals.

-*Encyclopedia of Child Behavior and Development*

Serious mental illness

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

-*NIMH Mental Illness*

Sexual minority

Individuals who identify as gay, lesbian, or bisexual, or who are attracted to or have sexual contact with people of the same gender.

-CDC

Sexual orientation, gender identity, and expression (SOGIE)

SOGIE refers to characteristics common to all human beings as everyone has a sexual orientation and a gender identity.

-Health Ny

An umbrella term that describes people whose gender identity or gender expression differs from expectations associated with the sex assigned to them at birth.

-Utimes

Slovin's formula

Slovin's formula is used to calculate an appropriate sample size from a population.

-StatisticsHowTo

Slovin's formula calculates the number of samples required when the population is too large to directly sample every member.

-Sciening

Social anxiety disorder

Social anxiety disorder includes fear, anxiety and avoidance that interfere with relationships, daily routines, work, school or other activities.

-Mayo Clinic

Social determinants of health

The social determinants of health (SDH) are the non-medical factors that influence health outcomes.

-WHO

The social determinants of health (SDH) are the social and economic factors that influence people's health.

-CPHA

Social emotional learning

SEL is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions, and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions.

-CASEL

Social support

Social support refers to the various ways in which individuals aid others.
-Psychology research

Socioeconomic status

Is the social standing or class of an individual or group. It is often measured as a combination of education, income, and occupation.
-APA

Stigma

Involves negative attitudes or discrimination against someone based on a distinguishing characteristic such as a mental illness, health condition, or disability.
-Very well mind

Strong Black Woman (SBW)

The term "Strong Black Womanhood" (SBW) schema has described the culturally specific and multidimensional construct internalized by African American women to overcome oppression (e.g., racism, sexism).
-Journal of Black Psychology

Structural determinants of health

The root causes of health disparities which include governing processes and economic/social policies that affect income, working conditions, housing, and education, among others.
-IGI Global

Structural racism

Refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice.
-AMA-ASSN

Substance use disorder/substance misuse and abuse

Substance use disorder/substance misuse and abuse is a pattern of drug use that leads to significant problems such as failure to attend work or school, driving a vehicle while.
-HopkinsMedicine

It also refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.
-Afro WHO

Suicidal ideation/suicidality

Suicidality is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.

-*National Library of Medicine*

Telehealth

The delivery of health care, health education, and health information services via remote technologies.

-*NEJM*

Third-generation immigrant

The third generation denotes U.S.-born individuals with two U.S.-born parents but at least one foreign-born grandparent.

-*Brian Duncan and Stephen J. Trejo*

Transgender and gender diverse (TGD)

Designated individuals who have a gender identity that differs from the sex they were assigned at birth.

-*NCBI*

Trauma

Trauma is an emotional response to a terrible event like an accident, rape, or natural disaster.

-*American Psychological Association*

Unhoused/houseless

These terms describe individuals without a physical address.

-*Blanchethouse*

Wellness apps

Mobile applications that promote a healthy lifestyle and vary from specialized activity tracking, sleep analysis, nutrition management, mindfulness apps to general wellness monitoring solutions.

-*scnsoft*

White supremacy

The beliefs and ideas purporting natural superiority of the lighter-skinned, or "white," human races over other racial groups.

-*Britannica*

Whitelist

It is a list of entities approved for authorized access or privileged membership to enter a specific area in the computing world.

-Techopedia

World Health Organization (WHO)

The United Nations agency which works to promote health, keep the world safe, and serve the vulnerable.

-WHO

Appendix

Gender

A Patient's Perceived A Patient's Perceived Effect of the "No Visitor Policy" Implemented During COVID on Their Overall Mental and Physical Health: A Retrospective, Observational Study

Figure 1: Age Profile of Respondents Sample, n=538
Age Profile

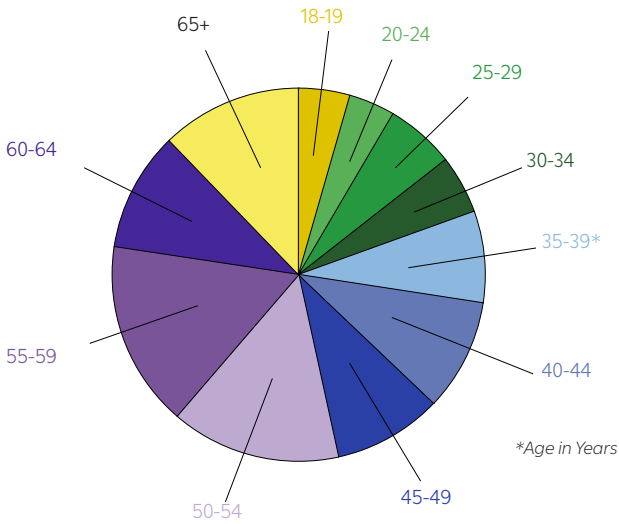


Figure 1 shows the ages of the people who participated in the survey at the heart of the COVID "No Visitor Policy" observational study. The population skewed middle aged and older.

Table 1: Demographic Characteristics of Age Profile for Respondents Sample, n=538

Age Groups	Frequency	Percentage
18 to 19 years	23	4.28%
20 to 24 years	23	4.28%
25 to 29 years	32	5.95%
30 to 34 years	28	5.20%
35 to 39 years	43	7.99%
40 to 44 years	52	9.67%
45 to 49 years	52	9.67%
50 to 54 years	75	14.94%
55 to 59 years	86	15.99%
60 to 65 years	60	11.15%
65 years and older	64	11.90%
Total	538	100%

Included in table 1 are the frequency of the ages of the people who participated in the survey at the heart of the COVID “No Visitor Policy” observational study. The population skewed middle aged and older.

Figure 2: Gender Profile of Respondents Sample, n=538

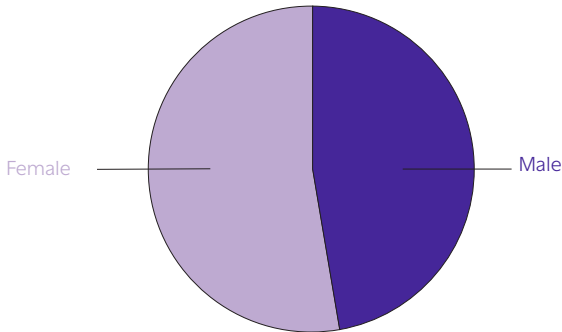


Figure 2 includes the proportions of the genders that were measured of the people who participated in the survey at the heart of the COVID “No Visitor Policy” observational study. There were slightly more women than men in the survey.

Table 2: Demographic Characteristics of Gender Profile for Respondents Sample, n=538

Gender	Frequency	Percentage
Male	255	47.40%
Female	238	52.60%
Total	538	100%

Table 2 shows the frequency and percentage of the genders that were measured of the people who participated in the survey at the heart of the COVID “No Visitor Policy” observational study. There were slightly more women than men.

Figure 3: Results of Perceived Physical Health Impact on Respondents

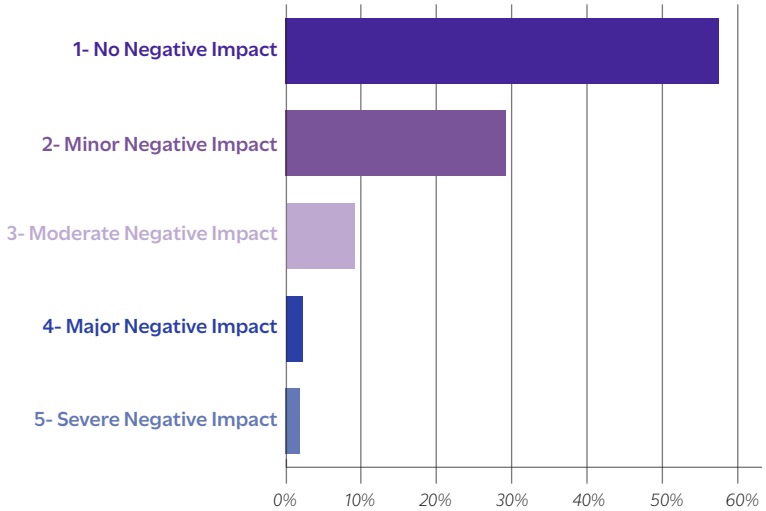


Figure 3 depicts the physical health impact the survey respondents perceived as a result of the “No Visitor Policy” during the worst of the COVID pandemic. According to the survey, most people perceived no or minor negative impacts on their physical health.

Table 3: Characteristics of Perceived Physical Health Impact on Respondents.

Description	Frequency	Percentage
1- No Negative Impact	311	57.81%
2- Minor Negative	158	29.37%
3- Moderate Negative Impact	48	8.92%
4- Major Negative Impact	12	2.23%
5- Severe Negative Impact	9	1.67%
Total	538	100%

Table 3 lists the frequency and percentage of the physical health impact the survey respondents who perceived “no negative impact”, “minor negative impact”, “moderate negative impact”, “major negative impact”, and “severe negative impact” of the “No Visitor Policy” on their physical health during the worst of the COVID pandemic. Most people perceived no impact on their physical health.

Table 4: One-Way Analysis of Variance for Perceived Physical Health Impact by Genders

Sources	df	SS	MS	F	P
Between Groups	1	3.452	3.452	4.612	0.32*
Within Groups	536	401.009	.748		
Total	537	401.461			

Note: * Significant at 0.05

Table 4 demonstrates a statistically significant difference in perceived physical health impacts between males versus females and whether their physical health was impacted.

Table 5: One-Way Analysis of Variance for Perceived Physical Health Impact by Age

Sources	df	SS	MS	F	P
Between Groups	10	19.865	1.987	2.72	0.003**
Within Groups	527	384.594	.730		
Total	537	401.461			

Note: ** Highly Significant at 0.01

Table 5 demonstrates a statistically significant difference between age and perceived impact of the No Visitor Policy on their physical health.

Figure 4: Results of Perceived Mental Health Impact on Respondents.

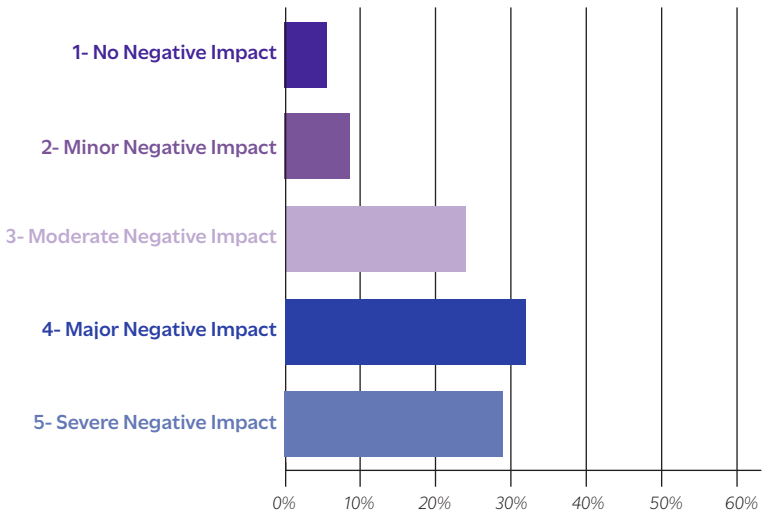


Figure 4 depicts the mental health impact the survey respondents perceived as a result of the “No Visitor Policy” during the worst of the COVID pandemic. Most people perceived a major negative impact, severe negative impact, or moderate negative impact on their mental health

Table 6: Characteristics of Perceived Mental Health Impact on Respondents.

Description	Frequency	Percentage
1- No Negative Impact	30	5.58%
2- Minor Negative	47	8.74%
3- Moderate Negative Impact	131	24.35%
4- Major Negative Impact	173	32.16%
5- Severe Negative Impact	157	29.18%
Total	538	100%

Table 6 lists the frequency and percentage of survey respondents who perceived “no negative impact”, “minor negative impact”, “moderate negative impact”, “major negative impact”, and “severe negative impact” on their mental health as a result of the “No Visitor Policy” during the worst of the COVID pandemic. Most people perceived a major negative impact, severe negative impact, or moderate negative impact on their mental health as a result of the policy

Table 7: One-Way Analysis of Variance for Perceived Mental Health Impact by Gender

Sources	df	SS	MS	F	P
Between Groups	10	27.842	27.842	22.214	0.000**
Within Groups	527	671.756	1.253		
Total	537	699.599			

Note: ** Highly Significant at 0.01

Table 7 a statistically significant difference in perceived mental health changes between females and males.

Table 8: One-Way Analysis of Variance for Perceived Mental Health Impact by Age

Sources	df	SS	MS	F	P
Between Groups	10	21.209	2.121	1.648	0.90 ^{NS}
Within Groups	527	678.389	1.287		
Total	537	699.599			

Note: NS not significant

Table 8 indicates no statistically significant difference between age groups and perceived mental health impacts based on the No Visitor Policy during the height of the Covid-19 pandemic.

Table 9: Correlations Between Perceived Physical Health, Mental Health and Age

Variable	Age	Physical Health	Mental Health
Pearson Correlation	1	-0.076	-0.016
Sig. (2-tailed)		0.080 ^{NS}	0.716 ^{NS}

Note: NS not significant

Table 9 shows no correlation between age and perceived impacts on physical health of the No Visitor Policy during the height of the Covid-19 pandemic. The data also indicates no correlation between age groups and perceived mental health impact of the No Visitor Policy during the height of the Covid-19 pandemic.

Table 10: Chi-Square Tests: Relationship between Gender and Physical Health

	Value	Df	Asymptomatic Significance (2-Sided)
Person Chi-Square	6.541	4	-0.016

Note: NS not significant

In Table 10, a Chi-Square test was used to examine whether a statistically significant relationship exists between gender and perceived physical health impacts of the No Visitor policy. The data indicates no relationship between gender and perceived physical health impacts of the No Visitor Policy during the height of the Covid-19 pandemic.

Table 11: Chi-Square Tests: Relationship between Gender and Mental Health

	Value	Df	Asymptomatic Significance (2-Sided)
Person Chi-Square	29.299	4	0.000**

*Note: ** Highly Significant at 0.01*

Table 11 shows a Chi-Square test that was used to examine whether a statistically significant relationship exists between gender and perceived mental health impacts of the No Visitor policy during the Covid-19 pandemic. The data indicates a statistically significant relationship between gender and perceived mental health impacts

Race and Ethnicity

The Mental Health Impact of Police Violence Among Black Americans in the U.S. A Review

Figure 1 – Police killings per 1 million people in the U.S. between 2013 to 2022 stratified by ethnicity. Credit: MappingViolence.org

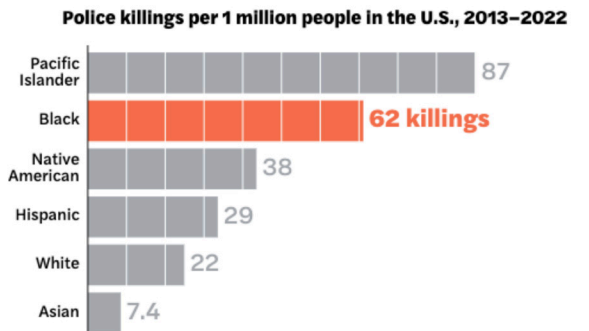


Figure 1 shows the number of police killings per 1 million people in the United States during the time period of 2013 to 2022. It is notable that there is a significant racial disparity in police killings. For instance, over the course of a 9 year period, Black people are killed at rates almost triple that of white people, and Pacific Islanders are killed at even higher rates than that.

Age

The Impact of Exercise on Organizational Empathy

Figure 1

	Sedentary	Exercised	Difference	%Diff
Missed Responses	0.40	0.24	-0.16	40%
Adjective Variety	10.34	11.73	1.39	12.44%

Figure 1 demonstrates a 40% decrease in missed responses and a 13.44% improvement in adjective variety on a survey measuring perceptions of emotion and emotional granularity. Exercise appears to have a positive impact on the ability to perceive and describe a variety of emotional descriptors about individual faces. to

Socioeconomic Status

Employee Engagement Policy Recommendations for Sustaining Wellbeing of A Diverse Workforce in A Hybrid Setup-Based on Learnings from Adverse Impact of Middle-Income Employees In The Service Industry

Figure 1: Employee experience over the employee life cycle (Source: Author)

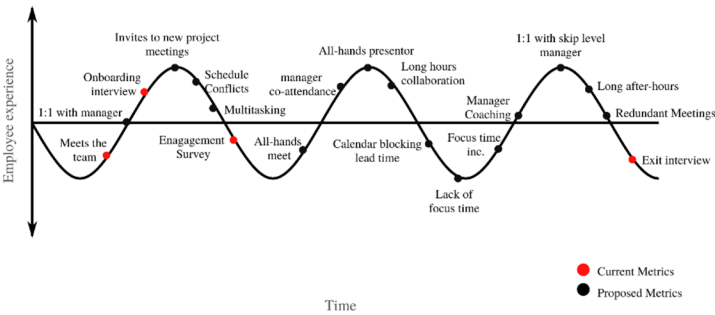


Figure 1 depicts the events that mark the different experiences that play out over the entire term of an employee's tenure, with current opportunities to gather feedback and metrics noted in red and proposed opportunities in black.

Migrant Status

A Preliminary Report of Trauma Impact on Language Skills in Bilingual Adults: A Case for Trauma-Informed Services

Table 1. Participant Characteristics

Characteristics	Participants (N = 212)
Age – M (SD)	34.94(6.72)
Gender – n (%)	
Men	119 (56)
Women	93 (44)
Hispanic Origin – n (%)	
Yes	111 (48)
No	102 (52)
Race – n (%)	
American Indian or Alaska Native	7 (3)
Asian	20 (9)
Black or African American	44 (21)
Native Hawaiian or Pacific Islander	7 (3)
White	103 (49)
Prefer not to say	31 (15)
Education – n (%)	
High School	6 (3)
Some High School	5 (2)
Bachelor’s Degree	83 (37)
Master’s Degree	81 (36)
PhD or higher	25 (11)
Associate’s Degree	10 (4)
Trade School	1 (<1)
Prefer not to say	1 (<1)
Primary Language – n (%)	
English	161 (76)
Spanish	48 (23)
Both	2 (<1)
Other*	1 (<1)

Table 1 lists the various demographics of the people who completed the survey as measured by survey questions. The majority of participants were 35 years of age, African American and Asian, had a Bachelor’s degree or Master’s degree, and predominantly spoke English as a primary language.

Figure 1. Reported Traumatic Experiences

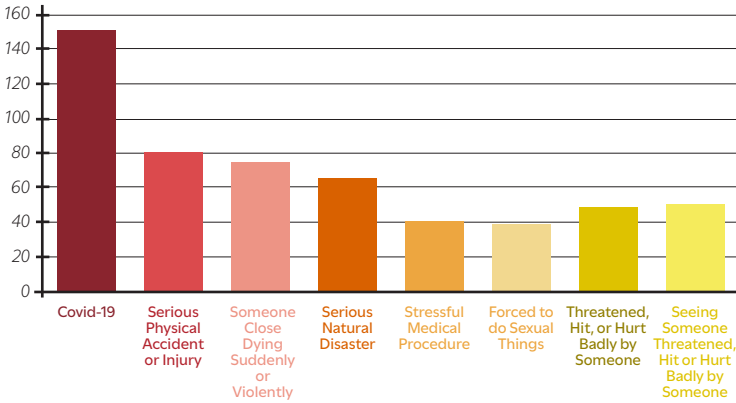


Figure 1 shows the number of respondents who reported that they had experienced the listed traumatic experiences within the past 5 years. Almost all participants reported at least one traumatic experience from COVID-19, serious physical accident or injury, someone close dying suddenly or violently, serious natural disaster, stressful medical procedure, forced sexual encounters, and/or physical threats or assaults.

Figure 2. Reported Trauma Currently Impacting Language Skills

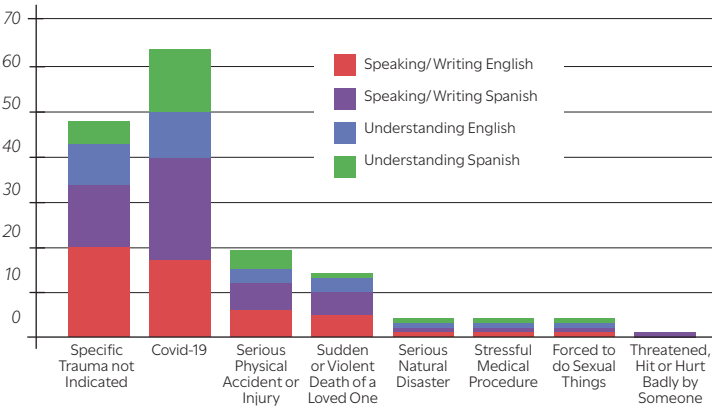


Figure 2 shows the number of respondents who reported the trauma they had experienced and the impact on their English and Spanish language abilities, specifically language production and language comprehension. For each type of trauma, the chart depicts the proportions of respondents who experienced particular issues related to speaking and writing English, speaking and writing Spanish, understanding English, and understanding Spanish. Language skills were most greatly impacted by COVID-19, serious physical injuries and accidents, and unspecified traumas.

