

# Addressing Racial Trauma in the Treatment of Substance Use Disorders

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Recognition that trauma is a key contributor to the development of substance use disorders (SUDs) has been critical to developing effective clinical approaches for this patient population. Understanding the substantial increase in risk for SUDs conferred by a history of early traumatic experiences allows the health care community to shift the standard clinical frame from “What is wrong with you?” to “What has happened to you?” This framing promotes an attitude of compassion and understanding, which underlies effective treatment approaches to all individuals with SUDs.

Not all groups, however, experience trauma the same way; and because of these differences, which often fall along racial lines, the precise nature of the relationship between trauma and SUDs also differs. Although Felitti and

co-workers<sup>1</sup> original conceptualization of the relationship between adverse childhood experiences (ACEs) and increased risk of SUDs, mental illness, and physical illness was based on data from a largely white, employed, and insured population, these relationships have also been demonstrated in an urban Black population.<sup>2</sup> However, the concept of ACEs itself, as well as widely used instruments to measure exposure to ACEs, does not incorporate the impact of racial trauma (ie, stress caused by interpersonal or systemic racism that may cause emotional and physical health problems).<sup>3</sup> How ongoing racial trauma informs the development of SUDs and may limit the effectiveness of treatment approaches for young Black adults are critical issues for the addiction community to address.

Black and white populations in the United States have similar rates of SUDs

associated with most substances.<sup>4</sup> Similar prevalence rates across groups, however, do not mean similar etiologies, experiences of illness, rates of engagement with effective services, or outcomes. In the Black population, experiences of racial trauma in youth are consistently associated with worse health, including substance use outcomes.<sup>5</sup> Racial differences in physiologic markers of stress response and cellular aging (ie, “allostatic load”) are observed even among young adults, and the effects of racism during youth appear more closely associated with adult health outcomes than later experiences of racism.<sup>6</sup> This implies different factors contribute to the development of SUDs in Black and white populations.

Because anti-Black racism is persistent and pervasive, racial trauma is likely to play an ongoing role in perpetuating

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SUDs and impeding recovery in Black people, just as it appears to do in impeding recovery from posttraumatic stress disorder.<sup>7</sup> Any SUD treatment framework addressing the role of racial trauma in Black youth must take into account racism that occurs at multiple levels (systemic, organizational, and individual).

At the systemic or structural level, one of the many aspects of racism related to SUDs is within the policing and legal system: Black Americans are subjected to biased search and seizure, discriminatory patterns of arrest, conviction, sentencing, and incarceration related to drug use, making the life consequences of drug use much more severe for Black people than white people. According to the Pew Research Center, approximately one-third of the US prison population is Black, and one-third is white, contrasted with their shares of the US population: 12% Black and 63% white.<sup>8</sup>

At the organizational or institutional level, Black people face multiple barriers to receiving equitable treatment of SUDs. Black people are less likely than white people to receive specialty treatment of SUDs compared with white or Hispanic people.<sup>9</sup> Buprenorphine, which was developed in part to overcome the stigma associated with methadone, is predominantly prescribed to privately insured white patients, with Black patients one-fourth as likely to be prescribed buprenorphine as white patients.<sup>10</sup> Yet in settings like the Veterans Affairs Healthcare System, in which access barriers are minimized, Black patients seek treatment at higher rates than white patients and have higher rates of initiation and engagement with specialty addiction treatment of alcohol use disorder than white patients.<sup>11</sup>

At the interpersonal or individual level, although racial trauma plays

a role in predisposing to development of SUDs, inquiring about experiences of racial discrimination or the impact of structural racism is not part of standard intake evaluations for people with SUDs. Research indicates implicit racial bias among physicians is common across specialties and settings (although substantially less among providers of color). Black people who perceive their medical provider as discriminatory are more likely to drop out of SUD treatment.<sup>12</sup>

In light of these entwined issues, how can we chart a way forward to combat the effects of racial bias so that we can provide effective treatment to young Black adults? Reforms aimed at the level of individual interactions are necessary but not sufficient. In broad terms, we need to revision the mission of health care as described by Berwick<sup>13</sup> in his recent call to action, “The Moral Determinants of Health.” Namely, we start by committing ourselves to actively addressing systemic factors that contribute to the oppression of Black people. Then, as we focus on our own treatment systems, we need to ensure that we are suited to provide treatment to diverse patients by learning about our internal biases and starting the long process of challenging these deeply held assumptions. We also need to better recruit Black treatment providers into our health care institutions and support them in their careers so that we can decrease the disparities within the ranks of physicians in particular.

Within the framework of SUD treatment itself, we can learn about and affirm our patients’ reports of their experiences of racial trauma. In intake evaluations, we can incorporate questions about racial trauma to acknowledge its pervasiveness and open the door for discussion. We can invite our patients to share experiences of structural and individual racial trauma if they wish to, and we can acknowledge the harm

that such experiences cause. It may be helpful to our patients if we acknowledge the relationship between experiences of racial trauma and the increased risk of developing SUDs. We can also acknowledge that Black patients have a higher risk of harsh and discriminatory response to their substance use than white patients and advocate for harm-reduction approaches to help reduce the risk of encounters with law enforcement while using or obtaining substances. When developing a treatment plan, we can ensure that we offer the full range of treatment options to every patient in an unbiased way. And we can help patients to locate treatment settings that offer a lower risk of reexperiencing racial trauma, such as settings with Black treatment providers and staff who are more culturally sensitive to the needs of young Black patients and committed to delivering trauma-informed care.<sup>14</sup>

Significant structural, organizational, and individual work is required to address the relationships between racial trauma and SUDs. Upstream reforms to policies and societal norms are essential to this work. Research is also urgently needed to understand how we can be most effective in helping young Black adults to heal from their experiences of racial trauma. In the meantime, the SUD treatment measures listed offer actionable steps for people caring for young Black adults with SUDs.

#### ABBREVIATIONS

ACE: adverse childhood experience  
SUD: substance use disorder

#### REFERENCES

1. Dube SR, Miller JW, Brown DW, et al. Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *J Adolesc Health*. 2006; 38(4):444.e1-444.e10

2. Mersky JP, Topitzes J, Reynolds AJ. Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: a cohort study of an urban, minority sample in the U.S. *Child Abuse Negl.* 2013;37(11):917–925
3. Carter RT. Racism and psychological and emotional injury: recognizing and assessing race-based traumatic stress. *Couns Psychol.* 2007;35(1):13–105
4. Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. Results from the 2018 National Survey on Drug Use and Health: detailed tables. 2018. Available at: <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect5pe2018.htm>. Accessed July 27, 2020
5. Cave L, Cooper MN, Zubrick SR, Shepherd CCJ. Racial discrimination and child and adolescent health in longitudinal studies: a systematic review. *Soc Sci Med.* 2020;250:112864
6. Simons RL, Lei M-K, Beach SRH, et al. Discrimination, segregation, and chronic inflammation: testing the weathering explanation for the poor health of Black Americans. *Dev Psychol.* 2018;54(10):1993–2006
7. Sibrava NJ, Bjornsson AS, Pérez Benítez ACI, Moitra E, Weisberg RB, Keller MB. Posttraumatic stress disorder in African American and Latinx adults: clinical course and the role of racial and ethnic discrimination. *Am Psychol.* 2019;74(1):101–116
8. Gramlich J. Black imprisonment rate in the U.S. has fallen by a third since 2006. 2020. Available at: <https://www.pewresearch.org/fact-tank/2020/05/06/black-imprisonment-rate-in-the-u-s-has-fallen-by-a-third-since-2006/>. Accessed July 27, 2020
9. Pinedo M. A current re-examination of racial/ethnic disparities in the use of substance abuse treatment: do disparities persist? *Drug Alcohol Depend.* 2019;202:162–167
10. Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine treatment divide by race/ethnicity and payment. *JAMA Psychiatry.* 2019;76(9):979–981
11. Bensley KM, Harris AHS, Gupta S, et al. Racial/ethnic differences in initiation of and engagement with addictions treatment among patients with alcohol use disorders in the Veterans Health Administration. *J Subst Abuse Treat.* 2017;73:27–34
12. Mays VM, Jones AL, Delany-Brumsey A, Coles C, Cochran SD. Perceived discrimination in health care and mental health/substance abuse treatment among blacks, Latinos, and whites. *Med Care.* 2017;55(2):173–181
13. Berwick DM. The moral determinants of health. *JAMA.* 2020;324(3):225–226
14. James K, Jordan A. The opioid crisis in Black communities. *J Law Med Ethics.* 2018;46(2):404–421

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