


Contributions of trauma and economic insecurity to psychological distress in response to the COVID-19 pandemic

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Abstract

Racially minoritized women with limited socioeconomic resources are at increased risk for adverse psychological outcomes in response to the coronavirus disease 2019 (COVID-19) pandemic. Disproportionate rates of trauma exposure and economic insecurity likely heighten risk for these outcomes among socioeconomically vulnerable individuals, but the unique contributions of these factors are poorly understood. As such, we examined trauma and economic factors as predictors of pandemic-related psychological distress and symptoms. Ninety-six women recruited for a trauma research study (91.7% Black, $M_{\text{age}} = 38.3$ years, $SD_{\text{age}} = 11.8$ years) completed measures of trauma exposure, economic insecurity, and several items assessing psychological distress and symptoms related to the COVID-19 pandemic. We examined concern for mental and physical health impacts of COVID-19 as well as changes in self-reported levels of anxiety and anhedonia from the 3 months before the pandemic to the previous 2 weeks. Linear regression analyses were used to assess contributions of trauma exposure and economic insecurity to COVID-19-related distress. Childhood maltreatment and lifetime trauma exposure did not predict COVID-19-related distress; however, financial concern significantly contributed to concern for the physical health impact of COVID-19 ($B = 0.30, p < 0.05$). Food insecurity emerged as the only significant predictor of concern for the mental health impact of COVID-19 ($B = 0.91, p < 0.01$). Housing instability was the only significant predictor of COVID-19-related increases in anhedonia ($B = -0.30, p < 0.05$). Economic insecurity, namely, self-reported financial concern, food insecurity, and housing instability, was related to COVID-19-related psychological distress and symptoms in a sample of predominately Black American women living in under-resourced communities. Findings may help identify populations at risk for COVID-19-related psychological distress and symptoms and appropriate interventions, such as expanding access to nutritious food sources and housing support, for minoritized community members.

KEYWORDS

COVID-19, economic insecurity, psychological distress, psychological symptoms, trauma

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1 | INTRODUCTION

Coronavirus disease 2019 (COVID-19), a highly contagious respiratory illness caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus, has contributed to an estimated 6.7 million deaths internationally (World Health Organization, 2023). After emerging in 2019, COVID-19 quickly spread across the world in the form of a pandemic outbreak and created unprecedented challenges and uncertainties for physical and mental well-being. Shortages in cleaning and protective equipment along with 24-h news coverage contributed to a widespread fear of contamination, particularly in individuals with pre-existing health anxiety (Dennis et al., 2021). In response, many countries, including the United States, enforced strict quarantine measures to contain the transmission of the virus. This sudden change adversely impacted the mental health of many, as social networks were disrupted and feelings of isolation were magnified (Wang et al., 2021).

Notably, COVID-19 and its negative effects were not equally distributed in the United States. Particular communities, namely those who are marginalized with few socioeconomic resources, have been disproportionately burdened by COVID-19 cases, complications, and deaths (Hatef et al., 2020; Tsur & Abu-Raiya, 2020; Webb Hooper et al., 2020). This increased risk may be, at least in part, explained by several psychosocial factors, including trauma exposure and economic insecurity. Socioeconomically vulnerable individuals are at increased risk for experiencing trauma across the lifespan. Of note, those with childhood maltreatment histories were at risk of elevated distress and posttraumatic stress symptom levels during the COVID-19 pandemic (Gewirtz-Meydan & Lassri, 2022; Janiri et al., 2021; Powers et al., 2015; Seitz et al., 2021; Tsur & Abu-Raiya, 2020). Individuals exposed to trauma are more likely to experience elevated psychological distress in reaction to later traumatic events and psychosocial stressors (Hammen et al., 2000; Horwitz et al., 2001; Kaplow & Widom, 2007; McLaughlin et al., 2010). Several international studies conducted in the early stages of the pandemic describe an increased risk of COVID-19-related psychological symptoms, including depression, anxiety, and posttraumatic stress disorder (PTSD), in adults who experienced childhood trauma (Békés et al., 2022; Kim et al., 2022; Seitz et al., 2021). In light of these findings, the COVID-19 pandemic may have acted as a stressor to which individuals with childhood maltreatment and lifetime trauma histories were more susceptible to various negative psychological outcomes.

Moreover, many marginalized individuals, including those who are racially minoritized, live in communities with low access to resources, and identify as women, have been disproportionately affected by the negative physical and mental health, financial, and social outcomes accompanying COVID-19 (Hatef et al., 2020; Wilson et al., 2020). Racially minoritized groups, particularly Black/African American individuals, are overrepresented in underresourced communities (Gould & Schieder, 2018) and are more likely to be diagnosed with health conditions that heighten the risk of experiencing severe COVID-19 symptoms and death, such as cardiovascular disease, diabetes, and chronic respiratory diseases (Bailey et al., 2017; Hertz et al., 2005;

Lovasi et al., 2009; Richardson et al., 2020; Young et al., 2018). Socioeconomic disadvantage is also linked to COVID-19; Hatef et al. (2020) found that even when controlling for age and gender, more disadvantaged neighborhoods had higher COVID-19 prevalence compared to less disadvantaged neighborhoods (Hatef et al., 2020). Taken together, findings highlight the impact of race, economic insecurity, and gender on COVID-19-related health outcomes (Centers for Disease Control and Prevention, 2019; Cunningham et al., 2017; Hatef et al., 2020; Murray et al., 2006; Richardson et al., 2020).

The necessary social isolation/distancing and quarantine mandates of the pandemic have also had a clear psychological impact on communities around the globe, with the most pronounced effects in marginalized communities (Jones, 2021; Peek et al., 2021; Snowden & Graaf, 2021). Extended periods of isolation can contribute to or exacerbate existing psychological distress, specifically symptoms of anxiety and anhedonia (i.e., an inability to derive pleasure from activities once considered enjoyable) (Brooks et al., 2020). According to social stress theory, those who are socioeconomically disadvantaged experience more proximal and distal stressors, such as financial stress, housing instability, and food insecurity, are more vulnerable to psychological concerns (Aneshensel, 1992). While financial stress, housing instability, and food insecurity have been linked to poor psychological health, the literature has not yet examined how these facets of economic insecurity relate to COVID-19-related mental health concerns. Thus, further examination of the associations between specific measures of economic insecurity, such as financial stress, housing instability, and food insecurity, and COVID-19-related psychological distress and symptoms is warranted.

As such, the primary aim of this study was to examine the contributions of trauma exposure (childhood maltreatment and lifetime trauma) and economic insecurity (food insecurity, housing instability, financial concerns) on COVID-19-related psychological distress (i.e., concern for mental and physical health impacts of COVID-19) and symptoms (i.e., pre-to-peri-pandemic change in anxiety and anhedonia) in a sample of trauma-exposed and primarily Black/African American women. Participants were recruited from a long-standing study of civilian trauma and PTSD in a large city in the southeastern United States. Our outcome variables included pre-versus peri-pandemic change in symptoms (i.e., symptoms in the 3 months before the pandemic compared to the 2 weeks before survey administration). Four separate regression models that included childhood maltreatment, lifetime trauma, and severity of economic insecurity in several domains—food insecurity, housing instability, financial concerns—were examined as predictors of psychological distress and symptoms.

2 | METHODS

2.1 | Participants and procedure

Participants ($n = 96$; $M_{\text{age}} = 38.3$ years, $SD_{\text{age}} = 11.8$ years) were majority Black/African American (91.7%, $n = 88$) and reported their

sex as female. Participants were recruited from the waiting rooms of clinics in a large public hospital, flyers posted in the community, and social media advertisements for involvement in ongoing studies of trauma exposure and related symptoms. Study eligibility included: age between 18 and 65 years; no evidence of active psychosis or significant cognitive compromise; and ability to give informed consent. Following informed consent, participants completed an interview in which a research assistant administered clinical assessments (detailed below) via telephone or videoconference. Data collection and study procedures were approved by Emory University Institutional Review Board and Grady Research Oversight Committee. Informed consent was obtained from all participants after the nature of study procedures was explained. Data were collected from August 2020 to August 2021. Clinical and demographic characteristics of participants are detailed in Table 1. Following participation in the interview, participants were compensated for their time and offered a list of community resources including information regarding accessible housing, employment, and healthcare services.

2.2 | Measures

Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998): The CTQ is a self-report measure that assesses childhood abuse (sexual, physical, and emotional) and neglect (physical and emotional). Participants rate the extent to which each of the 28 items describes their experiences in childhood and adolescence, using a scale of 1 (*Never true*) to 5 (*Always true*). Scores were summed to create a composite score for childhood maltreatment, which was entered into analyses. Higher scores indicate more severe or frequent experiences of childhood abuse and neglect. Total scores of childhood maltreatment, as reported on the Childhood Trauma Questionnaire (CTQ), ranged from 25 to 115 ($M = 53.08$, $SD = 22.28$, $\alpha = 0.81$).

Traumatic Events Inventory (TEI) (Gillespie et al., 2009): The TEI, a 14-item screening instrument, was used to assess lifetime exposure to potentially traumatic events. Participants identified whether they had experienced, witnessed, or been confronted with traumas ranging from natural disasters to sexual and physical abuse. In the current study, the mean number of trauma exposure types across the lifetime, excluding childhood maltreatment, was used in analyses to represent lifetime trauma load. Prior research has shown strong construct validity of trauma exposure as measured by the TEI in predicting adverse mental health outcomes (Mekawi et al., 2021).

COVID-19-related psychological distress: COVID-19-related psychological distress was assessed using the following two items: "During the past two weeks, how worried have you been about your physical health being influenced by Coronavirus/COVID-19?" and "During the past two weeks, how worried have you been about your mental/emotional health being influenced by Coronavirus/COVID-19?" Responses ranged from 1 (*Not at all*) to 5 (*Extremely*).

COVID-19-related psychological symptoms: Participants' self-reported psychological symptoms, namely anxiety and anhedonia, were assessed in the 3 months before the COVID-19 outbreak

TABLE 1 Demographic and clinical characteristics ($n = 96$).

Variable	n	%
Race/ethnicity		
African American/Black	88	91.7
White	1	1.0
Multiracial	5	5.2
Other	2	2.1
Employment status		
Unemployed	53	55.2
Employed	43	44.8
Disability support ^a		
Yes	20	20.8
No	75	78.1
Monthly household income (US\$) ^b		
0–249	21	21.9
250–499	2	2.1
500–999	16	16.7
1000–1999	23	24.0
2000 or more	29	30.2
Healthcare coverage status		
Insured	54	56.3
Uninsured	42	43.8
Education level		
Less than 12th	16	16.7
12th grade/high school graduate	19	19.8
GED	3	3.1
Some college or technical school	21	21.9
Technical school graduate	11	11.5
College graduate	18	18.8
Graduate school	8	8.3
Food insecurity		
Yes	26	27.1
No	70	72.9
	Mean (SD, range)	
Age	38.25 (11.82, 18–65)	
TEI lifetime trauma load ^a	2.93 (1.28, 1–6.14)	
CTQ total score	53.08 (22.28, 25–115)	
Physical abuse	9.91 (4.76, 5–25)	
Emotional abuse	11.75 (6.20, 5–25)	
Sexual abuse	11.14 (6.72, 5–25)	
Physical neglect	7.86 (3.58, 5–19)	
Emotional neglect	11.75 (6.20, 5–25)	

(Continues)

TABLE 1 (Continued)

	Mean (SD, range)
Financial concerns	2.79 (1.50, 1–5)
Housing Instability	2.50 (1.56, 1–5)

Abbreviations: CTQ, Childhood Trauma Questionnaire; GED, General Educational; TEI, trauma exposure inventory.

^aData missing from one participant.

^bData missing from five participants.

(pre-pandemic) and in the 2 weeks before the study visit (peri-pandemic). For pre-pandemic values, participants were instructed to think back to December 2019. Participants responded to two items: “How relaxed versus anxious were you?” [1 (*Very relaxed/calm*) to 5 (*Very nervous/anxious*)] and “How much have you been able to enjoy your usual activities?” [1 (*Not at all*) to 5 (*A lot*)]. Enjoyment of usual activities was reverse scored, such that a higher score reflects an increase in anhedonia. The magnitude of symptom change in response to COVID-19 was calculated by subtracting the peri-pandemic (2 weeks before visit) scores from pre-pandemic (3 months prior) scores.

Financial concerns: Financial concerns were assessed via the following self-report item: “In the past two weeks, to what degree have changes related to the Coronavirus/COVID-19 crisis in your area created financial problems for you and your family?” Responses were rated on a scale of 1 (*Not at all*) to 5 (*Extremely*). A higher score indicates more financial concerns.

Housing instability: Housing instability was assessed via the following self-report item: “In the past two weeks, to what degree are you concerned about the stability of your living situation?” Responses were rated on a scale of 1 (*Not at all*) to 5 (*Extremely*). A higher score indicates more concern about housing instability.

Food insecurity: Food insecurity was assessed via the following self-report item: “In the past two weeks, did you worry whether your food would run out because of lack of money?” Responses were rated on a binary scale (0 = *No*, 1 = *Yes*).

2.3 | Data analyses

All analyses were conducted using SPSS version 28. Data were checked for normality before descriptive statistics were generated. A correlation matrix was generated to examine bivariate relations among variables. The threshold for statistical significance was $p \leq 0.05$. Four separate multiple regression analyses were conducted to examine predictors of concern for the physical and mental health impacts of COVID-19 and pre-/peri-COVID-19 changes in anxiety and anhedonia. In each model, childhood maltreatment, lifetime trauma, financial concerns, housing instability, and food insecurity were entered as predictors. Bonferroni correction was applied to correct for error due to multiple comparisons; statistical significance was set at $p \leq 0.025$ for each family of tests (i.e., COVID-19-related distress and psychological symptoms).

2.4 | Results

Descriptions of COVID-19-related psychological distress and symptoms are detailed in Table 2, and correlations between trauma exposure, economic insecurity, and psychological distress and symptoms are provided in Table 3. Financial concerns were positively associated with COVID-19-related physical ($r = 0.34$, $p < 0.001$) and mental ($r = 0.21$, $p = 0.043$) health concerns and with pre-/peri-COVID-19 changes in anxiety ($r = 0.25$, $p < 0.014$) and anhedonia ($r = 0.32$, $p = 0.001$). Housing instability, like financial concerns, was also positively associated with COVID-19-related changes in anxiety ($r = 0.27$, $p = 0.008$) and anhedonia ($r = 0.35$, $p < 0.001$). Food insecurity was positively correlated with physical ($r_{pb} = 0.30$, $p = 0.003$) and mental ($r_{pb} = 0.32$, $p = 0.002$) health concerns. Food insecurity was positively associated with COVID-19-related changes in anxiety ($r_{pb} = 0.23$, $p = 0.026$). Lifetime trauma exposure, childhood maltreatment, and income were not associated with COVID-19-related changes in anxiety and anhedonia or concern about the impact of COVID-19 on physical and mental well-being.

Regression models are detailed in Table 4. The first model predicting concern for physical health impact of COVID-19 was significant, $F(5, 89) = 3.24$, $p = 0.010$, $R^2 = 0.15$, with financial concerns emerging as the only significant predictor, $B = 0.30$, $p = 0.022$. A follow-up analysis with self-reported income included as a predictor was conducted to examine whether the inclusion of an objective measure of socioeconomic status would account for the findings. Results did not change with inclusion of self-reported income in the model. The second model predicting concern for the mental health impact of COVID-19 was also significant, $F(5, 89) = 2.88$, $p = 0.019$, $R^2 = 0.14$; in this model, food insecurity emerged as the only significant predictor, $B = 1.06$, $p = 0.003$. The third regression model predicting change in anxiety demonstrated a marginally significant trend, $F(5, 89) = 2.29$, $p = 0.053$, $R^2 = 0.11$, with no individual predictor emerging as significant. Finally, the fourth regression model predicting change in anhedonia was statistically significant, $F(5, 89) = 3.02$, $p = 0.015$, $R^2 = 0.15$, with housing instability emerging as the only significant predictor, $B = 0.30$, $p = 0.036$.

3 | DISCUSSION

The goal of this study was to examine the relations among lifetime trauma exposure, economic insecurity, and psychological distress and symptoms related to COVID-19 in a sample of predominantly Black/African American women. Specifically, we examined the unique contributions of childhood maltreatment, lifetime trauma load, financial concerns, housing instability, and food insecurity on concern for the physical and mental health impacts of COVID-19 as well as pre-to-peri-pandemic changes in anxiety and anhedonia. Food insecurity better predicted concern for the mental health impact of the COVID-19 pandemic than other forms of economic insecurity and trauma exposure. Self-reported financial concerns emerged as the only significant predictor of concern for the physical health

TABLE 2 Psychological distress related to the COVID-19 pandemic (*n* = 96).

	3 months before COVID-19	Past 2 weeks	Change in distress	<i>t</i>
	Mean (SD, range)	Mean (SD, range)	Mean (SD, range)	
Anxiety	2.84 (1.31, 1–5)	3.18 (1.16, 1–5)	0.33 (1.48, –4 to 4)	2.20*
Anhedonia	2.81 (1.33, 1–5)	3.82 (1.23, 1–5)	1.01 (1.73, –4 to 4)	5.72***
	Mean (SD, range)			
Concern about physical health impact of COVID-19	2.47 (1.55, 1–5)			
Concern about mental health impact of COVID-19	2.44 (1.45, 1–5)			

Abbreviation: COVID, coronavirus disease.

p* < 0.05; **p* < 0.001.

TABLE 3 Associations between trauma, economic insecurity, and COVID-related distress.

Variable	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. CTQ total	0.33**	–0.18	0.25*	0.19	0.00	0.02	0.13	0.01	0.07
2. TEI lifetime trauma	–	0.03	0.02	–0.09	–0.06	0.05	0.08	0.08	–0.01
3. Income	–	–	–0.03	–0.10	–0.08	0.13	0.02	0.19	0.02
4. Financial concerns	–	–	–	0.59***	0.37***	0.34***	0.21*	0.25*	0.32***
5. Housing instability	–	–	–	–	0.38***	0.20	0.07	0.27**	0.35***
6. Food insecurity ^a	–	–	–	–	–	0.30**	0.32**	0.23*	0.09
7. Physical health impact of COVID-19	–	–	–	–	–	–	0.65***	0.34***	0.13
8. Mental health impact of COVID-19	–	–	–	–	–	–	–	0.30**	0.09
9. Change in anxiety	–	–	--	--	–	–	–	–	0.45***
10. Change in anhedonia	–	–	–	–	–	–	–	–	–

Abbreviations: COVID, coronavirus disease; CTQ, Childhood Trauma Questionnaire; GED, General Educational; TEI, trauma exposure inventory.

p* < 0.05; *p* < 0.01; ****p* < 0.001.

^aBecause food insecurity is a binary variable, point-biserial correlations are reported.

impacts of COVID-19. Housing instability was the best predictor of pandemic-related changes in anhedonia symptoms. These striking findings suggest that self-reported economic insecurity is more predictive of COVID-19-related psychological distress and symptoms than prior trauma exposure.

The racial distribution of this sample (91.7% Black/African American) is crucial to consider when contextualizing current findings. Due to historic and systemic oppression and inequities, Black/African American individuals have been disproportionately affected by socioeconomic disadvantage and adverse childhood experiences. Exposure to these inequities has been linked to vulnerability to psychiatric disorders (Hampton-Anderson et al., 2021). Furthermore, experiences of racial discrimination compound this risk, increasing susceptibility to race-related health disparities (Fani et al., 2021). Such discriminatory experiences may interact with socioeconomic stress to increase lifetime risk for increased psychological distress in the face of psychosocial stressors. Future studies exploring the potentially additive effect of race-related stress and financial concerns on COVID-19-related psychological distress are warranted.

Similarly, food insecurity was associated with an increase in pandemic-related anxiety as well as greater concern about the physical and mental health impacts of COVID-19 (Wolfson et al., 2021). Further, food insecurity better predicted concern for the mental health impact of the COVID-19 pandemic than other forms of economic insecurity and trauma exposure. Perhaps, those with more food insecurity, coupled with reduced availability of food options due to quarantine and isolation protocols, have greater concern for the potential negative consequences of lack of food access. Both malnutrition and psychological distress have myriad physical health consequences, including greater immune dysfunction (Bourke et al., 2016; Guo et al., 2020; Yuan et al., 2020), which could, in turn, contribute to greater risk of contracting and increased severity of COVID-19 symptoms (Foolchand et al., 2022). In addition, low-income communities are more likely to reside in food deserts, areas with lower access to fresh groceries, and thus, could have experienced food insecurity as a community stressor during the COVID-19 pandemic (Crowe et al., 2018; Ghosh-Dastidar et al., 2014). While findings point to less access to food contributing to higher

TABLE 4 Predictors of self-reported physical and mental health impact of COVID.

	<i>B</i>	<i>SE B</i>	β	<i>F</i>	<i>df</i>	<i>R</i> ²
Physical health impact of COVID				3.24**	5, 89	0.15
Childhood maltreatment	-0.01	0.01	-0.08			
Lifetime trauma load	0.10	0.13	0.08			
Financial concerns	0.30	0.13	0.29*			
Housing instability	-0.04	0.12	-0.04			
Food insecurity	0.73	0.37	0.21			
Mental health impact of COVID				2.88*	5, 89	0.14
Childhood maltreatment	0.01	0.01	0.10			
Lifetime trauma load	0.05	0.12	0.04			
Financial concerns	0.15	0.12	0.15			
Housing instability	-0.16	0.12	-0.17			
Food insecurity	1.06	0.35	0.33**			
Change in anxiety				2.29	5, 89	0.11
Childhood maltreatment	-0.01	0.01	-0.14			
Lifetime trauma load	0.17	0.12	0.15			
Financial concerns	0.10	0.12	0.10			
Housing instability	0.17	0.12	0.19			
Food insecurity	0.39	0.35	0.12			
Change in anhedonia				3.02*	5, 89	0.15
Childhood maltreatment	0.00	0.01	-0.03			
Lifetime trauma load	0.02	0.14	0.02			
Financial concerns	0.23	0.15	0.20			
Housing instability	0.30	0.14	0.27*			
Food insecurity	-0.32	0.42	-0.08			

Abbreviation: COVID, coronavirus disease.

* $p < 0.05$; ** $p < 0.01$

symptoms of worry and anxiety, future research would benefit from examining these relationships using longitudinal data.

Financial concerns were the only significant predictor of distress related to the physical impact of COVID-19; notably, findings from our follow-up analysis did not show that self-reported income was a significant predictor in this model. These findings are consistent with those of previous studies, suggesting that subjective measures of socioeconomic status better predict psychological symptoms than objective measures, like income and education, in samples of minoritized Americans (Burgard et al., 2012; Hatfeg et al., 2020). In other words, subjective evaluations of economic insecurity may be a

better predictor of psychological distress in response to major psychosocial stressors than objective indicators, such as self-reported income. Current findings highlight the need to develop more comprehensive measures of each participant's economic insecurity, both actual and perceived, beyond self-reported income, housing, and employment status.

Additionally, more self-reported housing instability was associated with increased pandemic-related changes in anxiety and anhedonia symptoms at the bivariate level. Our findings provide further support for the notion that housing insecurity is related to poor health outcomes, including depression, anxiety, psychological distress, and suicidal ideation (Vásquez-Vera et al., 2017). We build on prior studies focused on housing instability during the pandemic but focus on a marginalized Black/African American community in the United States (Jones et al., 2021; Scarlett et al., 2021; Vásquez-Vera et al., 2017). Black/African American and Latinx communities have also been disproportionately affected by both the pandemic and the nationwide housing crisis, highlighting the racial inequities within social systems (Webb Hooper et al., 2020). The threat of eviction can serve as a major stressor, and moving to a new neighborhood and employment insecurity can contribute to further psychological distress (Acharya et al., 2022). As such, those experiencing housing instability would likely benefit from community-based support systems, like housing assistance programs, in managing COVID-19-related psychological distress and symptoms of anhedonia.

Unlike prior studies (Békés et al., 2022; Kim et al., 2022; Seitz et al., 2021), neither childhood maltreatment nor lifetime trauma exposure was related to the self-reported psychological impact of COVID-19. This may underscore how, in the context of economic insecurity, prior trauma exposure may have comparatively less influence on pandemic-related distress. More detailed trauma assays would likely increase sensitivity to the relative influence of trauma-related variables or allow for the examination of potential interactions. Furthermore, future studies may benefit from longitudinal data on economic insecurity factors collected before and during the pandemic, specifically in socioeconomically disadvantaged communities. Overall, current findings point to economic factors as playing a relatively larger role in COVID-19-related psychological distress than trauma across the lifespan.

Several limitations of the current study should be noted. This study relied on participants' self-report of their COVID-19-related psychological distress and symptoms. It is worth reiterating that the current study did not focus on the psychological response to contracting COVID-19, but instead, the psychological response to impact of the pandemic, more globally (i.e., regardless of whether the virus was contracted). Anhedonia and anxiety symptoms were reported retrospectively, so the possibility of symptom under- or overreporting must be acknowledged. Furthermore, because a diagnostic measure was not administered, the clinical significance of increases in anxiety and anhedonia observed pre- to peripandemic remains unknown. Another limitation of the current study is the variation in the timing of the initial interview used for data collection. Each initial month of the COVID-19 pandemic varied considerably in terms of infection rates, quarantine/lockdown mandates, job layoffs

and associated financial concerns, and social restrictions. Our data are not representative of the nuances of each stage of the COVID-19 pandemic. Because data were collected during the pandemic, a baseline level of economic insecurity and psychological distress was not available to evaluate potential changes over time.

Lastly, several potential confounding variables, such as participants' mental and physical health histories and the greater rates of various physical health conditions experienced by Black individuals, should be considered when interpreting results. Further, the high visibility of racial traumas in media outlets at the time of data collection in 2020 (e.g., the murder of George Floyd) may have contributed to increased psychological distress in the Black community (Fix, 2021). Future research may benefit from considering the role of current and past diagnoses and race-related stress on COVID-19-related psychological distress and symptoms. While this study primarily focuses on risk factors associated with COVID-19-related psychological distress and symptoms, it is also important to consider how individual- and system-level factors, such as resilience, social support, and community-based programs, may buffer against pandemic-related psychological concerns. Marginalized communities may benefit from future research examining COVID-19-related psychological distress using a strength-based approach (Mammarella et al., 2018; Nebbitt et al., 2016; Zimmermann et al., 2020).

In sum, various facets of self-reported economic insecurity, including food insecurity, housing insecurity better predicted COVID-19-related psychological distress and symptoms than childhood maltreatment or lifetime trauma in a sample of predominantly Black women. Altogether, those with higher levels of financial concerns, food insecurity, or housing instability endured more negative changes in self-reported anxiety and anhedonia as well as more concern for their physical health, highlighting the importance of enacting broader policy change to ensure adequate food and housing support in marginalized communities.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data and materials that support the results or analyses presented in this study will be made available via email to the corresponding author, S. A. G. (sarah.a.abdulghani@gmail.com), upon reasonable request.

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PEER REVIEW

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