Sharon S. Laing, PhD
Assistant Professor
School of Nursing and Healthcare Leadership
University of Washington Tacoma

UNIVERSITY of WASHINGTON | TACOMA

*There needs to be a shift in mindset. A lot of people think about health as something that's largely within our control. They think that if you just make certain choices or if you behave in a certain way, you can be a healthier person — just stop smoking, don't drink alcohol, eat properly, exercise and go to the doctor. What they don't realize is that the decisions we make and the behaviors we engage in are shaped by our environment and opportunities … and many of those things aren't within an individual's control…*

*– Dr. Lisa Cooper, Bloomberg Distinguished Professor for Equity and Health*
*Johns Hopkins Bloomberg School of Public Health*

# Color of Coronavirus: Relationship to Racism and Health

UNIVERSITY *of* WASHINGTON | TACOMA

- In 17 states, more than 1 in 1,000 Black residents have died
- In 13 states, more than 1 in 1,000 Indigenous residents have died
- Race and ethnicity are documented for 94% of the cumulative deaths in the US
- *Black and Indigenous Americans* now suffer the greatest losses - both groups experience a covid-19 death toll exceeding 1 in 800 nationally…

(APM Research Lab, 2020)

# SDOH Predictors of COVID-19 Cases and Deaths in Mostly *Black* Counties

| Characteristics | Other counties (<13% Black) n=2436 [1.3 % Black] | Disproportionately Black (>=13%) n=677 [29% Black] |
|---|---|---|
| % Uninsured | 10.1 (7.0, 14.6) | **13.9 (10.9, 17.0)** |
| % Unemployed | 3.7 (3.0, 4.6) | **4.4 (3.7, 5.3)** |
| % Household occupancy (> 1 person per room) | 1.8 (1.3, 2.8) | **2.2 (1.5, 3.1)** |
| Air toxin ($PM_{2.5}$) | 5.6 (4.1, 7.1) | **(7.7 (6.9, 8.2)** |
| **Chronic Disease Status** | | |
| % Diabetes diagnoses | 11.1 (8.9, 13.8) | **13.9 (11.3, 16.7)** |
| **COVID-19 Status** | | |
| Diagnosis rate (per 100,000) | 5.0 (1.0, 24.2) | **22.0 (8.0, 100.0)** |
| Death rate (cases >200, n=270) | 3.8 (1.7, 9.5) | **4.6 (1.9, 13.1)** |

Millet, G.A., Jones, A.T., Benkeser, D., Baral, S., Mercer, L., Beyrer, C.,...Sullivan, P.S. (2020). Assessing differential impacts of COVID-19 on black communities. *Annals of Epidemiology*,47, 37-44.

# SDOH Predictors of COVID-19 Cases and Deaths in Mostly *Latinx* Counties

| Characteristic | Other counties (<17.8% Latinx) n=2700 | Disproportionately Latinx (>=17.8%) n=443 |
|---|---|---|
| % Unemployed* | 4.2 (3.4, 5.4) | **4.0 (3.3, 5.0)** |
| % Uninsured | 10.5 (7.2, 14.5) | **16.2 (11.6, 21.3)** |
| % Occupancy per room (>1 per room) | 1.7 (1.2, 2.5) | **3.9 (2.8, 5.7)** |
| % Monolingual (Spanish) | 8.4 (2.2, 16.5) | **15.1 (9.5, 21.5)** |
| COVID-19 Diagnosis rate (per 100,000) | 82.0 (34.1, 198.5) | **90.9 (35.1, 262.7)** |
| COVID-10 Death rate (per 100,000) | 0.0 (0.0, 7.3) | **1.3 (0.9, 7.6)** |

Rodriguez-Diaz, CE, Guilamo-Ramos, V, Mena, L., Hall, E., Honermann, B., Crowley, J.S., …Millet, G.A. (2020). Risk for COVID-19 infection and death among Latinos in the United States: examining heterogeneity in transmission dynamics. *Annals of Epidemiology*,52, 46-53. e2.

# SDOH Predictors of COVID-19 Cases and Deaths for Black and Latinx Counties

- Counties with a higher proportion of Black and Latinx residents had *greater household occupancy density* relative to other counties
- Counties with a higher proportion of Black and Latinx residents reported *lower rates of being insured*

# SDOH Predictors of COVID-19 Cases and Deaths

- Counties with a higher proportion of Black residents have higher prevalence of *underlying chronic health conditions* (Diabetes)
- *Air pollution* in the form of fine particulate matter is elevated in predominantly Black counties and these counties were likely to have higher COVID-19 cases and deaths
- Counties with more Black residents are more likely to have higher number of COVID-19 cases and deaths
- Counties with more Latinx residents are more likely to have a higher number of COVID-19 deaths

Disease and deaths are magnified by COVID-19 and should be a call to action to recognize and remove systemic structural factors that negatively affect Black/Brown, Indigenous and other People of Color

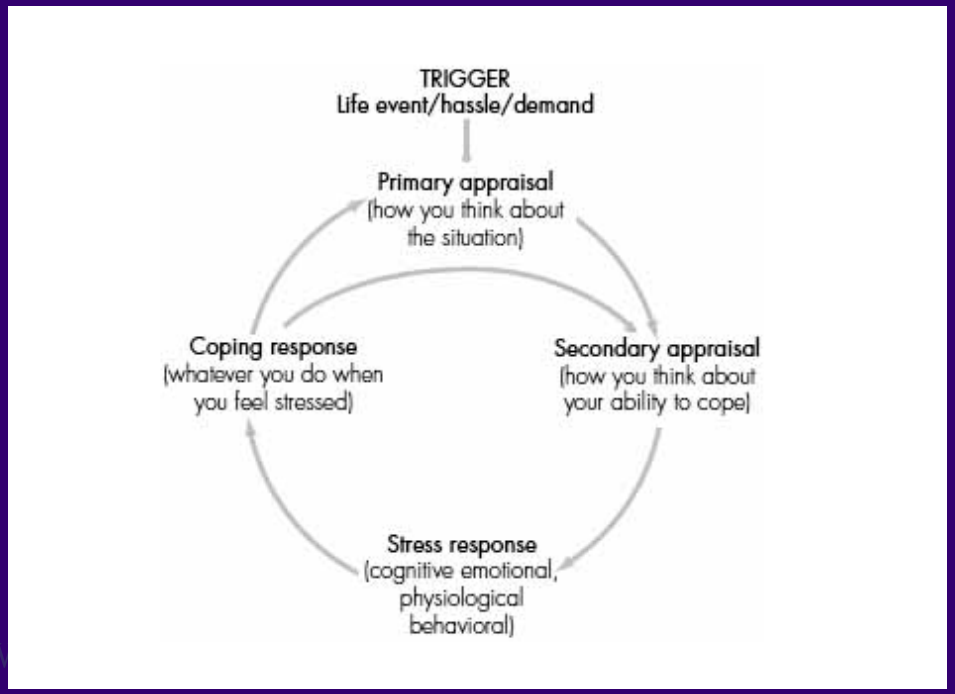
| **Key elements leading to COVID 19 impact** | **Racist correlates** |
|---|---|
| ○ Overcrowding | Red-lining and segregation |
| ○ Lack of sufficient testing | Segregation and resources |
| ○ Underlying health conditions | Inadequate health resources |
| ○ Comorbid health conditions | Inadequate health care |
| ○ Respiratory problems | Environmental toxins |
| ○ High rate of COVID 19 exposure | Type of jobs held |
| ○ Inability to social distance/telecommute | Neighborhood density/jobs held |

# Racism and Health

UNIVERSITY *of* WASHINGTON | TACOMA

Perception of an environmental stimulus as racist = exaggerated psychological and physiological stress responses influenced by sociodemographic, psychological and behavioral factors as well as coping responses…

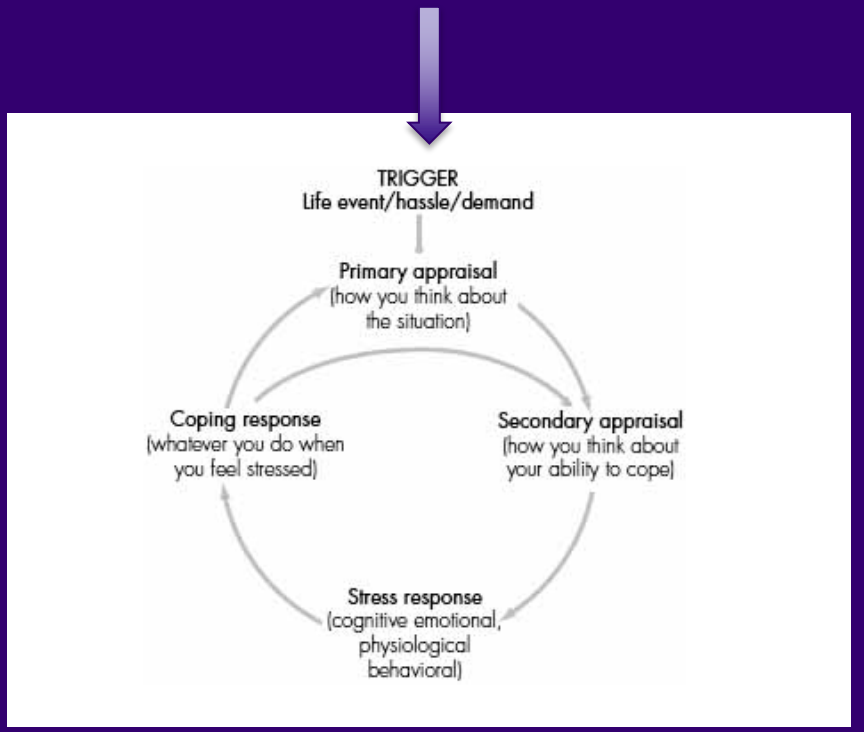
**Model of Stress and Coping**



**Trigger (Racial Stressor – source of chronic and acute stress)**

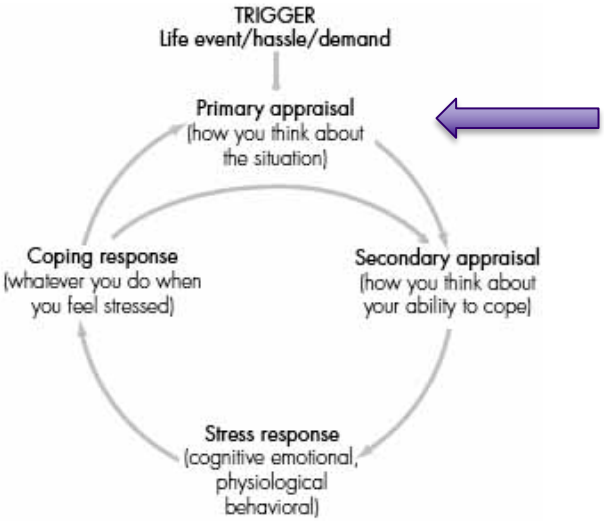
- *Institutional Racism* – housing segregation, substandard living environments, low wages, judicial treatment, economic deprivation, residential instability, and high population density

- *Personal Racism* – micro-aggressions, daily hassles, workplace stress, school yard bullying



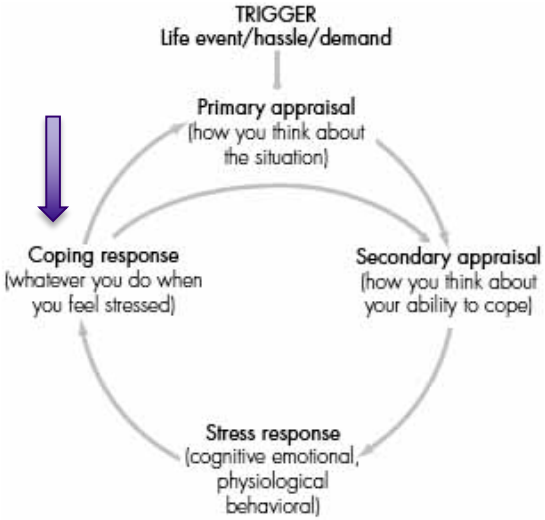
**Primary Appraisal (How the person feels about the stressor)**

- Moderated by other factors:
  - Age,
  - Gender
  - SES (Who needs the most intervention)



**Coping Response (What is the person likely to do when they experience the racial stressor)**

- *Active Coping* – overt expression of emotions
  ***Anger out***
  - Most effective for short or acute racially disruptive situations
  - Helps person use the emotion to engage in problem-focused coping which promotes some autonomy
  - Feasible only for acute racial stressors

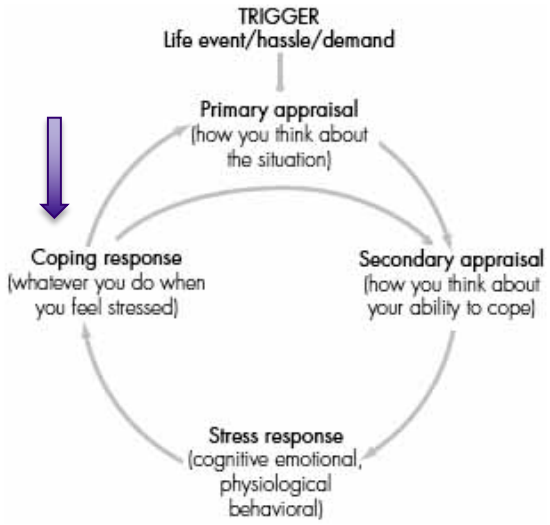



- *Passive Coping* – not reporting discrimination or accepting the racial slight/attack as a fact of life
  - Least effective and most damaging physiologically

## **Coping Response** (What is the person likely to do when they experience the racial stressor)

- *Learning and Unlearning* – repeated adjustments and adaptation to racism and marginalization
  - Lead to *weathering* - ongoing adaptation to structural marginalization
  - Leads to accelerated physiologic aging in Black women and other stigmatized groups

- *John Henryism*
  - Coping with prolonged exposure to racial discrimination by extending effort level – *persist in face of substantial odds*
  - Physiological costs are increased risks for hypertension and CVDs
  - Seen among higher SES racial groups experiencing racism in their workplaces or neighborhoods



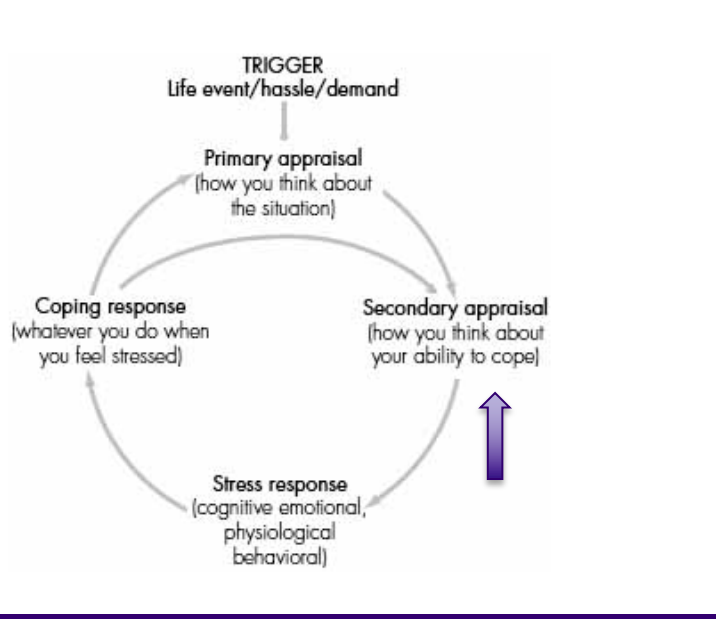
**Secondary Appraisal (What is person's assessment of ability to cope with the racial stressor)**

- Resources available to deal with the racially noxious event will determine the experience of stress/distress and attendant physiological, emotional, cognitive and behavioral outcomes

- Varying levels of impact based on result of 2ndary appraisal

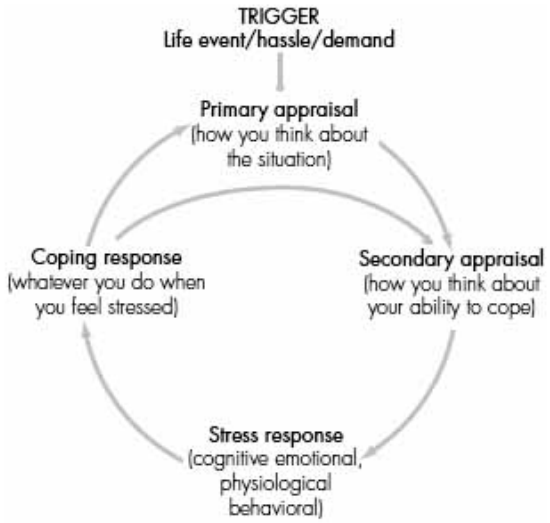
  - Higher SES but lack of social support

  - Lower SES (sustained exposure to noxious events including segregated neighborhoods and attendant toxic stressors)



**Stress Response (cognitive, emotional, physiological, behavioral)**

- Based on the coping mechanism deployed, we will see the impact of the racially noxious event on the physiology (and mental health) of the person




**Behavioral Outcome**

- *John Henryism* can accelerate occurrence of cardiovascular occurrences
- *Learning and unlearning* and trying to adapt can lead to sustained and accumulated stress on the body, and will wear down the system
- *Anger-out* is the most feasible approach and most effective coping strategy but only for acute racial stressors

# Long Term Impact

**Stress is linked to:**

- Healing process
- Breast cancer survival
- Cardiovascular diseases
- Mean arterial blood pressure
- Chronic obstructive pulmonary disease
- Upper respiratory tract infections

**Coping is not the answer…we must change the structure of and practices within the healthcare system**

# Moving Ahead and Anti-Racist Practices

UNIVERSITY *of* WASHINGTON | TACOMA

# Moving Ahead and Anti-Racist Practices

We must not blame the victim; we must recognize that the *person is responding to burdens that have accumulated over time*

- Be empathetic and compassionate

We must not let Blackness = *sickness*; we must call out the root causes of poor health: *Racism, Not Race*

- When we say that Blacks have a 2.3 times infant mortality rate than non-Hispanic whites, *we must state the fact that the mortality rate for Black babies is cut dramatically when delivered by Black doctors*

- When we talk about the fact that Blacks develop high blood pressure at younger ages than other groups in the US and are more likely to develop complications associated with hypertension, *we must include in the discussion the established correlation between sustained and chronic structural racism and the occurrence of CVDs*

# Moving Ahead and Anti-Racist Practices

We must be mindful of using disempowering identifiers (words/language) to characterize populations in our communities...

Examples include:

***Marginalized***

***Minority***

***Oppressed***

***Disenfranchised***

***Vulnerable***

Therefore:

- We must not speak about a person who is "oppressed" but a ***system that oppresses…***
- We must not speak of a person who is "disenfranchised" ***but a system that has disenfranchised***

# Moving Ahead and Anti-Racist Practices

We must think about the fact that bias exists on all levels – implicit and *explicit.* This permits more authentic conversations...

Let's acknowledge *explicit bias* because if we continue to think that our actions are beyond our consciousness (implicit), then we make a tacit pronouncement that *our actions cannot be changed*…

Talk about our personal world views, our narratives and derivation of these cognitions…
Discuss barriers to critical thinking and analysis - psychological processes/mental habits:

- Belief perseverance
- Stereotypes
- Availability Heuristics

*We each have a part that we can play. Each of us has a neighborhood where we live, a place where we work, other organizations that we're involved in where we have a voice — and that's where (we) can share knowledge and understanding of issues to have influence*

*– Dr. Lisa Cooper, Bloomberg Distinguished Professor for Equity and Health*
*Johns Hopkins Bloomberg School of Public Health*

# Thank you….

UNIVERSITY *of* WASHINGTON | TACOMA