



## Addressing the Vaccine “Hesitancy” Crisis in Black Communities: Behavioral Health Can Do Something About This.

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*“Good information” and “trusted messengers” about the COVID-19 vaccines are essential, but how can they overcome mistrust born of centuries’ worth of betrayal on a massive scale? This kind of mistrust is fused with pain, shame, trauma, loss, alienation, anger, and grief. This kind of mistrust speaks the language learned in disempowered communities, where often the only kind of power available is the power to refuse, resist, and remain silent.*

Behavioral health professionals often feel just as helpless as everyone else as we have watched the COVID-19 delta variant take over the pandemic, devour more and more human lives and capabilities, and push us closer and closer to the next economically punishing lockdown.

Concern—even deep concern—is appropriate at a time like this. So are empathy, anger, frustration, and grief. But helplessness? The authors of this essay believe that the field’s sense of helplessness in this matter is unwarranted—and it may be the delta variant’s best friend.

We must never forget that we in the behavioral health field have a number of superpowers that we usually keep hidden in our offices, group rooms, and Zoom rooms. Now it is urgent that we take our superpowers out into the community:

### **Vaccinating Panola, Alabama: The Power of True Community**

Dorothy Oliver is no stranger to illness and death. The COVID-19 pandemic has reached into Panola, her isolated rural Alabama town of about 400, and changed everything.

With the nearest vaccine site 39 miles away and many people with no transportation and more questions than answers, Panola suffered from both vaccine scarcity and vaccine confusion. Then, with the help of Crenshaw County Commissioner Drucilla Russ-Jackson and a team of neighbors, Ms. Oliver arranged for a “pop-up” vaccination site and started a campaign to recruit every eligible soul in town.

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- before too much more of the community is gone;
- before too much more of the medical community is physically and psychologically shredded; and
- before too many more people are left motherless, fatherless, childless, homeless, and/or lost in the cognitive and emotional swamp of “long COVID” and the other legacies of this pandemic.

The U.S. Food and Drug Administration’s recent full approval of the Pfizer-BioNTech vaccine may well provide more leverage for vaccine promotion. However, to make the best use of this development, public health efforts must also reflect an understanding of the forces behind the low vaccination rates in each community. And in many Black communities, these forces are very different from those at work in many White communities.

### Seek First to Understand

The term “vaccine hesitancy” is certainly accurate in some cases, but many of the merely “hesitant” have already taken the plunge (Palosky, 2021). In many African American communities, we may soon be left with the people whose obstacles to being vaccinated are more deeply rooted in lifelong and historical challenges. Here are some examples.

### Stress and Overwhelm

Although most unvaccinated adults are White, Black, and Hispanic/Latino adults are less likely than White adults to have received vaccinations against COVID-19 (Kaiser Family Foundation, 2021a). With the virulent and hyper-contagious delta variant at the helm—and the high vulnerability of African Americans to severe illness, hospitalization, and death from COVID-19 (CDC, 2020)—the slowly rising vaccination rates among Black adults (Kaiser Family Foundation, 2021a) might seem like “too little, too late.”

### Vaccinating Panola, Alabama (Continued)

“I just felt like I had to do it,” she told Yasmine Al-Sayyad of *The New Yorker*, “because the government, nobody does enough in this area. This area here is majority Black. Kind of puts you on the back burner. That’s just it. I mean, you don’t have to put nothing else with that. That’s just it. I don’t have to elaborate on that one.” In “[The Panola Project](#),” a *New Yorker* documentary by Rachael DeCruz and Jeremy S. Levine, the filmmakers captured Ms. Oliver’s and her friends’ patient and loving efforts to attract 40 people to the first pop-up vaccination.

But that was just a start. By August 11, in a state where only 37% of the eligible population is fully vaccinated (USA Facts, 2021), 94% of adults in Panola—and 100% of residents over 65—were fully vaccinated. How did they do it? The *New Yorker* article quotes one of the filmmakers: “There’s this very warm and kind of loving and caring way that Dorothy and Ms. Jackson approached those conversations, even when people aren’t in agreement. And it wasn’t done in a way that’s, like, ‘I know better than you.’”

Or, in Ms. Oliver’s words, “I just be nice to them.”

*To watch the documentary, click on this link:*  
<https://www.newyorker.com/culture/the-new-yorker-documentary/an-alabama-womans-neighborly-vaccination-campaign>

Particularly in low-income communities, much of the vulnerability among African Americans is due to high rates of lifelong chronic stress due to racism, discrimination, economic hardship, restricted opportunities and resources, environmental toxins, and other blows to the “social determinants of health” that have such profound effects on health and wellness (CDC, 2020). These life conditions have led to high levels of chronic illness and vulnerability, which in turn has promoted higher susceptibility to COVID-19, more severe symptoms, and higher mortality. African Americans are also more likely to live in cramped quarters and fill the “essential worker” roles that raise the risk of exposure to the virus (CDC, 2020).

Unfortunately, many of the circumstances that elevate risk also make it harder to get vaccinated.

- We who have studied and served these communities have some idea of the massive sense of overwhelm that poverty, fatigue, complex caregiving responsibilities, lack of transportation, and seemingly endless obstacles can create in a human life.
- Under that level of overwhelm, taking on even one extra task can threaten to topple delicately balanced loads of obligation and need.
- The more complex informational, technical, and logistical challenges a task entails—e.g., getting expert answers to questions and concerns, weighing conflicting information from disparate sources all claiming credibility, navigating new websites, registering for medical appointments on confusing systems, taking time off work, finding childcare and transportation to a mass vaccination site—the more likely that task is to slide to the bottom of the list.

For individuals who are looking for rationalizations for their inaction, the internet is virtually overflowing with misinformation and disinformation about the COVID vaccines and vaccines in general (CDC, 2021). As of July, 2021, more than half of unvaccinated Americans (53%) believed the vaccines were more dangerous than the illness itself (Suliman, 2021). Apparently massive amounts of effort are going into the campaign to spread disinformation (Associated Press, 2021).

### ***Mistrust: The Tip of the Iceberg***

Beneath and beyond the sense of overwhelm in disempowered communities lies that other curious term, “vaccine mistrust.” But here in the U.S., where vaccines with staggeringly high success rates are ours for the asking, what is there not to trust?

- Like any medicine, vaccines can have side-effects, but data collected by individual states still show a small chance (less than 1%) of “breakthrough infections” in people who have been fully vaccinated, and the chance is even lower for the subset who live in areas with high vaccination rates. As of July 26, Centers for Disease Control and Prevention data revealed that less than 0.004% of fully vaccinated people had developed breakthrough cases that led to hospitalization, and less than 0.001% of fully vaccinated people had developed fatal breakthrough cases (McPhillips & Maxouris, 2021).

- In preventing severe disease and hospitalizations, data suggest that the available mRNA vaccines (Pfizer-BioNTech and Moderna) are between 42% and 96% effective against the delta variant and nearly 95% effective against the original strain and other identified strains (Sakay, 2021; CDC, 2021b; CDC, 2021c). The Janssen vaccine by Johnson & Johnson is shown to be 67% effective against the delta variant and 66% effective against the original strain and other identified strains (Sakay, 2021; CDC, 2021a).
- In our current “pandemic of the unvaccinated,” CDC Director Rochelle Walensky, MD, MPH reported preliminary data that suggested 99.5% of the people who had died from COVID-19 since January were unvaccinated (Sakay, 2021).

With these impressive results, how do we understand levels of mistrust that—as of August 16, 2021—had allowed only 40% of African Americans to get vaccinated (Kaiser Family Foundation, 2021b)?

Most human beings learn the hard way that trust, once broken, is difficult to repair. If trust is broken more than once, it may never be repaired. And if it is broken again and again—in multiple ways, in multiple systems, in multiple communities, with multiple people, over a span of 400 years—what does it take to heal it?

Even many White Americans now have some knowledge of the historical and contemporary abuses of Black Americans by medical systems and the research community—from the brutal experimentation inflicted on enslaved African American women by J. Marion Sims (the “father of modern gynecology”) to the medical murders committed under the auspices of the Tuskegee Experiment, and ongoing abuses in countless other studies (Washington, 2006). There is also a slowly growing national awareness that prejudice, discrimination, misdiagnosis, and maltreatment are still significant problems in medical treatment of African Americans.

But in Black communities, all this knowledge adds up to far more than a sad chapter in history. Instead, it has been an indelible fact of life and lore all along, passed down through the generations and frequently reinforced with fresh examples from present-day experience. The fact that this cloud also hangs over so many other aspects of Black history and contemporary life makes it all the more powerful: *See? Nowhere is safe. Not even the places you go to heal.*

In this cloud there is certainly trauma and fear and mistrust, but there is also the aching pain that comes from centuries’ worth of unwelcome, “othering,” disempowerment, dehumanization, betrayal, losses, and lies. And there among the many symbols of all this are the healthcare expert, the healthcare profession, and the studies, treatments, and preventive measures we offer.

So “good information” and “trusted messengers” about the COVID-19 vaccines are essential, but how can they overcome mistrust born of centuries’ worth of betrayal on a massive scale? This kind of mistrust is fused with pain, shame, trauma, loss, alienation, anger, and grief. This kind of mistrust speaks the language learned in disempowered communities, where often the only kind of power available is the power to refuse, resist, and remain silent.

What power can we offer to replace the power to refuse, resist, and remain silent? What truths can we offer to heal the lies that African American communities have been told all along about their own experience? How can we honor such enormous losses? How can we expect people to accept this chance at health and dignity before we have proved that *we really mean it this time*?

## Meet Your New Patient

This is where the behavioral health field can be essential to the life-and-death struggle against the delta variant of COVID-19 in African American communities. In your work, you have regularly responded to the pain, frustration, anger, trauma, loss, alienation, and grief of the individuals and families you serve. And you have done it in ways that have significantly helped their stabilization, healing, and recovery. Their stories of healing are all examples of your superpowers at work.

We have a new patient in need of healing and support: the community. Public health models are built on the understanding that the well-being of each individual depends on the well-being of the whole population, and seldom is this understanding more important than in a pandemic. The population as a whole—our long-term physical, mental, social, and economic well-being—depends on our ability to defeat this virus.

So, how many of your superpowers are you willing to use to help the communities you serve? Here are a few suggestions:

- ***Collaborative Relationships:*** As national, state, and local governments have expanded their efforts to promote incentives for vaccination, many experts still confirm that trusted local authorities wield the most effective influence. Do the key players in local healthcare efforts, community and cultural organizations, faith communities, and recovery community organizations understand the depths of pain and betrayal that might underlie an individual’s reluctance to be vaccinated? Do they need support for their communication efforts? How might your organization create a safe forum for dialogue on the subject among the community leaders and influencers who are trying to help?
- ***Empathic listening:*** A central element of the historical oppression that Black, Indigenous, and other people of color have experienced in healthcare systems has been the whirlwind of information “thrown” at them, the important decisions made for them, the failure to seek their input and respect their knowledge and experience, and the overall unwillingness of “experts” to listen, take them seriously, and respond thoughtfully to their questions. If anyone can instill an attitude of respectful, empathic listening within allied service systems, it is behavioral health professionals steeped in culturally responsive, trauma-informed, recovery-oriented approaches.
- ***Validating difficult truths:*** Another highly damaging force has been the “gaslighting” that African Americans have experienced throughout history. Recalling the 1944 film in

which Charles Boyer systematically convinced his wife that she could not trust her perceptions or her judgement, this term well describes a common and long-standing psychological weapon used against people of color. Time and again, harmful and inequitable policies, attitudes, and practices have been denied roundly—and anyone who dares to name them has been characterized as delusional or dangerous. However, in your behavioral health practice, how many times have you helped participants recover from the denial and betrayal they encountered in their families of origin when they tried to tell the truth about their experiences? You know how to respect the truth. By learning about and affirming the historical and contemporary experiences of African Americans, how might you help individuals and communities speak their truths and restore a sense of shared dignity and integrity (Woll, 2021)?

- **Earning trust:** You have no doubt learned in your practice that it is neither your credentials nor your willingness to help that brings you the trust of the people you serve. It is your own words, actions, and attitudes, and the congruency and consistency among them. It is your willingness to listen to the realities of people’s lives and learn exactly what constitutes respect and compassion for this particular individual standing before you. It is your willingness to relate in an equal, collaborative, non-hierarchical way, even to individuals who seem to have lost their way. How can you earn the trust of community and allied healthcare leaders and influencers, so that they might accept your help in shaping their responses to this public health crisis? And how can your skills in gaining trust be an inspiration to hierarchical systems that need to adapt to a more participatory model?
- **Facilitating empowerment:** The idea that no one actually empowers someone else resonates with many in the behavioral health field, possibly because true power takes hold at deep levels and involves many everyday choices within the individual. However, our field has spent several decades learning about culturally responsive, trauma-informed, and recovery-oriented approaches. Under these influences, we have been honing ways of combining empowerment skill training with encouragement and “permission” to try out attitudes and actions that foster shared, collaborative power among people whose disempowerment has been a major burden. Cultural disempowerment has been a profound effect of historical medical abuses. Now, in some communities, it also seems to be an obstacle to acceptance of public health measures. So what might community empowerment efforts do to help remove that obstacle, and how can behavioral health professionals help?
- **Mobilizing the peer workforce:** To meet the chronic nature of behavioral health conditions and support long-term wellness and recovery, our field has begun to train and mobilize people in recovery, creating a skilled peer support workforce. In some areas and some organizations, peer networks and services are highly developed and highly effective, and most peers are driven by a sense of purpose and a will to be of service. What if you were to prepare selected peers to: 1) fully understand the roots of vaccine reluctance, 2) connect with local public health authorities to receive training and preparation, and 3) reach out within the recovery community and the larger community to learn about the obstacles people are facing and help them overcome those

obstacles? The story of Dorothy Oliver (pp. 1-2, above) shows what one determined individual can do to help a challenged community transform its vaccine response.

- ***Helping individuals and communities find their voices:*** Whether the system in question is a family, an organization, a service system, or a governmental system, people who are denied appropriate shared power tend to find or develop their power by any means necessary—even if it is only the “power of the victim.” All too often, this includes bitter resignation to abuse and injustice and the adoption of inaction and silence as the only safe forms of communication available: *You cannot be trusted with the truth. I judge you and reject you by my silence.* Unfortunately, that form of communication is limited, easy to misinterpret, and easy to dismiss. And there is so much that urgently needs to be communicated. As a professional field offering our support, we can help pave the way, but we cannot be the leaders or the major messengers. We are not the ones whose voices matter. As it has been in your professional services, it is in this endeavor: If we would promote healing and recovery, we need to help people find, strengthen, and use their own voices. Whatever it takes to do that, we must do.

So, if we are willing to use our behavioral health superpowers to help people in disempowered communities find their **own** powers, we will be intervening successfully in the spread of the delta variant, of the next variant, and of the next virus. We will be doing our part to promote the health of the community, of the population, of the economy, and of ourselves and our families.

*Some in our field have already started on this quest. The authors would like to hear from you, to learn about and magnify your efforts, strategies, and successes in the communities you serve. Please send your stories to [pamelawoll@sbcglobal.net](mailto:pamelawoll@sbcglobal.net)*

*Thank you.*

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