Questions Asked During Live Webinar Broadcast on 7/15/2020

Cultural Humility Series, Part II: Social Class Bias and the Negative Impact on Treatment Outcomes

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What are some non "middle class" or non classist self care techniques you can suggest?

A:Walking outside, sitting in a quiet place, reading, breathing techniques, mindfulness, sensory related decompression: tactile, olfactory, auditory, visual, and kinesthetic. Doodling, journaling, muscle relaxtion techniques, processing with a friend, being in nature (parks, fields etc).

What are Racial bias in pain assessment treatment of black and white patients studies that you are familiar with as clinicians?

A: This is not an exhaustive list, there are many more that I did not include:

Anderson, K. O., Green, C. R., & Payne, R. (2009). Racial and ethnic disparities in pain: Causes and consequences of unequal care. The Journal of Pain, 10, 1187–1204. http://dx.doi.org/10.1016/j.jpain.2009 .10.002 Anderson, S

Becker, W. C., Starrels, J. L., Heo, M., Li, X., Weiner, M. G., & Turner, B. J. (2011). Racial differences in primary care opioid risk reduction strategies. Annals of Family Medicine, 9, 219 –225. http://dx.doi.org/10 .1370/afm.1242

Bernstein, M. J., Young, S. G., & Hugenberg, K. (2007). The crosscategory effect: Mere social categorization is sufficient to elicit an own-group bias in face recognition. Psychological Science, 18, 706 – 712. http://dx.doi.org/10.1111/j.1467-9280.2007.01964.x

Bonham, V. L. (2001). Race, ethnicity, and pain treatment: Striving to understand the causes and solutions to the disparities in pain treatment. The Journal of Law, Medicine & Ethics, 28, 52– 68. http://dx.doi.org/ 10.1111/j.1748-720X.2001.tb00039.x

Brosch, T., Bar-David, E., & Phelps, E. A. (2013). Implicit race bias decreases the similarity of neural representations of black and white faces. Psychological Science, 24, 160 –166. http://dx.doi.org/10.1177/ 0956797612451465

Burgess, D. J., van Ryn, M., Crowley-Matoka, M., & Malat, J. (2006). Understanding the provider contribution to race/ethnicity disparities in pain treatment: Insights from dual process models of stereotyping. Pain Medicine, 7, 119 –134. http://dx.doi.org/10.1111/j.1526-4637.2006.00105.x

Caharel, S., Montalan, B., Fromager, E., Bernard, C., Lalonde, R., & Mohamed, R. (2011). Other-race and inversion effects during the structural encoding stage of face processing in a race categorization task: An event-related brain potential study. International Journal of Psychophysiology, 79, 266 –271. http://dx.doi.org/10.1016/j.ijpsycho.2010.10.018

Cassidy, B. S., Krendl, A. C., Stanko, K. A., Rydell, R. J., Young, S. G., & Hugenberg, K. (2017). Configural face processing impacts race disparities in humanization and trust. Journal of Experimental Social Psychology, 73, 111–124. http://dx.doi.org/10.1016/j.jesp.2017.06.018

Centers for Disease Control and Prevention. (2005). Health disparities experienced by black or African Americans—United States. Morbidity and
Mortality Weekly Report, 54, 1–3

Cleeland, C. S., Gonin, R., Baez, L., Loehrer, P., & Pandya, K. J. (1997). Pain and treatment of pain in minority patients with cancer. The Eastern Cooperative Oncology Group Minority Outpatient Pain Study. Annals of Internal Medicine, 127, 813– 816. http://dx.doi.org/10.7326/0003-4819- 127-9-199711010-00006

Drwecki, B. B., Moore, C. F., Ward, S. E., & Prkachin, K. M. (2011). Reducing racial disparities in pain treatment: The role of empathy and perspective-taking. Pain, 152, 1001–1006.

Edwards, C. L., Fillingim, R. B., & Keefe, F. (2001). Race, ethnicity and pain. Pain, 94, 133–137. http://dx.doi.org/10.1016/S0304-3959(01)00408-0
Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. Social Science & Medicine, 103, 7–14. http://dx.doi.org/10 .1016/j.socscimed.2013.09.006

Geronimus, A. T., Bound, J., Waidmann, T. A., & Colen, C. G. (2001). Inequality in life expectancy, functional status, and active life expectancy across selected Black and White populations in the United States. *Demography*, *38*, 227–251.

Geronimus, A. T., Bound, J., & Colen, C. G. (2011). Excess Black mortality in the United States and in selected Black and White high-poverty areas, 1980–2000. American Journal of Public Health, 101, 720–729.

Inequality, Family Processes,and Health in the "New" Rural America

Mende-Siedlecki, P., Qu-Lee, J., Backer, R., Van Bavel, J.J., (2019) Perceptual Contributions to Racial Bias in Pain Recognition, J*ournal of Experimental Psychology: General*, Vol 148(5), May, 2019 pp. 863-889. Publisher: American Psychological Association;

Newton, D. E. (2018). The opioid crisis: A reference handbook. Retrieved from https://ebookcentral.proquest.com

Santoro, T.N. & Santoro, J.D. (2018). Racial bias in the US opioid epidemic: A review of the history of systemic bias and implications for care. Cureus, 10.12, E3733. doi: 10.7759/cureus.3733

Tait, Raymond C.; Chibnall, John T.; American Psychologist, Vol 69(2), Feb-Mar, 2014 Special Issue: Chronic Pain and Psychology. pp. 131-141. Publisher: American Psychological Association;

How many low income people have dentist and medical doctors who will prescribe OxyContin?

A: There is not a direct answer, as prescriptions are not tracked by SES, I have pasted a link to The National Center for Biotechnology Information: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2622774/ and the CDC https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html. What we do know is that at the peak of prescribing in 2012, the prescribing rate was 81.3 prescriptions per 100 persons. Also of those individuals who began abusing opioids in the 2000s, 75 percent reported that their first opioid was prescribed to them by a PCP or dentist (Cicero et al., 2014). In her Blog Dr. Nora Volkow from NIDA indicated that Addressing the Opioid Crisis Means Confronting Socioeconomic Disparities, where it is cited that the CDC considers low income individuals to be at a high risk for prescription drug overdose. According to the US Department of Health and Human Services, individuals on Medicaid are prescribed opioids at higher doses, and for longer durations—increasing their risk for addiction and its associated consequences. https://www.drugabuse.gov/about-nida/noras-

blog/2017/10/addressing-opioid-crisis-means-confronting-socioeconomic-disparities

Can you comment on the importance of Cultural Humility Trainings verses Cultural Diversity Trainings?
A: They are both important yet have different foci, I believ by incorporating cultural humility into the diversity trainings organizations would have more robust trainings and better outcomes, this is my opinion and I have not researched this topic regarding training.

Do you think that classes like this and Cultural Awareness Classroom hours should be mandatory like ethics classes are?
A: I believe that cultural awareness should be taught in conjunction with ethics, theories, human growth & development, because they intersect in all these realms.

Are there any reliable studies of the upper class to identify intergenerational trauma and brain development under stress? Is it even possible to get accurate information due to fears of disclosure?
A: Not that I have found, all the studies I have found have shown that high ses acts as a prophylaxis against stress disorders due to the easy access of preventative care, healthy foods, recreation etc. This does not exclude the fact that intergenerational trauma can occur in high ses individuals.

How can I as a clinician who was not aware of the bias that I carry-- be more productive and efficient about working on my biases to continue on assisting my client?
A: The first step is, as it is with any bias, is to identify that we have them. Read on the topic, be more aware of disparities, and learn as much as you can from your client regarding their circumstances. Be open to understanding and be aware when we assess and diagnose them what role SES is presenting as. Be aware when making diagnostic and assessment recommendations, ex. are your biases impacting your diagnostic impression?

Can we advocate to break the barriers with office by using telehealth sites in the lower income areas to access therapy and medications?
A: Yes! We should be advocating, Principles I-20, III-29, III-30, III-31, III-32, IV-9, of the NAADAC code of ethics speaks to advocacy. One part of our role as an addiction professional is to increase access to care, telehealth is a necessity for lower income individuals, individuals in rural communities, and the disabled.

What does the panel think is most effective therapy to work with African American youths with intergenerational vulnerabilities?
A: Some considerations among many, are understanding that these youth are generally from a systematically disenfranchised group that has experienced systematic racism, oppression, and intergenerational trauma. Therefore this group is more frequently subjected to both SES bias as well as systemic oppression within healthcare, refer to journal articles above. Therefore, acknowledging any priviledge held by the therapist and honoring the clients experiences are a vital first step. Understanding intergenerational trauma and its impact on both the family system must be considered in diagnosis, treatment planning, and treatment. Understanding that poverty and oppression are expressed behaviorally, emotionally, and psychologically, thus working from a TIC approach.

In the workplace, as a soon to be counselor, group counselor or community health worker how would I address observed potentially concerning client interactions of a superior or colleague in which the person interacts with the client, knowingly/intentionally or unconsciously in a condescending or demeaning manner due to internal biases they may have towards the client? How would I address such an issue without causing a rift in the relationship with colleague or superior at the workplace?
A: Speak up, have open and honest communication, remember that systems with rigid boundries and covert languaging are often the dysfunctional ones. Take the opportunity to educate them on the negative impacts of SES bias on the clinical relationship, educate them on the body of research out there supporting this. Most clinicians are open to learn about themselves and how to better serve clients. We are the agents of change, if we don't do it, who will?