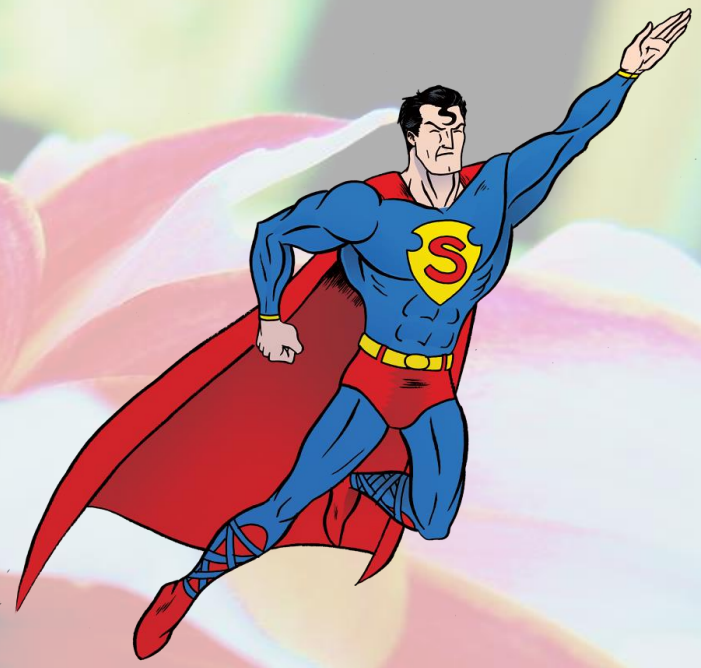

Main St
HOTEL
BALMORAL
HOTEL
WASHINGTON
ATM
PUB

CanMeds roles



- Medical Expert
- Professional
- Communicator
- Scholar
- Collaborator
- Leader
- Health Advocate

Health

'Opioidphobia' stigmatizes chronic pain sufferers, expert says

Opioids a lifesaver for chronic pain sufferers but access is getting harder due to new prescribing guidelines

Kas Roussy · CBC News · Posted: Nov 03, 2019 4:00 AM ET | Last Updated: November 3

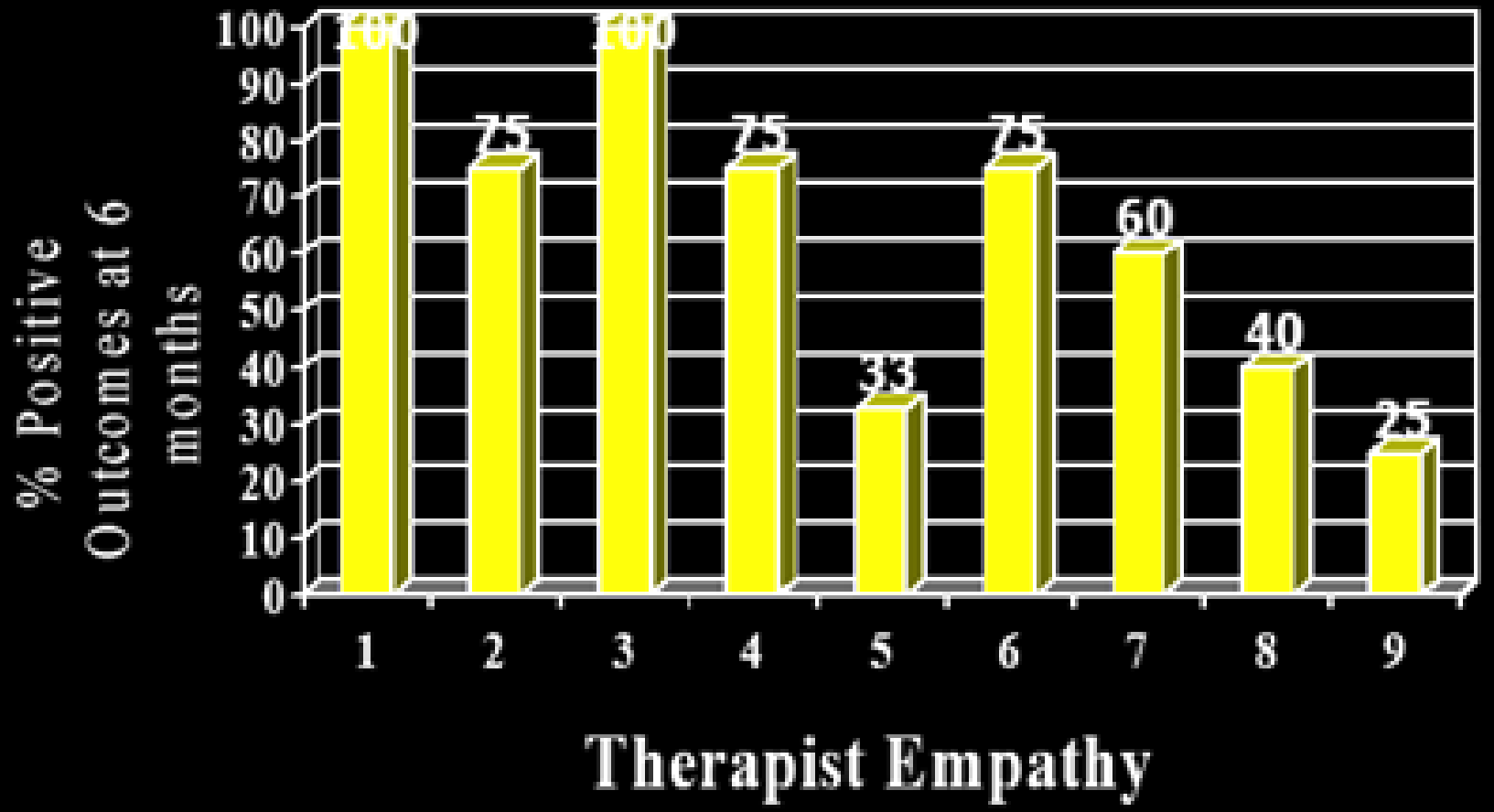
Dr. Andrea Furlan is a pain specialist in Toronto and teaches other health-care professionals how to use opioids for pain management. 'I have had patients referred to us because their doctors cut them from opioids,' she said. 'That's ridiculous because they were not addicted.' (Craig Chivers/CBC)

Miller, Taylor & West, 1980

Journal of Consulting and Clinical Psychology 48:590-601

- Problem drinkers were randomly assigned to one of nine counselors delivering manual-guided behavior therapy
- 3 supervisors rated counselors' levels of accurate empathy (Truax & Carkhuff scale) with high inter-rater reliability

Counselor Empathy and Client Outcomes



Published in final edited form as:

Group Process Intergroup Relat. 2016 July ; 19(4): 528–542. doi:10.1177/1368430216642029.

Examining the Presence, Consequences, and Reduction of Implicit Bias in Health Care: A Narrative Review

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University of Arizona

Irene V. Blair, and
University of Colorado Boulder

Jeff Stone
University of Arizona

Abstract

Recent evidence suggests that one possible cause of disparities in health outcomes for stigmatized groups is the implicit biases held by health care providers. In response, several health care organizations have called for, and developed, new training in implicit bias for their providers. This review examines current evidence on the role that provider implicit bias may play in health disparities, and whether training in implicit bias can effectively reduce the biases that providers exhibit. Directions for future research on the presence and consequences of provider implicit bias, and best practices for training to reduce such bias, will be discussed.

Published in final edited form as:
Soc Issues Policy Rev. 2011 December 1; 5(1): 257–291. doi:10.1111/j.1751-2409.2011.01032.x.

The Nonverbal Transmission of Intergroup Bias: A Model of Bias Contagion with Implications for Social Policy

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Abstract

Social and policy interventions over the last half-century have achieved laudable reductions in blatant discrimination. Yet members of devalued social groups continue to face subtle discrimination. In this article, we argue that decades of anti-discrimination interventions have failed to eliminate intergroup bias because such bias is contagious. We present a model of bias contagion in which intergroup bias is subtly communicated through nonverbal behavior. Exposure to such nonverbal bias "infects" observers with intergroup bias. The model we present details two means by which nonverbal bias can be expressed—either as a veridical index of intergroup bias or as a symptom of worry about appearing biased. Exposure to this nonverbal bias can increase perceivers' own intergroup biases through processes of implicit learning, informational influence, and normative influence. We identify critical moderators that may interfere with these processes and consequently propose several social and educational interventions based on these moderators.

Psychological Science
XX(X) 1–7

DOI: 10.1177/0956797610374741
http://pss.sagepub.com

Acetaminophen Reduces Social Pain: Behavioral and Neural Evidence

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Abstract

Pain, whether caused by physical injury or social rejection, is an inevitable part of life. These two types of pain—physical and social—may rely on some of the same behavioral and neural mechanisms that register pain-related affect. To the extent that these pain processes overlap, acetaminophen, a physical pain suppressant that acts through central (rather than peripheral) neural mechanisms, may also reduce behavioral and neural responses to social rejection. In two experiments, participants took acetaminophen or placebo daily for 3 weeks. Doses of acetaminophen reduced reports of social pain on a daily basis (Experiment 1). We used functional magnetic resonance imaging to measure participants' brain activity (Experiment 2), and found that acetaminophen reduced neural responses to social rejection in brain regions previously associated with distress caused by social pain and the affective component of physical pain (dorsal anterior cingulate cortex, anterior insula). Thus, acetaminophen reduces behavioral and neural responses associated with the pain of social rejection, demonstrating substantial overlap between social and physical pain.

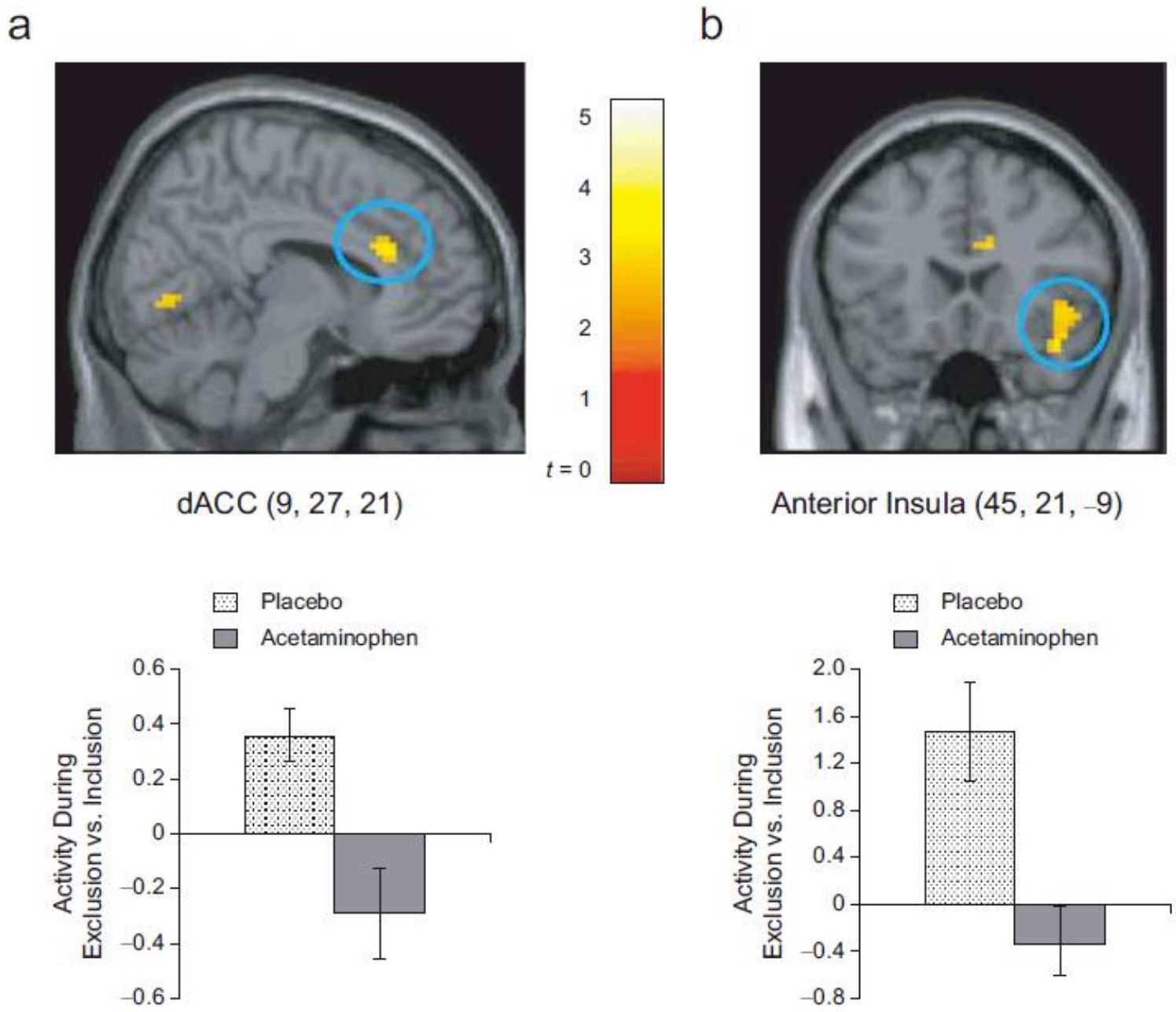

Fig. 3. Results from the whole-brain, between-groups analysis in Experiment 2: change in neural activity (parameter estimates during exclusion vs. inclusion) in (a) dorsal anterior cingulate cortex (dACC) and (b) right anterior insula in participants who took acetaminophen and those who took placebo. Error bars represent standard errors. Comparisons were calculated using a significance level of $p < .005$, with a 20-voxel extent

Variation in the μ-opioid receptor gene (*OPRM1*) is associated with dispositional and neural sensitivity to social rejection

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Edited by Edward E. Smith, Columbia University, New York, NY, and approved July 14, 2009 (received for review December 10, 2008)

Scientific understanding of social pain—the hurt feelings resulting from social rejection, separation, or loss—has been facilitated by the hypothesis that such feelings arise, in part, from some of the same neural and neurochemical systems that generate the unpleasant feelings resulting from physical pain. Accordingly, in animals, the painkiller morphine not only alleviates the distress of physical pain, but also the distress of social separation. Because morphine acts on the μ-opioid receptor, we examined whether variation in the μ-opioid receptor gene (*OPRM1*), as measured by the functional A118G polymorphism, was associated with individual differences in rejection sensitivity. Participants (n = 122) completed a self-report inventory of dispositional sensitivity to social rejection and a subsample (n = 31) completed a functional MRI session in which they were rejected from an online ball-tossing game played with two supposed others. The A118G polymorphism was associated with dispositional sensitivity to rejection in the entire sample and in the fMRI subsample. Consistent with these results, G allele carriers showed greater reactivity to social rejection in neural regions previously shown to be involved in processing social pain as well as the unpleasantness of physical pain, particularly the dorsal anterior cingulate cortex (dACC) and anterior insula. Furthermore, dACC activity mediated the relationship between the A118G polymorphism and dispositional sensitivity to rejection, suggesting that this is a critical site for μ-opioid-related influence on social pain. Taken together, these data suggest that the A118G polymorphism specifically, and the μ-opioid receptor more generally, are involved in social pain in addition to physical pain.

similar vocalizations (13, 14), suggesting a critical role for the ACC in the distress of being separated from others. Likewise, in humans, the distress of social rejection has been associated with activation of the dACC and anterior insula (15, 16), and greater feelings of social distress in response to social exclusion are directly related to greater dACC activity (17).

At the neurochemical level, physical pain and social pain share common substrates as well, in particular μ-opioid receptor (MOR) mediated signaling. Opiates, such as morphine, have well-documented pain-relieving effects (18) that appear to be mediated by the MOR. Thus, MOR knockout mice are unresponsive to the pain-relieving effects of morphine (19) and show altered baseline responses to multiple measures of physical pain (20).

With respect to social pain, low, nonsedative doses of morphine specifically reduce distress vocalizations made by infants when separated from their mother in multiple species, including monkeys (21), dogs (22), guinea pigs (23), rats (24), and chickens (25). The MOR would appear to be critical for these effects, as deletion of the MOR gene from mice reduces pups' distress during mother-infant separation (26). Similarly, in human adults, μ-opioid-related activity appears to signal the pain of social loss. In a positron emission tomography study (27), women exhibited decreased μ-opioid mediated neurotransmission when recalling the death of a loved one or the breakup of a romantic relationship, indicating that the MOR is involved in responding to the loss of connections to significant others.

In light of this evidence connecting the MOR to both physical and social pain, individual differences in the intensity of physically and socially painful feelings may depend, in part, on

J Exp Psychol Gen. 2019 Aug 15. doi: 10.1037/xge0000674. [Epub ahead of print]

Opioids and social bonding: Effect of naltrexone on feelings of social connection and ventral striatum activity to close others.

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Abstract

Close social bonds are critical to immediate and long-term well-being. However, the neurochemical mechanisms by which we remain connected to our closest loved ones are not well understood. Opioids have long been theorized to contribute to social bonding via their actions on the brain. But feelings of social connection toward one's own close others and direct comparisons of ventral striatum (VS) activity in response to close others and strangers, a neural correlate of social bonding, have not been explored. Therefore, the current clinical trial examined whether opioids causally affect neural and experiential signatures of social bonding. Eighty participants were administered naltrexone (n = 40), an opioid antagonist that blocks natural opioid processing, or placebo (n = 40) before completing a functional MRI scan where they viewed images of their close others and individuals they had not seen before (i.e., strangers). Feelings of social connection to the close others and physical symptoms commonly experienced when taking naltrexone were also collected. In support of hypotheses, naltrexone (vs. placebo) reduced feelings of social connection toward the close others (e.g., family, friends, romantic partners). Furthermore, naltrexone (vs. placebo) reduced left VS activity in response to images of the same close others, but did not alter left VS activity to strangers. Finally, the positive correlation between feelings of connection and VS activity to close others present in the placebo condition was erased by naltrexone. Effects remained after adjusting for physical symptoms. Together, results lend support to theories suggesting that opioids contribute to social bonding, especially with our closest loved ones. (PsycINFO Database Record (c) 2019 APA, all rights reserved).

TRIAL REGISTRATION: ClinicalTrials.gov NCT02818036.

Therapist Empathy Scale rating item descriptions and empathy component.

Item	Item Description
Concern	A therapist conveys concern by showing a regard for and interest in the client. The therapist s attentive to what the client has said. The therapist's voice has a soft resonance that supports a
Expressiveness	A therapist's voice demonstrates expressiveness when the therapist speaks with energy and va the mood or disposition of the client.
Resonate or capture client feelings	A therapist resonates with or captures the intensity of the client's feelings when he or she spe client's emotional state or that pitches words or phrases in a manner that underscores how the
Warmth	A therapist demonstrates warmth by speaking in a friendly, cordial, and sincere manner. The t client's efforts to express him- or herself. In some way, the therapist seems kindly disposed to
Attuned to client's inner world	A client's inner world is defined as the client's feelings, perceptions, memories, meanings, bo attuned to a client's inner world when he or she provides moment-to-moment verbal acknowl acknowledgements suit, agree with, or support the mood and reflections of the client. The the feeling conveyed in a client's statements beyond surface content and shows a genuine underst
Understanding cognitive framework	A therapist demonstrates an understanding of the client's cognitive framework and meanings has said and accurately reflects this understanding to the client. In short, the therapist and clie to provide ample opportunities for the client to state his or her views in order to permit the ful client. The interaction conveys that the therapist values knowing what the client means or inte predetermination or judgment.
Understanding feelings/inner experience	A therapist conveys an understanding of a client's feelings and inner experience when he or s caring for the client's emotional state. A therapist provides ample opportunities for the client therapist accurately reflects how the client feels by appropriately labeling feeling states with v metaphors (e.g., "It's as if you are pent up and feel about to explode") to clarify and crystalliz emotionally.
Acceptance of feelings/inner experiences	A therapist shows acceptance of the client's feelings and inner experience when he or she vali client's feelings without judgment or a dismissive attitude. The therapist is unconditionally op therapist's stance is one of genuineness and honesty instead of seemingly feigning concern or
Responsiveness	A therapist shows responsiveness to the client by adjusting his or her responses to the client's the conversation. The therapist follows the client's lead in the conversation instead of trying t interests.

SIX LEVELS OF VALIDATION

1. Wide awake, mindful listening
2. Accurately reflecting the client's communications
3. Articulating the client's non-verbalized thoughts, emotions, and behavioral patterns ("reading the mind")
4. Making sense of the client's behavior in light of the past and in terms of biological responses
5. Finding the way in which the client's behavior makes sense in the current context (normative)
6. Radical genuineness (validating the whole individual)

Tips:

- Develop a reflective awareness of your emotional/cognitive states in clinical environments
- Advocate for practice supervision
- Practice empathy/validation strategies regularly