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Safety First: The Health Implications of Social Belonging Among Utah Women

For over three decades, health psychologists have documented disproportionately high mental and physical health problems among individuals who are socially marginalized due to their race/ethnicity, sexual identity, gender identity, or socioeconomic status.[1] The prevailing explanation for these health disparities has been "minority stress," defined as the cumulative chronic stress provoked by everyday instances of discrimination, unfair treatment, and shame.[2] This explanation predicts that the poorest health outcomes should be observed in those with the greatest minority stressors, yet studies suggest that this model might be oversimplified. Although marginalized individuals with high exposure to mistreatment *do* have compromised mental/physical health, so do those with low exposure.[3] Because links between stigma and health do not depend solely on the frequency and magnitude of overt stigma-related stressors, we need to better understand how stigma harms the health of individuals in Utah and beyond.

Social safety may be the missing piece. Social safety refers to reliable social connection, social belongingness, social inclusion, social recognition, and social protection, which are essential human needs at all life stages.[4] Most of us give and receive hundreds of subtle cues and reminders of social connectedness as we go about our everyday lives, such as smiling at strangers, responding to requests for help, and showing interest in other people's lives and families. These routine indicators of human concern and connection allow us to move through our social worlds without fear, reminding us that we belong to an interconnected and protective social fabric. A growing body of neuroscience research has shown that without clear indicators of social belonging and inclusion, the human brain "defaults" to a state of chronic hypervigilance, constantly scanning the environment for threat and uncertainty.[5] Chronic hypervigilance takes a heavy toll on a person's mental and physical health over time, increasing individuals' risks for rumination, depressive symptoms, anxiety, suicidal ideation, and immune system dysfunction.[6] Thus, the *lack* of social safety may pose just as great a threat to human health as excess psychological stress.

Study Background

Existing measures of minority stress and stigma focus exclusively on the potential negative effects of social marginalization, such as harassment, victimization, and unfair/denigrating treatment. Yet, according to the social safety framework, without careful assessment of positive experiences of inclusion and belonging, our understanding of the impact of marginalization will be incomplete.

To address this gap, the author and her research team designed a novel self-report measure that asks individuals to report on social safety in seven social domains (see Appendix A for the domains and questions included in this measure). This set of questions was included as part of a Qualtrics survey that was administered online to a statewide, representative sample of Utah women and men, with a higher representation of individuals facing ethnic or economic marginalization. The analytic sample for this brief consisted of 398 Utah women. In addition to the social safety measure and demographic questions, the survey also included the following measures: ostracization, everyday discrimination and disrespect, exposure to community violence, complex trauma, adverse childhood experiences, and health outcomes (see Appendix B for more details). Overall, this research provides an unprecedented assessment of Utah women's experiences of social safety, marginalization, and health. The following research questions were explored:

1) How often do Utah women experience social safety within different social domains?
2) How does social marginalization affect Utah women's social safety?
3) Do Utah women who experience low social safety have unique risks for complex trauma and mental/physical health problems, independent of other health risk factors such as community violence and childhood adversity?

Sample Characteristics

In all, 21 out of 29 Utah counties were represented in the sample. The largest proportion of respondents lived in Salt Lake (33.4%), Utah (18.8%), and Davis counties (12.1%). Participants ranged from 18 to 84 years old (average = 38.2 years). In all, 41.0% were married, 17.1% had been divorced, 24.4% had children who lived with them, and 10.1% had children who did not live with them. In terms of religious affiliation, 51.3% of participants were raised in The Church of Jesus Christ of Latter-day Saints (the predominant religion in Utah), and 34.4% were current members of the Church. The next most common religious affiliations were none (35.6%), spiritual (14.3%), Catholic (10.6%), and Protestant (6.3%).

Women were classified into four income groupings based on their household income, household size, and whether they currently qualified for government assistance. The groupings follow thresholds used by the state of Utah and the Kem C. Gardner Policy Institute at the University of Utah.[7] For example, the "very low" category includes individuals with single-person households under $20,000, with an additional $7,710 added for each additional household member (54.0% of women in the "very low" category were currently receiving government assistance). Table 1 provides additional demographic information.

Table 1: Participant Demographics

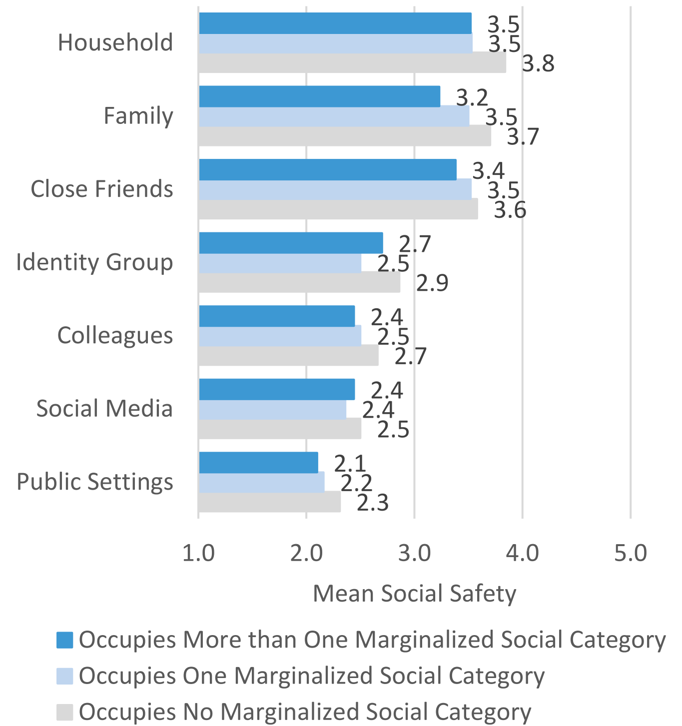
Category	%
Race	
White, Non-Hispanic	72.9%
Latinx	10.1%
Asian	3.6%
Pacific Islander	1.0%
American Indian	0.8%
Black	0.8%
Middle Eastern	0.3%
Other, Mixed	10.6%
Employment[8]	
Employed, Full-Time	35.4%
Employed, Part-Time	21.1%
Student, Full-Time	4.8%
Student, Part-Time	2.0%
Not Employed and Not a Student	36.7%
Income	
Very Low Income	38.2%
Low Income	27.9%
Middle Income	13.3%
High Income	20.6%
Education	
High School	26.7%
Some College	30.8%
Associate's Degree	13.6%
Bachelor's Degree (BA)	19.3%
Post-BA Degree	7.5%
Sexual Orientation and Gender Identity[9]	
Non-Heterosexual	19.1%
Non-Cisgender	3.3%

The results are reported as follows, in four major sections: 1) social safety, 2) predicting social safety, 3) the impact of social safety on physical and mental health, and 4) the impact of social safety on suicidality.

Social Safety

Across all participants, 34.9% had at least three social domains in which they experienced high safety (a rating of 4 or 5 on a scale of 5), 58.0% had one or two safe domains, and 7.1% had no safe domains. Figure 1 presents women's average self-reported levels of social safety across the seven domains. Results are grouped by women's marginalized social categories (being in the lowest income category, being an ethnic/racial minority, or being non-heterosexual or non-cisgender). In all, 57.8% of women occupied no marginalized social categories (i.e., they were White, heterosexual, cisgender, and not low-income), 22.6% of women occupied at least one marginalized category, and 19.6% occupied more than one. Women who occupied one or more marginalized categories reported significantly lower social safety across all domains than women without any forms of marginalization (differences were statistically significant for all domains except for close friends and social media).

Figure 1: Mean Social Safety Across Social Domains by Marginalization Levels



Predicting Social Safety

Women who occupied one or more marginalized social category generally reported higher levels of community violence exposure, childhood adversity, everyday disrespect, and ostracization (see Figure 2 on the next page). Experiences of interpersonal disrespect and ostracization, as well as individuals' prior histories of adversity and violence, may erode women's overall experiences of social safety. To test this, a statistical technique, linear regression, was used to predict women's overall safety scores—the sum of social safety and inclusion ratings across all seven domains[10]—from their marginalization status, age, social isolation, and exposure to ostracization, disrespect, community violence, and childhood adversity. Each of these, except for community violence, independently and significantly predicted social safety levels. For example, greater exposure to ostracization predicted lower levels of social safety.

Notably, a woman's marginalization status predicted her social safety independently of her social isolation and her exposure to ostracization, disrespect, childhood adversity, and community violence. This indicates that occupying a marginalized social category can interfere with women's social safety independently of their *direct* experiences of exclusion, shame, and violence. Furthermore, the effects of disrespect and ostracization on social safety remained highly significant even after controlling for women's overall exposure to neighborhood violence, childhood adversity, and social isolation.

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These findings provide powerful confirmation that social safety is specifically related to experiences of exclusion, rather than experiences of hardship and violence exposure more generally. It is also consistent with research on *structural* stigma that indicates that occupying a subordinate position within social hierarchies and institutions can negatively affect wellbeing even in the absence of explicit discrimination and harassment. The results confirm that the health effects of stigma go beyond the accumulation of incidents "in which one person does something bad to another."[11] Rather, a primary effect of stigma and social marginalization is *insufficient* social safety—insufficient experiences of unconditional connection, inclusion, and belonging with others.

Figure 2: Standardized Means of Violence, Adversity, Disrespect & Ostracization by Marginalization Levels[12]

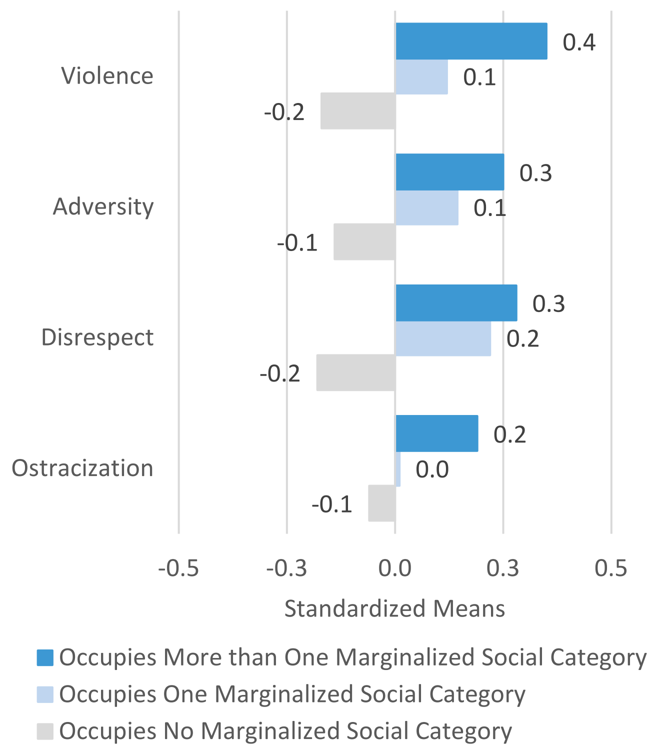
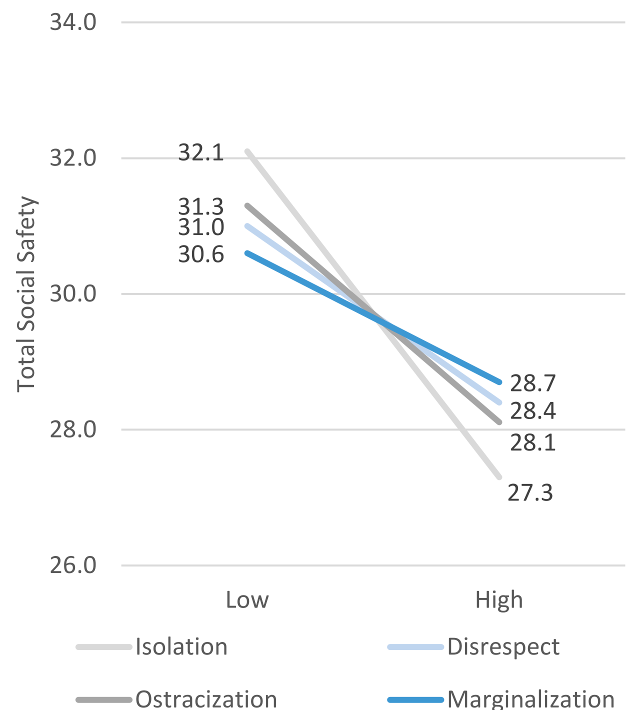


Figure 3 shows the differences in total social safety between women reporting low versus high (one standard deviation below or above the mean) levels of disrespect and ostracization, and low versus high ("yes" versus "no") levels of isolation or marginalization. Each effect is estimated independently of the others (e.g., the difference in total safety among women with high versus low levels of disrespect is calculated after adjusting for her levels of the other variables). The steepness of each line represents the strength of the association between each predictor and social safety. Social isolation showed the strongest negative association with social safety, consistent with prior research indicating that social isolation poses one of the most important threats to mental and physical health across the lifespan.[13] Yet, social safety was also significantly and uniquely imperiled by ostracization, marginalization, and everyday disrespect.

The parallel and additive nature of these effects is consistent with the social safety framework, which argues that a key component of social marginalization is the absence or withdrawal of social protection and belonging. Humans are a deeply social species, and from the earliest days of life, people seek closeness and contact with protective social partners when they are afraid or distressed.[14] This drive for social attachment endures throughout adulthood. In other words, the human brain treats social connection as a "baseline condition" for human functioning.[15] This is why social marginalization has such a profound effect on our health and well-being. The absence and/or withdrawal of social belonging registers as "danger" to the human brain. Hence, when individuals do not receive regular indicators of inclusion and protection, and instead receive indicators of a subordinate or denigrated status, their overall experience of social safety becomes jeopardized.

Figure 3: Social Safety Among Women with Low vs. High Levels of Isolation, Disrespect, Ostracization, and Marginalization



Impact of Social Safety on Health

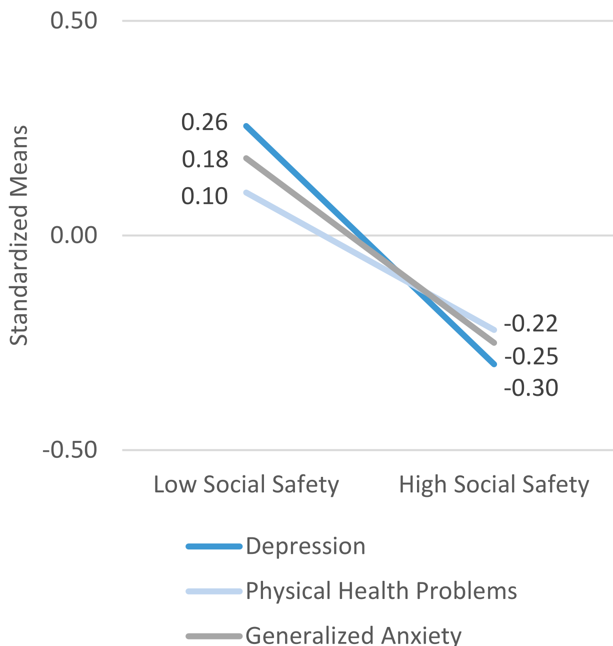
Further analyses sought to identify the consequences of low social safety on physical health, mental health, and complex trauma symptomology. Each analysis controlled for participant age, marginalization status, exposure to community violence, exposure to childhood adversity, and social isolation.

Physical & Mental Health

Individuals with lower social safety reported significantly greater physical health problems, greater depressive symptoms, and greater anxiety symptoms (as shown in Figure 4). The figure contrasts individuals with low social safety (one

standard deviation below the sample mean) versus high social safety (one standard deviation above the sample mean). Hence, each line represents the increase in mental and physical health symptoms associated with having low versus high social safety. The fact that these associations were significant even after controlling for other variables is important because it indicates that experiencing feelings of affirmation and inclusion from social ties has powerful and unique benefits for mental and physical health that are independent of other factors. These findings further confirm that we cannot promote community-wide mental and physical health simply by reducing individuals' exposure to victimization and adversity. To foster optimal health, we must simultaneously *increase* individuals' access to safe and affirmative social ties.

Figure 4. Associations Between Overall Social Safety & Measures of Physical & Mental Health



Complex Trauma & Chronic Unsafety

When individuals are chronically exposed to social relationships that place them at risk for shame, fear, harm, or coercion (i.e., chronic unsafety), they sometimes develop trauma symptoms such as nightmares, unwanted thoughts, emotional numbing, feelings of dread, and hypervigilance, all of which have been found to erode mental and physical well-being over time. Scholars use the term "complex trauma" to describe this phenomenon, and to differentiate it from post-traumatic stress reactions that develop in response to single, acute events (e.g., assaults, accidents, natural disasters).[16]

In this study, 45.6% of Utah women reported having experienced chronic unsafety at some point in their lives, and 13.6% said they were currently experiencing chronic unsafety. Table 3 presents the contexts and timing of chronic unsafety among women who reported such experiences. The most common contexts for chronic unsafety were romantic and household relationships. This highlights the importance of assessing Utah women's vulnerability to chronic threats in their social ties across their lifespan.

Table 3: Contexts and Timing of Chronic Unsafety

Category	% Within Women Reporting Chronic Unsafety	% Among Entire Sample
Context		
Romantic Relationship	52.5%	27.9%
Household	41.4%	26.6 %
Religious Setting	18.2%	9.3%
Work	18.2%	9.5%
Neighborhood	16.6%	10.8%
School	16.0%	8.8%%
Timing		
Prior to Age 12	32.6%	20.6%
Adolescence	48.6%	27.6%
Adulthood	50.3%	28.1%
Currently Experiencing	21.5%	13.6%

Rates of chronic unsafety were significantly higher among women who were unmarried, were non-heterosexual/non-cisgender, had very low income, had experienced adult assault or childhood abuse, or had been suicidal (see Table 4 on the next page). On a survey item about religious experience, women who reported having been "shunned by a religious group" also reported higher rates of chronic unsafety. This corresponds with previous research showing that being excluded from institutions that traditionally provide sanctuary or unconditional refuge (e.g., churches, hospitals) can be experienced as particularly harmful.[17] Although associations between women's ethnicity and their reports of chronic unsafety (or complex trauma symptoms) were not significant, marginalization status was associated with chronic unsafety (Table 4), which indicates the need for future research on the specific social conditions and statuses that increase women's vulnerability to chronic unsafety.

Two-thirds of women who had experienced chronic unsafety reported having developed trauma symptoms in relation to this experience, such as feelings of dread, intrusive thoughts, nightmares, threat vigilance, and numbness. Over 40.0% of women reported experiencing four or more trauma symptoms related to their experience of chronic unsafety, and 21.0% of women reported six or seven trauma symptoms. Women with a greater number of complex trauma symptoms had significantly greater physical health problems, depressive symptoms, and generalized anxiety, even after controlling for age, violence exposure, and childhood adversity. These findings demonstrate that complex trauma in response to chronically unsafe social relationships poses a risk to the mental and physical health of Utah woman.

Table 4: Rates of Chronic Unsafety in Different Groups

Characteristic (% of Sample with Characteristic)	% Chronic Unsafety for Those with Characteristic	% Chronic Unsafety for Those without Characteristic
Has been shunned by a religious tradition (26.9%)	72.9%	35.4 %
Has experienced physical assault as an adult (47%)	63.6%	29.4 %
Has experienced physical, sexual, or emotional abuse as a child (27.6%)	62.9%	29.6%
Non-heterosexual or non-cisgender (22.4%)	61.8%	41.6%
Has been suicidal (34.6%)	58.1%	39.7%
Occupies at least one marginalized social category (47.2%)	54.8%	38.7 %
Very low income (38.2%)	53.3 %	40.7%
Unmarried (59.0%)	51.1%	37.4 %

Impact of Social Safety on Suicidality

Perhaps the most striking findings of the study concerned suicidal ideation and behavior. In all, 31.0% of participants reported prior suicidal ideation, and 13.5% reported a previous suicide attempt. Predicting the odds of each outcome (ever having had suicidal ideation and ever having attempted suicide) from social safety, age, ethnicity, income, sexual/gender identity, exposure to violence, and exposure to adversity, results showed that social safety was significantly related to both suicidal ideation and behavior independent of other factors. Specifically, women who were below the sample mean for social safety had approximately twice the odds of suicidal ideation and suicidal attempts as women who were above the sample mean on social safety. Social safety was a more powerful predictor of suicidality than any other examined predictor.

Conclusions and Recommendations

Many scholars argue that health disparities in marginalized groups stem from the fact that such groups have less access to health-protective resources, such as financial resources and access to preventive health care.[18] Yet, the findings of this study indicate that reliable social safety is another fundamental health resource that plays a critical role in psychological and physical well-being. Social safety experiences are just as influential on individuals' vulnerability to depression, anxiety, health problems, and suicidality as individuals' marginalization, exposure to community violence, childhood adversity, and direct experiences with disrespect and mistreatment. The findings of this research confirm that we cannot promote well-being among Utah women simply by reducing their exposure to stress and hardship: we must also amplify their experiences of connection, validation, and affirmation at all stages of life and across all social contexts. As one set of researchers stated, "The dominant ecology to which humans are adapted is not any one terrain, diet, or climate, but rather each other,"[19] and hence the "need to belong" is a fundamental and primary human motivation.[20] One of the most important steps that we can take to support the health and well-being of all Utahns is to enhance opportunities to form and maintain affirming, validating, and protective social relationships. And, as this research confirms, strong support is particularly important for people within Utah's marginalized communities.

Perhaps the most important recommendation arising from this report is that we need to devote as much attention to *amplifying* social safety as we have devoted to *reducing* discrimination and maltreatment. But how can we do this? These research findings suggest that a critical component is helping individuals experience certainty and reliability in their social connections. People need to *know* that those around them will approve, protect, and care about them, more than to *suspect* that they might. Accordingly, workplaces, schools, and organizations should consider where and when members of the community might feel *uncertain* of their belonging. They may then ask: What can we do to replace that uncertainty with unequivocal evidence of belonging? How can we make sure that individuals know they can say "no" when they need to, and that we take their well-being as seriously as our own? These are not merely organizational and institutional questions, but personal ones. Each of us can examine how we communicate belonging to those around us, how we show the people around us that they matter to us, and how we prioritize opportunities for face-to-face, authentic joy and pleasure in one another's company. We can also examine how we identify those in our social world who feel uncertain, left out, on guard, or wary, and how we replace those feelings with warmth and unconditional regard.

Social safety is more pressing in the wake of the pandemic: Many individuals now spend a significant amount of their workday or school day online, working alone instead of with others.[21] Remote work has numerous advantages regarding accessibility and flexibility, but the loss of face-to-face social contact may erode individuals' access to the basic nourishment of affirmative social connection. Workplaces, schools, and organizations that primarily interact online should seek and promote opportunities for individuals to connect personally and authentically with one another, in person, and in settings that promote relaxation, comfort, and unguardedness.

As Utah policymakers and community leaders continue seeking ways to enhance Utah women's economic opportunities, health status, and social standing, we must treat social safety with equal importance. Accordingly, health promotion efforts should adopt a "safety first" approach that begins by identifying whether individuals have sufficient and reliable access to affirmative and protective social relationships that provide

them with consistent validation, affirmation, protection, and belonging. In the same way that "housing first" approaches to social services emphasize the primary importance of having a safe place to live, "safety first" approaches to psychological well-being must emphasize the primary importance of having social ties that make people feel that they matter to those around them. Ensuring that all Utahns have opportunities for meaningful connection with protective social ties may be one of the most powerful steps that we can take to promote thriving among all Utahns.

APPENDIX A
Social Safety Scale

Women rated how often (from 1-never to 5-always) they experienced the following 14 indicators of social safety within seven social domains: 1) their household; 2) family, 3) close friends, 4) work/school colleagues, 5) their most important identity group, 6) public indoor and outdoor spaces, and 7) social media. Women also rated how included (0, not applicable, or 1-never to 5-always) they felt in each social domain.
Do you look forward to seeing or talking to these people?
Do you feel certain about how things will go?
Do these people notice and care if you are absent, sick, uncomfortable, or hurt?
Do you feel certain about whether these people approve of you?
Do you feel so comfortable that you don't notice time passing?
Do you see or hear something that makes you feel specifically affirmed and included (this could be something that someone says or does, something that you see or hear about, or something that you overhear)?
Do you feel like you matter to these people?
Do you feel like you can say no to these people?
Do you feel like there's someone here who would stick up for you, or who you can always go to for help?
Do you feel so secure with these people that you don't have to devote any thought or attention to how they perceive or treat you?
Do these people treat you, talk to you, or refer to you the way you want them to?
Does someone in this setting make you laugh or feel really good?
Do you feel like your real self with these people?
Do you experience joy and pleasure with these people?

APPENDIX B
Other Measures

Demographics Questionnaire: General questions included county of residence, age, marital status, education, and religion. Marginalization levels were determined by race/ethnicity, income, and sexual/gender identity. Questions about living alone and not being in a committed relationship were used to determine social isolation.
Ostracization Measure:[22] Across the seven social domains, women rated how often (never, once, more than once) they had been betrayed or let down, had felt ashamed or embarrassed, and had been ghosted or cut off.
Everyday Discrimination Scale:[23] Women rated how often they received less courtesy, respect, and service than others; how often they felt looked down upon; and how often they were insulted or harassed. Women also indicated what they perceived to be the basis for their mistreatment (e.g., race/ethnicity, weight).
Community Experiences Questionnaire:[24] Women indicated their cumulative exposure to neighborhood violence (i.e., violence occurring outside the home), either through direct or observed experiences. This could include physical assault, threats of assault, muggings, robberies, break-ins, being coerced to do something, being chased, and needing to call the police.
Chronic Unsafety and Complex Trauma: Chronic unsafety was assessed by asking women to indicate whether they had ever been repeatedly exposed to an environment where they risked being mistreated, shamed, hurt, or pressured to do something they did not want to do. Women answering "yes" were asked to report whether they had experienced trauma symptoms associated with these situations in the past month (e.g., had nightmares; had unwanted thoughts about the experience; avoided thoughts, people, or places about the experience; felt jumpy or numb; felt guilt or shame; felt dread). The number of symptoms experienced served as our index of complex trauma.
Philadelphia Adverse Childhood Experiences Survey:[25] Participants rated their exposure to stress and adversity in childhood and adolescence, including incidences of financial hardship, emotional abuse, neglect, physical abuse, sexual abuse, substance use and suicidality in the home, neighborhood racism, and bullying.
Health Outcomes: Participants completed the Rand SF-36 Medical Outcomes Survey,[26] which assesses subjective perceptions of poor health, difficulties with daily tasks, and physical functioning. Participants also completed standard assessments of depressive symptoms, generalized anxiety symptoms, and suicidality.

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[8] The remaining 36.7% of women were unemployed.

[9] Because the present study focuses on effects of stigma and social exclusion, women were categorized according to their divergence from the culturally-approved and dominant categories of "heterosexual" and "cisgender." The non-heterosexual group includes all participants who claimed a sexual identity other than heterosexual, and the non-cisgender group includes all participants whose gender identity differed from their birth-assigned gender.

[10] The social safety scale showed excellent reliability within each domain (i.e., the 14 experiences "hung together" within each social domain, suggesting that they captured the same underlying experience). The total safety measure used in Figures 3 and 4 was based on a sum of social safety and inclusion ratings across the seven domains.

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[21] In the present sample, less than half of respondents pursued their work or school activities entirely in person, and one in five respondents were working/studying entirely online.

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