ABSTRACT

Title of Thesis:	"IT'S HOW THEY FOUND RELIEF AND COMFORT FROM ALL THE TRAGEDIES THAT LIFE THROWS AT THEM ON A REGULAR BASIS": EXPLORING THE ASSOCIATION BETWEEN TRAUMA, OPIOID USE, AND OPIOID USE DISORDER IN WASHINGTON D.C.
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In Washington D.C, African American residents of underserved neighborhoods are disproportionately affected by opioid use (OU), opioid use disorder (OUD), and opioid overdose deaths (OOD), highlighting the need for a more effective intervention to address these issues. Existing literature indicates an association between OUD and trauma, but this relationship is minimally explored in urban, African American communities. This study aimed to qualitatively explore the association between trauma, OU, and OUD from the perspective of community leaders and clinicians (*N*=78) working in Wards 7&8 of DC, the neighborhoods hardest hit by the problem. Data showed that interpersonal and intergenerational trauma contributed directly to OU and OUD, and that historical trauma and structural violence act synergistically with other traumas to contribute to OU and OUD. Findings suggest a need for early interventions to address the harmful effects of interpersonal and intergenerational trauma and underscore a need for culturally informed political and socio-economic interventions to address structural violence and historical trauma that perpetuate trauma, OU, and OUD.

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by

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Chapter 1: Introduction

In the past ten years, opioids, especially of the synthetic type, have killed African Americans at a higher rate compared to any other race or ethnicity (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020; Foundation for Opioid Response Efforts, 2021). Urban dwelling African Americans experienced the largest absolute and percentage increases in opioid overdose deaths.

Washington, D.C is one of the cities with the highest rates of opioid overdose deaths (OOD) among African Americans, which has seen a steady increase over the past ten years since 2014 (District of Columbia Department of Behavioral Health [DC DBH], 2019). Opioid use disorder (OUD) is the problematic pattern of opioid drug use leading to clinically significant physical, emotional and mental impairment and distress (Centers for Disease Control and Prevention [CDC, n.d.]; Dydyk et al., 2024). Risk factors for OOD include not only OUD, but opioid use (OU) involving fentanyl (very potent/deadly opioid drug), inadvertent OU via fentanyl-laced drugs (Steven-Watkins, 2020), resumption of OU after an extended period of abstinence, and medical comorbidities (Weiner et al., 2022; World Health Organization (WHO), 2023). The monthly average of OOD in Washington, DC increased from 17 in 2018 to 23 in 2019, and from 34 to 36 from 2020 to 2021 (DC Office of the Chief Medical Examiner [DC OCME], 2023). In 2023, this number peaked at 43 persons per month, the highest number of people dying from opioids in the city since 2014 (Bensen, 2024; DC OCME, 2024; Iannelli, 2024). These data clearly reflect a continued increase in opioid overdose deaths among African Americans in Washington, D.C., despite efforts taken by the local government in 2017 to combat the epidemic through

the expansion of prevention, harm reduction, and treatment services. Thus, other strategies may be necessary to counter the scourge of OU, OUD, and OOD.

One promising avenue for reducing the prevalence and severity of opioid use among D.C. residents is by targeting trauma and expanding trauma-informed care. Trauma is defined as an emotional response to a harmful or threatening event (APA, 2023; SAMHSA, 2014; Structured Clinical Interview for Psychological Disorders [SCID], 2016). Although traumatic exposure is narrowly defined by the DSM-V as "actual or threatened death, serious injury, or sexual violence," and witnessing the pain or terror that trauma survivors have endured (American Counselling Association, 2016; DSM-5-TR, 2022; Figley, 1995), a more inclusive definition of trauma have been more recently proposed by SAMHSA (2012, 2014). This definition asserts that "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012; 2014). This more expansive definition includes experiences such as adverse childhood events (child abuse/neglect; SUD in family), social conditions such economic hardship; intimate partner violence (physical, sexual, psychological abuse), and importantly, historical, and structural trauma (SAMHSA, 2012). It is this broader definition of trauma that we employ throughout the current study.

Responses to traumatic events and/or posttraumatic stress disorder can manifest as re-experiencing the event, avoidance of stimuli associated with the event, emotional numbing, negative (distorted) cognitions, and hyper-arousal (APA, 2013;

Roberts, 2011; SCID, 2016). People experiencing these negative alterations in mood, cognition, and arousal (hypervigilance, irritability, insomnia, etc.) are more likely to cope with these symptoms by self-medicating with substances (Hassan et al., 2017; Khoury et al., 2010; Roberts, 2011; Schacht et al, 2017; van Dam et al., 2010 & 2012). Patients experiencing comorbid post-traumatic stress disorder (PTSD) and OUD experience greater drug use severity and cue-elicited drug craving; they also have poorer SUD treatment outcomes compared to SUD/OUD patients without PTSD (Hassan et al., 2017; van Dam et al., 2010). Less than one-third of patients with co-morbid PTSD-SUD achieve abstinence two years following treatment, and research suggests that an exacerbation of PTSD symptoms may be the most important factor in predicting relapse following substance use treatment (Gielen et al., 2014; Han et al., 2016; van Dam et al., 2010).

Interpersonal trauma, historical trauma, intergenerational trauma, and structural violence are traumatic experiences that are linked to substance use (Danzer et al, 2016; Kirmayer et al., 2014; Sotero, 2006; Williams-Washington & Mills, 2018). Interpersonal trauma is defined as violence and abuse between two or more people where one or more people harms the other(s) (APA, 2024). *Interpersonal trauma* involves traumatic experiences such as emotional abuse/neglect, physical abuse/neglect, and sexual abuse (SA) in childhood and/or adulthood (APA, 2024; Fischer et al, 2016). Common interpersonal trauma experiences such as direct experience of sexual and physical abuse or witnessing the abuse of other people is associated with increased rates of substance use disorder (Cole et al., 2018; Fischer et al, 2016; Gielen et al., 2014; van Dam et al., 2010).

Historical trauma is the cumulative, intergenerational emotional and psychological wounding of a people of a specific ethnicity, race, nationality, religious affiliation due to mass group trauma (Danzer et al, 2016; Ehlers et al., 2022; Brave Heart, 2003; Mutuyimana & Maercker, 2023; Sotero, 2006; Williams-Washington & Mills, 2018). Three important elements of historical trauma often discussed, namely: 1) the cause - collective trauma; 2) the victim, groups that share a similar social, historical, or political background; and 3) the consequence - intergenerational trauma (Evans-Campbell, 2008; Mutuyimana & Maercker, 2023; Sotero, 2006).

There have been multiple acts of historical trauma visited on African Americans, including chattel slavery, mass incarceration, and state violence (Danzer et al., 2016; Williams-Washington & Mills, 2018; Alexander 2012). Historical trauma has both clinical and nonclinical implications; typical clinical consequences include symptoms of mood and trauma-related disorders, and substance use disorder, as well as other physiological and psychological problems. Among those outcomes viewed as non-clinical are discrimination and oppression, learned mistrust, historical thoughts of loss, child and intimate partner violence (Mutuyimana & Maercker, 2023; Williams-Washington & Mills, 2018). Other outcomes associated with historical trauma include higher rates of socioeconomic adversity including poverty and violence, unemployment, lack of access to healthcare (Danzer et al., 2016).

The influence of historical trauma on disease has been explained through three related frameworks (Danzer, 2016; Sotero, 2006). According to psychosocial theory, physical and psychological stressors directly cause and increase susceptibility to disease. The political-economic perspective asserts that political, economic, and

structural inequalities result in disease. Social-ecological systems theory recognizes the multilevel dynamics and interdependences between the past and present, proximate and distal, and life factors that contribute to disease (Danzer, 2016; Sotero, 2006). These frameworks are used for understanding the impact of historical trauma on the traumatized population.

Intergenerational trauma overlaps with historical trauma while being distinct in some ways (Mutuyimana & Maercker, 2023). Firstly, intergenerational trauma relates *to the mechanism of trauma transmission across generations* and related consequences (Evans-Campbell, 2008; Hankerson et al., 2022; Kirmayer et al., 2014; Mutuyimana & Maercker, 2023). Mutuyimana & Maercker (2023) also explain that while historical trauma considers both clinical (e.g., psychological disorders) and nonclinical consequences of trauma (e.g., mistrust), intergenerational trauma focuses on the clinical aspects of trauma that are shared by individuals across familial generations.

The literature demonstrates that intergenerational trauma manifests at multiple levels, including individual, family, and community levels, which though distinct, have significant overlap (Evans-Campbell, 2008; Hankerson et al., 2022; Kirmayer et al., 2014; Mutuyimana & Maercker, 2023). At the individual level, the trauma response often manifests as depression and PTSD, and trauma response symptoms often include helplessness, psychic numbing, and substance use (Brave Heart, 2003; Danzer et al., 2016; Ehlers et al., 2022; Gameon & Skewes, 2021; Garcia, 2020; Menzies, 2010; Sotero, 2006).

In the family context, the relationship between intergenerational trauma and substance use manifests in multiple ways. Intergenerational trauma may result in a direct path to substance use if children replicate the maladaptive trauma coping strategies they observe and/or if familial substance use makes drugs easily accessible. Trauma may also result in an indirect path if children self-medicate to cope with the abuse and neglect that results from the parental trauma response (Kirmayer et al, 2014; Sotero, 2006; Tsering & Pal, 2009; Williams-Washington & Mills, 2018).

Childhood abuse and neglect in the context of intergenerational trauma could also result in child placement in the welfare system (Spector et al, 2021; Bruskas & Tessin, 2013; Hedges, 2012). In the aforementioned study by Jones et al (2023), each increase in parent or grandparent substance use that resulted in female study participant substance use was also associated with 40% increased odds of these women's children being placed in Child Protective Services. For many mothers, the loss of child custody is traumatic and can compound their psychological distress and substance use (Bruskas & Tessin, 2013; Hedges, 2012; Spector et al, 2021). Children may also experience removal from their parents as traumatic and this may increase psychological and substance use problems for them as well (Bruskas & Tessin, 2013; Hedges, 2012).

In this paper, we go further to argue that intergenerational substance use is a form of trauma. This is consistent with SAMHSA's (2012) more expansive definition of trauma that includes substance use within the family, given that such adverse childhood experiences "can have a negative effect on an individual's well-being that often lasts into adulthood." Among the many adverse psychosocial consequences

associated with substance use within family are depression, suicidality, risky sexual behavior, sexual victimization in adulthood, and importantly, alcohol and drug use disorders. So traumatic and deleterious are the consequences of exposing a child to drugs and giving a child drugs that many states have expand their definitions of child abuse to include these issues.

Finally, intergenerational trauma and substance use are evident at the community level. Factors such as displacement may lead to a breakdown of community connectedness, cultural values, and social norms (Evans-Campbell, 2008; Kirmayer et al., 2014; Menzies, 2010; Williams-Washington & Mills, 2018). These are all factors that help confer cultural pride and psychological strength and well-being; their erosion increases risk for substance use (Schultz et al., 2016; Kirmayer et al., 2014; Williams-Washington & Mills, 2018).

Structural violence, alternatively known as social injustice or institutionalized violence, refers to preventable harm caused to people by structures that maintain the unequal distribution of economic resources and power through social factors such as racism, poverty, gender inequality, and political violence (Farmer et al., 2006; Turvey et al., 2023; Weigert, 2008). Consistent with aspects of historical trauma, structural violence is embedded in systems and processes that threaten the health and wellbeing of people; the effect of structural violence tends to manifest as public health issues like physical and mental health disparities, as well as socioeconomic problems like joblessness, homelessness, and incarceration (Scott-Jones et al, 2020; Turvey et al., 2023; Weigert, 2008). When structural violence is directed towards members of a

particular racioethnic group, structural violence is known as structural racism (Bluthenthal, 2020; Sharif et al, 2022).

There is a demonstrable link between substance use disorder and structural violence. In a study of examining factors that impede women's treatment seeking behaviors, researchers found that structural violence manifesting as financial insecurity limited access to treatment options (Spector et al., 2021). Punishment of drug use via imprisonment and custodial removal is also an act of structural violence that is visited on drug users (Spector et al, 2021; Bruskas & Tessin, 2013; Hedges, 2012), and possibly has the effect of creating further substance use problems downstream. Bluthenthal (2021) adds that stigma towards those with SUD has historically precluded those presenting with this condition from employment, education, and housing. A vicious cycle becomes apparent as the same structural factors that could be protective against substance use are the same ones made inaccessible.

African Americans as a racioethnic group experience some of the highest levels of structural racism in the US (Danzer et al., 2018; Hankerson et al., 2022; Olivet et al., 2019; Scott-Jones & Kamara, 2020). This includes the highest rates of homelessness (Hankerson et al., 2022; Olivet et al., 2019); punitive and discriminatory drug laws such as 1973 Rockefeller Laws, 1986 Anti-Drug Abuse Act that enacted harsh sentencing and mass incarceration for the possession and sale of heroin and cocaine (SAMHSA, 2020; Williams-Washington & Mills, 2018; Bluthenthal, 2021, and the 1994 Crime Bill (Alexander, 2010, 2012). Additionally, historical events like the Tuskegee syphilis trials perpetuated mistrust of and

reluctance to participate in the medical system (Williams-Washington & Mills, 2018; Gordon Achebe et al., 2019). Discriminatory lending practices such as redlining excluded African Americans from government-secured loans leading to neighborhood segregation, lower home values, and increased prevalence of community violence and drug distribution and use (Aalbers, 2005; Bluthenthal, 2021; Olivet et al., pp. 58, 2019; Poulson et al., 2021).

Complex trauma is the experience of multiple and/or chronic traumatic events, most often of an interpersonal nature and with early-life onset (Kemmis-Riggs et al., 2022; Williams et al., 2024; SAMHSA, 2014). There is a well-established association between complex trauma and substance use that often first presents in adolescent substance use that persists into adulthood (Cohen & Hien, 2006; Rosenkranz, Muller, & Henderson, 2014). With respect to OUD in particular, complex trauma is linked to a higher craving for opioids and higher risk of OUD (Castellanos et al., 2023). A study by Winiker et al. (2023) assessing barriers to treating trauma among patients with OUD in Baltimore, whose overall opioid using population is very similar geographically and demographically to those in Washington, DC (Gondré-Lewis et al., 2022). The researchers found that a multifaceted trauma history was highly associated with OUD and the primary barrier to treatment. This extensive trauma history included interpersonal, historical, and structural traumas such as racism, police brutality, deaths and murder of significant others, sexual and physical assault, homelessness, among others (Winiker et al., 2023).

The prevalence of these traumas may in some part be attributable to cultural violence. Cultural violence refers to prevailing social norms that render direct

violence (e.g., murder, physical/sexual assault) and structural violence as "natural", "right" or at least acceptable (Harvard Divinity School, n.d.). According to Gauteng (1990), the direct violence of the transatlantic slave trade lives on today as discrimination (massive structural violence) and prejudice (massive cultural violence). By justifying or legitimizing direct or structural violence, direct, structural, and cultural violence are mutually reinforcing.

Our literature review identified several gaps concerning the relationship between OUD and trauma in African Americans. Firstly, though there have been several studies probing the association between interpersonal trauma and OUD, none of the studies included a majority African American sample (Cicero & Ellis, 2017). Secondly, the relationship between historical trauma and opioid use/opioid use disorder among African Americans is conspicuously missing from the literature. Additionally, though there is research examining the relationship between structural violence and substance use, our literature review did not turn up any studies that specifically probed this dynamic among impoverished African Americans (Albers, 2005; Bluthenthal, 2021; Paravantavida, 2023; Sharif et al. 2021; Spector, 2021). The current study will make contributions to filling these gaps.

In addition to a lack of focused investigation on African American samples, there is a need for *qualitative research* to explore the linkage between trauma and OUD in the population of interest. Most studies of this relationship to date examine the quantitative neurobiological underpinnings of the relationship or focus on other vulnerable groups such as pregnant women (Huhn & Dunn, 2020; Elman & Borsook, 2019; Somer, 2019; Danovitch, 2016). A systematic review of seventeen qualitative

studies examining the relationship between trauma and OUD (Cicero & Ellis, 2017) captures the perspective of people who use drugs and a few subsequent studies have included providers and clinicians in training (Kapadia et al., 2021; Lewis and Jarvis, 2019; Click et al., 2018). We believe that probing community leaders' views on this relationship may provide additional key insight as they can marshal efforts around important causes, including expansion of culturally responsive and effective approaches which may help to stem opioid overdose deaths (Nunn et al., 2015; Lantz et al., 2001).

Current study

Given the gaps in current research, this study aimed to explore community leaders' and clinicians' perspectives on the association between trauma, OU, and OUD for African Americans experiencing problematic opioid use in Washington, D.C.

Our specific aims are to explore:

1) How do interpersonal, historical, intergenerational traumas and structural violence contribute to OU and OUD?

2) How do interpersonal trauma, historical trauma, intergenerational trauma, and structural violence interact to contribute to OU and OUD?

We hope the findings will inform a more robust, effective, and trauma-informed strategy to combat the scourge of opioid use disorder in Washington D.C., and in comparable settings.

Chapter 2: Methods

Setting

This sub-study was embedded within a larger formative evaluation project conducted by the Howard University Department of Psychiatry. This was to identify barriers and facilitators to engagement with medication for opioid use disorder (MOUD) treatment in Washington, D.C. Guided by principles of community based participatory research (CBPR) which calls for the involvement of community members to collaborate on all aspects of the project (National Institute on Minority Health & Health Disparities, 2024) the parent study was conducted in conjunction with community partners and a Community Advisory Board (CAB) composed of people who reside and work in Wards 7 & 8 of Washington, D.C., the neighborhoods hit hardest by opioid overdose deaths.

Including focus group and individual interviews, a total of 117 individuals were interviewed in the parent study. The parent study involved clinicians (*n*=57), community leaders (*n*=20), people with lived experience of OUD (*n*=31) (both those in and not in treatment), and friends and family of people with OUD (*n*=9). Clinicians, administrators, and patients in treatment for OUD were sampled from three federally qualified health centers (FQHC) in Wards 7 and 8 that primarily serve low-income community members. The FQHCs are part of a wider network of such facilities throughout the city. The community advisory board (elaborated on below) was instrumental in referring community leaders as well as people with experience of OUD who were not engaged in treatment during the study period. The parent study

began in August 2019, after being approved by the Howard University Institutional Review Board. Data were collected between August 2019 and November 2021. The current study examines responses from a subsample of participants from the larger study, constituting i) clinicians (*n*=57) and ii) community leaders (*n*=21). This smaller sample consisting of these respondent groups were chosen because they spoke to the relationship between trauma and OUD.

Community Advisory Board

As part of the initial activities for the proposed project and part of our initial outreach and engagement strategy, a Community Advisory Board (CAB) was established. This body was composed of residents and people working in the neighborhoods of interest, who were also representative of the segments of informants who were interviewed throughout the study. Members of the CAB included community leaders, clinicians and providers involved in the treatment of OUD, persons with lived experience of OUD, and their friends and families.

The CAB played a critical role throughout the project in informing the research goals, objectives, and methods. They met once per month and advised on recruitment strategies, the scope of the project, and the framing and phrasing of interview questions. Consistent with the principles and evidence-based benefits of community-based participatory research, this approach was selected based on greatest likelihood of garnering community support and leading to sustainable programs, services, and continuing clinical research with the engagement of a CAB (Israel 1998; Jagosh 2012; Macaulay 2017; O'Toole 2003; Porter 2016; Schulz 1998; Viswanathan 2004; Wallerstein 2010).

Recruitment and Sample

Snowball sampling methods were instrumental to participant recruitment, and the CAB was active in identifying community leaders in the neighborhoods of interest. Clinicians at the health care center tended to be referred by their supervisors or peers. As indicated above, the current study examines responses from i) clinicians (*n*=57) and ii) community leaders (*n*=20). Among the clinicians, 26 were interviewed in focus groups, while the other 31 were interviewed individually. They included medication for opioid use disorder (MOUD) providers (including physicians and nurse practitioners; *n*=22), behavioral health specialists (*n*=10), support nursing staff (*n*=4), medical assistants (*n*=10), and care coordinators (*n*=5). Among the community leaders were business leaders (*n*=4), faith leaders (n=10), heads of community/health service organizations (n=7), and local government leaders (n=3).

Using secondary analysis, the current study focused on the clinician and community leader perspectives (*N*=78) given the paucity of these in prior research and our belief that these two groups could provide unique perspectives given their roles in promoting community mobilization and policy change in advancing health equity (Nunn et al., 2015; O'Kane et al., 2021).

Procedures

In-depth semi-structured interviews and focus groups lasted 60 minutes on average and were conducted by trained research assistant(s). The interview guide included open-ended questions that solicited respondents' knowledge of and attitudes to OUD and medications for opioid use disorder (MOUD), and their suggestions for

addressing OUD in the community [see appendix A for interview guide]. We used preliminary interview data to adapt questions iteratively. Each interview was audio recorded (either in person via Olympus WS-852 Digital Voice Recorder or virtually on Zoom), transcribed verbatim, and reviewed, for accuracy.

Interview Guide

For both community leaders and clinicians, the interview guide broadly probed respondent's views on drug problems in the community, the effect of opioid drugs in the community, their views on people who use opioids, their knowledge and attitudes on treatments opioid use disorder, with a particular focus on for medications for opioid use disorder (MOUD); their recommendations for increasing treatment outreach, access, and uptake of treatment.

In addition to these, clinicians were asked about their role in treating patients with OUD, methods to identify patients with OUD, OUD treatment operationalized in clinical settings, and ideas for optimizing clinical treatment. The research team solicited community leaders' roles in the community, their more global views on both the biggest strengths and problems in the community, and their views on the most pressing substance use problems within the community.

Trauma was *not* explicitly probed in the interview guide, as it was not a main aim of the parent study. However, it emerged organically, especially in response to the following questions: "How do you view people who use opioids?", "How do others in your community view people who use opioids?", "What are effective ways to engage people with OUD in treatment?". Multiple respondents associated trauma, with the etiology and prevalence of OUD. On this basis, researchers pursued this

secondary analysis to further understand how residents describe the association between trauma and OUD in Washington, DC.

Data Analysis

Our overall methodological approach was guided by thematic analysis (Braun & Clark, 2006). This approach allows for the identification, analysis and reporting of themes within the data and facilitates a more holistic, accurate and nuanced understanding of a given topic (Boyatzis, 1998; Nicholls et al., 2022). The hybrid method includes inductive and deductive approaches to coding, which is appropriate when one has a priori explanatory model but also wants to avoid missing any new information that may arise organically from the data (Fereday & Muir-Cochrane, 2006; Roberts et al., 2019).

Given that the topic of trauma was not directly probed by the interview guide, the research team initially used a combined inductive/deductive approach, allowing for data driven themes to emerge directly from responses as well as identifying certain established relationships between trauma and OUD by searching for certain keywords (eg. “violence/abuse”, “molestation”, “poverty”) (Fereday & Muir-Cochrane E, 2006; Forman & Damschroder, 2007; Hseih et al., 2005; Morgan et al. 1993; Roberts et al., 2019). Through rapid coding, a method used to analyze data on a shorter time frame (Gayle et al., 2019; Lewinski et al., 2021), we identified recurrent themes around “mental health/illness”, “psychiatry”, “psychology”, “oppression”, and “(inter)generational trauma.” By randomly selecting four interviews, two (2) from each respondent category, researchers used these inductive and deductive key terms to conduct textual analysis to further probe respondent

perspectives on how these themes related to OUD. Researchers also continued to inductively search for any other themes related to trauma that fell outside of our preliminary key phrases and iteratively added them to the codebook (Boyatzis, 1998). Based on these observations, a preliminary codebook was created that reflected these initial themes and their definitions, elucidating participants' perspectives on the relationship between trauma and OUD, including perspectives on historical trauma, physical/sexual trauma, and the trauma of desperation/deprivation. Subsequently, two interviews were selected at random and independently coded by each of the three members of the research team using this initial codebook. The team then reconvened to discuss and resolve discrepancies and revise the codebook, modifying and adding new codes as necessary. Using this finalized version of the codebook, two coders analyzed each interview using NVivo. To optimize the reliability within the 3-member coding team, every fifth interview was also reviewed by a third coder who acted as an arbiter to resolve discrepancies between the original two coders, as needed. Upon completion of the coding process, thematic analysis was used to assess the relationships between codes and to identify cross-cutting themes (Braun & Clarke, 2006). The findings from these analyses are expounded on below.

Chapter 3: Results

The majority of interviews were conducted with clinicians (n = 57, 74.0%). Demographic data was missing for 12 of these participants, and for the 45 for whom this data was reported, 68.4% were within ages 31-45 years, 52.7% (n=30) were African American, and 57.9% were female (n=33). Among the 21 community leaders

interviewed, data was missing for four. 33.3% (n = 7) were 46-60 years old, 76.2% (16) were African American, and 66.6% were male.

This study uncovered four major themes related to clinicians' and community leaders' perspectives on the relationship between trauma and opioid use/OUD in Washington DC, namely: 1) OUD develops as a coping mechanism for escaping the psychological trauma associated with untreated interpersonal trauma and structural violence; 2) Historical trauma makes people less likely to engage in help-seeking behavior for their traumatic victimization because they are mistrustful of the healthcare and law enforcement systems; and 3) Structural violence, and interactive effects between structural violence and different types of traumas contribute to OU and OUD. In what follows, we will elucidate each of these themes.

Theme 1: OUD in an escape mechanism for coping with interpersonal trauma and structural violence

Respondents reported OUD may either be caused or prolonged by people turning to drugs as a means of self-medicating for symptoms of psychological trauma associated with interpersonal trauma and structural violence. The interpersonal traumas span a host of events, including sexual and physical assault, childhood abuse and neglect, among others. Structural violence is mainly reflected in socioeconomic deprivation like homelessness, unemployment, and poverty.

Escaping interpersonal trauma

Multiple respondents expressed that people used opioids to escape or cope with lingering psychological wounds, especially in the absence of other more

adaptive outlets. One community leader, when asked to describe the population of people that use opioids, remarked that:

> *"For me, I would probably describe it as someone who's been through something very traumatizing in their life or detrimental to their life to the point where they feel like using drugs is probably the only way that they can overcome their problem… A lot of time, if someone [with OUD] then talked about what happened to them that traumatized them, a lot of times, it kind of changed their life. A lot of times, these people don't have no outlet, so the only thing they do is what they been doing. They might want to turn to a drug."*
>
> - Community leader, Community/opioid treatment program organization

Another community leader shared a similar perspective about people using opioids to escape pain and trauma:

> *"So that's a coping mechanism in order for us to deal with the pain or to escape the thoughts of the abuse, neglect, the rape, the molestation, or whatever else it is that we had had in our lives."*
>
> - Community leader, social support service organization

Clinicians also expressed that opioids were used to cope with psychological trauma which was often associated with childhood adverse experiences including abuse and neglect. For instance, one clinician shared that:

> *"I'm definitely not a therapist, but I'd find myself doing a lot of therapy in my visits. I'm learning about patients who finally are revealing that they have issues of child abuse. And this is when they started using."*

- MOUD provider

This same provider goes on to add that for some of these patients who experienced childhood sexual abuse, they were also abused by those within the healthcare system who should have provided them care:

> *"I'm learning about patient who finally are revealing that they have issues of child abuse…. and though the and then fear oy [have] seen other providers, that was never mentioned. And it's coming out [they have a] fear of doing one-on-one counselling, because their therapists even though they went to the therapist for child abuse, started abusing them."*

Escaping the hopelessness of economic desperation

Respondents also shared that structural violence creates conditions of destitution that lead people to OU and OUD as a means of coping with their harsh realities. Several respondents opined as to how rampant poverty, joblessness, and a sense of hopelessness around these factors may drive people to use opioids. One community leader aptly summed up this sentiment below:

> *"So I feel because of the stress, because of the plight of a lot of oppression of our people in our neighborhoods, that some feel that they can't handle the poverty that they're dealing with, the issues that they're dealing with and mentally have decided to check out ... There's no jobs, or there's not enough jobs so guys and young ladies are hanging out and trying to escape. There are not enough opportunities for success in our community, so they use the drugs to escape."*

- Business leader

Another provider commented that imprisonment for drug use makes it especially challenging for them to find employment upon their return to the community. Desperation of unemployability increases the likelihood of drug use as an escape mechanism and or drug sale as a means of economic survival, thereby perpetuating OU and OUD:

> *"[The] legal system continues to interact with our patients still treating [opioid use] like a criminal issue… We have some [formerly incarcerated] guys that I'm trying to get to work. It's hard for me to get [them] a job, and if [they're] feeling discouraged, there's temptation to go back out to the streets to sell or just want to use because they get discouraged."*

- Mental health provider

Some interviewees suggested that desperation due to chronic or acute housing and food insecurity may lead people to start or resume opioid use. One provider opined that trauma resulting from disruptions to employment and housing may influence substance use:

> *"I think, if you have a history of substance abuse, and you have anything delicate in your world thrown off, like you lose your housing security, or you have no source of income, or you have any other kind of like traumatic life event occur, that it makes it that much more challenging to try and stay sober, because it's the coping mechanism that people are used to turning to. It's how they found relief and comfort from all the tragedies that life throws at them on a regular basis."*

- MOUD Provider

Finally, another provider suggested that patients with opioid use disorder may persist with or be reluctant to seek treatment for opioid use because they view their basic needs and socioeconomic circumstances as more pressing and prioritize those:

> *"But then they are like, 'You know, at this point of time in my life, there are things I'm more worried about than this drug affecting my life.' ... There's poverty, there's all of these other, income inequality, and all these things contribute as well. 'Where am I going to get the next meal for the day?' or stuff like that. So that's why they're more worried about those things."*

- MOUD provider

The themes above elucidate respondents' views on the discrete and direct relationships between OU/OUD and interpersonal trauma. Throughout much of the data though, participants highlighted other mechanisms through which trauma, acting both indirectly and synergistically with other traumas, contribute to and exacerbate opioid use and opioid use disorder within DC communities. Themes relating to these indirect and syndemic, or mutually exacerbating, relationships between trauma and OUD are detailed below.

Theme 2: OUD develops and is maintained through intergenerational trauma

Respondents highlighted that intergenerational trauma, manifesting as substance use exposure and transmission across familial generations, was one way in which OUD was perpetuated among families in Washington DC. Family members, likely using opioids as a form of their own trauma response, transmit opioid use to their younger

family members. A provider shared that one of his patients was directly introduced to opioids by his parents:

> *"I had a patient, like a mid 30-year-old, fairly young male, wanted to do Suboxone, and I kind of asked like, 'So how long have you been using this heroin?' And he said, like since he was probably 15 or 16. 'Like, how did you start doing it?' And he's like, 'Well, my parents actually gave it to me.' He didn't have any chance, right?"*
>
> - MOUD provider

Community leaders also shared the perspective that OUD is perpetuated by learnt behavior for children who grow up in families who use drugs:

> *"Many of them was introduced to drugs, first and foremost, by observation or perhaps an older sibling, a cousin or uncle or auntie, perhaps even parents or grandparents. And so many of them believe early on in life that, 'Because my mama or daddy do it, I'm entitled to do it as well.' And what we find out once we get ourselves involved in the substance use, we find out that it is very quickly habit-forming… once you cross a certain invisible line, you could easily put yourself beyond."*
>
> - Community leader, community service organization

For the most part, the themes above elucidate respondents' views on the discrete relationships between OU/OUD and 1) interpersonal and 2) intergenerational trauma. Throughout much of the data though, participants suggested that multiple levels of trauma act synergistically to exacerbate opioid use and opioid use disorder within DC

communities. Themes relating to the syndemic, or mutually exacerbating, relationships between different traumas are detailed below.

Theme 3: Historical Trauma and OUD

Historical trauma manifesting as cultural mistrust of medical and law enforcement systems also leads to the perpetuation of trauma, and by extension - OUD. Respondents suggested that people do not report or get treatment for interpersonal trauma from these institutions; left untreated, traumatic symptoms may worsen, and individuals may resort to drugs as a coping mechanism or outlet for their unresolved trauma. The following community leader elaborated on these ideas below, additionally suggesting that people may be threatened by violence from the community if they report trauma.

> *"And when you are outside on the porch, whatever happens around this community stays in this community, snitches get stitches. That's right. You know, so a lot of times us as a community, as a whole, we just don't have a[n] outlet, you know, for the frustration that we have built up for all the trauma that we seen in life, all the detrimental things that we've probably been through in life."*
>
> - Community leader, community service organization

In explaining the link between cultural mistrust, experiences of trauma, and OUD, one community leader explained how community members rejected psychotherapy for themselves and viewed them as only appropriate for "outsiders".

"So, for us we tie [OUD] all together with how people are coping with trauma… Now the interesting thing is if you ask someone upfront, 'Do you think it's okay to have a counselor?' They'd be like, 'No, man, I ain't really talking about it. That's for those other people, those invaders who are coming into our community. That's what they do, but we don't need it ourself.'

- Community leader, community service organization

Theme 4: Structural violence, its interaction with other traumas, and OUD

Structural violence and intergenerational OU

Structural violence was at play in intergenerational opioid use because respondents expressed that it was the prevalence and normalization of opioid use, especially in socioeconomically disadvantaged families and communities, that caused youth to be susceptible to drug use. One community leader shared that intergenerational substance use is not uncommon, especially among impoverished families in Washington D.C.:

"So, you are born into things like this. It is not foreign to you because just about everyone has an addictive person in their families, especially if you're living below the poverty line… My mother died of a drug overdose… I have a son who's actively using drugs right now."

- *Community leader, community service organization*

Extending from family substance use, drug use also becomes normalized within the broader community context. The same community leader asserted that

opioid use is so commonplace that residents have become desensitized to opioid use; this respondent poignantly comments that:

> *"So, in this particular community, nothing is being said, because this has been the way of life for years in areas like this. This has been a way of life. So, it's like grass. You see it, it's there every day, you just walk over it. You know what it is, right? So, it's nothing foreign to you."*
>
> - Community leader, social support service organization

In offering some potential insight into why opioid use is normalized, a business leader highlighted that heroin use was an entrenched and longstanding problem in African American communities in Washington, DC:

> *"[Compared to other opioids] I would say that I've seen more heroin concern and that's been that way for a very long time. I've never not heard of a time when heroin was not a concern to be a hundred percent honest."*
>
> - Business leader

Structural violence and historical trauma

Some community leaders believe that opioids were introduced, and are maintained within African American communities, a manifestation of current day economic structural violence that has its origins in the historical traumas of slavery. Implicit in these perspectives are also ideas about cultural mistrust. A religious leader summed up these sentiments below:

> *"When you look at where it's happening, it's generally happening among black and brown people. That's the legacy of slavery. It's keeping those who are the descendants of enslaved people, it's keeping them at a point where*

they cannot thrive. It basically keeps them enslaved, albeit the master has changed, but they're still enslaved. To some degree the master has not changed necessarily, because the one that provides and makes the drugs accessible but not food accessible, is still the master."

- Business leader

For some, not only are opioids introduced to stagnate the social and economic growth of African American communities, but also for the financial benefit of institutions. One community leader expresses distrust towards the entities that make medically indicated opiates (like morphine), and asserts that due to profit motives, these same companies make the illicit street opioids that cause people to develop opioid use disorder.

"Too many people for too long are invested in the money, which comes from the treatment industrial complex and the pharmaceutical industrial complex. Yes, I said pharmaceutical industrial complex. The same Chinese chemists that get the opium from Afghanistan and Southeast Asia and turn it into morphine base [are] the same Chinese chemists that worked for the pharmaceutical companies in China and in the South of France. [These] are the same ones that refine heroin into number one, two, three, and four China white, China rock."

- Community leader, community service organization

Structural violence and psychological trauma

The traumatic effects of structural violence are evident in the punitive approaches to drug control. Two clinicians commented that the punishment for drug use, namely incarceration and child custody loss, further traumatizes already vulnerable individuals and frustrates efforts at sobriety. This in turn perpetuates OUD. A clinician reported that:

> *"And this particular patient is extremely vulnerable. He's extremely depressed. So expecting him to be clean, right now, just isn't feasible. [He said] the judge is like, 'I'm sorry, if you get one more dirty urine, we're going to lock [you] back up.' I feel like it frustrates the process of someone getting to sobriety. [Because] what we're going to do is lock him up for having a health issue for being depressed, [he's] going to experience more trauma in jail and feel more like a loser. I don't see how that's helping*."

- Mental health provider

Another clinician highlighted how the removal of children from families due to substance use traumatizes parents and perpetuates opioid use:

> "*One mom in particular, she is schizophrenic. And one way that she was dealing with her schizophrenia was to self-medicate with drugs… [She had] six children, all of whom were taken. And so that contributes to her drug abuse…because she lost her children because of her mental health problems."*

- Nurse manager

Chapter 4: Discussion

This research set out to shed light on the ways in which interpersonal trauma, historical trauma, intergenerational trauma, and structural violence contribute to OU and OUD in Washington, DC. This is the first known study to explore these issues qualitatively. Among the most important takeaways were that people tend to turn to opioids to cope with psychological trauma resulting from interpersonal trauma and structural violence**.** Historical trauma acts on interpersonal trauma to reduce help-seeking behavior for both trauma and OUD, thereby perpetuating OU and OUD**.** Finally, we also found that structural violence interacts with historical and psychological, and intergenerational traumas to exacerbate and/or perpetuate trauma, OU, and OUD in DC. These ideas are reflected in Figure 1 of the Appendices.

At the level of interpersonal trauma, the data demonstrate that people turn to opioids as a means of coping with unresolved psychological trauma. This is consistent with literature that demonstrates that people who have experienced trauma may develop negative changes in their cognitions, mood, and levels of arousal and may self-medicate to alleviate these symptoms (Hassan et al., 2017; Khoury et al., 2010; Roberts, 2011; Schacht et al, 2017; van Dam et al., 2010 & 2012). Given the syndemic interactions between structural violence and interpersonal trauma, African Americans who are economically disadvantaged and interpersonally traumatized are at increased risk of psychological maladjustment, use less effective coping styles, and experience lower levels of social support and professional help seeking, all of which increases the likelihood of their substance use (Danzer et al, 2016; Graves et al., 2010; SAMHSA, 2014; Stevens-Watkins et al., 2014).

We also found that learned mistrust, a facet of historical trauma, interacted with interpersonal trauma to compound the effects of the latter. Because the African American community is skeptical of medical, law-enforcement and government authorities (Ganz et al, 2018; SAMHSA, 2020; Williams-Washington & Mills, 2018), they fail the report and seek help for traumatic experiences and problematic opioid use. This in turn results in opioid use when they use drugs as a coping mechanism for untreated trauma, and/or exacerbates preexisting opioid use (Graves et al., 2010; SAMHSA, 2020).

Respondents also highlighted the syndemic relationship between structural violence and other traumas that exacerbate OU and OUD. Structural violence in the form of poverty and commonplace, untreated opioid use within the community contribute to cycles of intergenerational trauma-mediated substance use. Structural violence evidenced by the criminalization of substance use further traumatizes individuals and increases their substance use. Study participants also perceived that the historical trauma of social and economic subjugation that began in slavery is currently perpetuated via structural factors; academic institutions failing to eradicate OUD within communities and pharmaceutical companies contributing to OUD for profit motives are acts of structural violence.

The view that the socioeconomic legacy of historical trauma lives on through acts of structural violence is one that is addressed by researchers such as Kirmayer et al. (2014) and Scott-Jones & Kamara (2020). Both assert that while historical trauma contributes to deleterious psychological, social, and economic outcomes, there are more proximal causes of current adversity - namely, structural factors (Kirmayer et

al., 2014; Scott-Jones & Kamara, 2020). Thus, structural violence helps account for why populations that have suffered historical traumas continue to experience disproportionately high rates of socioeconomic hardship and health disparities (Farmer et al., 2006; Danzer et al, 2018; Hankerson et al, 2022; Hedges, 2012; Kirmayer et al., 2014; Scott-Jones & Kamara, 2020).

Relatedly, another important contribution of this research is to add to the growing body of literature that establishes the traumatic effects of structural violence. Scott-Jones & Kamara (2020) unequivocally assert that structural violence creates trauma, and data from this study provides overwhelming evidence for this claim. The finding that structural violence plays a major role in OU and OUD among African Americans in Washington, DC is consistent with research highlighting that the most underserved and impoverished neighborhoods in the city are those hardest hit by OUD (DC OCME, 2023; DC DBH, 2019). According to Ganz et al. (2018), Wards 7&8 are "emblematic of distressed, isolated, and historically disadvantaged communities in cities across the United States" (pp.1-2). Neighborhoods in these wards have the highest rates of chronic community and gun violence; data published by the DC Policy Center (Din, 2021) reflected vast disparities in the exposure to homicide within a half mile in 2021. While some affluent neighborhoods had little to no exposure, communities in Wards 7 and 8 recorded between 6 and 30 homicides within a half (Din, 2021). Not surprisingly, some of this community and gun violence is directly attributable to drug-related turf wars (Metropolitan Police, Washington DC 2023; National Drug Intelligence Center, 2002). In the poorest of these neighborhoods, 14% of children were victims or witnesses of neighborhood violence,

compared to 6.8% of their peers nationally (Brann, 2023; Din, 2021). Exposure to such violence can produce traumatic symptoms including anxiety, emotional dysregulation, and the development of full-blown PTSD.

In addition to elevated rates of community violence, residents of these neighborhoods experience staggering rates of poverty, unemployment, homelessness, food insecurity, and reduced access to physical and mental health care (Brann, 2023; DC Hunger Solutions, 2021; DC Policy Center, 2018; King et al., 2022; Open Data D.C., n.d.; Ganz et al., 2018; Scully, 2022; Smith, 2022); these factors are known correlates of adverse psychosocial outcomes, substance use and community violence being primary among them (Bluthenthal, 2021; Kirmayer, 2014; SAMHSA, 2020; Spector et al, 2021). The fact that residents of these neighborhoods are over 90% African American means that these communities are disproportionately plagued by these problems. (DC Policy Center, 2018; Open Data D.C., n.d.; Ganz et al., 2018; Scully, 2022; Smith, 2022; Wild, 2022).

Data from this study additionally reveals that trauma exists at the individual (interpersonal trauma), family and community (intergenerational trauma), and broader social and economic levels (structural and historical trauma). On the one hand, trauma influences opioid use and opioid use disorder via discrete mechanisms involving interpersonal trauma and intergenerational trauma. Trauma and OUD are also related through more complex, syndemic interactions between interpersonal and intergenerational trauma, historical trauma and structural violence which not only exacerbate each other's effects (Danzer et al, 2016; Sotero, 2006; Williams-Washington & Mills, 2018). Given the interaction between the traumas, they can be

viewed as existing via overlapping levels. This is consistent with the social-ecological model, which considers the complex interplay between individuals, relationships, community, and societal factors, as well as past and present and life course factors that contribute to disease (Dahlberg & Krug, 2002; Evans-Campbell, 2008; Danzer et al., 2016; Sotero, 2006). A diagram representing the social ecological model for trauma and OU and OUD in DC is provided in Figure 2 of the Appendices.

Findings on syndemic trauma effects are demonstrative of complex traumas that DC residents experience. The data reflect that DC residents experience complex trauma such as interpersonal trauma of childhood sexual assault that is compounded by cultural mistrust that dictate that they not report these traumas to the authorities; or instances where children, seeking care for sexual abuse are also abused by those who should be providing care to them. Consistent with the literature, our findings suggest that complex trauma contributes to OUD for Washington, DC residents.

Additionally, findings also highlight the potential role of cultural violence in the perpetuation of OUD in Washington, DC. According to Gauteng, cultural violence are those aspects of culture that legitimize direct and/or structural violence (Harvard Divinity School, n.d.; Gauteng, 1990). Opioid use among African Americans, and African Americans in DC has been a problem for decades. In 2017, as more White rural and suburban individuals died from OOD, an opioid epidemic was declared a national public health emergency, and generated significant federal and state funding for prevention, treatment, and recovery services (SAMHSA, 2020). By contrast, as African Americans primarily died of OOD in the decades including and after the 1980s, a war on drugs was declared, resulting in the criminalization of

drug use and possession and the mass incarceration of African American individuals (Hansen et al., 2020; SAMHSA, 2020). We can use the lens of cultural violence to also understand how structural violence, such as closure and inaccessibility of OUD treatment facilities, rampant poverty that perpetuates cycles of substance use, persisted in these African American communities. It also explains why in these neighborhoods, residents were resigned to opioid use; it was so ubiquitous and normalized that it was "like grass" (community leader, social support service organization).

In considering strengths of our study, this analysis employs qualitative methods to explore the association between trauma and OUD. We had a large sample size that reflected viewpoints of two groups of stakeholders. Due to inherent qualities of the data itself, as well as the collection and analysis processes, the knowledge gained through qualitative inquiries is informative, rich and promotes a more comprehensive understanding compared to facts garnered from quantitative research (Tewksbury, 2009). Qualitative data offers a unique means of understanding topics of interests because researchers are attempting to make sense of phenomena in terms of the meaning that people put to them, focusing on the "what, how, when, and where of a thing – its essence and ambience" (Tewksbury, 2009; Jones, 1995). Though the aims evaluated in this study were not primary to the parent study, during preliminary rapid analyses rich themes emerged organically around how clinicians and community leaders observe trauma and its relationship to OUD outcomes, providing a novel opportunity to explore these relationships in this study. That trauma emerged

from interviews that did not probe the topic speaks to the perceived importance of trauma as a contributing factor for OU, OUD and OOD in Washington, DC.

Limitations and future directions

There are a few noteworthy design considerations and limitations that we would like to highlight. Firstly, though the parent study involved multiple informants, this analysis is limited to two groups of respondents, namely the community leaders and clinicians. The fact that people with lived experience of OUD shared limited information about the association between trauma and PTSD could be indicative of several possibilities. It may be the case that clinicians and community leaders tend to have more exposure to psychoeducation and are able to bring this particular perspective to the experiences of people living with OUD (Back et al., 2010; Najavits, 2015; Torchalla et al., 2012). Relatedly, among our sample of people with OUD, some may not have insight into underlying factors contributing to their condition (Khoury et al., 2010; Maremmani et al., 2012). Most importantly, this finding could be an artifact of this secondary analysis method, in that people with OUD may have elaborated on the issue of trauma had they been probed more directly on it (Hinds, 2018; Moore, 2022; Sherif, 2018). Given that the parent study included interviews with individuals with lived experience of OUD, an important next step would be to review these interviews in more detail for themes related to trauma and OUD. Additionally, future qualitative studies should be conducted with people with OUD to directly inquire into trauma's contributions to their substance use to provide an even richer understanding of this relationship from different perspectives.

During interviews, some respondents also provided insight into how other mental illness problems, like depression and schizophrenia contributed to OUD. Similarly, during interviews, data was also shared about trauma's contribution to other substance use disorders, most notably, cannabis. These relationships were outside the scope of our current inquiry but could be pursued in future studies. Relatedly, while our findings speak to Wards 7 & 8 broadly, there may be neighborhood specific differences in trauma exposure and drug use within certain neighborhoods within these broader geographical subdivisions (Metropolitan Police, Washington DC 2023; Our Healthy DC, n.d.). In certain communities within these wards, other drugs may be more prevalent than opioids, and as such, future studies could aim for more specificity in understanding the geographical distribution of trauma and related OU, OUD, OOD.

Though current trends reflect that people currently developing OUD are younger and often experience injury, chronic pain, prescription opioids (Live.Long.DC, n.d.) as their entry point into substance use disorder, our data did not. Historically in DC the majority of those affected by OU and OUD have been adults between the ages of 40-69 years old who started using opioids before the widespread prescription opioid problems emerged in the 1990s and 2000s (Live.Long.DC, 2019). From 2016 to 2020, 76% of all opioid overdose deaths occurred among adults between the ages of 40–69 years old, with people in the age group 50–59 (35%) experiencing the most fatalities; this trend seems to have persisted in more recent years, with this age group compromising 72% of all opioid fatal overdoses as of 2023 (DC OCME, 2014; Live.Long.DC, 2019). Our data also did not reveal a peer

influence on the relationship between trauma and opioid use, but future studies could probe these relationships.

Similarly, the COVID-19 pandemic shelter-in-place mandates resulted in disrupted access to treatment, limited social support, economic stress, and increased isolation and an increase in mental health symptoms such as depression and anxiety (Abramson, 2021; Gondré-Lewis et al., 2022). These factors exacerbated substance use, and there was a sharp rise in OUD and OOD (Abramson, 2021; Gomes et al., 2023; Gondré-Lewis et al., 2022). A substantial number of interviews were conducted before COVID lockdowns, and even for those conducted subsequently, COVID did not emerge as a theme that significantly affected the relationship between trauma, OU, OUD, and OOD. This is a direction that future studies could pursue.

Demographic data was also missing for 12 of 57 clinicians and 4 of 21 community leaders due to an administrative oversight, but we think it is safe to assume that those data were confident with those that were captured.

Conclusions

Our findings suggest that multiple levels of trauma - including interpersonal, intergenerational, and historical trauma, as well as structural violence are important factors that contribute to and/or synergistically exacerbate OU and OUD in Washington, DC. Thus, to effectively address OU and OUD among African American DC residents, efforts should be taken to address these underlying traumas. These efforts could include increasing awareness about the relationships between trauma and OUD, increasing access to treatment for both trauma and OUD, and

importantly, dismantling these oppressive structures that perpetuate these traumas in the first place. Additionally, collective and affirming approaches may facilitate healing and resilience may prove useful. Future research should be conducted to develop and evaluate the effectiveness of these strategies in reducing OU and OUD.

Tables

Table 1. Demographics of study respondents (N=78)

	Clinicians	Community Leaders
n	57	21
Age (range, %)		
31-45	39 (68.4)	4 (19.1)
46-60	5 (8.8)	7 (33.3)
60+	1 (1.7)	6 (28.5)
Missing	12 (21.1)	4 (19.1)
Race (n, %)		
Black	30 (52.6)	16 (76.2)
Other (White, Asian)	15 (26.3)	1 (4.8)
Missing	12 (21.1)	4 (19.1)
Hispanic	2 (3.5)	0 (0)
Gender (n, %)		
Female	33 (57.9)	7 (33.3)
Male	12 (21.1)	14 (66.6)
Missing	12 (21.1)	0 (0)

Figures

Figure 1: Interacting Levels of Trauma and their contributions to opioid use and opioid use disorder

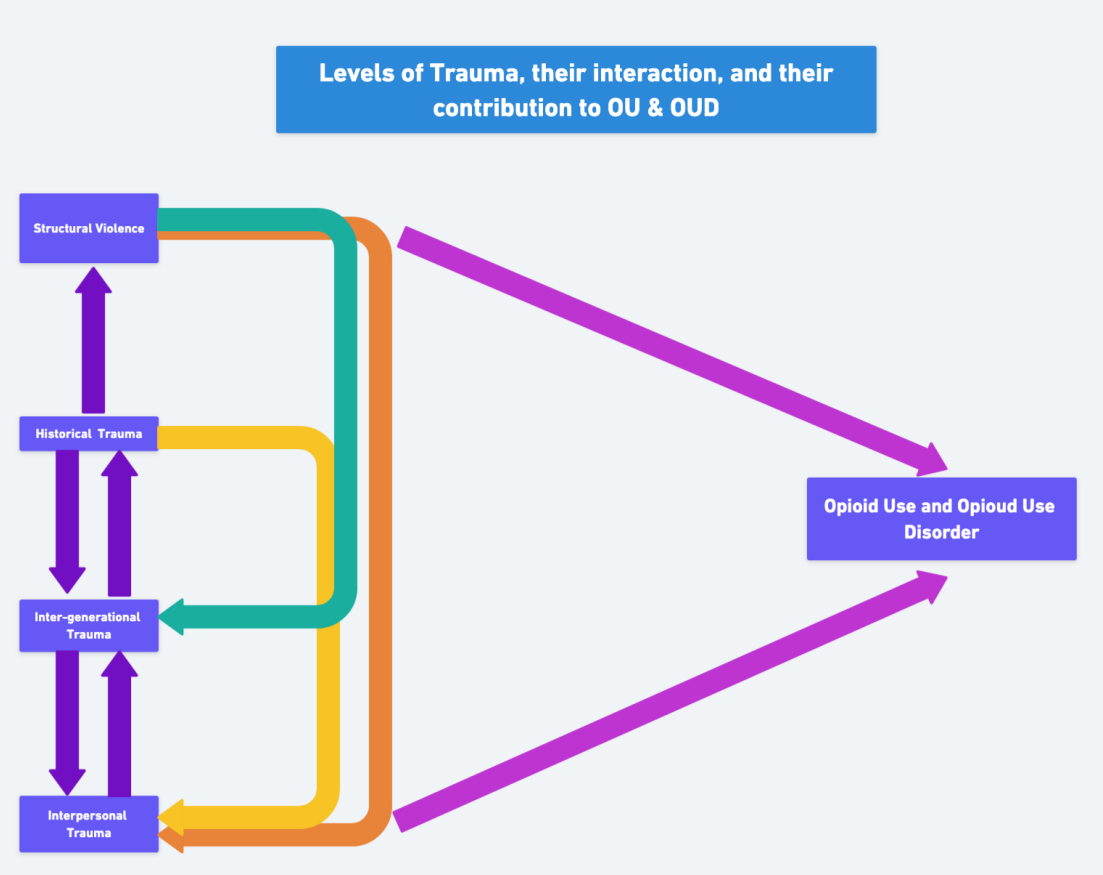
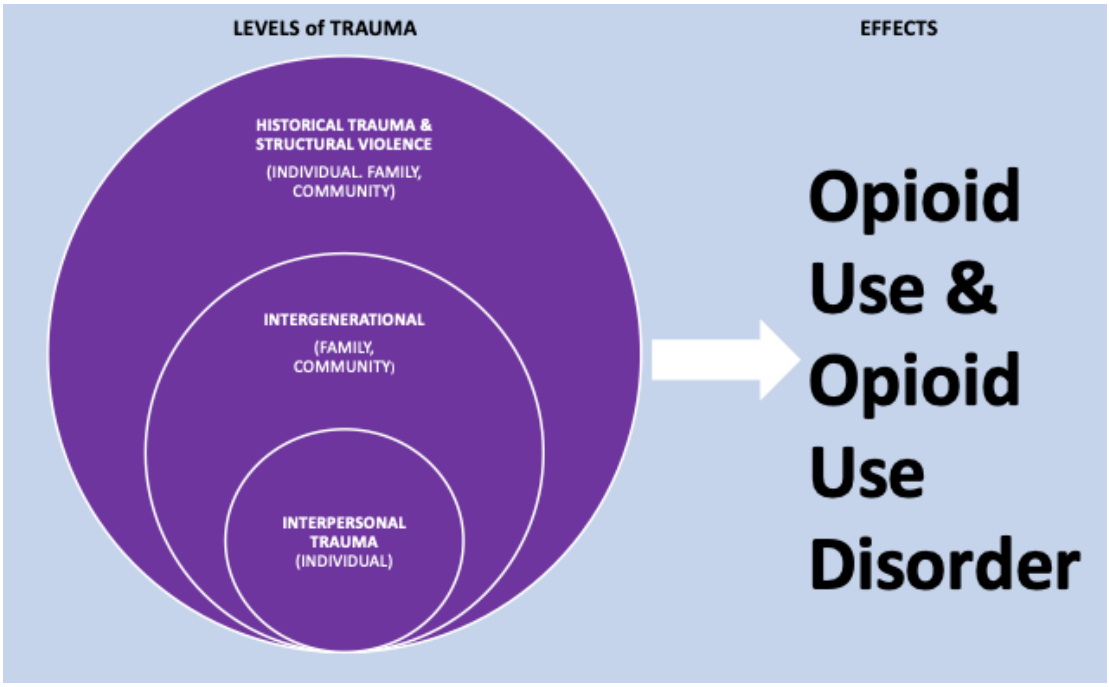


Figure 2: Overlapping Levels of Trauma from the perspective of the social ecological framework



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