NAADAC

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INTERSECTION OF RACE, CULTURE, CHRONIC DISEASE, AND CHRONIC PAIN

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>> The broadcast is now starting. All attendees are in listen only mode.

>> MODERATOR: Hello, everyone, and welcome to today's webinar on the Intersection of Race, Culture, Chronic Disease and Chronic Pain by Sherra Watkins. I'm the Director of training and development for NAADAC, association for addiction professionals. I'll be the organizer of today's online event. This is produced by NAADAC, The Association for Addiction Professionals and captioning by CaptionAccess, please check your inbox and the link for closed captioning.

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Today we're using Go To Webinar. Here is important instructions. You are in listen only mode that means your mic is muted to avoid any background noise. If you have trouble hearing the presenter for any reason, I recommend switching to a telephone line as some Internet connections are not strong enough to handle webinars. If you have any questions for the presenter, just type them into the questions' box of the Go To Webinar Control Panel, that looks something like you see here on the slide. We will collect and gather all of your questions and we will have two Q&As in this webinar. One at the mid point where we'll pose the questions to the presenter and she will answer them, and then another one toward the end.

If your questions are not answered during this webinar, we'll have them all typed up in a document and they will be sent to the presenter and posted online later on.

Now, let me tell you about today's very skilled presenter. Dr. Sherra Watkins is the psychosocial Manager at Levine cancer Center, earned degrees from a doctor's of philosophy in rehabilitation counseling and administration, a master of science degree in clinical counseling and substance abuse counseling, a master of arts in education degree in health education. Bachelor of Science degree in school health education. Dr. Watkins research focuses on decreasing stigma of chronic pain and chronic diseases such as HIV/AIDS, sickle sell disease and Lupus, acute pain management, sexual assault trauma, and reducing stig significant mattizing. Received personal honors and recognized with a ECU leadership aword 40 under 40 inAugust regard class.

NAADAC is delighted to provide this webinar presented by this accomplished expert, so Dr. Watkins, if you are ready, I'll hand this over to you.

>> SHERRA WATKINS: Good afternoon, everyone, and I look forward to presenting on this and thank you so much Samson for the wonderful read of my bio.

We want to go ahead and get started on today. What learning objectives that I hope to cover will be focused on the participants will learn the difference between tolerance, physical dependence, withdrawal and also addiction. Participants will identify how race and culture intersects with pain and chronic disease treatment, and also participants will discuss how chronic pain and chronic disease impacts mental health and learn the counselor's role in the treatment of it.

So what we do now to start off on what I would like to know, I'm sorry, is which of the following best describes your professional affiliation for all the attendees on, a physician, nurse, counselor/therapist, social worker, or psychologist?

>> MODERATOR: This is Samson, this is the first of many chances to interact with the presenter today. You are seeing a live poll opening up with five answer options. Please take a moment to answer this poll. It looks like you guys are very used to this, we've already got 60%, so I'll give you about 15 more seconds to answer the poll and then turn it back over to Dr. Watkins to speak to the results.

Excellent. Thank you, everyone. 75%. 5 more seconds, and as you answer these, just a reminder, as you interact with the poll we'll have two Q&As and these question and answer opportunities will be live and facilitated with our presenter. We will break at the mid point of the presentation for some questions and then again at the end, so please go ahead and send your questions into the Question's Box.

All right. We're going to go ahead and close this poll and share the results. I'll turn this back over to Dr. Watkins.

>> SHERRA WATKINS: It is great to see that we have the majority of our counselors are social workers and then of course nurses and also psychologists. This is very important to be aware of, those actually engaging in today's webinar, because what we know about chronic pain treatment is that it

takes a team approach, both the bio and medical on pieces and also the psychosocial pieces in order for us to best treat our patients in this field and concerning this particular topic.

And so we want to talk about each person's role, so we'll go ahead and move forward when it comes to our presentation.

So what we know about chronic diseases in the United States is that it represents approximately 63% of all deaths in the U.S., so that is about 7 in 10 deaths each year is attributed to chronic diseases. 1 in almost 2 adults live with one chronic disease, and we know there are a variety of ones more prevalent in the U.S. and we'll get to that too, but what is very interesting is that more than 75% of healthcare costs are due to chronic conditions and they can affect people of all ages, so as we're talking about chronic disease, and especially in regards to race and culture, I'm not just talking about the adult population. I'm also talking about the whole gamut, the whole paradigm of the lifespan, so everybody from birth to death.

So we know that chronic diseases can also affect vulnerable populations at greater rates, so when we talk about the vulnerability of certain populations we're looking at racial and ethnic disparities, so we're looking at minorities such as Hispanic, African American, Asian, migrant farm workers or disenfranchised ethnic group, and also Native Americans. Rural and urban disparities, those who once again maybe in the outset of farmland or once again may not be close to any type of close medical care in the city limits, socioeconomic status, reading ability, education, housing, those type of things fall into this particular category, and no to low education. When we look at the treatment of chronic pain and the intersection with race and culture, these variables do intersect with them in how our patients have been treated in past studies and also current studies, so a person's ethnicity, education, and even medical literacy all will have a major impact and affect the treatment of chronic pain and we'll get more into that.

So, when we look at what are some of the most common chronic diseases among minorities, cardiovascular diseases, HIV and AIDS, diabetes, lupus, sickle cell disease, hypertension, heart disease which falls under cardiovascular, and asthma, are some of the most chronic diseases that face minorities in the U.S.

This is not an exhaustive list or maybe even the top 10 but some of the most prevalent and common that we see, and so I do have to mention that though HIV is listed on here, AIDS, of course is the end stage of it, but it's combined together for the purpose of discussing the most commonalities among minorities.

So when we look at the prevalence of chronic pain, so we've talked about what are some of the most common chronic diseases among Americans that we have to say, what are some variables to contribute to that, and so now we want to make sure that we have a good understanding that though we talked about those common chronic diseases, what about chronic pain, what does that look like in the U.S.? What we know is that the 50 million Americans live with chronic pain at any given time. That's approximately 20% of U.S. adults and 8% report having high impact chronic pain, which means that for their high impact they're recording high pain scores, typically scores that would be based out of 10 as the highest score, so anything above 7.

Meaning also, that the pain is restricted at least one major life activity, so how they're also able to function in day to day living is impacted for those that report having high impact chronic pain. It's also linked to restricted mobility, could be linked to opioid depend sees and depression, reduction in quality of life, and contributes to about 560 billion annually in direct medical costs and lost productivity and disability programs in the United States, so we do know this is a major prevalence in the U.S.; however, how do we focus on, once again, treating chronic pain and also treating it accurately when we look at race and culture and those different variables.

So how we define chronic pain is that chronic pain is defined as any pain lasting more than 12 weeks, anything less than 12 weeks would be acute pain. Chronic pain also persists often for months or even longer, and longer can be unfortunately to death. Chronic pain is usually classified as pathophysolgy that is nociceptic, ongoing tissue injury, or neuropathic from damage to the brain, or spinal cord or peripheral nerves or mixture or contribution of all of the above that I mentioned along with negative psychosocial effects, so when we're looking at the definition of chronic pain, we're looking at how long has it been prevalent, will it most likely continue for months or even longer as far as years, and then we want again to look at what is the underlying factors that may have caused the chronic pain to once again develop? Was it developed by some type of injury or some kind of treatment? Cancer treatment can also sometimes have chronic damage to nerves so that can lead to chronic pain in certain cancer survivors, and so we look at this, so we have to make sure that we're treating chronic pain differently than how we treat acute pain, and that can be very important to remember as we get further along in the webinar because there have now been medical mandates that also speak specifically to how we treat chronic pain versus acute pain and that very much impacts our minority clients and patients that are dealing with chronic pain on a day to day basis.

It's important to come up with these topics I'm sorry, these definitions when it comes to tolerance, dependence, and addiction because in my line of work over the past 10 years and working with chronic pain, I often once again, have had our patients that are minorities that have been termed drug seekers because there is a lack of understanding, and when it comes to these basic definitions, what we know is that tolerance is defined as a person's response to a drug as a result of repeated use, and we know by education and we're hopefully talking to our patients in very simple words, I tell my patient, the very first time you take a drug the tolerance begins, so we have to make sure that when you're going into your doctor's office and creating this language with medical providers, if they're saying you're addicted because you're seeking more, once again we have to make sure they're using the right terminology and they're providing facts when it comes to dependency versus tolerance versus addiction.

So dependency is defined as often used interchangeably but not the same, but it is the value of adaptive response to the presence of a drug, and so again when we lack of presence, of course, we can go into a withdrawal syndrome and so we want to make sure that we're educating our patients with these terminologies because often times it's the patients who have to sometimes educate the medical staff when they've been labeled as drug seekers or pill mills or things like that, so we want to make sure that we understand the difference between tolerance and dependency, and how does that play a part with someone who has chronic pain and put on some time of pain management plan and how that may affect the body long term and how we treat that with opioids or also other alternatives of pain medication.

So addiction, accord according to NIDA is chronic relapsing brain disease that is characterized by compulsive drug seeking use and can he spite harmful consequences. And so overwhelming use to need the drug. So when we compare to dependency intolerance, once again they're not interchangeable and that's very important to know because often times when patients are labeled as drug seekers or pill seekers because of a lack of understanding and knowledge, they're labeled as addicts and once again, those labels can cause miseducation and treatment to minority patients all because, once again, lack of understanding.

Some other important terms that are also related to miseducation is psycho somatic pain or which pain is psychological parts of triggers and sometimes classified as medically unexplained because it affect both the mind and body so the parents experience symptoms that are inconsistency or cannot be linked or explained by their underlying general medical issue, and so when patients are coming in or saying that pain is extremely high and we're looking at labs that could be linked to the underlying disease and it's not making sense, it could be possibly be falling under psycho somatic pain, what we know from the psychosomatic pain is when left treated unprobably there is a increase in depression so therefore you have a increase in pain because all of it is linked together and so I make sure that I try to educate our patients that you have to make sure that you're communicating to your provider, but also you're being knowledgable of different types of stressors that may be present in your life that could also contribute to psychosomatic pain, and some of those stresses that could lead to anxiety and depression diagnosis that are left untreated.

Pseudoaddiction is a very controversial term but to describe current drug related behaviors that resemble patients with addiction that is typically associated again with inadequate treatment of pain, so they may come in and they're always in pain, the pain scores are high, and may even show other signs of addiction, but again it's not addiction and it's pseudoaddiction and it's all related to untreated or inadequate treatment of the chronic pain and also the underlying disease.

So these are a few important terms that will kind of give us a good foundation as remove forward in the webinar. So we've defined chronic disease, we've also defined some of the top chronic diseases, and now we've talked about the definition of chronic pain, and so I ask you this question, number two, what psychological issues do people living with chronic diseases face? A, they don't face any specific psychological issues? B, their psychological issues are no different than those living with that chronic disease? C, they have higher rates of depression only? Or D, they have higher rates of anxiety and depression.

>> MODERATOR: Thank you, Dr. Watkins. Everyone you see the poll launch on the screen now with all four options. As a reminder as you finish the poll, we'll do a live Q&A at the midpoint of this webinar and toward the end of the webinar and you'll get to interact directly with Dr. Watkins with live questions and answers. Thank you for responding to the poll. It looks like we've got over 68% of those in attendance have answered and we'll give you just about 5 more seconds.

Excellent. Thank you so much, everyone. We're going to go ahead and close the poll and share the results so that Dr. Watkins can speak to this and I'll turn it back over to our presenter.

>> SHERRA WATKINS: Wonderful. You all are very much keyed in to the residual effects of chronic pain, and so 97% of you all are correct. They do have higher rates of anxiety and depression, an

often times they coincide and it's very unique in trying to treat these patients with their chronic disease because it can be a little tough in deciding sometimes which one do we treat the most or sometimes find the right medication to tap in both of the diagnoses of anxiety and depression.

What we do know is there is a reciprocal relationship between pain and our psychological processes, so not only can they have a residual effect into multiple dimensions of a person, but it's very significant, for example, in our attention and the ability to focus. So there is a decreased ability to focus as most of the time the foe discuss on the pain stimulus, which is that I want to be pain free or in pain or I know I'm going to be in pain in a couple hours because my medicine is going to wear out, so there is a hypersensitive focus on their pain.

In relation to cognitive thinking and cognition, pain is typically interpreted as sensory information and so as it's perceived, the individuals generally experience less functional impairment so we want their perception of chronic pain to be as diminished as possible so they can have more functionality in their day to day living. So that's why when you look at current treatment psychologically for chronic pain, we look at CBT as a baseline treatment too because again focusing on cognition and thinking.

However, perceived control over one's pain can be perceived as less intense if, once again, they have control and they feel like they're able to handle it. Pain catastrophizing and that means linked to more physical impairment regarding scale and heightenedness of it is linked to more physical impairment such as disability, greater psychological distress, anxiety and depression, and also a higher risk of suicide and so we want to make sure that as we're treating the person who is living with chronic pain, we have to treat the whole person and so biopsychosocial. We have to treat both the medical pieces and realize they're more pro exposed to anxiety and depression compared to someone without a chronic disease.

Some of the emotional reactions that typically pain can lead to anger, fear, sadness and also trigger autonomic responses such as stress related multiple contradiction and create a self perpetuating cycle. One of the most difficult pieces is seeing our patients in pain and they're sometimes in the hospital and curled up in a ball because they're in so much pain, but what we know is that muscle contradiction is once again being tightly balled up into a ball is not the healthiest when treating the pain. We want them up and moving as much as possible to get that circulation, and so we do know that we have to be mindful that there can be muscle constriction that might be caused by the person's paralysis due to chronic pain but it could be constriction related to the chronic pain.

The behavior reaction and the social aspects, reduction in activity, long term reduction in activity and once again can increase the persons pain and disability. As you heard me mention, we want them as mobile as possible, so as we're looking at the whole person we may include physical therapy, occupational therapy, along with once again, treating chronic pain. So as a counselor, as we talk about a little bit further it, may be linking our patients to these outside resources.

Also avoidant behaviors, so aid voidant behaviors are reinforced so because they may be fearful if they do certain activities the pain may become present or spike, they may once again be fearful of doing certain things and but what we want it to not be reluctant and live the most active and healthiest lives as they possibly can.

So when we look at the comorbidity of chronic pain and also chronic diseases, mostly anxiety and depression are the top two diagnoses that are linked with chronic pain between 30 and 60 percent of individuals with a pain report also report having depression and approximately half the patients with depression also report pain, so we're seeing some comorbidity between decompression and pain, with pain being present along with depression and also depression being present along with the pain.

So as we use the analogy, what came first? Often times they almost sometimes end up being present together so we have to make sure we make treatment plans that look at both psychological pieces of the comorbid behavioral health and chronic medical conditions we have to be mindful of, we look at percentages of other chronic diseases like arthritis and hypertension, and when we look at this chart, we still see that chronic pain, when compared to some of the other chronic medical conditions, that there is a higher percentage of depression and anxiety with chronic pain, and second of course would follow asthma.

So then we look at the treatment for it, and so 61% approximately in the U.S. may report having chronic pain and also depression and anxiety, but only approximately 6% are actually seeking treatment for that depression and anxiety, so we have to begin the ask the question of, are clinicians educated and also trained enough to treat both?

So what we do know is that it's 50/50. There are some physicians that do not mind treating for depression and anxiety and know what to look for and examine and assess for it, and then there are those that once again, only want to focus on, you're here for chronic pain, this is what we're going to focus on. So culturally what we know is often times minority patients, it's hard to step foot in any medical office, so the person may serve as a gatekeeper for both that chronic condition and the chronic pain and the presence of a psychological issue, we need physicians and clinicians to include ACP and APC, that's the name, interchangeable, to then treat all three. We need for them to make sure they're able to focus and assess on treating the presence of depression and anxiety or even other psychological issues.

Some of the most common unhealthy thinking styles I typically see with patients dealing with chronic disease and chronic pain is an all or nothing mentality, which means that it's either always sick or I'm not, or it's either going to be this way or it's not. They typically do not live in the gray area and that can be very disparaging when trying to work with patients in setting goals and even creating treatment plans with these patients, so we want to make sure we're examining some of the unhealthy things such as the all or nothing. Some other ones are overgeneralizing, mental filter, jumping to conclusions, and once again almost as if they are maybe forecasting or once again feel like they be because they often know what's going to happen and often sometimes may not magnification or making the problem bigger. They may minimize or it it's just pain and because I'm in pain I have to be depressed so I might as well not worry about it at all.

Should and must, personalization such as this is my fault, emotional reasoning, and labeling. So when we're looking at some of these unhealthy thinking styles, many of these thinking styles are what we learn in counseling, typically become present starting out at a younger age. We begin to, once again, be immersed into different types of environments and people who sometimes input and impact our lives, so when we're living with a chronic disease or chronic pain, often times the automatic

negative thoughts come back and lead to unhealthy thinking styles for a person living with this day to day.

For example, pain catatrophizing looking at the outcomes much worse than it is, so longer hospital stays or greater pain management or functional intentment, sometimes it may be true and they may be in the hospital a little longer, but it doesn't have to be every single hospital stay will be a 10 day stay, and so we try to make sure that we don't catastrophize and keep them present and doing grounding techniques and being realistic in what exactly is going on is going to be very important because with our patients they're often times fearful of so many things that these unhealthy thinking styles are almost a part of their norm.

So, just going over a few pictures of them. So we see some examples of all or nothing thinking. I'm not perfect, I have failed, overgeneralizing once again, nothing good ever happens to me, or everything is always rubbish. The mental filter, once again only looking at the presence of evidence, you're noticing your failures but not noticing your successes, disqualifying the positive, so discounting the good things that have happened and that the person may have done by saying oh, that doesn't count, or so you have pain scores less than 5 for the past three weeks, well it doesn't matter because it's going to happen once again and I'll be back up to a higher pain score because it's about to be this weekend, so that would be an example of disqualifying the positive.

Jumping to conclusions, so as I mentioned before, mindreading or fortune telling to trying to forget the future are some common ones, magnification and catastrophising, I gave an example, but once again shrinking something to make it seem less important or blowing it out of proportion.

Emotional reasoning, an example is I feel embarrassed so I must be an idiot. Assuming once again because you feel a certain way that it must be true. Should and must, using critical words such as should and must can make us often times feel guilty so you often times hear patients with chronic pain use this in their everyday language. So I begin to teach them these terms, and once again, have often even assigned homework assignments of asking them to monitor and track how often throughout one given day they are using these terms and words in their everyday language just so they can be aware and knowledgable of how they may be speaking some things into existence.

Labeling, assigning labels, I'm a loser or I'm going to always be in pain or I'm just a pain person or whatever it may be. And personalization, this is my fault, blaming yourself, once again taking responsibility for something that may not necessarily belong to you.

So we've talked about the top two common ones, anxiety and depression as far as diagnosis associated with chronic pain, but we also must be realistic when we talk about suicide. There is an increased risk of suicide associated with chronic pain and when we look at some of the research, we associate two or three times more likely to report suicidal ideations for those living with chronic pain. Those with persistent pain are more likely to die by suicide. And we need to make sure that when we see clients coming to the office, not only do we assess for pain score, not only to assess for medication adherence for taking medication and but also for the presence of anxiety, depression, and possibility of suicidal ideation or even a plan.

17 66 percent of people with chronic pain report serious thoughts of suicide, and 20% of people with pain report a suicide attempt in their lifetime, so we have to be well trained to sometimes ask ourselves questions, but when we look at this intersection of race and culture, we have to be mindful that we may have patients that may say certain examples such as sometimes I just don't feel like living anymore or sometimes I just feel like I wish God would just take the pain away or call me home. We have to make sure that we're having very clear and transparent conversations with our minority patients because those statements may not necessarily relate to suicidal ideations; however, you won't know that until you begin to question a little bit deeper and be more intuitive. So if a person is saying I don't feel like being here anymore, it may be a red flag to have a conversation, engage in therapy or refer for therapy, but also ultimately ask if that means that they want to harm themself.

So once we make sure that we're assessing for suicidalty, we have to be culturalty competent because often times the language of those living with chronic pain and when we're looking at the minority community, which is a higher association of spiritualty and their faith and religion is very important to them, they may associate some conversations and some feelings associated with being angry or, once again, wanting to have higher powers take them home or taking everything away or all of these conversations may come up so we want to make sure that we're clear as we're looking at assessing for suicidal ity.

So we ask why so high when it comes to comorbidity for high the prevalence of all of these. These are all intersecting. So having a mental disorder is a risk factor for chronic conditions and also vice versa. So a chronic condition is also a risk factor for a mental health disorder and so that's very significant because when we look at these pathways of comorbidity they're bidirectional and often times complex, and so often times I try to use the visual analogy of a tiered wedding cake because we have to take it tier by tier and often times it can be very convoluted when we're looking at multiple risk factors, and sometimes the multiple chronic medical conditions and that means they're often very, very sick.

So we have to look at some of the common risk factors are childhood adversity so we're looking at loss, abuse and neglect, dysfunction, presence of violence in the home or in their external environment. We're looking at adverse life events and chronic stressors and once again at socioeconomic status, poverty, the neighborhood they were raised in or live in, social support, isolation and also education and housing.

So we are going to talk a little bit further coming up about how these also once again are impactful to our patients, so when we look at once again the bidirectionalty, we see in this picture it's all once again linked together.

So as we talk about race, ethnicity and pain, let's begin to bring it together. So we set the foundation of having good definitions and then able to look at the percentages of what's currently present in the U.S. in regards to chronic pain, what's associated to chronic pain in regards to mental health diagnosis, but now let's look at it within the context of once again, race and culture.

So when we look the a race and culture and chronic pain and chronic disease and its treatment, we have to remember that the cedes of race related health stigma is grounded in this conversation for a significant amount of time. So inequality in the U.S. in relation to race and culture,

once again, it starts off with a basic definition of stigma. So when we look at stigma, we do know that often times those who may be diagnosed with certain chronic diseases are stigmatized based off of, again, their lifestyle, their behaviors, those type of things. We look at it as defined as a mark, credit, or shame, and can be associated with circumstance, quality, or persons, and so a diagnostic sign of a disease or disorder tend to be identifying marks or characteristics. For example, in my current clinic I work with patients with Sickle cell and that's 97 to 98 percent African American and then there are other minorities that can contract sickle cell too her he had tarely so often times they know if it's sickle cell it's associated with them being most likely African American and most likely that they may be on chronic pain medication and that can be a stigma for that so some do not like to share their status with future spouses and partners and their job, and so it's often times hard to look at the stigma and also in relation to their treatment, if once again we're dealing with this and we're trying to create treatment plans that, once again, may have to use some type of disclosure.

So when we're looking at the pathophysolgy of pain disease in African Americans, it's very complex again in the intersection between biological and psycho psychological social process. Each may be the own entity but with the intersection of chronic pain in the middle, they're all overlapping, so what we see is the residual effects in social context, how they interact outside the home and inside the home with family and loved one, we see the chronic condition which may be biological and we also see how it may overlap with cognitive behavior and also emotional issues too, so we have to be mindful, again, as you heard me to say that we have to treat the whole person.

So we treat the whole person by also needing to ask the tough questions. So we want to start off with talking about why it may be difficult in the treatment or why minority patients may be mistreated or undertreated in regards to chronic pain and chronic disease in regards to historical trauma. What is historical trauma? It is typically described as multi generational trauma, typically experienced by a specific cultural group. Historical trauma can be experienced by anyone living anyone living in families affected by severe levels of trauma, poverty, war, et cetera, that are still suffering as a result, so it's not just those who experienced it who lived it in the moment, but it may also be the generations that have came after that.

So it is cumulative and collective and the impact of this can typically manifest itself emotionally and psychologically in members of different cultural groups, and I'm going to give you some examples of historical trauma groups that typically are prevalent in the U.S., and so when we look at what's the definition of trauma, it's bodily or mental injury usually called by an external agent, and so we want to make sure that we're understanding that historical trauma to certain groups, again, have been a part of the U.S. culture for a significant amount of time.

So my question to you all. These populations would be susceptible to historical trauma, native Americans, African Americans, Hispanic, immigrants, people living in poverty? True or false?

>> MODERATOR: Thank you Dr. Watkins. This is the third poll. We'll launch it, true or false. It should pop up in a moment. You'll be able to answer as just a reminder. Thank you to those that have already been sending in questions to the Q&A Box, we're collecting those in the order in which they're received and we'll have our presenter answer those in our next live Q&A. Please continue to send those questions in and I'll give you about 5 more seconds to answer this question on your screen. The.

Excellent. Thank you so much, everyone. Three quarters of the group, a little over 75% have answered and we're going to close the poll and share this on the screen so I can turn it back over to Dr. Watkins.

>> SHERRA WATKINS: And the answer to the poll is correct. It is true. All of these different populations of native Americans, African Americans and Hispanic and immigrants and those who may be living in poverty or examples of those who have experienced or are experiencing historical trauma.

So, we're going to talk about each group and also provide you with some specific examples as to what are some common items or themes associated with each one of those different groups?

So we know the American Indians are the first group I'm going to talk about the First Nation people, they've been exposed to generations of violent colonization, assimilation policies and general laws, and so an example of this would be the Americanization of Indian Boarding Schools and forced assimilation among their students. So when we look at some of the current of this historical trauma, this particular culture has a high rate of suicide, homicide, domestic violence, child abuse, alcoholism and many other social problems and we've seen some recent also news in reports of not just alcoholism but drug abuse, too, and so we know that historical trauma states that it all may be from Americanization or colonization and we often have to remind ourselves of what is the difference between assimilation and also acculturation?

What we know is that assimilation is when you take person and you input them into a larger culture and that person takes often that larger culture in order again to make it function. That's a major difference between the acculturation in which the person who may be of a certain culture can go and spill into the larger culture, learn how to navigate and learn how to go through the nuances of living but also allowed to keep ownership of their own culture and values.

So when we're looking at assimilation, they were forced to sometimes negate many of their values and beliefs, so the residual aspects including some of the current manifestations can be seen below, as I discussed.

When we're looking at immigrants, forced migration may be a result of conflict, natural disaster, famine and policies and chemical disasters and also just governmental policies and it can go on and on and on.

So what we know is that because of this, various populations of immigrants can be very, very varied and have been exposed to discrimination, racism, forced assimilation and acculturation, colonization and genocide.

So one example is that we often have heard in the news, sometimes we've seen it in movies, or once again in our neighborhoods or in our home. When it comes to the Hispanic population in the U.S., and often times people may make inappropriate comments such as, why don't they just learn how to speak English, or why don't they just speak English and that falls upon assimilation. Again, in order to live in our state doesn't mean they should be forced to, once again, negate their native language just in order to stay here.

So we have to remember that immigrants are also affected, once again, by trauma and historically can have some residual effects that will lead to other issues down the line.

African Americans and Black, this population has been exposed to generations, again, of discrimination, racism, and race based segregation, and also we have to be mindful of poverty. And so when we look at poverty, we also are mindful that the poverty may stem from the lack or inability to gain adequate housing or fair housing is also among this, and so we look at some examples of stretches in colonialism and some of the current manifestation is mistrust with police, self worth, and also medical providers because we cannot forget the Tuskege studies in which they were effected so that is historical trauma in which we see, African Americans once again, have a very skewed view of the medical society, and so again that resistance will be will cause them more unlikely to seek medical care, and we can also see that when it comes to immigrants being weary of seeking medical care in our states too because sometimes they may be worried for a variety of reasons.

So when we look at the self Hatred of blacks and African Americans that act out aggression on people that look like them, it's inherent of the culture based off of some of the historical treatment that African Americans and Blacks have endured due to discrimination, segregation, and also poverty.

So when we talk about this mistrust, we have to look at clients who may not necessarily come into their appointments on a regular basis because we no he that regular treatment, regular appointments have to be in line for medical adherence for the direct treatment of medical pain, why don't they come on a regular basis, so there is mistrust that needs to be talked about when it comes to patients and doctor relations.

Communities impacted by historical trauma, and so poverty can lead to family stress, child abuse and neglect, substance use, mental health challenges, also the presence of domestic violence or intimate partner violence, and so we know that when there is poverty, there also be a comorbidity to either one of these or arguably can sometimes be all. When we know that poor individuals or families are not evenly distributed across communities. You typically don't see a neighborhood with both poor, middle class, and rich people all in one location. It's typically segregated, an sometimes on different sides of town, and so when you have that associated with, once again, clustered together so you may see a predisposition of pockets of depression and anxiety and chronic diseases associated with that poverty because, again, they're all housed within the same area or location and so this concentration of poverty typically results in higher crime rates, underperforming public schools that deals with education, poor housing and health conditions, as well as limited access to private services and job opportunities, so we have to make sure that we have these discussions because, again, all of this is looking at the historical prevalence of why and how we got here and then when we look at our future as far as treatment for our patients.

So when we look at a visual depiction of historical trauma and progression, we're looking at racial profiling and micro aggression as continued racism, a loss of identity of their homeland, family, and culture, genocide and slavery, and of course we're looking at the Tuskege experiment and sterilization and Henrietta, Lacks so all of these deal with race and ethnicity in relation to historical laws in discrimination and and also children and grandchildren not to trust the dominant culture or also having a lack of self worth and value. So when our patients come in, we sometimes have to have what we call those uncomfortable conversations of asking some questions in regards to the treatment

plan for the chronic disease and asking some questions that may be related cultural, such as asking them about what's their home life, what do they do the home, who is in the home, what do they say, access to fruits and vegetables, a bed to sleep nrks you're allowing normative questions, but also if you're starting to see the prevalence of causing a conversation to not have those conversations.

And so in relation to historical trauma, once again, there is there are some positive aspects that arise from historical trauma. You see with many of these minority communities or populations, they have also a higher resiliency. The ability to become strong and healthy and successful again after something bad happens because they often times may experience it multiple times over and over again, so they have the innate ability to resiliency. Sometimes it may be low, but it's there.

They have adaptive survival skills and behaviors, and so they know how to do it because we go back to the scenario of fight, flight or freeze, and so they learn how to adapt. Sometimes we may have patients who are constantly in fight mode so they want to constantly argue and due to mistrust once again may not necessarily be on board automatically to our recommendation, and again, it comes from them having to develop these adaptive skills for survival, so we have to remember that in order to transition our patients to live healthier lives with chronic pain and chronic disease, we have to often times turn off the survival behaviors and survival mode, and so we want to make sure that we're taking them holistically through different types of treatment plans and using multiple professionals to help you and help that patient to be well.

Also, you see a higher association of increased religion and spiritual coping, and what we know is there is a higher sense of prayer. And so when we ask them what their pain score may be, they say well it's a 8 today and we're asking them, you are very calm, they may say because I've already prayed about it and it may impact the person's ability to have a good treatment and may have self con fron age if they overutilize the spiritualty that may impact their willingness and also their medical treatment because sometimes they may say that I prayed about it and I went to church and I'm not taking medication. It can positive and negatives to it, but we're looking at the positive, and we know that the presence of religion and spiritualty typically gives them that kind of higher chance of wellness and well being.

The evolutionary enhancement, such as having higher access to education and those type of things, higher access to jobs and job training, and we know that they sometimes think only the strong survive, so again talk about survival mode. And so we look at them knowing they may be survivers and they strong, but we try to make sure realistically as clinicians, what happens when you don't feel strong or when your pain is too unpredictable or to the point where it's unbearable and uncontrolled?

And so we want to make sure that we can flip flop on both sides of that coin to say, hey, you are very resilient and you come in here with a smile on your face and it's great that you're going to church every day and you have the belief of a higher power or maybe going to the mosk, it doesn't matter, so we want to make sure that we're creating holistic treatment plans, but if it may be impacting the person's medical treatment, we also once again, have to confront that behavior too.

So I do want to pause before we move to the next section of it to ask for any questions so far?

>> MODERATOR: Thank you so much, Dr. Watkins. Yes, we have a lot of questions. I'll present in the order they were received. Everyone, we will do our best to get to all of your questions, but for this moment we'll probably cover about three or four and then please keep them coming in the Questions Box and we'll get to the rest toward the end of the webinar or they'll be ended on the website in the Q&A Document.

The first question, Dr. Watkins, comes from David. David asks, chronic pains increases likelihood of anxiety and or depression, but can anxiety or depression exacerbate a low grade pain into becoming chronic pain?

>> SHERRA WATKINS: It can't exacerbate to chronic pain, but it can to having a higher pain presence and also identification. So in order to be chronic pain, there are some medical variables that have to considered to be labeled from acute to chronic. You heard me mention that number one it, has to be present for a certain amount of time, but also a medical provider will have to once again, give you that designation. Just because you may have had some pain for a significant amount of time, doesn't necessarily mandate that it's chronic so we want to look at the medical components of it too.

But what we do know is that with depression and anxiety, if there is a presence of it and it's untreated, it can make a person's pain scores even higher so that's why we go back to the psychosomatic pain or the sensory or the pain that I mentioned before, is that they're, once again, the pain can be higher, it can be in places typically not associated with their pain areas.

And the examples I give by that is typically for example when I work with sickle cell patients when they have a pain crisis it's typically associated with a certain area of the body. When they typically have higher pain score, I'm asking where is the pain, what does it feel like, is it throbbing? And it begins to be visible or show up in other areas, and it may be an indicator that it may be linked to stressors. If I begin to ask them, are you stressed out about anything, what's going on at home or at work, and so we do know that the presence of anxiety can exacerbate chronic pain, but not once again, turn it into chronic pain.

>> MODERATOR: Thank you, Dr. Watkins. Another question from an anonymous questioner asks, how do you address historical trauma since history already lived and does not change?

>> SHERRA WATKINS: We address historical trauma based off of more of a case by case or patient or client by client basis. When we're developing the treatment plan, we often once again, want to look at what is this person's perception of medicine, once again the medical treatment, and so we use historical trauma, once again, to give us cultural competency, but also once again once we have that understanding that, again, it's an underlying, always evolving, always present condition, when we begin to have difficulty with treating a patient, we can have some more transparent conversations, such as, do you feel like you're being heard, do you feel like your doctor is listening to you and you're being treated fairly? Do you know about your medication and understand why we're prescribing it? And so, again, if we know there is an underlying mistrust that could possibly be there, again, every person is different and we have to always be person centered, it can give us context, so as I say a different lens in treating the patient.

So we look at historical trauma and but we also use historical trauma not as a labeling, but once again as a lens to once again, help guide us in more cultural competence and wellness treatment of the patient.

>> MODERATOR: Thank you, Dr. Watkins. Another question, and is it okay to do two more?

>> SHERRA WATKINS: Uh huh. That's fine.

>> MODERATOR: We'll do two more. Another question is, how do the symptoms of depression of weight and appetite change I'm sorry. I'm trying to read it. How do the symptoms of weight and appetite change present differently for those with co occurring chronic pain? So they're asking, it looks like they're asking about those specific symptoms of depression, the symptom of appetite change and weight change, how does that present differently for those with co occurring chronic pain?

>> SHERRA WATKINS: What I've seen in my practice and with high background, I've worked with all the diseases you heard mention in my bio, is that it can actually go different ways. I've seen increased and decreases in appetite. I've seen increases and decreases in sleep. I've also seen increases and decreases in just various changes to their biological pieces that include the nutrition and physical activity pieces too.

What's interesting about that question is that it varies from person to person. I've had people who start overeating, I've had people develop, once again, eating disorders. Each person is different. It's not one specific one and if you go and look at the current research, it tells you that it goes along that continuum and it's bidirectional. Some people, once again, will lose their appetite and lose sleep and some will oversleep and some can have intermittent sleep and some people may not be able to sleep at all, so it really changes from person to person.

What I can say is that when looking at the symtomatology of depression and looking at the variables we typically use to assess, we ask for patients, how is your eating and sleeping habits? That can sometimes be indication of presence of anxiety and decompression. I can say with chronic disease and chronic pain, it almost throws it out the window, you have to be very knowledgable of the patient because if they're in pain they won't be able to sleep, they feel like they can't lay down, so you got to be able to ask the more in depth questions besides sometimes just the normative questions, and even the use of the PHQ9 and GAT7 is often excused when you work with chronic pain and chronic disease, so you really have to begin to use a variety ways to assess for the presence of anxiety because those as a screen are or assessment would not concretely say the person is decompressed or has anxiety.

>> MODERATOR: Great. We have a lot coming in, everyone. Thank you so much for your questions and we'll get to them in the second Q&A. Keep them coming and we'll answer them or ask them in the order they were received.

Last question for this Q&A portion, Dr. Watkins and then feel free to continue with the presentation. This one asks, how do African American women enter into our treatment, referring to addiction treatment? Some follow up here is what's the most likely entry experience like for them and how are they most commonly referred to treatment for substance use disorders, and then how does that differ in comparison to other cultures?

>> SHERRA WATKINS: I will have to say that's not my expertise and to be very transparent, I haven't worked in drug addiction as far as outpatient therapy as far as entering into it or detox, so I don't know what the current studies are saying, so I can only speak to it from me being integrated into a medical specialty center, and so in my role, it's very similar to a social worker or therapist into primary care and it's just different that I particularly have worked in specialty areas such as internal medicine or now hematology, so I can only speak from my experiences that typically I'm referring our female African American patients to drug treatment because of positive drug tests, because we do test our patients randomly, or I'm starting to see exacerbation of symptoms such as the misuse of their pain medication and also, once again, I start to see them begin to trickle away, so not adherent to come to medical appointments. So I'm sorry I can't provide more from a community based outpatient view point, but I can give a viewpoint based off of embedded into the clinics, I get to see the patients in a different light, and I get to see them based off of working with the physicians and also when they're referred to me for therapy or sometimes when I just pop up in their medical session with their doctor because often times multiple viewpoints of either the doctor's viewpoint of the patient and what they're seeing as far as possible addiction or maybe a mental health crisis, and what I see and also I have two social workers that work under me and what they may see, so if multiple people are touching the patient and by the time we redeem that patient who may need to be referred for treatment, we're all typically on board.

So in order to move on, I want to make sure we're talking about the responses to trauma, again from a cultural context, and so when we're looking at studies done by researchers in regards to culture and genetics and race and pain, what we do know is that there are physiological responses to trauma in regards to the body, and so we know that it overwhelms the emotional regulatory system and the mind and body instinctively goes into automatic survival mode as we've already talked about.

The biggest thing I do see in the commonality is the hypervigilance and it looks very interesting in our patients with chronic disease and chronic pain. Often times they're hypervigilant based off when it comes to the changes in their environment, but they also become hypervigilant in their pain and so all sometimes they can focus on is pain, the pain score, what it feels like, and often they lose focus as to other external stimuli and factors that may be going on in their everyday life, and you begin to sometimes see their persistence in that person's language.

They also may react fast to movement, maybe to loud speech and sound, particular quick indecisive actions to protect themselves, and very reactionary for that one, and maintain high levels of arousal, which robs their mind and body of vital energy, so I can see they're constantly tense, so they report long sad and loss of energy and fatigue and exhaustion is a biggy I hear on a everyday basis. So going back to the question someone asked about eating and sleeping, sometimes when it comes to the sleeping piece and they're saying they're tired and fatigued, it goes into a rabbit hole so I have to dig a little further to see what that fatigue and exhaustion feels and looks like and how long it's been present, so we go a little deep are than just asking how do you feel as far as do you feel tired or fatigued.

Some additional psychological responses are the false beliefs that are common to trauma because the brain begins to change and doubt and question things that they thought would happen before the trauma, so it creates almost a false sense of reality. So some examples would be that others cannot be trusted and that can include us as clinicians and also medical providers, or I can only count

on myself, and often times I've seen this a lot when it comes to chronic pain patients who have to be admitted to the hospital when because of their chronic disease and they often have to be hospitalized multiple times throughout a given year, they're by themselves so the family members stop showing up, so they come with the mindset of it's only me so don't worry about it, I'll just be here by myself, how long am I going to be in the hospital? Or you don't really care about me, I'm just another number, I'm not important or valued and I feel trapped, and things will never get better. I think that's the most difficult part hearing is that, you know, when it comes to working with those who have genetic bleeding disorders such as sickle cell and other diseases that I work with here at the cancer center, they're born with it. It's never going away, so they've been dealing with their disease all their lives, so they often sometimes hear and you can also associate with other chronic diseases of, this is a dying disease, or you're not going to make it passed this age, so they come and begin to develop the psychological response by saying it's not going to ever get better and I'm going to die before the age of 27 and that's what we have to work with, so that can cause and develop the existence of depression and anxiety, and of course therefore in turn, increase their pain scores and presence of pain. So it's all once again, cyclical. Everything is interconnected so it's sometimes difficult to decide where to start.

The trauma of having a chronic disease, I will always experience some level of pain, having a shortened life expectancy, few people may understand the disease, especially if it's rare, and everyone assumes I'm drug seeking, people judge my pain based on how I present, and so am I on my phone, am I playing a video game, am I sleeping, laughing, watching TV, or often times you don't look like your pain is a 9 out of 10.

This has been very difficult as we're talking about the opioid epidemic or whatever you choose to call it, and also educating our minority patients here at our cancer institute because we teach them CBT based interventions to divert their attention away from their pain, but when they go to in patient, they may have go to go to one of their other medical providers and they're called drug seeking because there are different types of diversions and techniques and now they're drug seeking because they utilize that, so they're doing deep breathing and watching law and order at the same time, and they're told that they're liars, and so or I have patients who often say that I know I'm in a pain crisis, but I have to get dressed before I come to the ED, and what I mean by get dressed, they have to put on a suit or dress and do hair and makeup and can't just come in jogging pants and T shirt because there is a predecision position based on having the chronic disease and what's the name of the disease and what it may be associated with. If it's a chronic disease with chronic pain and they're on pain medication, opioids, again, they have to take that all into consideration when they have to enter into treatment, whether it's in patient or they're coming in for treatment in an out patient setting because they feel judged, what are people going to say, are they going to believe me?

So, I try to educate our clients on, once again, as you heard me mention at the very beginning, the definitions of addiction, tolerance, and dependency, but also educating them on using the therapy that we use, this is my CBT intervention that my therapist taught me. If I have questions about my interventions I'm doing while I watch TV or smiling or walking around, you can contact my therapist because my therapist is teaching me these diversion technique, and so it's very difficult often times, that this is the trauma associated often times with being a minority and being questioned over the truthfulness of what you're reporting as your pain and also your disease.

And whenever I talk about this topic, I often hear people say it can't be thatdifficult for patients to report pain and belief and discomfort and but the research backs it up. This is what they're saying in regards to the genetics race and pain. So one study looked at blacks and Hispanics and found they were more likely than whites to have their pain underestimated by clinicians, and one even found that minority patients were less likely than whites to have their pain recorded in their chart. Not only were they questioned less, but they also once again, had their pain that was reported underestimated, so if the patient reported maybe they had a 9, the clinician may say it's only at a 6 or maybe just faking it or not being completely truthful.

African Americans and Hispanics wait longer for pain medication and are given less pain medication than Caucasians for the same illness. We tell our patients to ask for a pain pump with the patient so that way it's indicated to the chart that it's recommended by us as the clinic and this would be the best regimen because it allows for them to get their pain medication on a regimen schedule without the presence of having to page or call the nurse or wait for the nurse to come if you're having pain.

After American Americans underreport pain and there are more concerns with addiction and less likely to aabuse opioid drugs more frequently than white counterparts yet that's not portrayed in some areas of our society. Instead, we see that African Americans are more susceptible to using opioid drugs, especially if they, once again, may have used them for pain treatment. What we know through the research is that many African Americans do not like taking medications at all, let alone taking a medication for pain treatment. Again, going back to the historical trauma, they pray about it first or take Tylenol first, or my grandmother took goody powder for years, and I was like you know that's horrible, but they self treat and use other regimens before they most likely even take something that would be subscribed that's a little higher as far as the potency.

Ethnic minorities are found to rely more on prayer and hoping religious activities as coping strategies and often related with higher pain scores and was a predictor of disability. What does that mean? Because they relied more on praying and hoping and faith, their pain scores were typically higher, which means often times they let the disease manifest and often grow more intense and more debilitating, which by that time, by the time they seek medical treatment they're at a more further out or have a more developed disease compared to coming in three or four months ago or three or four years ago. They're typically more disabled and the disease is more prolonged or at a more difficult stage because they're relying more on their coping skills.

They found that the socioeconomics disadvantage such as low income, unemployment, and education were more important than race or ethnicity in predicting disabling pain.

Lower tolerance to pain some studies suggest that this there is a suggestion in relation to chronic stress and how they were socialized to pain and also acculturative when it comes to stress, so acculturative stress such as racism and discrimination, can again have a relationship with how one perceives their pain, can they tolerate pain higher or lower, and again the research shows it's based off of once again how they were socialized to it. Again, some minorities were socialized to take on the pain a lot higher because we just don't complain, we just once again have to endure, again in the survival mode.

So I want to stop and ask you all a question. Are African American patients prescribed pain medications at the same rate as other patients? True or false?

>> MODERATOR: Thank you, Dr. Watkins. Everyone, I'm launching the poll here and you should see it on the screen in a moment. Go ahead and answer this last poll and then we'll have another Q&A with our presenter towards the end of the webinar. The question is asking, African American patients are prescribed pain medications at the same rate as other patients. It looks like we have a little over half, I'll give you about 5 more seconds, a little over 60% of you now have responded.

Thank you so much, everyone, keep those questions coming in the Question Box and we'll get to them shortly. We're going to go ahead an close the poll now and I'll turn this back over to Dr. Watkins as we discuss the results.

>> SHERRA WATKINS: All right, so unfortunately only 8% got the correct answer. I'm sorry, I said that backwards. I apologize. 92% are not prescribed at the same rate and so unfortunately there is some discrimination and stigma associatedded with prescribing pain medications to African American patients compared to other races, and so we're going to talk about that and I'm going to go over some Institute of Medicine studies looking at what are some of the issues that prescribers are seeing in relation to prescribing to minorities, particularly African American patients.

So when we look at the Institute of Medicine on Disparities their research has shown a couple of things. The very first thing they show is that people of color receive lower quality health care than whites do, even when insurance status, income, age and severity of the conditions are comparable.

So what we know is that if we use all of those variables and we put everyone on the same playing field, people of color are still receiving lower quality healthcare, they're not listened to, not heard, may not receive the best treatment.

Another of the research stated that people of color are more likely to be treated with disrespect by the healthcare system and more likely to believe they would receive better care if they were a different race. So these are some of their beliefs, so when we go back to some of the questions that you all asked about the historical trauma, you may these are some of the things that people may perceive based off of a family member's experience at the hospital and them coming back and sharing with relative, this is how they treated me, they're going to treat you the same way, or even if they don't say that, there is a perception they may be treated the same way based on how their friends and family members have had difficult experiences inside of our medical systems.

Major disparities found in many key diagnostic areas of cardiovascular disease, cancer, stroke, kidney or dialysis, HIV and AIDS, asthma, diabetes, mental health and maternal and child health, and so we know that very popular in conversation right now is the maternal and child health disparities between African American women and other women, and with he do know there are many disparities in regards when it comes to race, when it comes to many chronic diseases or issues, and so we have to be realistic and understanding that these are some of the things that are facing our minority patients that they have to think about even before they step foot in the door, so we got to get them in the door, and then we got to keep them in the door.

Disparities in pain management, the research at the University of Virginia quizzed white medical students to see how many believed inaccurate and at times differences between blacks and whites. An example would be black people's skin is thicker, black people's blood coagulates more quickly, and what they found is that only half thought at least one of the false statements presented was possibly, probably, or definitely true, so there is some stigma and misperceptions that many medical students and residents have, and if the medical schools are not tackling these discussions and educating these students, these students therefore become our doctors and once again, they in turn treat us.

So sometimes we have to listen to our patients about what they may have endured in a recent medical visit and we can't automatically discount them out or discount them based off of their story.

They also found that black Americans are systemically undertreated for pain relative to white Americans likely due to both the overprescription and overuse of pain medications among white patients in the underprescription of pain medications for black patients, so when we talk about pain, African American patients are typically underprescribed but typically underprescribed based off again of the ideology that they will use and abuse and become addicts. When we look at the research and see that typically it's the overuse and overprescription of medication is associated with white Americans.

So these research has shown that black patients are undertreated for pain, not only relative to white patients but relative to the World Health Organization guidelines and we know this research has been looked at for a significant amount of time, so this is not something that is new based off the last two or three years. We know that pain management has been linked to racial bias and we have begun to have these conversations, so we teach our patients to advocate for themselves but often times we as clinicians have to begin to have those discussions with our patients and advocate with them too.

So when we look at historical trauma informed care, we have to be aware of and challenge our own bias, how we feel about patients with chronic diseases and have to utilize opioid, how do we establish trust and safety, and do you listen to the patient and trust each person is a individual and not a disease, and so do you walk into the room and then walk out and still carry what that person is saying into the next patient's room? You should do your best to put your patient at ease and help them feel safe. Other things can you do is use a calm, soothing voice, slow down your speech, make sure you remember they may be hypervigilant, and so you often times can change the whole atmosphere of the whole environment just with the change of your voice, asking questions to make sure that they understand what you're saying. Be confident in your skills and abilities, fear can be further the patient's fears. The doctor said they didn't know much about Sickle cell or Lupus or about HIV or what stage I'm in so they said they're just going to prescribe something, and that scared the patient, it would scare me, and again if you're not confident and able to tackle patients who may have chronic pain and chronic disease, then again based off best practice and working within the scope of practice, you should refer out if you don't feel you could be adequate in treating that person.

Don't take it personally if the person has questions, anger, fears, may question you relentlessly when you comes to your understanding of them and also what you're doing to them. Don't

be afraid to have hard conversations with race, fears and thought belief, and again you want to acknowledge the patient's strength, they are resilient, and they once again have been using coping strategies for generations before them, so many of those coping strategies are good, but they may be in overuse or underuse, and so we want to make sure that we acknowledge their strength but also help them in in developing a good plan.

So as we have talked about chronic disease and chronic pain and making sure we're educated clinicians and having the safety and also ability to have conversations with our patients on the experiences within our medical systems, and why is it that this topic is near and dear to my heart, but is why is it something that we need to discuss?

And one of the main reasons, of course, is the infamous term of the opioid epidemic, but also because of the CDC Guidelines that came out in 2016 that affected those with chronic pain significantly. So in 2016, the CDC came out with guidelines on how we help correct prescribing practices for those who have chronic pain, so number one, it delineated between what is acute pain and then also what is chronic pain. And if a person has chronic pain, the very first thing that they said in the second bullet you should avoid opioid therapy if you can avoid it and find another regimen of treatment that may be closer to, once again, providing that type of treatment for the patient.

And then if you have to use long term opioid therapy, a couple of things should be recommended through the guidelines. It needs to be interdisciplinary, pain, substance use disorders, mental health problems for patients that may be present or may be at high risk of developing those, and then again for patients who are younger than 30, again, they're at higher risk of opioid use disorder and overdose and so for patients younger than 30, currently opioid long term use therapy, once again was recommended to have very close monitoring and again considered to have a tapering recommendation compared to just consistent long term therapy.

So all of this has changed the prescribing practices of many physicians because now they have to have interdisciplinary care and some of them don't have it in their clinics. But some other things came with these guidelines that I want to discuss. Number one, they require the physician to assess for potential risk factors, and so some common tools that can be used to assess would be the opioid risk tool or SOAPP or SOAPP R, and again you want to assess the patient for pain, prior elicit drug use, mental health, family history, legal issues, trauma, history of overdose, overdose, education, suicidalty, and also lack thereof of social support and once the clinician assesses for potential risk, they need to stratify into a low risk, moderate risk, or high risk, and if that physician feels the person may be high risk, at this stage the physician can choose not to prescribe to that patient. Even if they may have been prescribing to the patient before or that patient was referred to them because this doctor may be the expert. If this patient has been assessed and they feel, once again, that it's high risk, a doctor can now choose not to write any type of prescription.

If they do choose to one again, write a prescription for someone that is moderate or high risk, the guidelines now state they have to be closely monitored, and again, using some of the other recommendations that they give.

So, if they do write the prescription, they recommend the use of a treatment agreement and so they have to consent for treatment and they have to be aware that they are taking a short acting,

long acting opioid, the long term and short term side effects and all of that is written into a concept. They also have to sign a narcotic prescribing contract, which means that they have one prescriber, one pharmacy, and all of those type of things. Talk about attending to their medical appointments, avoidance of alcohol, benzo or other elicit drugs and random urinalyisis and those type of things and not following an agreement.

Why is it significant to many patients? Many minority patients, the doctors may choose to not go through the necessary hassles of developing the documents, even though the CDC prescribed templates for people, but again it's based off of choice, so if the doctor doesn't want to do all the guidelines and recommendations, it may put our patients in limbo of trying to find someone else, or again, it may once again we have to make sure they can understand what they're signing, if there are some socioeconomic issues, too.

A treatment plan is also recommended. And again, some physicians don't have an education of what exactly a treatment plan is, do they have someone from the behavioral health spectrum that can help development and it needs to focus once again on the patient's cause of pain and risk and benefits of also developing other aspects for the patient.

Again, four, avoid concurrent opioid and Benzo prescribing. And five, they recommend the patient be reassessed every three months and so the assessment tools they recommend, of course at onset of entering into the clinic, they have to make sure they're not in any type of withdraw with the COWS. They can use the addiction behaviors checklist or current opioid misuse measure the COMM are all recommended to assess the patient. Again, why is this significant? If they're reassessed and they need to be moved up to higher risk or lower risk, the person's pain medication can be dropped or cut, or again they can be dismissed from the clinic.

The use of random drug screens, and what they recommend under this one is that they have one that is on site a point of contact, which means that it would give you a simple pop up if present or not present test and then be sent off for a more intricate test that will come back within a few days. Utilize prescription drug monitoring programs which many states have begun to implement a number of years ago, but having someone designated to check to make sure that that patient is following having only one prescriber and only one prescriber and having only one pharmacy that they go to.

So let's just say a person didn't necessarily have a car and they were utilizing family members which can sometimes happen with minority patient, and they happen to go pick up their prescription from another pharmacy or they went to the EB and the they gave them medication and got it filled somewhere else, and if they go and see that, again, a person who is not well educated in these recommendations would, if they have low education on once again medical literacy, they could be dismissed from the program too, so we have to make sure that they are understanding what they're signing and getting themselves into.

And then also considering offering the lock zone, and those are the eight best practice recommendations for our patients, and so many clinics, again once these recommendations came out, they chose not for follow the recommendations and many patients were left to be referred out or had to find someone on their own, but also these recommendations, they did provide a safetynet for our doctors and so I would be remiss by not saying that the recommendations did need to come down for

consistency among medical providers, and so is this a way to make sure that the doctors are all working within their scope and within best practices at prescribing long term therapy for those with chronic pain, so there is some positives to having these recommendations that came down from the CDC, and there are also some negatives.

One of the biggest negatives that I've seen is that because of this fear, if they don't follow the recommendations to the T or they don't write the prescription based off the best practice, that they may lose their license and their livelihood, so many physicians are sometimes practicing up under fear. Well, though your hematologist has prescribed this level of pain medication, I don't feel comfortable writing this medication. If you happen to be in a hospital and I'm going to prescribe to you what I want.

So we have seen that too, and so again that's that undertreatment and also the fear from the physicians based off of these new CDC guidelines and also this strictness is coming out with once again tracking our physicians prescribing practices that some physicians no longer practice or some have chosen to once again, be very rigid. And sometimes rigidity can affect certain kinds of diseases that are associated with our minority patients if you're not a expert or willing to work as an interdisciplinary team with that person's provider who may be specializing in their treatment, and so we want to make sure that these guidelines are just that guideline, but you should be asking questions.

So the model changes to treatment, so what I definitely recommend in regard to having this intersection and having better care for our patients, of course, is that team approach. Once again, treatment for function and well being and also once again, changing the brain. Pain is an experience. Once again, it is not, once again, an ever lasting focus or feeling that should be focused on on every basis. We want to fix the problem, but it has to be a team effort, and so my recommendation to the office that you can see through the current research is having the interdisciplinary or multidisciplinary approach. Many minority patients try to use a specialist as the wunl all be all, and so many of the patients don't have a primary care providers and unfortunately just because we may treat your HIV or lupus doesn't mean I can write a prescription for a yeast infection or once again because your blood pressure might be up, so we want to make sure we link our parents, because as you saw a few slides ago, the presence of one chronic condition may predispose for others, so of course they may have diabetes and cardiovascular issues, HIV and diabetes or something along those lines, so you want to have someone that is an expert in pain or addiction medicine, you want to have a medical practitioner, you want to have a nurse and sometimes you might have a nurse care manager and if you can have access to a pharmacist, a psychiatrist would also be helpful in prescribing mental health or behavior health medications if that medical provider is not experienced in writing those prescriptions, then you want to have a clinical psychologist, PT, or OC, especially when it deals with mobility and disability, and also behavior health treatment specialist, a clinical theirist with addiction focus because again chronic disease and chronic pain can have the intersection within their family life. Counselors and social workers, and one that I didn't put up there but should have, would be also certified rehab counselors, they can also work congestively with PT and OT and making sure that they can do some assessments that they can't do, but also work with job and occupational coaching and things like that.

So in my current clinic, we have a pain and medicine specialist, and I serve as the primary therapist for all of our patients, and we have MD doctors and we have mid level doctors and we have a nurse, nurse care managers, we have embedded pharmacist and we also have links to an out patient clinic for our psychiatrists and also for psychologists and also for PT and OT, so if it's not embedded in

our clinic, it's been our cancer institute so we can send them either upstairs or downstairs so that's a positive of working with chronic pain to develop this or once again develop a resource list for it, it helps once again in creating a holistic treatment plan for the patient.

As clinicians, we want to make sure that not only we educate them on short acting and long acting chronic pain medicine but we also want to look at nonpharmacological interventions so here are some common ones that we utilize, massage, therapy to touch, movement therapy such as yoga and tai chi, and movement therapies, decreasing environmental stimuli, especially when it comes to temperature, range and motion physical therapy, antidepressants can help with chronic pain, hypnosis, sleep hygiene, nutrition, psychosocial interventions, support groups, mindfulness and medication, guided imagery support group, psychosocial, stress reduction, time management and relaxation and also acupressure and acupuncture and this is not a complete list of nonpharmacological interventions but hopeful to provide to you as key ways to helping someone with chronic pain also living with a chronic disease.

So counseling interventions, there are good we're working with population, trauma narrative, allows for the patient to tell their story, and again it allows for them to develop a meaning about what is happening to them in in regards to their disease and also their life. In the personal narratives with storytelling, again, it can be spoken word, music or movement, writing, healing and again it helps them to make sense of what is happening and taking flais their day to day living and so we have trauma narratives and personal narratives such as storytelling.

Alternatives to, and so for patient who are on long term opioid treatment, because we know they're safer, not safe, but safer recommendations or alternatives may want to look at Methadone or Suboxone to long acting medications that are prescribed. There are pros and cons for both. We know the prones for Methadone long half life, fewer highs and low, typically inexpensive and typically more insurance plans than Suboxone, we have some run ins with always having to do justifications for many insurance companies because Suboxone is more on the expensive side.

Some of the cons though is that a high likelihood of overdose, highly addictive, and also the toxicity as far as the rapid increase in the dosage, and the use of elicit drugs and alcohol with Methodone can be fatal, and of course, there is still a stigma. With the suboxone it's effective for pain and opioid use disorder and so for those patients that we work with with both, we can utilize Suboxone to treat chronic pain management and opioid use disorder. There is a lower overdose risk, minimal drug interactions except with Benzo and alcohol, and also it's recommended for those that may be high risk that once again have a history of substance abuse but also have chronic pain.

And also, patients on high dose opioids also require alternative treatments due to higher tolerance and also hyperallergesia through long term use and many of the patients may have been opioids or long term treatment since the age of 5 or 6, and so the tolerance in getting to high doses of the opioids is very realistic and so we look at alternatives as another means.

Some of the time training is required to prescribe it so the doctors have to go through training. The cost of the medication, potential for precipitated withdrawal and I also have to mention if you're switching between short and long acting ones, taking that patient through withdrawal in order to start the Suboxone that's been interesting as we have now implemented a Suboxone clinic within

my current role, I also do that clinic too, and then the biggest piece is stigma, and so we have many patients who are on Methadone and Suboxone and when they're in patient or picking up prescription medications, many of them have stated that they have been told that they're drug addicts because they're on those, so there is a lack of education by the physicians that also can be used for pain management. That is a down side, too.

So we have to look at it from the cultural piece too, that many of the minority patients when they hear Methadone or Suboxone they often accuse us of saying they're addicts or drug seekers and we have to explain to them that we can be your friend but we want to have a conversation as could why we're recommending this to you, and so we have to look at that context of many of them will look it up on the Internet and we have to be ready for those conversations and sometimes the difficult conversations of do you think I'm an addict is this why you're prescribing this medication for me?

So when we're looking at future treatments with regard to genetics, race, and pain, there are a couple of studies over the past couple of years that hopefully should lead to better treatment when it comes to chronic pain as it relates to genetics and race. So pharmacogenomics looks at how genes affect the person's response to drugs, they're looking at it to develop doses that can be tailored to a person's genetic makeup, so we can look it up, and we're actually doing some of that now in our clinic for certain cancer treatments and also within our hematology department with our embedded pharmacist, so we're doing some of that now for our concurrent studies which is very interesting.

We're also looking at pharmacodynamics to look at effect drugs have on the body and monitor side effects and keeping track so that if there are some things we're seeing with a certain drug in a certain theme of patients, we're noting that to then have better prescribing practices.

And then pharmacokinetics, is the study of the way in which drugs move through the body during absorption, distribution, metabolism and ebbing kreetion, so before the drug can begin to exert an effect we look at the body. So does it look different when it comes to a person's race? So that has been looked at and we're look at how and what we prescribe for certain races due to absorption and particular metabolisms that could be affected by a certain subscull chur and so when we look at future treatments we can be more specific in how we prescribe and effectively treat the person and so again, patients won't feel as a common theme like ginea pigs and all of that.

I wanted to go over at least one case study to go over with you all and then I'll go into Q&A. I want to go over this case study, and so a patient is a 21 year old African American male who has increased visits to the ED, 8 hospitalizations over the last year, and he presents to your clinic and reports the need to use more of his pain medication, and so his medical diagnosis is Sickle Cell, he's a student, currently under medical withdrawal, screenings for medical health include the PHQ 9 which is mild, a GAD 7 score which is also mild, and psychosocially he has childhood trauma but would not disclose what it may be, traumatic hospitalization which was being in the ICU for two weeks, and what I mean by that is he came in for a chronic pain or pain crisis and ended up once again contracting a hospital borne illness and had to be put in ICU and also incubated, and almost died, unfortunately, but did not die.

Socially a good relationship with mom and dad, okay relationship with sibling, and medication wise he's on short and long acting pain medications, so when we look at this particular

patient who is a 21 year old African American male, but we're also focused on that he's needing more and more of his pain medications and looking at it from a cultural and also race perspective, what are some typical things to look at? Well, he's 21 years old, he's no longer working and he's no longer in school, so asking him how important school may be to him, what does being on medical withdrawal feel like for me, what does he feel like his future purpose would be? Because again, we don't know how it may be related.

Also, again, processing with him the traumatic event of the hospitalization in which he almost passed away, there may be some long term trauma or PTSD associated with that event, and also again, he has a good relationship with his patients about scg who are his supports and who he confides in and why is his relationship with his siblings only okay? Is there a better recommendation? We know through CDC, he's 21, so under 30, and they recommend those under 30 are strictly watched and monitored and they also recommend that if there is an alternative that they be used more compared to short and long acting so we may want to see if he's a candidate for Methadone or Suboxone and that's just one of the case studies I wanted to go over because I want to leave time for questions and answers, but there is another case that you can look on that talks about a patient that is also Hispanic.

The biggest piece in sharing some of these case studies is that many about education, were taught once again to look at different dimensions of the patient, physical, social, occupational, intellectual, what can he call in the field, the dimensions of wellness. We want to make sure we take it into consideration with the addition of race and culture when making sure we're helping and assessing for someone living with a chronic disease and chronic pain. And clinicians, if we have patients who are having difficulties with communicating and advocating for themselves, how do we help them, again, having this conversation and participating in this webinar, what could you do differently in the future of helping a patient?

So some good resources that I also would like to share. They sometimes help with the communication of sharing their pain because often times they feel that they're not heard, so Pain Logs, or charts, it's a free app that can be downloaded. Web MD has a Pain Coach app where they can track it and get different types of tools, these are all good resources to share with the patients as alternatives to help give an additional voice, so they can track their pain, they can track their mood, they can share that, but now they have quantitative data to share with their physician so that way they have additional support.

And often times that may be helpful to the patients because they question the legitimacy of their pain and also the accuracy of their pain.

So that's just a bibliography which you all can look at on your own. And now we'll open it up for questions.

>> MODERATOR: Thank you so much, Dr. Sherra Watkins for that really informative and excellent presentation. We do have a lot of questions. We will not have time for all of them; however, we will continue to ask them in the order they were received and everyone else, please continue to send in your questions to the Question Box and they will get added to a document that is sent to

Dr. Watkins and she'll have some time to answer that and we'll post it online with the online presentation, with the online recording.

So the next question is from Jaze l and she asks for transgender persons trauma is especially high, especially among black and brown people, any tips on working with the population more effectively? The rates of depression and self harm seem to be super high.

>> SHERRA WATKINS: There were a number of tools that came out in regard to working with these patients, I think SAMSA had some and often times many of our local I don't know what each state may have but we have a local education entity known as the ail identify health consortium that provides specific things for mental health and so they provide training to work better with this population. Now, when I was working with patients living with HIV and AIDS and other comorbidities, what I found as far as what was beneficial is doing a lot of trauma narratives, and also when it came to helping them share what their traumas may have been that they have endured and giving them a voice.

Also, I found that being very transparent in expectations, as though I definitely didn't do narcotic contracts, but often times with these patients, contracting when it comes to expectations in regards to counseling and medical care works great because it holds accountability on both sides of that continuum, and so that's what I found to be useful.

I can say currently, I don't work with a lot of transgender in my current position. I'm not saying there are not any out there living with Sickle Cell, I'm sure there are, but the best I can say is make sure you're trained. If not, it's always great to be an Allie that you can refer out to those that are more specialized and more knowledge ability.

>> MODERATOR: Thank you for asking that question and thank you Dr. Watkins. The next is from another attendee asking, do we have the racial/cultural studies that you mentioned on the slide about genetics, race, and pain available to read?

>> SHERRA WATKINS: Sher if I put that question inside the application I can prose those so it can be posted.

>> MODERATOR: Thank you so much. And then the positive outcomes 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?

>> SHERRA WATKINS: The research didn't speak to that specifically. It didn't talk about the sense of collectivism versus being more stagnated when it comes to certain groups. It mainly talked about in the study that I looked at in regards to historical trauma and just the presence of spiritualty, and that's what I focused on with my knowledge in relation to that group so I can't specifically answer that question.

>> MODERATOR: Thank you so much, Dr. Watkins. Another asks how perspective are practitioners to not judging automatically or suspiciously.

>> SHERRA WATKINS: I've had hit and misses. I went to medical conferences and presented on this topic, and I think the biggest thing is they want to make sure that others, cliniciansnd a patients understand that it's their livelihood too and they don't want to lose their job or actually kill someone, that's been the biggest thing that I've heard from medical providers and even nurses, because I've done a couple of the nursing conferences over the years, too, and they all want to make sure that they understand that they have licenses and ethical practices too, and I think that's the biggest thing that they want other people to acknowledge.

However, just based off of experiences, it's typically 50/50. I've sometimes had to go with patients to try to educate a physician on our patient and state that, you know, we have an outline pain treatment plan, so if you follow it step by step we tell you what to do from day 1 to 3, 4 to 5, and 6 to 7 and they still won't follow it because they feel like they want to do what they want to do, so you just never know what you're going to get.

But I know within our hospital system, we've provided many education opportunities for physicians and other medical providers to come and learn about chronic pain treatment for minority patients and really talking about stigma and belief.

>> MODERATOR: Another question. You mentioned examples of historical trauma and I'm wondering, this Jay asks, I'm wondering if you would consider multigenerational substance abuse in families as an example.

>> SHERRA WATKINS: Definitely. Definitely would fall up under when we look at socioeconomic status, typically we have to look at if there is the presence of multigenerational substance abuse and addiction, we may see some residual effects when it comes to housing, education, mental health, those other things may be present too, and so I definitely would say that when you have generations of addiction that can be considered definitely a subculture within historical trauma.

>> MODERATOR: Okay. Unfortunately, our last one. We have a lot more, so everyone who had questions, don't worry we'll get put on the Q&A document and you'll see it on the website in probably less than two weeks and we'll get it to Dr. Watkins right away and be able to answer the questions right away and get it on the website.

The last one, any information on the Alaska Native population regarding historical trauma including rural settings and isolated painmotion denied.

>> SHERRA WATKINS: That's a good question. I haven't looked into that. I mainly looked into it as a general population of native Americans so I have not looked specifically toward those that may be in Alaska and but it might be definitely something interesting to be looked at in forms of historical trauma and how it impacted their mental health and I know they have some issues with substance abuse in that particular area, too.

>> MODERATOR: Well, thank you, again, Dr. Sherra Watkins for that information. Everyone, you see her contact information here on the screen, it will also be on your PowerPoint slide deck that you will have access to, three slides per page, and it will be on the website if you don't have that already. Just to remind you, everything you need to know about the particular presentation is always on the

NAADAC website. You can watch the recording after the live event, download the PowerPoint slides, take the CE quiz and make a payment if you're not a NAADAC member. The web address for this webinar is right at the top of the screen, and again it will also be on the PowerPoint slide deck. It is www.NAADAC.org/race culture disease and pain webinar.

And just in case if you missed earlier, here are the instructions again for receiving CE credit. So for those who missed the introductory statement you have to complete all four step, watch and listen to the entire webinar, whether you're here live with us today or if you are viewing this as an archived recording, so you will have to pass the online CE Quiz which is on the website you see here, and if applicable submit payment, and then a CE Certificate will be mailed to you within 21 days of submitting that quiz.

If you have questions or concerns or run into any hiccups along the way, please do not hesitate to email us at CE@NAADAC.org e. that's ce@NAADAC.org. Ce@NAADAC.org. The quiz will be posted in about an hour or less on the website.

Here is a short schedule for upcoming webinar, there is a reason for that, because in particular this coming Saturday, August 31, 12:00 to 1:30 eastern is Part 2 of the six part specialty training series on addiction treatment and military and veteran culture and that started last Saturday, but you will have access to the on demand recording on our website. We'll go ahead and send you a link right now in the Chat Box. For those of you who are here, you'll see it in the Chat Box and here is the website. It will look just like this, so please make sure to register for Part 2 this Saturday, August 31, 12:00 noon to 1:30 p.m. eastern standard time. This coming Saturday's topic is on supporting life after service, addiction and transition to post military life. Registration is only $25 per webinar and includes eligibility for certificate of treatment for addiction treatment in military and veteran culture.

The website is as you'll see here, https www.NAADAC.org military training webinar series.

And, of course, if you have not done so already, please make our website, www.NAADAC.org/webinars your bookmark it as our home page because we will continue to update our 2020 webinar series and any other future specialty training series coming up soon, we'll update them on that web page.

A quick review as a NAADAC member, so many benefits of becoming a member with us. If you join NAADAC, you have access to over 145CEs through educational webinar, quarterly advances in addiction recovery magazine, which is also eligible for CEs, and NAADAC offers in person seminars throughout the U.S. and internationally, and also included in membership are independent study courses, regional and annual conferences and certificate programs for advanced education in specialty topics.

Thank you again to participating in this webinar and thank you so much Dr. Sherra Watkins for your valuable expertise. I encourage you all to take some time to browse our website and learn more about how NAADAC helps others. Please stay connected with us on LinkedIn, Facebook, and Twitter. Have a great day, everyone.

(session completed at 4:00 p.m. CST)

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