WEBINAR VIDEO TRANSCRIPT

Minority Fellowship Program Coordinating Center

Understanding Deaths of Despair

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ASYA LOUIS: Good afternoon, everyone. My name is Asya Louis, and I'd like to welcome you to Understanding Deaths of Despair webinar. This webinar is brought to you by the SAMHSA Minority Fellowship Program Coordinating Center.

We'd like to draw your attention to the disclaimer. "The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the US Department of Health and Human Services. I'd now like to introduce today's presenters.

Dr. Faye Gary is the Medical Mutual of Ohio Kent W. Clapp Chair and professor of nursing who also holds a secondary appointment in the Department of Psychiatry at the School of Medicine at Case Western Reserve University in Cleveland, Ohio. Dr. Gary has studied and designed culturally-relevant interventions for more than three decades, and has researched the areas of health disparities in vulnerable populations.

She has served on the NIH National Advisory Council on Minority Health and Health Disparities, The SAMHSA National Advisory Council, the NIH roadmap health disparities sub work group, and a joint commission expert advisory panel to guide the development of standards for culturally-competent and patient-centered care. Dr. Gary is the founder and director of the Provost Scholars Program, a novel initiative that is a partnership between Case Western Reserve University and public schools that provides enhanced academic opportunities for youth and their families.

She's published more than 120 research and scholarly papers and has received the Book of the Year Award from the American Nurses Association. Her work spans six continents and a variety of academic and practice settings. She is currently collaborating with colleagues to produce an interprofessional-focused textbook on population health and health disparities.

Our second presenter, Dr. Mona Hassan received her doctorate degree from Case Western Reserve University, where her research focused on child maltreatment. During her tenure at Case Western, she acquired extensive knowledge and hands-on experiences in several area hospitals and clinics as a rape crisis center volunteer, and also worked to collect emergency department data on young people who were alleged victims of sexual abuse.

Her research has been presented at several scientific conferences and she has published numerous research articles on African-American communities in Florida, Ohio, Haiti, and the US

Virgin Islands. Dr. Hassan currently teaches family health nursing and research methods for undergraduate students in the College of Nursing at Prairie View A&M University. I will now turn it over to our speakers. Dr. Gary?

FAYE A. GARY: Thank you so very much. It is a pleasure to be here with my colleagues today, at home, I can't see, but whom I know toil every day to improve the human condition. Thank you for joining us.

Today, we will be discussing deaths of despair, and we have formulated four objectives. The fourth objective will be an area where we would ask you to participate and begin to formulate what you think might be the next steps to reduce and eliminate deaths of despair or any level of despair. Today, we will be discussing some conceptual formulations related to deaths of despair, identify causes of death and despair, and you will hear me talk a lot about suicide, substance use abuse, and liver disease.

However, the major weighting part of the discussion would be on suicide because as you know, that is irreversible and final. And also, preventable. We will discuss despair among populations that have experienced this phenomenon for generations, but perhaps not yet gotten the attention that they deserve so that they, too, can have a more fulfilling life.

Deaths of despair is a relatively new concept that has recently entered the literature and certainly captured the attention of many researchers across the United States. What you need to remember is deaths of despair are linked to economic social determinants of health particularly among rural white males. Again, I'm repeating they include suicide, substance use and abuse, and liver disease, of course, which is related to the substance use abuse, including alcohol.

And just as a brief introduction, we will play a brief video so that you can have more contextual information about deaths of despair. Please listen to the video.

White individuals with a high school degree or less experiencing higher rates of deaths than those with four year degrees. This finding has brought attention to the social forces that create these deaths of despair, primarily among Whites. In some regions of the United States, White middle class men experienced a decline in health expectancy over the last number of years, a phenomenon that had not existed before World War I. And just to help you understand this context, I'd like to share with you that World War I ended in 1918. That was the same year that the pandemic flu, or the Spanish flu, as it is sometimes referred to, emerged.

Now the Spanish flu is responsible for the lives of more than 50 million people worldwide. The world has not seen a pandemic such as the one we are experiencing now since about 1918. So I just wanted to help put that into perspective, so we can understand all of the dynamics that we are dealing with.

The other piece of tidbit that I'd like to share with you is that the Spanish flu, also known as the 1918 flu, did not, had nothing to do with Spain. In fact, it originated at Fort Riley, Kansas, at a military institution, swept through the nation, and then across the world. Deaths of despair is a concept that has been popularized by economists. And of course, Dr. Kane, who just saw in video, at Princeton University, is an economist. And she and her colleagues suggest that the increase in life expectancy of people in the United States is related to the rising rates of deaths caused by suicide, drug overdose, and alcohol related conditions.

Now, let's just dig a little deeper with that. Suicide, the 10th leading cause of death in the United States, taken the lives of about 45,000 people a year, to a 30% increase across half of the states in the United States in the past year. Now the deaths that are related to drugs have tripled between 2010 and 2016. Associated with those deaths are liver diseases that have increased by 31% since 2000 and between 2000 and 2015, among populations aged 45 to 64 years of age.

Another look at deaths of the despair-- this slide shows us the highest and lowest, as experienced by states during the years 2005 and 2016. You would see from this slide that Nebraska has the lowest and West Virginia the highest. Now look to the left of your slide. Because that, those green bars, indicate the combined conditions, the combined three conditions, of which I speak are drug overdose, alcohol, and suicide.

Now we go to the right of your screen, where the orange color is. You see Nebraska is still relatively low, and West Virginia is high. If you look at alcohol, you see that Nebraska is lower, and Virginia, West Virginia is higher, even though the alcohol use is not as profound as the drug overdose. Of course, the suicide follows. Nebraska is lower, and West Virginia is a bit higher.

When we look at deaths of despair, we are amazed at the fact that the leading causes of death in the United States are trending downward, except deaths of despair is trending upward. Now, this information comes from the Commonwealth Fund, published in 2017, where you see that heart disease decreased, and deaths per 100,000, cancer, deaths per 100,000 decreased, stroke, the same, lung disease, COPD-- COPD chronic obstructive pulmonary disease-- slight decrease.

The next bar is deaths of despair. And you will see an increase. Diabetes, we had a slight decrease. And pneumonia and flu, a slight decrease. So of all of the major health conditions that we are trying to address in the United States, we are trending in the right direction-- that is downward-- except for disease of despair, and those conditions that comprise our collective concept that we are calling disease of despair.

Deaths from drug overdose doubled. And this accounts for a lot of the increase in disease in disease of despair. So if you look at this top green line, again, from the Commonwealth Fund, these data are 2018. Collectively, you'll see this line. Again, we are talking about deaths per 100,000. Starting to the left, you will see the year 2005. And it's a steady trend line upward

when we look at the combined rate of the three causes. It's a steady increase from 2005 to 2016.

So the question then would be, what's driving that trend line upward? So if we look further down on the screen, you will see that orange line is drugs. And drugs is the lethal culprit that's driving it the most. Now when we look at alcohol, which is the purple line, and suicide, which is the blue line, it's a slight, slight, very slight, trend upward. But you see drugs is the driving force that leads to the contributions or creating deaths of despair.

This is an interesting, slide because we are looking at deaths of despair now by gender or by sex. Starting in 1999 to 2088, a continuous increase upward. Again, this is deaths by 100,000 population. And males have had a continuous increase of deaths from overdose since 1999.

Now if we look at females, females, too, have been dying from the deaths of overdoses of drugs. Of course, the trend line is not as intense. But what I want you to take a look at is the females, and follow the yellow line all the way to 2005. And you will find that in about 2018, females are the same age adjusted rates that males had in about 2005.

These are some other details about suicide. Remember, I told you that I was going to focus a lot on suicide? Because it's irreversible. It's a finality. And it's also a condition that if we are careful enough, can be prevented. It's the 10th leading cause of death. I'm repeating myself for emphasis. On average, about 132 Americans die by suicide every day.

By the same token, 1.4 million Americans attempt suicide. Now if you look at the next block over, you will see that the second leading cause of death among certain ages 12-13, 12-34, I'm sorry, 10 to 34, that is amazing. This is life is just beginning between the ages of 10 and 34.

The fourth leading cause of death are among those individuals 35 to 54. This is the prime or one's life, and despair has taken over. We also know, and we have known for years, that men are more successful in committing suicide. But women make more frequent attempts. And I'd like to add that as a researcher, a clinician, that I've found that it's very tricky. And when females or males continue to manifest suicidal behaviors or threaten suicide, I consider them to be in the category of high lethality. Because they just might do it.

I can recall, and I'm just going to give a quick vignette here. I can recall some years ago, a young lady coming into the emergency room. She was a very bright woman, a student at a university. And she had taken an overdose of some pills. And of course, you do know that one of the last senses to leave is hearing. And apparently, she had heard the staff who were taking care of her, made comments about her inability to be successful with her suicidal act, or maybe it was a hysterical act, or whatever.

And she didn't discuss that with anyone. But I guess it was maybe two or three months. Later, she came in, where she almost died from a suicide attempt. So we have to, whatever that

expression of behavior is, we have to consider it high lethality, and be sure that we never trigger that for any reason.

Now I also need to just share with you that firearms account for slightly more than half of all suicide deaths. And yet, in our great nation, there is a certain kind of romantic affiliation with guns. The other thing that I need to impress from this data is that veterans have a higher rate of suicidal behaviors, and actually are committing suicide than non-veterans. This is over the age of 18.

We also now have a number that one can call to get help for suicidal behavior, suicidal activities, information. And that's 988. I want to stress among all of our participants today that you need to memorize this number. Inculcate it in your daily activities, so it's always near. because. You'll never know when you need to use 988 and save someone's life. It's a new number, and we are trying to get the word out that this is the number one could call for help. And I'm happy that we now have it.

If you want to see two sad rates in the United States, I think this is a good quick way to do this. States in the top one third of suicide rates in the United States are the heavy, heavy blue. And you can see how they almost kind of cluster together, with the female liaison over here in West Virginia up in New Hampshire. Now states in the middle third of suicide rates in the United States are the ones with the blue that's just a bit darker. And they, in a sense, kind of cluster together somewhat. And of course, it's my home state, Florida, is in this middle category.

And then the states in the lower one third with suicide rates are the ones with the lighter colors. And you can see that states in the top one third are the largest-- I think I counted about 17, maybe 18 states in this category, to include Alaska. If you look at suicide by age, suicide rate by age, again, this is per 100,000. For men, those men who were 65 years of age and older are at greater risk. But if you bring you, just let your eyes come all the way down to 45-54, you'll see that there are high rise in that age, too.

And if you just look a little farther down, you'll see 27.0, 35-44. These are relatively young people now. 65 is considered to be relatively young anymore. But yet it's the people are beginning to feel despair, to the extent that their lives would be considered as a way to end the despair.

Now if you look at females, and that's to the left of your screen, you would see that the females who are at greatest risk are those females between the ages 45 and 54. They are young women. They are heads of household. They are in the prime of their lives, their working lives. They are women, taking care of parents. And they are women also with children and with grandchildren. So these are years wasted, in terms of productivity and well-being, taken away, snipped away, because of the despair. The ultimate of despair is indeed suicide.

And this is now suicide by race. We've known for a long time, and we continue to see, patterns of this behavior. American Indian, and Alaska Native-- if you look down at the bottom of the

slide, you'll see a key that would help you follow along. So we know American Indians and Alaska natives-- not Hispanic, especially the men, are the highest rates of suicide per 100,000. The women, the highest, 11.0 per 100,000, followed by White not Hispanic men, and then by White non-Hispanic women.

Again, as we look at policy, as we look at our research, as we do our teaching, participate in our clinical encounters every day, I think we need to just understand some broad, broad demographic factors about the populations that with care for, and put their at risk are for certain kinds of conditions.

Again, I am going to deaths of despair. And I'm switching now from White males, the general population, to a particular group of people. COVID-19 represents a catastrophic threat to Navajo nation people in Arizona. We know that the Navajo nation has higher rates per capita of suicide, other people in that state, and the national capita rate. They COVID infection is about 10 times that of Arizona's other population. When I say overpopulation, I mean non-Whites, non-Native Americans. And are predominantly Whites, some Hispanics, and some Blacks.

So one of the reasons it's very high is the difficulty in being able to wash one's hands. Here's a way you can transmit the virus. And this is a quote from a newspaper. It's really hard for families who don't have access to water to wash your hands for 20 seconds. And of course, that's what the CDC requires. 40% to 50% of Navajo homes have no running water. Inadequate water makes it impossible to follow the CDC guidelines to control the virus. And hand washing, and wearing masks, and distance six feet away, are the basic kinds of behaviors that need to be manifested in order to control this virus, which is deadly.

Nevertheless, there are some people who can-not-- not will not, or cannot-- follow the CDC guidelines. You also need to know that all homes in America within the reservation and across the nation do not have running water. American Indians live in homes, but 12% of those homes have no running water, compared to other Americans, where 0.6%. And I make these kinds of factors set up despair, and set up situations that tend to interrupt the life course of people, and certainly diminish the possibility that their well-being will be the best that it can be, and these individuals can make the greatest contributions that they are capable of making.

All of that wanes. And not able to wash your hands is just one example of what begins to happen to interrupt people's lives. Just to go back and show you that these data about Native Americans and suicide is not new, I found this slide about young adults, aged 18 to 24. And young adults, aged 18 to 24, just emerging from late adolescence. And in fact, some definitions of late adolescence is up to age 26. So we can call it young adults, or we could call it late adolescence.

Whatever your conceptualization is, we still see American Indian and Alaska natives, males and females, having the highest suicide rates in our nation, followed again by White men, White women. Deaths of despair among American Indian youth needs us to think about this in an alarming manner and respond. Even though we know that deaths of despair among white men

and women must be addressed, and it's good to have it in the forefront and to understand what might be some of the driving factors, and we have identified that those driving factors for white men and white women are education levels, which helps to create the deaths of despair.

I propose, I have hypothesize, we could use the same kind of assumption on underpinning address deaths of despair among American Indian youths and others. American Indians have a suicide rate that is 50% higher than their White counterparts. Death rates attributed to liver disease is 5.2 times that of their White counterparts. Consumption remains a major public health problem among Native Americans.

This information is not new. But the interventions that should follow and this fierceness with which they should be addressed, I think, it's what's missing. Just as a matter of reference, I just identified the three major causes of death among African-American populations. There are heart disease, cancer, and accidents-- unintentional injury, which can consist of numerous kinds of acts, such as motorcycle accidents, car accidents, et cetera, et cetera.

But heart disease and cancer, as major causes of death, do mirror the major causes of deaths of the majority of the American populations. If you will go to any major health science center in the United States, you will see the evidence of facilities to care for individuals with cardiovascular disease and cancer.

I wanted to share with you some conceptual models. There are many. And this conceptual model is one of my favorite ones. And my colleagues, Dr. Hassan-- that's Dr. Mona Hassan, who also is my co-presenter, and Dr. Hossein Yarandi the three of us have done several publications together. And I think this might be Dr. Hossein Yarandi's favorite model.

Now I like this model because if you look at the model, from the bottom. This is individual and population health. So what does that consist of? So the first three areas could be considered the macro piece. That's the individual biologic genetic structure. The next one, social relationships, living conditions, neighborhoods and communities, that's the interpersonal interactional piece. It's where one lives, where one works, play, and learn.

And then you look at the macro. And the macro levels are the social and economic policies and the institutions-- be them education institutions, or hospitals, clinics, or prisons, whatever-- America's institutions. Engulfing it all is the life course. And for me, the life course begins before conception and ends at death. And the environment, again, is where one live, learn, work, and play. It's the parks. It's the families. It's the church. It's the temple. It's the synagogue. It's your workplace, et cetera, et cetera.

Now I like this model, because it reminds me of a systems of theory. You can look at any one of these factors or variables, however you wish to set up your way of conceptualizing your work, that's research for our your clinical work. And you can deal with any one of them. But I caution you that we cannot oversimplify either one. Because they all are interrelated. And in many ways, it's a systems approach.

And unless we can clearly understand that individuals live in social relationships. They also live in neighborhoods. They also work in institutions, and they are governed by the social, economic, political legal policies of our society. And we have to understand that collective concept, as we go about trying to provide the best clinical care, for best practices we can, the best research, and also advance the policies and the laws, in the much more equitable kind of manner.

Now the next slide here is one that I use all the time. And I continually use it in my clinical teaching. Now, in this particular slide, and it comes from Smedley, Stith, and Nelson. And they are the individuals who wrote the book Unequal Treatment, that was published in 2003. And it was commissioned by the United States Congress to try and help us understand, what were some of the drivers that were creating and maintaining the disparities and unhealthy outcomes for so many American people?

So If you look at the upper left part, which to me is probably the bedrock of it, it talks here, or represents here, patient input. And that is, I call it the clinical encounter. But that is indeed the interaction between the patient, the client, and the provider, whomever you may be-- psychologist, social worker, psychiatrist, nurse-- whoever you may be. That is a major component of the clinical encounter, and sets the stage for other health outcomes for the individual.

So what happens here in the patient encounter? We get a medical history, and especially in psychiatry and behavioral health, where that our diagnosis is built heavily on what that history, that patient history is. How long have you had this? What has been the frequency of it? What have you done? How do you treated it? What's been the outcome? And why do you come now, is a question I always ask.

So given this data, and given other data, such as blood test, or urine test, or sputum test, or x-rays, MRIs, or whatever, those data are fed in to what I call the clinician's personal internal computer. But lurking above the clinician's internal computer issues surrounding social, economic, and cultural values of the clinician and the proceed social, economic, and cultural influences the patient presents.

It also involves money, whether you have insurance or not. It also involves what your status in your community, the power that you have in your community, perceived or real. Now underneath it all, lurking underneath, we have the conscious and unconscious stereotyping, and the conscious and unconscious prejudice that all of us come with, because we are human. And we all have our life experiences that have help to shape our values, and how we rate certain values, our belief systems, et cetera, as well as our theoretical and academic education.

So we take what's lurking above and what's lurking underneath. And it meets in the middle, where we see interpretation. Interpretation of all of the data, the diagnostic entity, interpretation of what I think, the interpretation of how I apply the DSM 5 or whatever else category I'm using. And then I began to get my data ready to present to a case conference, or to

make my own decision, or share it with colleagues. And we've come up with a diagnosis and an intervention.

And at best, we know that there is always a problem that this particular venture would not work with this particular person. But there is, of course, the best practices that we use, that are based on scientific data. And we utilize, or we should, and it is our best efforts to utilize cutting edge research and practice guidelines. So when all of these components come together, we make a decision. And we share [INAUDIBLE] decision to include that intervention for care with the patient and the family.

Now I'm just going to stop for a moment and share with you another vignette. And this is, well, I could call it a patient narrative. And it has to do with me. I went to see a clinician several years ago. And I shared what my problem was. I had never met the person before. The person that never met me before, and got a little history. And we did a little talk.

And then he looked at me, and he said well, I three things come to mind. I have a, we could do this, b, we could do this, and c, we could do this. But now c is a bit more complicated. And I don't know if you'd be able to manage c. I don't know if you have the capacity to manage c. So let's just take that one off the table.

So I said, well please share with me what c might be. And c did required several steps, to include something in the morning, and something in the evening, and XYZ. He said oh, you couldn't possibly manage that. That is too complex. So I think what I'll do is, I will prescribe a. And so that was very concerning to me.

So I asked, how is it that you make these decisions? And he said, oh well, you know, it's been my experience that Black people don't follow through. They don't keep their appointments, and whatever. So what he had done was to determine my capacity for self care, for health literacy, to understand a course of treatment, because of the skin I'm in. So I said to him, I would choose c, my right to have a c.

And I said I think I have also, an obligation to share with you some literature, so this won't happen with other people. And I did. I took him some books to read. And we had private conversations. And he apologized for that kind of behavior. And that's because I was able to say, sir, listen. But that's from the clinical encounter. That decision about me was made from the clinical encounter and the skin that I'm in.

I'd like to also pause and say that race is a social construct, and it is a very powerful and influential social construct, whether you are a patient or clinician or researcher or policy writer. I think we all must monitor very carefully our stereotyping, our prejudices, as we get more knowledge, and we undergird ourselves with more theory and research. Nothing replaces the continuous self-monitoring of how we present ourselves to others, and how we interact with others as they present themselves to us.

I like this one. I think this also is Dr. Hossein Yarandi... one of Dr. Hossein Yarandi's favorite ones. And he suggested I include this one. Thank you, Dr. Yarandi. This slide highlights the influence of stress. This comes from the National Institutes of Health. And if you look at the biological factors-- that's the genetics. That's our whole biological structure-- the environment within which we live, be where the toxic dumps are, or be it next to a nice, lovely park with growing flowering trees-- the social environment within which we live, work, and play, and also, the behavioral factors that we've learned over time, with regard to health and interactions and survival modes, and the discrimination-- perceived discrimination and actual discrimination.

When we put these five areas collectively and apply them to disadvantaged groups, whatever group that might be-- for you, might be the homeless. For someone else, it might be children good on the way. For some of you, it might be children who are in the migrant camps. But whatever the disadvantaged groups are, this is the way that dress gets under the skin. This is the mechanism by which dress gets under the skin.

Now once stress gets under the skin, we have negative impact with the biological factors, the biological components, the endocrine system, the immune system that we hear a lot about now because of the virus. But the immune system needs to be healthy at all times.

So once their disadvantage gets under the skin, then there's a possibility that the quality of one's life erodes. It's also the possibility that diseases will enter the body more regularly, that people will call in sick from work because they are, because their entire quality has been compromised.

I'm just going to return here for just a moment, and share with you another slide about alcohol use. And we have three categories. We have the current alcohol use, which is in the blue part of the bar. And it's very high among Whites. And if you look at Whites, too, when we binge drinking, it's very high, but not quite as high As. Native Americans. If you look at heavy alcohol drinking, you see that primarily, you're talking about Whites, and you're talking about Native Americans, native Hawaiians, some other Pacific islanders. So it's native Hawaiians and other Pacific islanders here. and of course, we are also talking about Blacks and African-Americans that have pretty high levels of binge drinking as well.

I'm going to discuss a particular study that my colleague, Dr. Hossein Yarandi. And Dr. Mona Hassan, and other colleagues, have helped us to do. We had a cadre very outstanding people in all three settings to help us with this study.

This is a study about Black women in three communities. The three communities are Ohio-- the little right at the top is Ohio. The ring with the shape of Florida is Florida. And way down in the Caribbean is the Virgin Islands. These are the three communities that I will be discussing. We use the Beck depression test as one of several instruments with a study that we were doing.

And this slide Jeff shares with you the Beck depression scale classification among the three women. You can see from this scale back most of them had minimum along scores of

depression, a smaller number mild, even smaller number of moderate, and severe. We had Florida having tested bit of severe depression.

I have another vignette to tell you. And this is from the clinician's perspective. When we were collecting the data in Florida, a lot of the individuals worked at hospitals. And they provided direct service to patients at hospitals. And this lady I had interviewed, and then we scored all of her items on the instruments. And I found that this particular lady had scored extremely high on the Beck depression scale.

And we had asked the women if they wanted to get the results of the study, if we had information about them, we would mail it to them. And this particular person work at a hospital. And when I saw the score, that there needed to be some additional intervention, as written out in our informed consent.

So I went looking for her. And I found her. And she was at work. Before I had any intervention, I went through the proper channels and talked with people at the facility, and asked if I might see her and a private conversation. So when I did interact with the lady, I said that I was concerned, et cetera, et cetera. And I had done the interview. All of us did face-to-face interviews. So somebody on the team knew her and interviewed her.

And anyway, when I said to her that I was concerned, and I wanted to take some further action, as we had written on the informed consent, and the ladies said, I can not afford to get off the clock. If I get off the clock and miss these hours, I won't have enough money to pay my rent to care for my family. So I'm sorry, but I can't get off the clock. I have to keep walking.

Of course,w e managed to help her get the care. But my point to you is that individuals are so stressed economically, as is indicated by other colleagues from Princeton, that even getting off the clock to care for one's physical and mental health is a major decision.

This is the education levels of the women in the three groups. You can see that out here with high school, we had the Florida group adding up the most high school degree. Some college was Ohio. The highest in college degrees was the Virgin Islands. And college graduates was Ohio.

We did a factor analysis the Beck depression test. We were very concerned. Because the Beck depression test is one that we use. It has 21 items. It's one of the most frequently used tests to document depressive symptoms. Now I make the point that we are talking about documenting depressive symptoms. It's not being used as a diagnostic tool, per se. It does is that alert you to whom you should do a more extensive clinical interview, to decide if depression or some other illness condition is present.

So with the help of Dr. Yarandi and Dr. Hassan, a factor analysis, just want to show you the items, and their loadings, on the Beck depression test. For the Florida group, the cognitive dimension, depression loaded at 0.81 level. Worthlessness loaded 0.7%. Punishment feelings at

0.65%. That's the loading. Not the cutoff point is 40% for both somatic and cognitive dimensions. So we start here at past failure, at 0.41. And you could see the others for yourself.

So now when we look back somatic effective dimensions, which is factor 2, the factor 2 loading, which is in the blue, tiredness and fatigue, 0.76 loading. Loads of energy, 0.62 loading, all the way down to loss of pleasure, 0.45, and all between. Now this is the Florida group, where we interviewed 206 women.

Now we'll move on to, I think it's the Cleveland group. The Cleveland group, the factor loadings on the cognitive dimensions-- you see suicidal thoughts or wishes loaded at 0.81. The highest loading was suicidal thoughts. Past families was 0.68 loading. Self-dislike loading at 0.66, all the way down to the cutoff point, 0.40, sadness, and all between.

Now the factors that loaded on somatic affected dimensions, again, are in the blue. For this group, we see irritability loading the highest, at 0.65. Changes in sleep patterns at 0.64, loss of energy, 0.52, all the way down to agitation, 0.43.

The Virgin Islands group, here we interviewed 126 women, same methodology, same instruments. Oh, I also need to point out that all of the individuals who did the interviews were nurses and psychologists. So for the Virgin Islands group, the cognitive dimensions loadings were-- punishment feelings, the loading with 0.86. Self-criticism, the loading was 0.81, all the way down to our cutoff point, which was pessimism, loading at 0.46. Suicidal ideation, for an example, in the middle, loaded at 0.63. Somatic effective dimensions for the group included a loss of pleasure, loading at 0.73, changes in sleeping patterns, 0.63, irritability, 0.62, all the way down to change in appetite, cut-off point, and change of appetite loaded at 0.42.

Now I showed you the results-- mild, moderate scores. But when you look at the factor loadings, you understand the conditions, The psychological, physiological, cognitive dimensions, somatic effective dimensions of the population in a very different way, or of the sample. This is the sample. You can make generalizations to the population. But this is our sample. And Dr. Yarandi and Dr. Hassan and I found this to be quite intriguing.

I'd like to also say that we have a paper that's coming out. I think Dr. Hassan told me it'll be out in two weeks. And we were looking at chronic stress and depression. And when Dr. Yarandi, who's our statistician par excellence at Wayne State University, ran our data for us. We were intrigued not to find some very strong correlations.

Because in our focus group data, we found a lot of commentary about depression and stress. And so our paper includes the fact that the qualitative data, the direct comments from the women, did not always match the analysis from the measures that we used to operationalize these concepts. And we make the case that perhaps more work needs to be done, in terms of how we go about studying depression, suicide, and other conditions, in populations that have not always been included as a part of the subjects in a sample, but also have not been included as part of the group that make the conceptual basis for study, determine which hypotheses will

be asked, or what questions would be most likely reasonable and beneficial, for the population, and then for the sample.

So, we are just about to conclude. And I wanted to share with you some findings from the Kaiser Family Foundation, as a way to kind of wrap this up. Because we have perceptions of the general population, and big lived experiences of others. And I will begin, first of all, by saying, in this document, there was no mention of Native Americans or Alaska natives or Hawaiian natives. But primarily, it was about Blacks, Hispanics, and Whites, and very little about Asian-Americans. I want to like to acknowledge that upfront, and say that as we go forward, we need to think about how we include people in our study and make sure that everyone has a voice, as that arc of justice bends in the direction for better health care for all.

In the meantime, I would like to suggest to you that about half of the public recognize that Black Americans are more likely to get sick or die from the virus. With fewer, 36%, are aware of the disproportionate impact that the virus is having on Hispanics. And there's no mention about the impact that the is having on Native Americans and Alaska natives, or Asian-Americans as well.

About half of Black adults, including 60% men and 30% women, say that they have been afraid that their lives were in danger because of the skin that they're in, or because of their race-- remember, which is a social construct, nevertheless very powerful and very influential in everyone's lives, and in all communities.

This compares to about a quarter of Hispanic adults and 16% of White adults. Approximately four in one say that Black Americans are more likely to receive a poor quality of health care, less likely to be covered by health insurance, even though there seems to be a continuous effort to repeal the Affordable Care Act, and less likely to be able to access the health care that they need, either because of the fact that they don't have any insurance, because of distance, because of the lack of appropriate health literacy, et cetera, et cetera.

A majority of Black adults and nearly half of Hispanic adults say that they have been treated unfairly in a variety of situations in the past 12 months, because of their race or their ethnicity. So I would conclude that deaths of despair also can be interrupted, regardless of whether we're talking about rural White men, who have a right to live good, solid, active life, too, as well as all other Americans. And those of us who toil every day to make life better, especially for those people who carry the burden of mental health, and substance abuse, and all of the other components that eventually are associated with it, the impact that it has on families and communities, I thank you for your toils. I thank you for your struggles.

It is an area that produces some of the best outcomes, because we all know that without sound mental health, there's hardly any health. So I thank you for your toils, for your knowledge, and ask that you look at how you can begin to identify those behaviors that you might see as antecedents to deaths of despair, and nip them all in the butt.

Thank you so very much, and good luck to each of you. Thank you for joining us today. On behalf of Dr. Mona Hassan and Dr. Hossein Yarandi, I wish to thank them for the help that we always provide for me, and the support, as we go forward with our mission. And thank you today for joining us.

ASYA LOUIS: Thank you so much, Dr. Gary. It's now time for our question and answer period. Dr. Hassan, before we move on we wanted to give you an opportunity to add anything, if you did have something you wanted to say.

AUDIENCE: I wanted to say thank you very much, Dr. Gary and everyone. I have a question, actually, too, for Dr. Gary. Do you suggest any future research for the deaths of despair? What should we focus on?

FAYE A. GARY: Well, if, now, I think, I think, Dr. Hassan, you know me well enough that I say we are going to begin to focus on prevention, which makes more sense, more reasonable. It provides a better life course. I think we need to focus on children, youth, families, and communities. Because if we can identify behavioral health problems or physical health problems in children and adolescents, I say the sooner the better, and put in place the kinds of mechanisms that are needed to assist them in their growth and development, and at the same time, teach families how to care for the children, with support from professionals.

I think that's where we get the best outcome. Because we want the children to grow and develop, and to finish school, and to become viable citizens. Now thank you for asking that question. Because I just want to share with you something about schools. You remember, I said earlier that our colleagues at Princeton, Dr. Case and others, had said that they identified this population of men. Because these White men had not gone on to college. They dropped out of high school or had attained only a high school diploma and that gone forth.

And she made the case about not having good jobs if you don't go onto college and have some kind of skill. And companies are not willing to pay for workers at a certain level, that there is no upward mobility.

But let me just share this with you. Every year, about 1.2 million students drop out of high school. One student every 26 seconds drop out of school. But that's about 7,000 students a day. That's in the United States.

And so we look at what our colleagues from Princeton are saying about the necessity of having a high school education, and some other kind of level of knowledge and skill sets, what we are doing is allowing children, or not intervening. And it was setting them up for deaths of despair. I find that to be alarming. White and Asian students have the highest rates of high school completion. Black and Hispanic students have the lowest. But some level of improvement, and some pockets across the United States.

There was no mention in that data that I've looked at about Native Americans and Alaska native students. Again, we have to make sure that all groups are considered. Because everybody's life is important. And if we're going to have a stronger America, we're going to have to have opportunities for everyone-- White men and rural communities as well as Native American and Alaska Native people, too.

ASYA LOUIS: Thanks so much, Dr. Gary. We'll get started with our Q&A session now. Our first question from the audience is, what are considered deaths of despair?

FAYE A. GARY: Well, I say earlier, I mentioned to you that according to these three people, they have identified suicide, substance use and abuse, alcohol use-- and of course, that leads also to liver disease. So in the conceptualization by the individuals that I mentioned today, those indeed all the deaths of despair. That's what they conceptualized to be the deaths of despair. And I suggest that same concept certainly could be applied to other populations. And I began to do that, when I looked at what was happening with Native people. That's also in the video that I played, where they described what those researchers meant by deaths of despair.

ASYA LOUIS: OK, and where does the concept of deaths of despair originate?

FAYE A. GARY: At Princeton, University among the economists. It's Dr. Case and Dr. Denton. D-E-N-T-O-N. That's where I think it originated. Now we also have Dr. Braverman, who's out at the University of California San Francisco, who talks about a similar phenomenon that she causes-- she labels it the causes of the causes. So Dr. Braverman would say, if we want to look at, let's say alcohol overdoses of, drug overdose, let's say, by let's say White men in rural communities, she would say we have to look at the causes of the causes.

And one way to unravel the causes of the causes, I think, is by using a conceptual framework, where we looked at the social determinants of health. And Kaplan's model that I share is one such model to do that. There are many others. And if the person I've asked the question with like for me to share others, I would certainly do that.

And I would hasten to say that plan back to Mona Hassan and Dr. Yarandi and I work with data about children, we use [INAUDIBLE] and [INAUDIBLE] model that's been around a long time. You might know that he was at Harvard University and published his model maybe 30 or so years ago, when he talks about how the child. the next level is interaction, the family, the unit, the school, the larger community that the child lives in.

So that's also another very good model for working with children and families, and also communities, because it's a model that communities can understand when they see the levels interacting with each other. And then the research or the clinician decides what particular area is the focus for the research, or for the clinical practice, or for the intervention, [INAUDIBLE].

I have a whole host of them. I'm happy to share this. So if the person just gives us the name and address, we can send a whole list of them.

ASYA LOUIS: And our next question is, what advice would you give for someone interested in focusing their protection research on deaths of despair?

FEMALE FAYE A. GARY: I would say, you could take that concept, deaths of despair, and you could use one major conditions as I have described, that were based on my findings from the economists at Princeton. Or you could take that concept and look at, let's say, a particular group. Let's say, you can look at the homeless populations. And you could determine among the homeless populations, let's say, in Ohio, what are the most frequent kinds of conditions that lead to early deaths or preventable deaths among the homeless?

And in a sense, you could frame that as deaths of despair among homeless populations in central Ohio or however you would like to do it. I think the term is a very catchy term. And it's certainly caught my eye. And that's one of the reasons I decided to explore it. But you're talking about deaths, preventable deaths. And so on these deaths are preventable, across the lifespan, and it's such young, vibrant ages, they are indeed deaths of despair. That's a very good question. Thank you for it.

ASYA LOUIS: Thank you. Our next question is, with this being a relatively new concept, how can this be incorporated into clinical practice?

FEMALE FAYE A. GARY: That's also a very interesting question. Again, I think you would determine-- I think it was so when I was on our committee at the joint commission. A question would always come up with people who had queries. Well, how could you possibly say that conditions need to be astute about or the cultural practices, health beliefs of individuals who come to our hospitals and clinics? And of course, our position was if you work at a hospital or clinic, whatever that might be, I think you have an obligation to understand the demographic profiles of the people that you serve. So in Ohio, that population might be very different than it is if I were at my home in Florida.

So who comes to your hospital for service? What percentage are Hispanic? What percentage might be Amish? What percentage might be people of African descent? Caucasian? What's the general profile? How many people have insurance? How many people don't?

So you need to understand who you've given service to. Take those data, and make sure that you develop some training and accountability among all of the providers in your system-- that's doctors, nurses, social workers, psychologists. And if you use the therapeutic community model, it's everyone. We don't use the therapeutic community model anymore, for a variety of reasons. One reason is that patients are not hospitalized for very long, and that's a time for a different discussion. But that is a fact.

They are not. They used to be hospitalized for a long period of time, for better or for worse. And the concept of the therapeutic community that was generated by Maxwell Jones in England, I thought was very useful. And that's a very simple concept that states that everybody in the therapeutic milieu is responsible for therapy are responsible for treatment.

So if you take that concept and put it to a general hospital, you would say that everyone who works at that hospital has a general understanding about the health beliefs and cultural practices of the majority of the populations that they serve. That's very different than saying I need to know something about everybody. That's not going to happen. But I think the focus should be on who you do serve, and teaching, and giving some accountability for those individuals.

And then when you find that you don't understand information about a particular subgroup, then you have mechanisms in place where you can provide a way to address their care and their needs. And the

Other issue is that those hospitals and health systems that have a diverse workforce-- to include Hispanics, Blacks, Whites, Asians, Native Americans-- I just think they're in a better position of having the potential to provide better care. And I say the potential, because someone is a specific effort to make it happen. It may not ever happen. It has to be discussed. It has to be a goal, an objective. It has to be discussed, evaluated, improved upon. It has to be a part of what the institution stands for, its mission. And the mission must be organic.

ASYA LOUIS: OK, great. And we have just one more question for you. A participant asked, so Dr. Gary seems to be saying that depression equals despair. And they're wondering if that's accurate, and if you can comment on the role of shame.

FEMALE FAYE A. GARY: Well, no. I'm glad you brought that question up. Depression does not necessarily mean despair. And if you look at the factor loadings so the three women, I never mentioned despair with them. But certainly, on the Beck depression inventory, their scores were mild and moderate. But if you look at the factor loadings, you saw suicide. You so pessimism. You saw guilt. You saw tiredness, and whatever.

So I think we need to be very clear about that. And we have depressive symptoms, and then we have clinical depression. You have to have a bifurcation between those two concepts. So please do not think that depression automatically means despair.

Now the woman I told you I had a conversation with, she was working full time, trying to play her rent and whatever else. Over time, clinical depression can lead to despair and suicide. We also know that as well.

Now in our paper that we will soon publish, we also found out that the women did not embrace the concept as we know and call depression. They all said we don't have depression. And one of the inferences that we made is that Black women work under such stressful conditions at work, at home, and in the community, it becomes a way of life. And they don't see it as something that they need to take any additional action for.

We couch our discussion in spirituality. And in our next paper coming out, the notion that if one is very spiritual, and truly believes in God, then seeking additional help means that you have

waned with your strength and spirituality. And perhaps, being very spiritual could be one of the barriers to seeking additional help and alleviating one's suffering.

I think shame, for some people, is more prominent. I think shame, in some cultures, is more prominent. And guilt, in some cultures, are more prominent. But it can happen at any time and across cultures. And again, when you talk about shame and guilt, you also have to talk about how much, how often, and how it impacts one's activities of daily living. So without that additional information. It's only a beginning conversation.

So I would suggest going further, and say, how often? Are you talking about a teaspoonful? Are you talking about a cup full? A jar full? What are you talking about? And how do you measure it?

And then ask the patient. What do you think is going on? How long do you think this would last? And how do you think it should be treated? Now I also need to tell you that in my clinical practice, I always use Kleinman's self-explanatory model. And I don't have it in my presentation. But if you just go and Google it, Kleinman's exploratory model, it is-- Kleinman is a psychiatrist and an anthropologist.

And the first question is, what do you call this illness? And I would just quickly say that my colleague at the University of Florida, Dr. Regina Bussing, a psychiatrist, child psychiatrist, and I would doing focus groups with families who had children diagnosed with ADHD. And using Kleinman's model, we asked the question, what do you think caused the illness? And I'll never forget, in the first focus group, the first comment was from a mother who said, my child had ADHD because we live close to power lines. Power lines are all over our community. And that's why my child has ADHD.

We published that paper, and it's in the Harvard Review of Psychiatry. I don't remember the year. But if you Google it, you'll find it. So that is the lack of understanding the patient's perspective. Because unless you do, and unless you have conversations about how the true perspectives can help the patient, then you don't have a grasp of all of the central attributes to make a viable plan of action that is patient and client centered, and one that can be addressed by the client the family, and the provider.

ASYA LOUIS: All right. Thank you so much for sharing, Dr. Gary. We have one final comment before I conclude the webinar. Patricia says, thank you so much for presenting today. This definitely sheds light to some of the disparities I was unaware of, such as that with Native Americans. There's so much to learn.

And with that, we would like to thank Dr. Gary, Dr. Hassan, and you, the participants, for a great question and answer period, and for joining us on this webinar today. We hope that you'll be able to utilize the information presented today to strengthen your work.

In closing, we would like your feedback on this webinar. After your close the webinar window, a new window will pop up that includes a brief survey. Thank you, and please save the date for our next webinar, scheduled for August 26, on the topic of culturally responsive substance use disorder treatment.

Thank you. This concludes our webinar.