Introduction and Guest Background

This is Dr. Greg Hall once again with Better Black Health brought to you by Genetic Sequence Multivitamins for African Americans, the only multivitamin made to address the unique nutritional needs of African Americans.

Today, we are welcoming Astajah Starr Booker, PhD RN. She's an assistant professor at the University of Florida. She's well known for her research on disparities, inequities, and justices, all of those bad things in the field of pain, right?

We haven't done an episode on pain. Dr. Booker's research has shed light on the lived experiences of older African Americans in chronic pain. It might be me.

She's been the recipient of several awards, including the 2020 American Society of Pain Management Nursing Excellence Award. She also got the Claudia J.

Beverly Innovation Award and the 2018 Great 100 Nurses of Louisiana. Wow, we have to hear about that. Starr, as she likes to be called, is an active in several organizations and served on the board of directors for the United States Association for the Study of Pain.

And most recently, she contributed an outstanding chapter to the next edition of my book, Precision Medicine in African America. So welcome, welcome, welcome.

Thank you. I'm so excited to be here. Well, thank you. We're excited to get this conversation. Everybody's got a little bit of pain. But I'm curious, how did you choose pain as a specialty?

Maybe it chose me. Right. So long story short, and it's two stories that really influenced my journey into pain management and pain research. The first began as an undergraduate student in nursing school and, of course, having to write research papers on a particular topic.

You have to choose the topic. And one thing I was noticing in my clinicals was the lack of pain assessment. and older adults, especially those who were nonverbal or who had limited verbal capacity or cognitive capacity.

So I was really interested in understanding what the literature was showing about what are the best ways to manage and assess pain in that population.

So that kind of opened the door to me wanting to know more about pain and dementia. And then as I went through undergraduate training, masters.

How Dr. Booker Entered Pain Research

I started looking more into the literature and seeing some other trends, such as pain in African-Americans was not being treated the same as whites. So I shifted my focus just a little bit.

I stuck with pain in older adults, but now I was painting older African-Americans. and really noticing that there was such a stark lack of research in this population.

So with that, I decided to get my PhD and study more about pain self-management and measurement in older African Americans. Okay, so that's the first.

The second thing that happened, I guess that has kept me in research, is while I was a PhD student, I actually had a traumatic fall, which led to me developing chronic pain.

So that not only gave me deeper insight into people's experience of living with chronic pain, but it also gave me more understanding on what it means to manage pain, whether you're young or older.

And so I think the combination of those two experiences really just fuel my passion for for pain management, especially in African-Americans. I mean, I don't want to make this really long, but even when I went to the emergency department seeking care after I fell, no one asked me about how bad the pain was.

There was no pain assessment. I wasn't offered any pain medication, whether it was a Tylenol or whatever, none of that. You know, that experience has really opened my eyes even more to, I wonder what's really going on.

Is that race or what? Right. Well, you know what you find out as you look into these disparities things that whatever you think, once you get into it, you find out it's worse, right?

And I was in the hospital, I think I talked about it before, with appendicitis, had acute appendicitis, had emergency surgery. And afterward, I wake up, I'm in the hospital bed, tubes, you know, an NG tube, an IV tube, tubes everywhere.

and in pain, right? Just had abdominal surgery in pain. And it wasn't, the pain they were giving me was not treating my pain. And I was instantly, even though they would walk in and say, Dr.

Hall, they knew I was a pretty good doctor, you know what I mean, a fairly popular doctor, I instantly became a drug seeking doctor. And I could see the look on her face, and I was like, this medicine you're giving me is not helping.

You know what I mean? And whatever it was, and unfortunately, I don't remember what it was. I didn't have an allergic reaction, but it made my pain worse, and it did it each time.

And I'm like, clinicals, I'm laying there, she gave it to me again, and I'm like, it happened twice, and I'm like, is this making my pain worse? No, I'm crazy, you know?

And then the third time she gave it to me, it literally made my pain, as soon as she infused in, The cramps came, and I'm like, that's making my pain worse.

I need something else. And then they looked at me like, you drug-seeking son of a gun. And so it wasn't until I talked to the surgeon, nice lady, and told her that stuff's not working because they passive aggressively didn't give me anything until she ordered it.

And then they passive aggressively waited as long as they possibly could to give me the pain medicine, which finally worked. It was the stuff that killed Michael Jackson, unfortunately.

But that's the stuff that actually worked in a controlled setting. So that's when I find out firsthand it's not just somebody off the street come in and doesn't get their pay measures.

Pain Disparities and Personal Experience

You're Black. And there was no other reason for this woman to think I'm Black. There was no other reason than I was Black. And I hate to come to that conclusion, but that's what it was.

And so if it was happening to me, then it's happening. It's just happening all over the place, right? Yeah. I mean, the disparities and inequities, it runs deep.

And it's unfortunate that sometimes even as healthcare professionals that we have to experience it firsthand. But I think it kind of solidifies what we already know from the research is that pain management is biased towards African-Americans.

Yeah, right. And that goes from children, you know, all the way up to geriatrics. I mean, it's been studied from, you

know, so a poor little child comes in with a fracture or something, they get less objectively left.

They look at the record to see how much pain medicine did they, what the order was given. Black people get less pain medicine, but the fear is what, that we're going to sell it or you know, that we're going to abuse or that we're going to get addicted.

What's the real data about us as it relates to getting addicted? I mean, we should be a little concerned about it. If someone's going to put me on some pain medicine, is it my first fear worried about becoming addicted to it?

I don't think that that should be your first fear. And, you know, here's the thing with us receiving certain, uh, receiving less medications for fear of becoming addicted is one.

It's not. I want to temper my words. Well, it's the black audience. So it's not up to certain people to try to quote unquote, protect us. from addiction by giving us less medications or inadequate types of medications, right?

You know, as healthcare professionals, our job is to provide good pain management. And yes, we want to safeguard people from becoming addicted, but we can't make that determination based on someone's race.

Well, I'm going to protect this black patient. from addiction by not giving them what they need, right? So I think we probably should be more concerned about their perspective of not even getting medication, right?

Versus getting medication and becoming addicted. I think what we are seeing in the research, the statistics that opioid or substance use disorders, opioid use disorders have increased in African-Americans are people identify as black over the past 10 to 15 years, but it still doesn't meet the same rate as white Americans with opioid use disorder.

And so I think there's maybe some changes with the demographics, but for example, I work with over African-Americans and I would say less than 20% are reporting that they take some type of opioid medication for pain.

So I have less concerns about older African-Americans to be honest about getting addicted. In fact, they probably safeguard themselves better than anybody because they don't want to get on those quote unquote addictive medication.

Right. And that's what I've seen as well. is that there are people that kind of don't want to, you know, oh my God, I'm gonna get addicted. I'm gonna give you one dose and it's kind of like heroin, right?

Oh, you're in, right? I've never seen that. But you know, what happened when I discovered your existence was I was preparing to talk on pain in African-Americans and your articles kept coming up.

And what surprised me is there was a way you could profile someone who's at increased risk for addiction. just doing like what you were talking about, an assessment, getting a history, talking about their history and the things that they've done.

Can you talk a little bit about what aspects of someone's history, say my history, what should I think about in my history that would make me think about, am I at an increased risk of getting addicted to a medicine if I have my wisdom teeth pulled or something like that?

Yeah, I think the first thing for anyone would be family history of substance use disorder or opioid use disorder. Which I have. I have a family history.

Assessing Addiction Risk and Family History

Okay, well let's start there. Of substance abuse, you know what I mean. I don't know about opioid use disorder, but he probably tried a little bit of everything.

Yeah, so I mean, And that's a lot of us too, right? Yeah. Oh yeah. And a lot of times, you know, in the African-American community, sometimes we know people who have problems with addiction to substances, but we, you know, we overlook it or we say, oh, you know, that's just pooky rain, you know.

But we don't take the time to go back and really fully understand and look through our family trees to see who had what you know, how long and why. And so I think for us, really getting a good understanding of our family history.

The other piece to that, which I'm really starting to advocate more for, is African-Americans getting more pharmacogenetic testing to see if they perhaps are at increased risk for certain medications being I guess you would say, well, let me say it like this.

To see which medications, one, would be more effective in managing our pain, and then using that profile as a basis to figure out what's the best medications.

Maybe that will not lead to misuse or substance use if we can really tailor that medication to people's genetic profile. I guess the second thing would be if you have a history maybe of multiple either acute pain issues where you've already been prescribed pain medications and thinking about maybe how those experiences might amplify each other or become additive in some way that over time, you know, you keep having different acute pain, you need medications, you know, how is your body becoming more dependent or tolerant of that?

And so that could be kind of a second thing to think about. Right, right. So if you've been addicted, you know, you have an addiction problem, you're higher, and that addiction problem even reaches into smoking, cigarettes, right?

And so if you're having trouble controlling you know, some people just lose their mind with everything, right? And there's people that smoke, and then there's these people who just lose their mind smoking, right?

And I think that that's something, you're at increased risk, what we call an addictive personality. Who knows if that's a real thing or not. So let's say, When you have that, how much you mentioned, how much is your brain?

I interviewed a guy who talked about bioenergy and said, you know, if I say stop, you know, shout stop, right? I can decrease my pain. Is there, you mentioned about how we perceive it.

Is there anything to that? I mean, I don't want to go, you go into something you don't feel like you want to talk about. If you're talking about the power of the brain in coping and managing pain.

Yes, the brain is, we know is a very powerful organ It does help to regulate pain sensations and process these, right? And so a lot of times when we think about pain mechanisms, we also think about neural mechanisms, right?

So central nervous system and then the brain and all of that stuff. And I mean, I think we do have some research that shows that especially for like cognitive behavioral therapy, various coping strategies, that if we can kind of retrain our brain to think about pain, that it does have an impact on reducing our pain.

I mean, I tell, you know, older African Americans when I'm out at community events and doing seminars that, you know, your pain health is brain health and vice versa.

You know, if you can, manage your pain well, that will also improve or decrease maybe the risk of cognitive issues. Right. Losing your memory issues, right?

Right. And then the flip side of it is if you take care of your brain, so do those recommendations that keep your brain healthy, exercise, reducing your stress levels, eating healthy, getting good sleep, all of those things.

If you take care of your brain, then your brain will also help take care of your pain. So it's kind of like a reciprocal relationship. Right. And I've got so many patients, we talk about older patients, that their pain is always 50 out of 10, right?

Even though I say, please tell me out of 10 what your pain is, 75. I'm surprised when someone says seven or eight, you know, it's like, but, but, um, they're in, they, they're in, they're subjectively, they say they're in excruciating pain.

Brain Health, Coping, and Pain Perception

And, um, I don't know what excruciating pain, you know, I was walking through the family room and my son was watching this. terrible movie where they set this guy on fire.

And it's like, I don't even know they make movies like this. You know what I mean? A guy was on fire screaming, excruciating. That looked excruciating, you know what I mean?

So that's Tim, right? And so in my mind, I'm thinking, you're not excruciating. You're sitting here talking to me, you're not crying and screaming out.

um you know so do we exaggerate when we talk about that or is it is it like the worst pain you've ever felt so i've ever felt this pain but you you know you ran me over with a car i'm at a new i know what 10 is is that is that what it is um yes and no so i'm going to say um yes it's your worst pain because pain is subjective And so your worst may not be my worst, but it is my worst because I say it's my worst.

Right. And then you have to think about how people rate pain. So they think about typically past experiences that they've had and they kind of compare, you know, maybe this fall pain, is it the same as the childbirth pain that I have?

And so they kind of use past events and experiences to really think about how they rate or or how they are perceiving the severity of the pain. I guess the no piece is when we kind of start to, I guess when we start to project what we think is worst onto other people, onto our patients that, no, it's not worse because like you say, you're not in you're not crying or you're not grimacing or you're not like balled up in the bed, you know, things like that.

That's when we started to really fall into perpetuating those biases and that's really going to impact the assessment and how we interact with the patients and respond to their reports and their expressions of pain.

So. So there are things that we shouldn't, that I shouldn't do. Um, you know, if I have somebody and I'm asking you, Dr. Booker, this is, this is your, your expert opinion.

If I walk in the room, black woman, perfect hair, eyelashes, makeup, coordinated clothes, talking about pain 15 out of 10. I don't believe them. You know what I mean?

Is that wrong? And you can tell me I'm wrong. Even I'm the host. Yes. There you go. All right. Well, hey, the true show set me free. So please tell me.

So, you know, one of the things that I teach, whether it's nursing students or nurses or other health care professionals, researchers is that we can't look at someone and make a values based judgment on whether or not they are experiencing the pain that they report to us.

And, you know, if I hadn't known you were going to go there, I would have called up a really good example of an African American woman who describes that exact situation where she was, I think, either in the emergency department or at a local maybe primary care clinic, but probably seeing me.

No. Well, I'll let you know, I hide all that because I know about all the disparities and everything. So this is what Greg Hall is thinking inside of his brain.

I don't know. So really, what is your answer? You know, it's good to be transparent because we all have biases. We've all questioned people and patients at some point.

It's just we have to really train ourselves to try to remove that level of bias in our assessments. But this one

particular African American woman, she described how essentially she had to change her behavior so that she could get the care that she needed.

So she would go in and she would cry to try to demonstrate how much pain she was having. And so, you know, you can kind of think of it as cold switching a little bit, right?

whether it's you have to go in and you have to cry, you have to do shows. Or even if you have to change maybe the clothes that you wear and the way that you speak so that people will maybe take you as being more reliable.

So making sure your appearance shows that I'm someone and I deserve care versus someone again, assuming that maybe someone is low income or, and really just trying to eliminate those potential points of life.

Bias in Pain Assessment and Patient Advocacy

Right, right, right. And that's an excellent point because I think what happens is that when I was preparing that talk, it shows that Black people who are mean, get more pain medicine.

If you act mean, you're more apt to get more pain medicine. Whereas white people, if they act nice and sweet, they're apt to get more pain medicine. So a nice, sweet black person less apt to, you know, that's what the data shows, less apt to get medicine than you have to really perform.

And it's not, It's not really based on the pain. And so you would say it's the assessment that allows you to really decide, not really decide whether they're having pain or not.

You're going to believe them if they say they have pain. You're also going to check things and make sure they don't have a history of drug use and things of that, right?

And I'm not saying that you can't use behaviors as important either indicators or important information in your pain assessment that, but you don't look at a person and make that judgment.

Right. Right. Right. That's like just maybe a small part of it, but you also kind of see other things. And then those, so then how do we tell the people who are trying to recreationally get, um, you know, opioids or is that even a concern for us?

You know, I'm really careful. not to position us in a way that people could take our conversation and say, yeah, African Americans aren't drug seeking or, you know, they are looking for opportunities to get pain medication.

So, so I answered this in a very kind of maybe maybe not a straight answer. Right. That's all right. Which is, again, I think the concern for use of pain medication outside of the way it's prescribed is a concern for anyone who's prescribed pain medication, whether you're black or white, young or old, speak English, don't speak English right.

And so, again, I don't know you know, that I wouldn't necessarily target us as a high-risk population, but I'm not going to say it doesn't happen because it does.

Well, it happened to me, you know, but I think what I know is you can't tell. I'm sorry, I couldn't tell, right? I had a little old lady who was actually selling the medicine for rent, and the guy with the hair and history and all that other stuff, he was taking his pain medicine as prescribed, you know.

And so it's like, I know I can't tell. You touched on something in terms of, now there's also people who will take, if one Motrin helps, five is the next thing I try.

You know, and they tell me, you know, they don't even hide that. You know, I took eight. I'm like, will you stop? I mean, you know, and it's not an addiction issue.

It's just, I'm in pain and I'm trying to get my pain treated, but people can jack themselves up that way. And so, I

when, how do you know when, when, you know, you take it as prescribed, but can you go over?

I mean, is there, I mean, is, is there evidence? Cause I, I know as a doctor, you know, I'm asking you that it plateaus, you know, the things that you get, you know, taking five motrin does not give you five times the treatment of one motrin, right?

When opioids, Percocets and stuff like that, is that generally true as well? Um, so I can't really speak to, um, maybe the plateauing effect made of certain medications.

What I will say is that, um, taking more pain medication, whether it's a leave or a Tylenol, um, there comes a point where either it's going to work or it's not.

Well, there's 250 milligrams or it's 500 milligrams. Um, and that's funny that you say, you know, people taking, if one helps, then five will help. Again, people are really just looking for some pain relief.

But I think even outside of pain medications, sometimes other strategies that people use also either it plateaus and it's helpfulness, or again, their body becomes tolerant to it.

And so, you know, a lot of this is education. You know, when I educate older adults in the community, I tell them, look, this is how much of this you can take in 24 hours.

period. And particularly older adults because they'll pass out, they'll go to sleep and not wake up, and it kind of sneaks up on them more so than younger people.

I've seen where people didn't know what was going on. And what's funny is I had a guy who was driving his daughter's car, grown daughter's car, diabetic, right?

And he felt like he was being hypoglycemic, so he looked into the glove compartment for some candy and found some, and it took it. And the next thing he knows, in the ER, And so it took him a few days to realize that he had taken some marijuana candy out of the glove compartment and overdosed.

I had no idea that there was any marijuana in it, no history of marijuana.

Pain-Affirming Care and Closing Remarks

And he was saying, no, no, no. They couldn't figure out why he was comatose. And it turned out he overdosed on what his daughter claimed he shouldn't have overdosed on, even with that, right?

But older people just react differently and they have different medication issues and things of that nature. Okay, so listen, this is Dr. Star Booker from Sonny, Florida.

And originally, the accent is Louisiana, right? It is very much so, country, country, country. Well, that's how it's been great having you here. If someone wanted to follow you on social media at all.

I'm on Instagram, Facebook, LinkedIn. I'm not going to say that I check all those things frequently. I'm also on X, but I, you know, Yeah, I get it. I know exactly what you mean.

I don't even call it, I still call it Twitter. I forget, but I haven't, I don't even open that up. I don't want them to know. I get it really. And so we'll put your follow thing in the little bio thing that we have on the thing.

It's been great having you. Thank you so much for joining us. Absolutely. Thank you. And if I could just kind of leave with this, one thought, which is, really, I've been focusing a lot on helping providers change their approach to caring for people with pain.

And so one of the things that my lab, and my lab is called My Pain Matters Lab, because I think it's important that

we understand that my pain, your pain, It matters, right?

But I want to advocate for pain-affirming care. And that really is a non-judgmental approach that goes beyond just accepting and believing one's report of pain.

But it really takes it further. It affirms that person's identity, right? So whether they're African-American, whether they're a woman, whether they're older.

It validates. their lived experience of pain. So it says, you are who you are. I believe that you are having pain and we are going to do whatever we can to help you get control of your pain and to do that in a very timely way, right?

Because that's another issue that, you know, impacts African-Americans is that we don't receive timely diagnoses and then we don't get timely pain management.

And so we really have to you know, identify and incorporate different ways of how we interact and care for people with pain. And especially for me, African-Americans, because we have such a long history of mistreatment.

Right. Right. So that's what I just kind of want to leave with is, you know, pain-affirming care. Absolutely. And I think when people go in thinking, you know, if you go into thinking something simple like this patient's pain matters, that just having your brain think about that as you go in can change the entire encounter.

You know what I mean? All the questions that you ask, and all that rather than that they're saying their pain doesn't matter. I mean, it may seem like a simple phrase, but I could see that changing how I would go in and interview a patient.

So I think those are great thoughts. I really appreciate it. Well, once again, thank you again for coming. We appreciate everything. Absolutely. Thank you.

All right. That's it. Hang on.