# Questions Asked During Live Webinar Broadcast on 8/28/19

## *Intersection of Race, Culture, Chronic Disease and Chronic Pain*

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**Chronic pain increases liklihood of anxiety and/or depression but can anxiety and/or depression exacerbate a low grade pain into becoming chronic pain?**

A: No, it can not exacerbate low-grade pain into chronic pain. It can however cause it to increase in severity (i.e., higher pain scores).

**The positive outcomes of historical trauma: are those correlated more with cultural groups that retain a cohesion, or with all historically traumatized in general, even if they are severely fragmented and have no group cohesion anymore historically?**

A: Research has not shown that positive outcomes are correlated with groups who retain cohesion.

**For tansgender persons, trauma is especialy high, especially among black and brown people. Any tips on working with this population effectively? The rates of vialence and depression and self-harm are super high.**

A: I definitely advocate for those working with this population to seek training and supervision to develop competency. Additional resources are: https://www.lgbthealtheducation.org/topic/transgender-health/ ; https://transgenderlawcenter.org ; https://www.apa.org/practice/guidelines/transgender.pdf

**Any information on the Alaska Native population regarding historical trauma (including extreme rural/isolated settings) and chronic pain?**

A: Links to articles and resources:

- https://geriatrics.stanford.edu/ethnomed/alaskan/introduction/history.html
- https://firstalaskans.org/alaska-native-policy-center/racial-equity/
- Evans-Campbell, T. (2008). Historical Trauma in American Indian/Native Alaska Communities: A Multilevel Framework for Exploring Impacts on Individuals, Families, and Communities. *Journal of Interpersonal Violence*
- Maria Yellow Horse Brave Heart Ph.D., Josephine Chase Ph.D., Jennifer Elkins Ph.D. & Deborah B. Altschul Ph.D. (2011) Historical Trauma Among Indigenous Peoples of the Americas: Concepts, Research, and Clinical Considerations, Journal of Psychoactive Drugs

**You mentioned examples of historical trauma. I'm wondering if you would consider multi generational substance-abuse and families an example?**

A: Substance Abuse among a families can be considered both Intergenerational Trauma and Historical Trauma depending on how you examine the issue. Because historical trauma consist of three primary elements: a "trauma" or wounding; the trauma is shared by a group of people, rather than an individually experienced; the trauma spans multiple generations, such that contemporary members of the affected group may experience trauma-related symptoms without having been present for the past traumatizing event(s). It is distinct from intergenerational trauma in that intergenerational trauma refers to the specific experience of trauma across familial generations, but does not necessarily imply a shared group trauma. Similarly, a collective trauma may not have the generational or historical aspect, though over time may develop into historical trauma.

### Has marijuana prescription increased in treating chronic pain and has research proved it beneficial?

A: I do not know if it has increased as legalization has been approved at different rates state by state.
Statistics on current use by State:

- http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx
- https://www.statista.com/statistics/585154/us-legal-medical-marijuana-patients-state/
- https://www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/

### How receptive are practitioners to not judging automatically or suspiciously?

A: The research shows that there are practitioners who are not racist and biased and some that are.

### How do you address historical trauma, since history already lived does not change?

A: You address it by acknowledging its existence (the event, issues, etc that occurred) and offer ways to help them begin to heal. Help with reconnecting people to the their ancestry and culture, helping people process the grief of past traumas, and creating new historical narratives can have healing effects for those experiencing historical trauma.
Resources: https://drive.google.com/file/d/1Y1fiEXAzqKYtiQTbGLH08VuqUIOjdqOA/view ;
https://drive.google.com/file/d/1IhZqrQWa_Q2sGuPWc_8kytLz4QcjG2WS/view

### Do we have the racial/cultural studies avaliable to be read? (Slide- Genetics, Race & Pain)

A:
A few great studies:

- Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med. 2007
- Sabin JA, Greenwald AG. The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma. Am J Public Health. 2012
- Burke, S. E., Dovidio, J. F., Perry, S. P., Burgess, D. J., Hardeman, R. R., Phelan, S. M., … van Ryn, M. (2017). Informal Training Experiences and Explicit Bias against African Americans among Medical Students. *Social Psychology Quarterly*

A few great articles:

- Smedley BD, Stith AY, Nelson AR. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington: National Academy Press
- Shavers VL, Fagan P, Jones D, et al. The state of research on racial/ethnic discrimination in the receipt of health care. Am J Public Health. 2012
- van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. Soc Sci Med. 2000
- Blair IV, Steiner JF, Fairclough DL, et al. Clinicians' implicit ethnic/racial bias and perceptions of care among black and latino patients. Ann Fam Med. 2013
- Penner LA, Dovidio JF, West TV, et al. Aversive Racism and Medical Interactions with Black Patients: A Field Study. J Exp Soc Psychol. 2010
- Smedley BD, Stith AY, Nelson AR, eds. Unequal Treatment: Confronting racial and ehtnic disparities in Health Care. Washington, D.C.: National Academy Press; 2002. Medicine; Io, ed.

Additional Resources: https://drive.google.com/file/d/1Y1fiEXAzqKYtiQTbGLH08VuqUIOjdqOA/view ;
https://drive.google.com/file/d/1IhZqrQWa_Q2sGuPWc_8kytLz4QcjG2WS/view

**Do you know if the medical field as a whole is susceptible to learning from the psychological field in regards to treating patients more holistically?**

A: I believe most doctors in the medical field are. This can be seen when you look at the increased integration of mental health into primary and specialty care.

**How do the symptoms of, depression of weight and appetite change, present differently for those with co-occurring chronic pain?**

A: How patients develop and express issues with depression and weight/appetite can be different due to the association of chronic pin and the disruption of sleep. Ongoing sleep interruptions can cause increases and/or decreases in eating, irritatability and depression. Common symptoms associated with depression and anxiety may still be possible.

**How do African American women enter into our treatment? What's the most likely entry experience like for them and how are they most commonly referred to treatment for SUDs? And how does that differ in comparison to other cultures?**

A: As I don't work in outpatient SA treatment, I would recommend looking at data given by SAMHSA as a start.

- https://www.samhsa.gov/behavioral-health-equity/black-african-american