FAMILY PROCESS

COVID-19 Interconnectedness: Health Inequity, the Climate Crisis, and Collective Trauma

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The COVID-19 pandemic brings to the forefront the complex interconnected dilemmas of globalization, health equity, economic security, environmental justice, and collective trauma, severely impacting the marginalized and people of color in the United States. This lack of access to and the quality of healthcare, affordable housing, and lack of financial resources also continue to have a more significant impact on documented and undocumented immigrants. This paper aims at examining these critical issues and developing a framework for family therapists to address these challenges by focusing on four interrelated dimensions: cultural values, social determinants of health, collective trauma, and the ethical and moral responsibility of family therapists. Given the fact that family therapists may unwittingly function as the best ally of an economic and political system that perpetuates institutionalized racism and class discrimination, we need to utilize a set of principles, values, and practices that are not just palliative or after the fact but bring forth into the psychotherapeutic and policy work a politics of care. Therefore, a strong call to promote and advocate for the broader continuum of health and critical thinking preparing professionals to meet the challenges of health equity, as well as economic and environmental justice, is needed. The issues discussed in this paper are specific to the United States despite their relevance to family therapy as a field. We are mindful not to generalize the United States' reality to the rest of the world, recognizing that issues discussed in this paper could potentially contribute to international discourse.

Keywords: COVID-19; Health Inequity; Social Determinants of Health; Ethics of Care; Collective Trauma; Climate Crisis

Fam Proc 59:832–846, 2020

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Family Process, Vol. 59, No. 3, 2020 © 2020 Family Process Institute
doi: 10.1111/famp.12572

I can't breathe. (George Floyd, May 25, 2020)

The COVID-19 pandemic is, metaphorically speaking, the canary in the coal mine, a rehearsal for the fragility of living in a neoliberal globalized world. It forces us to pay closer attention to the complex interwoven threats of health inequity, economic insecurity, environmental injustice, and collective trauma. These complexities have highlighted our global interdependence while also making visible racism, classism, and the climate crisis shaping our lives. In this paper, we aim to develop a framework for family therapists to address these challenges by focusing on four interrelated dimensions of cultural values, social determinants of health, collective trauma, and family therapists' ethical and moral responsibilities. These are all in line with supporting systems-level changes (Poteat et al., 2020; van Dorn, Cooney, & Sabin, 2020). Further, while we recognize that many of these challenges are global, our analysis focuses on the evidence in the United States.

The COVID-19 pandemic is a disaster reaching catastrophic proportions, sharing similar characteristics to other–disasters like air pollution or global warming, for it demonstrates local and global dynamics that are interconnected while also idiosyncratic. Since environmental injustices or disasters tend to develop slowly, people have difficulty observing, assessing its risk, and understanding its relationships to other aspects of our lives (Knowles, 2014). In the United States, the lack of access to and the quality of healthcare (Berger et al., 2020), appropriate housing, and lack of financial resources have and will continue to exert more significant impacts on Black Americans, other people of color, and immigrants (Maani & Galea, in press). This paper examines some of these barriers and offers family therapists some directions informed by an ethics of care framework.

Cultural Values and the Healthcare System

The dominant mainstream non-Latinx White cultural values inform and shape the healthcare system's macro- and micro-level practices. The current healthcare systems, therefore, reflect the underlying worldview and beliefs of the historically dominant White culture, setting the stage for how people of color are treated, defined, or what constitutes the "natural" or taken for granted behaviors and attitudes. The United States' emphasis on rugged individualism hints that being White is better, making the structures of power and privilege invisible. Hidden cultural values are thus continuing to influence health decisions and contribute to stigma. These cultural values also affect the amount of control individuals or groups are perceived to have in preventing or managing health conditions.

COVID-19 challenges the dominant cultural values of rugged individualism and self-determination, mainly because the pandemic reveals our interconnectedness, and interdependence as a global family. Most people in the United States are socialized to be responsible for their own destiny despite our embeddedness in relational networks and social structures of which we are actors and reactors, thus not solely accountable for our health. This pandemic crisis has made it clear that simplistic or reductionist views of health can be destructive to individuals, families, and/or communities and affect the health of everyone. It also challenges us to revisit our assumptions of health as not just a private asset but part of the commons, and a fundamental right for everyone.

Further, meritocracy is a dominant cultural value in the United States based on the belief that each individual has equal access to societal goods, including the social conditions that ensure good health and access to healthcare. The social expectation is for individuals to take control of their health as if individuals are disconnected from their social context. An adherence to an either–or philosophy accompanies individualism and self-determination. Health is often treated as an individual matter without consideration of the

global community and the fluid interplay that makes national borders irrelevant. This pandemic highlights the need for a *both–and* approach to health since our individual and family health is connected to the health of the people everywhere and not just the United States. We are not distinct or isolated, and part of a complex global human community (Steckler et al., 1993). Hence, the renewed significance of a systemic and global health perspective should help us better understand health inequity and help us with our ability to succeed at preventing, mitigating, and treating emerging and reemerging diseases as part of a global endeavor.

A significant body of research has shown the crucial role of families in individual's physical and mental health functioning (Lebow, 2020; Priest, Roberson, & Woods, 2019). However, the field of family therapy, too often, narrowly defines *systemic* as the individual in the family context without attending to broader social influences of human behavior and change, including the global context. Thus, we may end reaffirming the assumption of national exceptionality. The fluidity with which we travel internationally, as well as the influx of immigrant and refugee families, underscores the importance of thinking globally about physical and mental health, particularly when we confront a crisis (Atallah et al., 2019). As a nation of immigrants, we all represent transnational lives, comprising a significant relational system, which requires family therapists to think globally about individual issues at large (Bacigalupe & Lambe, 2011; Falicov, 2019). In addition, asylum seekers and refugees in the United States who have been affected by violence and persecution are likely to have interwoven physical and mental health issues. Family therapy practice and research, however, exploring migration experiences rarely approach it from a bioecological framework (Utrzan & Wieling, 2020).

Rethinking Rugged Individualism and Self-Determination

In his book, *Come Hell or High Water: Hurricane Katrina and the Color of Disaster*, Michael Eric Dyson (2005) posits that "we remain blissfully ignorant of their (Katrina victims) circumstances to avoid the brutal indictment of our consciences" (p. 3). The pandemic, as disastrous as it is, provides us with another opportunity to rethink nationalism, racism, classism, and all forms of exceptionalists beliefs and behaviors that affect our health as a nation. Nationalism impedes international cooperation on global health efforts, and bias is more than likely to confine marginalized citizens, especially people of color, to worse health outcomes. Population changes, along with worldwide digital connectivity, challenge us to rethink our assumptions and values about who we are and who we want to be. Rugged individualism and its associated belief, the *survival of the fittest*, misappropriated from Darwin's evolutionary theory, can, therefore, serve as a paradigm for understanding how the United States has approached the COVID-19 pandemic. This pandemic challenges individualism and stresses the need for collective actions. Further, our assumption that we all have the same chances to reach our full potentials and enjoy a healthy life (Walsh, 2019) seems obscene when witnessing the higher rates of suffrage from COVID-19 for Black and Latinx communities (Laurencin & McClinton, 2020; van Dorn et al., 2020).

Fear of people of color's advancement at White people's expense reinforces the dominant cultural value of rugged individualism as opposed to looking at the system of white supremacy. Through the lens of rugged individualism, people of color are generally seen as lacking motivation and looking for handouts. Despite documented accounts of inequities resulting from racism and classism, people of color are held responsible for every failure, from not being healthy to not achieving success (Walsh, 2019). The notion of rugged individualism also obscures the debate on universal health coverage. The all-consuming guiding principle of this concept prevents us as a nation from seeing health care as a human

right. Valuing humanity, above all, moves us closer to our aspirational goal of health equity. In the words of Stevenson (2015):

> We are all implicated when we allow other people to be mistreated. An absence of compassion can corrupt the decency of a community, a state, a nation. Fear and anger can make us vindictive and abusive, unjust, and unfair until we all suffer from the absence of mercy, and we condemn ourselves as much as we victimize others (p. 18).

Rugged individualism, therefore, can serve as a paradigm to understand how the country has approached this pandemic, including, for instance, the rejection of lockdowns by white supremacy groups or the continuous rejection of basic public health measures like the use of masks or appropriate physical distance to prevent the contagion of others. The public measures that are required involve adopting a framework that not only sustains health equity but also the mitigation of the pandemic.

Social Determinants of Health

Data about the unequal impact of COVID-19 are still being collected. However, media and research reports have shown a clear pattern. The demand by researchers for data on the effect of the virus (Haynes et al., 2020) and the measures to mitigate contagion face the usual obstacles, reflecting the institutional barriers that hide inequity. Data that demonstrate qualitatively and quantitatively the impact of a disaster on those who are poor, racialized, and/or undocumented are often scarce, particularly early on when decision-making is crucial, furthering the invisibility of these families in policymaking and the support of those who need help the most during the emergency. Historically, the research evidence documenting the differential impact of disasters on the most vulnerable, those in poverty, the undocumented recent immigrants, and communities of color, is undeniable **(**Walz, 2017). The early COVID-19 epidemiology of the pandemic in large urban settings follows this trend of higher mortality rates (Pilkington & Rao, 2020), and limited access to healthcare for people of color (Nuñez et al., 2020), as well as lack of access to tests and treatment for undocumented immigrants (Yearby & Mohapatra, 2020).

COVID-19 brings to the forefront the circular relationship of health and the social, economic, and political landscape. We must, therefore, understand and acknowledge the interactional and complex nature of health across race, class, and environment. Ending any pretense about racism and discrimination might lead to a more socially just system of physical and psychological health care (Waite, Sawyer, & Waite, 2020). Critical consciousness about the socioeconomic health of a nation being only as good as the physical and psychological health of its people also might lead to greater concern for all of humanity.

Further, integral to addressing health inequity is recognizing environmental factors (e.g., inadequate access to healthy food, poor transportation, air, and water pollution, and unsafe housing) and the unequal environmental protection provided through laws and government programs. By and large, we must confront unfair health practices and policies that lead to bias and rob society of fully participating members. As Bryan Stevenson (2015) so eloquently puts it:

> . . . the true measure of our society, our commitment to justice, the character of our society, our commitment to the rule of law, fairness, and equality cannot be measured by how we treat the rich, the powerful, the privileged, and the respected among us. The true measure of our character is how we treat the poor, the disfavored, the accused, the incarcerated, and the condemned (p. 18).

Negative social determinants of health for families of color in general and poor working-class families of color, in particular, impact their sense of safety and security daily. The

COVID-19 pandemic is another significant, threatening, long-term, and uncertain crisis, that families of color have to face, intensifying the burden on their lives and forcing them to continue as vulnerability bearers when disasters strike (Peterson, 2020). The systemic structures keep many families of color unable to withstand this disaster, and they are often criticized or blamed for their chronic health conditions (e.g., obesity, hypertension, diabetes). However, these families face the largest barriers (e.g., racism, classism, inadequate transportation) to address their basic physical and psychological health needs (Waite et al., 2020). Low-income families of color are also stigmatized and shamed relentlessly (Hardy, 2019). While racism and classism affect nearly every decision, a low-income family of color makes or avoids, physical and mental health professionals may not be attuned to racism and classism's "broad-sweeping, far-reaching systemic consequences" (p.60).

Racism

Race is undeniably the single most significant predictor of health and the quality of health care (Smedley, Stith, & Nelson, 2003). Dating back to the United States' early history to the present day, communities of color have suffered from barriers to healthy and quality living. The United States' healthcare system has long suffered from the misconception of race as biology (Kawachi, Daniels, & Robinson, 2005). From the time of slavery until now, Black people have been thought to be innately inferior to white people (DeGruy, 2005; Kendi, 2016). Although disproven and unethical, racial health disparities are frequently ascribed to inherent biological traits (Kawachi et al., 2005).

Furthermore, it is critical not to conflate race and class in the discourse on racial health inequity since race is a socially constructed phenomenon and not a substitute for class in the discourse on health disparities (Kawachi et al., 2005). Inequality in housing, employment, education, and overall access to fulfilling basic physical and psychological needs affects social determinants of health. Hence, communities of color are more at risk for poor health and disparate health outcomes, including mortality rates (Waite et al., 2020). However, race continues to be sidestepped in discourses about behavioral and physical health. The significance of race and racial conversations in therapy is also undeniable. Race and racism should be front and center in behavioral and physical health, not an afterthought. Failing to acknowledge race and racism along with stigmatizing communities of color, particularly Black people, as lazy, violent, and inferior contributes to people of color's health not being a priority, resulting in racial health disparities (Watson, 2013). In therapy, indeed, race is also ever-present for Black couples, informing their thinking, behavior, and conversations, whether explicitly named or addressed (Nightingale, Jones, & Smith, 2019).

COVID-19 is another vivid example of racism. The actual cause of the COVID-19 virus has yet to be entirely determined by the scientific community. Still, many in the United States continue to perpetuate a horrible misrepresentation of an entire group of people based on no conclusive data that have been accepted by the global community. Describing the coronavirus as the *Chinese* virus is demeaning and reinforces the very nature of racism. In contrast, the mad cow disease originated in the United Kingdom and was not called a British virus, and we have never berated the British community over this fact. The H1N1 virus emerged from North America and was transmitted from pigs, and yet, we do not refer to it as the North American flu. COVID-19, thus, seems to be used as a legitimate reason to act out the long-existed hidden prejudice and discrimination toward Asian Americans. Asian Americans not only face racial and language discrimination (e.g., skin color, speaking the language with an accent) but also tolerate the bias of *us* against *them* as outsiders/foreigners. The psychological toll of these discriminatory actions toward Asian Americans is beyond comprehensive documentation. Given the fact that racism is

all-encompassing, targeted, and blamed for the COVID-19 pandemic, Asian Americans' physical and mental health may be impacted far into the future (Qiu et al., 2020).

This pandemic has shown that communities of color suffer disproportionately from the disease in the United States, which is not surprising given the additive, adverse effects of racism and other harmful sociopolitical conditions (Anderson, McKenny, & Stevenson, 2019; Waite et al., 2020; Watson, 2019a,b). For example, social risk factors (i.e., racism) contribute to African American mothers having significantly higher rates of premature births and infant and maternal deaths regardless of class and educational status (Anderson et al., 2019).

Further, Alexander (2010) states that incarceration is the equivalent of a racial caste system. Black urban communities face massive rates of incarceration. Housing and employment policies and practices often exclude inmates, depriving them of the ability to meet basic needs, including health. Black and Brown inmates, therefore, face health disparities and should be included in discussions of health equity (McGowan et al., 2016). The COVID-19 pandemic is also highlighting how incarceration has a significant impact on health. In the United States, Black and Brown people are disproportionately incarcerated. Because many inmates are repeat offenders, they cycle back and forth from prison to home, which has implications for their families' health as well as the overall health of society. During this pandemic, reducing the prison population through early release has been a palliative measure to try to achieve better social distancing in prisons and jails (Akiyama et al., 2020) that highlights health inequity. Even if the states are able to thin the prison population to secure social distancing, the unjust core treatment of people of color in the justice system, including overconfinement, should be tackled with a rehaul of the legal system to prevent further injustice and vulnerability to disaster.

Classism

As of this writing, over seven million people worldwide have been diagnosed with the COVID-19 virus, and over 400,000 have died. The United States represents about one-third of the world's confirmed cases and close to a third of the deaths worldwide. The virus may not in itself discriminate, but its outcomes do. It has inflicted its terrible toll unequally on two segments of society within the United States. One segment of the nation was able to safely stay home with foods delivered, while those who used to be called *service* workers now became *essential* workers who are burdened by income insecurity. The majority of service workers are people of color. In New York City, for instance, most of the frontline workers are African American or Latinx and more than half of confirmed COVID-19 cases and deaths were African American (Pilkington & Rao, 2020). The pandemic makes visible the inequities in health as well as the chronic economic insecurity of people of color, which suffer the most when unemployment rises (Coibion et al., 2020; Gonzalez et al., 2020). The impact of the pandemic has compressed not only low-wage, low-skilled workers but also white-collar workers. Nonetheless, it is clear from the previous economic recession and now the COVID-19 pandemic that workers who hold precarious jobs (low-wage, low-skill, irregular work hours, and high instability) are hit the hardest. It has also changed the notion of what essential services are and how those providing these services compensated.

Recent workplace trends have not helped but hurt even more the dire situation faced by many workers, particularly the vulnerable ones. The global market, empowered by information technology and the service economy, has polarized the labor force. At one end are highly educated and highly skilled workers who typically receive job-associated benefits in exchange for working long hours at high intensity. At the other end are the low-wage, low-skilled workers, many of whom cannot make ends meet even when working more than one job (Kalleberg, 2013). This polarization has not only decreased job security since the

economic boom in 2000 but has brutally uncovered and further worsened job security during this pandemic. To think of the social class as a determinant is often perceived with skepticism or bluntly rejected in Western industrialized countries, which is one more manifestation of the value of individualism. A qualitative study on class and health conducted in a southern English town, Bolam et al. (2004) found resistance to the notion of class as an underpinning of health when linked to an individual's personal experience. Still, when connected to a broader sociopolitical perspective, social class was accepted as a determinant of health. As a result, those suffering from job insecurity or unable to make a living are blamed and labeled as lacking good character and making poor healthy lifestyle choices. Since health care is not a right but part of the goods that one can acquire in a neoliberal market system, seeking health care is surrounded by fear, blame, and shame. From an individual perspective, most citizens in the United States may not understand or consider the structural limitations imposed by social class that produce health inequalities. Attending to health as a more comprehensive social issue may improve access, encourage help-seeking behaviors, and be a source of human compassion, thereby reducing class health inequity. Thus, moving from an individual to a relational perspective better positions us in promoting health equity (Scambler & Higgs, 1999).

Further, colonization has been a significant cause of inequality globally, creating marked differences in housing, resources, and opportunities. The institutionalized racism, residential divide, and the accompanying class divide appear to prevail in postcolonial countries. For instance, the inequality in housing in India that resulted from British rule and occupation continues to be flagrantly present (Hague et al., 2020). Despite civil rights triumphs in the United States, decades of housing and employment discrimination have led to low-income communities that are disproportionately comprised of people of color today. For example, the covenants system of segregating Blacks from Whites in residential areas has created disparities for Black Americans (Kaul, 2019). Further, police brutality has been a major source of discrimination as we have seen in the brutal killing of George Floyd and many others across the United States (Beaumont, 2020).

The low-income communities, resulting from systemic colonization, reservations, and/or slavery, face severe public health and environmental risks. These risks include financially stressed public schools; a high presence of unhealthy food choices (e.g., fast foods) and low presence of supermarkets with fresh produce and other healthy foods for home-based preparation; a high per capita number of liquor stores and other sources of alcohol (e.g., delis, bodegas) as compared to more privileged neighborhoods and suburban areas; violence (including intimate partner violence); and lack of spaces for physical activities (McGowan et al., 2016).

Additionally, wealthier countries depend on migrant workers as cheap labor to sustain an economy based on labor exploitation. Since labor migration requires migrant workers to leave their countries or homes, they are not likely to have the power of position or relationship in host countries or locations to meet their healthcare needs. Migrant workers' access to health care is hampered by low wages and lack of employer-paid health insurance (Rosebaum & Shin, 2005). Just as structural racism serves to defend white privilege, the structural power exerted in migrant labor arrangements functions to protect class privilege. Hence, migrant workers' low social positioning and lower social class status impact their health status and quality of life (Castañeda et al., 2010).

In the current crisis, what amounts to conditions similar to those during slavery or indentured servitude creates tremendous risks that burden undocumented Latinx immigrants (Cabral & Cuevas, 2020; Zepeda-Millán, 2017). These undocumented Latinx immigrants continued to work tirelessly in agricultural and food-related industries such as meatpacking and construction during this pandemic. A dramatic example is the White House executive order that prevents shutting down meat processing plants. Once again,

as it was the case with the Bracero program in the 1940s, which aggressively hired Mexican nationals to avoid the United States' economy from collapsing during World War II, immigrants and the undocumented are at the center of work environments that sustain the critical production of food for the whole country. Ironically, the same groups that may be frustrated for the shortage of food and other basic necessities are the ones likely embracing xenophobic calls to expel undocumented immigrants in the next election cycle (Page et al., 2020).

It is important to note that human rights violations within our economic system that are closely related to the widening gap in income equality influenced by globalization, automation, and technology, lead to greater health inequity, which it is not abating. Reducing Medicaid and rolling back the Affordable Care Act are still part of the political and public policy agenda, compromising further the health and life chances of low-income individuals and families (Walsh, 2019). The pandemic and anticipated future disasters due to climate change are likely to have a negative impact on the health of low-income and possibly middle-income communities. Because of the rising costs of health insurance and the absence of universal health coverage, a more significant segment of society may also find themselves without the resources to combat, resulting in health issues. For instance, many first responders who suffered from residual health effects (e.g., cancer) of 9/11 did not have adequate health coverage (Gilbert & Ponder, 2013). And reduced Medicaid health benefits may become an increasing burden for the elderly and disabled (Mayes, 2004). Consequently, current political threats to health coverage (Social Security, Medicare, and Medicaid) should be a top concern for everyone and not just low-income families.

The staggering economic and health consequences of the COVID-19 pandemic also have significant potential ramifications for those who were insured, due to close ties between employment and insurance in the United States. For instance, job loss is a fallout of the pandemic leading to a rise in the number of uninsured persons. Given that health insurance is already a major concern for families across social strata, economic and healthcare concerns will deepen families' sense of insecurity and worries about sustaining well-being. This pandemic crisis and a better understanding of the significance of public health may, therefore, create the political support needed to advance the enactment of universal health care, which would aid in decreasing health inequity and prepare us more effectively to confront a pandemic and its consequences.

Environmental Injustice

From the water crisis in Michigan to toxic coal ash in landfills in Puerto Rico to Standing Rock Sioux in North Dakota, environmental injustices endanger the health and welfare of people in general and people of color in particular (Brender, Maantay, & Chakraborty, 2011; Bullard, Johnson, & Wright, 1997). Areas with a dense population of people of color and the poor often become sacrificial zones—dumping sites—for toxic waste and other contaminants or heavy mining or sites for high levels of carbon emission (Kjellstrom et al., 2007). Global environmental stressors and climate changes seem to make for a future of uncertainty and insecurity for the poor and people of color around the world (Babryemi, Ogundiran, & Osibanjo, 2016; Chen, Chen, & Landry, 2013). The COVID-19 pandemic like the climate crisis dramatically points to the dangers of not addressing courageously the threats imposed by a global crisis that, first and for the most part, severely impacts people of color and vulnerable communities.

Worldwide, refugees endure environmental injustices that affect their mental and physical health, from the deplorable conditions they experience in transit from countries of origin to horrific situations in refugee camps. Many refugees, particularly refugees of color, continue to withstand environmental injustices in resettlement due to barriers to safe, healthy, and affordable housing. People of color and the poor live in territories where

environmental hazards are a tremendous burden furthering health inequity (Levy et al., 2011). People of color comprise most of the low-paying jobs and live in economically stressed communities, which contribute to their vulnerability relative to climate changes and other environmental threats (Bullard, 1999; Downey, 1998). However, a both–and approach is needed when considering environmental justice since the loss of jobs if closing highly toxic industries requires new industries that can employ workers in the same communities.

Even more worrisome is the close link between environmental justice and the emergence of pandemics. Whereas there is no direct evidence to link climate change and the emergence and transmission of COVID-19, the World Health Organization (WHO) has indicated that almost all recent emerging infectious diseases originate in wildlife. There is evidence that man-made adverse changes (e.g., CO_2 emissions) in the natural environment may drive disease emergence (WHO, 2018). Importantly, despite the fact that COVID-19 has an immediate and substantial impact on health outcomes and mortality for those exposed to contaminants, the response to the climate crisis and the pandemic are compelling parallel. The response to this crisis has been slow and inadequate and on the shoulders of the most vulnerable. Hurricane Katrina in 2005 and Hurricane Sandy in 2012 are the two most recent examples of how at-risk communities were hit the hardest by the consequences of the climate crisis (Benevolenza & DeRigna, 2019).

Collective Trauma

Collective trauma refers to an entire group's psychological reaction to a traumatic event, such as the Trail of Tears (Native Americans), slavery, Japanese internment, and Holocaust. The COVID-19 pandemic is shared not only nationally but also globally, emotionally connecting people around the world through experiences of helplessness, uncertainty, loss, and grief. Collective trauma is significant because, unlike individual memory, it can persist across generations and time (Saul, 2013). The collective memory of the traumatic event that is transmitted across generations can give rise to family narratives and patterns. These family narratives and patterns are likely to be based on social location and personal experiences, affecting a family's sense of security and trust, decades after the original traumatizing events. This, for example, is the basis of Post-Traumatic Slave Syndrome, and certainly, the intergenerational effects of the Native American and Jewish Holocausts. Families of color and low-income families may be motivated to insulate themselves to preserve themselves against outside threats. Along with shaping the worldview of individuals, collective trauma can affect how one group understands its relationship to another group. The COVID-19 pandemic may have implications for how various nations and groups see each other (Hirschberger, 2018), especially given the inequality exposed and the United States' targeting of China.

Unlike the pandemic of 1918, we have tremendous access to information almost immediately, but our digital connectivity is not consistent with the development of the phenomenon itself. The World Health Organization defines access to a wealth of information, perhaps false information, as an epidemic itself. It is an infodemic, an information, and disinformation pandemic, where it is difficult to distinguish the primary from the secondary, the relevant from the superficial, and the truth from the patently false. It is challenging to understand the different dimensions of the pandemic, including its modeling, the development of mitigation measures (quarantine), prevention (vaccine), or treatment (medication or hospitalization). Aside from the difficulty in understanding the nonlinear progression of the virus infection and illness, we are yet to comprehend the social and emotional impact of coping with this disaster.

We hope to have conversations that are about solidarity, individual introspection, assessing couple and family relationships, and the commitments we make regarding the social changes necessary for the future. We need to recognize not only the sadness about the memory of those we lost or will lose but also of those we value and the emotion we feel when evaluating contact with others. We should remember that the pandemic taught us about the unequal social relations, where people of color are to carry a heavier burden when there is a threat to our health. We hope that this collective trauma drives us to less divisions, less hatred, and facilitate more forms of understanding with the other and with what surrounds us. In other words, we need to walk the bridge that connects collective trauma and collective healing.

Family Therapists' Ethical and Moral Responsibility

The COVID-19 crisis has mobilized professional associations, the research community, and policymakers working on guild issues related to servicing patients and their families, including, for instance, telehealth and remote learning. The pandemic's impact on mental health will be complex and requires acute attention by clinicians and researchers (Holmes et al., 2020). Psychotherapists are developing guidelines and gathering resources to deal with the consequences of quarantine, confronting grief and trauma, re-visioning health services online, and the initial identification of the psychosocial impact of the pandemic in our daily lives. These are critical practice issues.

The field of family therapy, however, should not lose sight of the importance of an ethics of care. The pandemic does not only severely impact the lives of families and communities, particularly those already subjected to social injustice. COVID-19 challenges the naturalized role of counseling as a whole, of the individualizing of problems, and the usual narrative that draws us to focus the solution to problems inside individual minds and couple or family interaction, rather than the deleterious impact of inequality on our daily lives. As such, it calls for family therapists to think about the broader spectrum of health, which is not commonplace for many family therapists. Psychotherapy may unwittingly function as the best ally of an economic and political system that perpetuates institutionalized racism and class discrimination. Often, therapists, even those that operate utilizing a systemic framework, may diagnose and intervene with individuals and families that are suffering the consequences of human exploitation by helping them to adapt to the same societal conditions that elicit or maintain the reasoning for consulting in the first place.

Recognizing, rethinking, and reevaluating our physical and mental health values and assumptions require, therefore, a deeper understanding of the ethics of care, which should compel family therapists to have an accurate understanding of the critical healthcare-related issues during this pandemic crisis. There are times that family therapists are fully informed about these issues but need to become more deliberate about how to respond to them. Other times, however, good care requires knowledge and expertise about the interconnectedness between inequity, trauma, and crisis. Once family therapists fully recognize the interconnectedness between inequity and crisis for those who suffer, attentiveness becomes the central disposition. According to Tronto (1993), attentiveness is "recognizing the needs of those around us" (p. 127), which encompasses "a suspension of one's self-interest, and a capacity genuinely to look from the perspective of the one in need" (Tronto, 2013, p. 25). Within this framework, family therapists should develop deeper empathy, humility, and openness to the worldview of those who suffer the most and advocate for them. Held (2006) states that "caring relations seem to require substantial capacities for being sensitive to the feelings of others" (p. 53) and Noddings (2007) emphasizes "engrossment," "stepping out of one's own personal frame of reference into the others" (p. 24).

The ethical care emphasis on empathy and emotion is not, however, mutually exclusive with dispositional sensitivities to other morally and politically salient issues. Caring well requires certain emotional capacities and the dispositions to exercise them, but it also requires a disposition to notice other relevant facts about the world. The COVID-19-related crisis in the United States with insufficient testing and tracing, lack of personal protective equipment, reduced intensive care units, and unequal access to the healthcare system exposes the deadly effects of racism and classism more than before. In addition, a discourse by authorities that frame the pandemic as mostly a question of when to reactivate the economy rather than intervening to prevent contagion and treat the sick undermines the trust and confidence of the most vulnerable.

It is, thus, evermore important that family therapists' attentiveness to these issues ought to include not only emotional sensitivity and empathy, but also all other morally salient issues that have already existed, but have become more salient during the recent pandemic crisis. Baier (1985) states that "a reliable sign of real caring is the intolerance of ignorance about the current state of what we care about" (p. 274). It is critical to recognize our interdependence with each other and with other countries and act to address social inequality related to racism, poverty, inadequate housing, unemployment, lack of healthcare access and quality, and structural violence which continues to perpetuate health inequity. We can no longer ignore that many families of color's social conditions shape their health, relationships, individual and social functioning, and quality of life.

Further, attentiveness hinges on a degree of epistemic humility and modesty. One cannot be a good family therapist if one is disposed to overestimate one's own epistemic standing to care. It is important to note that the epistemic standing to care well requires that one not exaggerate one's own knowledge or understanding, particularly when it comes to care ethicists' most-discussed subjects, which is the knowledge about disasters impacting the most vulnerable, those in poverty, the undocumented, immigrants, and communities of color. Proper attentiveness requires that one properly estimate one's own epistemic standing and, where necessary and possible, make efforts to improve it (Dalmiya, 2016). One important way to do so is to listen closely and with respectful curiosity to the families and communities with whom we work, treating them as the experts who can inform us about their experiences and realities (Fraenkel, 2006).

We need to recognize that family therapists may exhibit consequential inattentiveness by ignoring, downplaying, or inadequately informing themselves about the likely harms of lack of knowledge about many of these issues. We may also be insufficiently sensitive to the emotions or worldview of our clients, perhaps by being dismissive of their emotions and expecting stoicism of them, or by denying emotional depth/breadth of our clients' suffering. We might be morally or politically inattentive by failing to notice that our behavior is unacceptably paternalistic that we are imposing our own ethical and political views on others in a morally objectionable way. Therefore, unless we pay close attention to the impact of racism, classism, colonization, environmental injustices, and collective trauma during this pandemic crisis now and for many years after, as family therapists we would also be perpetuating the cycle of discrimination.

CONCLUSION

In COVID-19 as other looming global crises—health inequity and climate warming—the scientific evidence has been marginalized, the public perception of risk has been undermined, and the critical coordination at the local, city, state, and federal levels has been weakened. In all these situations, the utilitarian framework rather than an ethic of care prevails. To deal with the pandemic, climate crisis, health inequity, and even police brutality in the United States, we need human rights and ecosystemic frameworks. Social

determinants of health, climate crisis, and the reconceptualization of our collective ethos are all central elements in generating a framework for a just-based family therapy approach. Thus, family therapists need to utilize a set of principles, values, and practices that are not just palliative or after the fact but that bring forth into the psychotherapeutic and policy work the question of a politics of care.

Family therapists are now exposed to reliable and morally relevant information about these crises and must then decide what to do about it. An awareness of the interconnectedness of racism, the climate crisis, trauma, and the pandemic should lead us into a discussion of care epistemology and moral deliberation about what would be the best way to care for those who are in need of mental health services. The good news is that our knowledge about mental health has expanded. We have developed more nuanced ways of understanding how our chemistry and environments affect our brains and our behavior. We have developed game-changing drugs to allow people with debilitating mental illnesses to reclaim their lives. We have begun to dismantle stigmas around mental health disorders like depression and anxiety. Yet, there is still a lot that we have not fully addressed like the effects of racism, discrimination, and trauma on individuals impacted by the COVID-19 crisis, especially those who have historically lived in the margins of society. All too often, well-being is lifted up as a goal that is attainable through resiliency, which ignores the detrimental paradox that underserved populations often find themselves in. As systemic thinkers, we know that when resilient people work hard within a system that has not afforded them the same opportunities as others, their physical and mental health suffers. One can hope that family therapists would be on the front line advocating and promoting social justice-based care for marginalized groups needing our services more than ever. Our collective perspectives are based on the research evidence and combined experiences in various academic, clinical, and institutional settings across the country and abroad, stimulating us to see the need for local, national, regional, and global interconnectedness.

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