

# **Annotated Bibliography**

## **The Empathy Effect: Working with Vulnerable Populations**



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ACEs Connection Network (2016). <http://www.acesconnection.com/>

ACEs Connection is a social network that accelerates the global movement toward recognizing the impact of adverse childhood experiences in shaping adult behavior and health, and reforming all communities and institutions -- from schools to prisons to hospitals and churches -- to help heal and develop resilience rather than to continue to traumatize already traumatized people.

*The Adverse Childhood Experiences Study: A Springboard to Hope.* <http://www.cestudy.org/index.html>

Adams CL, Nestel D, Wolf P (2006). **Reflection: a critical proficiency essential to the effective development of a high competence in communication.** *J Vet Med Educ.* 2006 Spring;33(1):58-64. <http://www.ncbi.nlm.nih.gov/pubmed/16767639>

Reflection, or the ability to step back from an experience and consider it critically, in an analytical, non-subjective manner, is an essential aspect of problem solving and decision making, and also of effective communication with clients and colleagues. Reflective practice has been described as the essence of professionalism and is therefore a core professional skill; rarely, however, has it been explicitly taught in veterinary curricula, and it has only a recent history in undergraduate human medical curricula. We describe here two preliminary case studies, one in a veterinary medical education context and the other within a human medical education framework, as examples of approaches to assessing a student's ability for "reflection." The case studies also illustrate some of the key principles. Both of the case studies described had as their end goal the enhancement of communication skills through critical reflection. At Monash University, Australia, the majority of students were assessed as being at a level of "reflection in development." The students in the Ontario Veterinary College case study showed moderately good use of self-awareness and critical reflection as a basis for modifying and integrating communication skills into practice. While both preliminary case studies point to the fact that students recognize the importance of communication and value the opportunity to practice it, few students in either case study identified the importance of reflection for lifelong learning and professional competence. Opportunities to complete critical reflection exercises in other parts of curricula and outside of communication would likely reinforce its importance as a generic skill. Ongoing scholarly approaches to teaching, learning, and evaluating reflection and self-awareness are needed.

Agency for Healthcare Research and Quality (2016). **Improving Cultural Competence to Reduce Health Disparities.** *AHRQ Publication No. 16-EHC006-EF.* <https://www.effectivehealthcare.ahrq.gov/ehc/products/573/2206/cultural-competence-report-160327.pdf>

REVIEW: Objective. To examine existing system-, clinic-, provider-, and individual-level interventions to improve culturally appropriate health care for people with disabilities; lesbian, gay, bisexual, and transgender (LGBT) populations; and racial/ethnic minority populations.

CONCLUSIONS: None of the included studies measured the effect of cultural competence interventions on health care disparities. Most of the training interventions measured changes in professional attitudes toward the population of interest but did not measure the downstream effect of changing provider beliefs on the care delivered to patients. Interventions that altered existing protocols, empowered patients to interact with the formal health care system, or prompted provider behavior at the point of care were more likely to measure patient-centered outcomes. The medium or high risk of bias of the included studies, the heterogeneity of populations, and the lack of measurement consensus prohibited pooling estimates or commenting about efficacy in a meaningful or responsible way. The term "cultural competence" is not well defined for the LGBT and disability populations, and is often conflated with patient-centered or individualized care. There are many gaps in the literature; many large subpopulations are not represented.

Agency for Healthcare Research and Quality (July, 2014). ***The SHARE Approach—Taking Steps Toward Cultural Competence: A Fact Sheet***. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/tool-7/index.html>

The SHARE Approach is a 1-day training program developed by the Agency for Healthcare Research and Quality (AHRQ) to help health care professionals work with patients to make the best possible health care decisions. It supports shared decision making through the use of patient-centered outcomes research (PCOR).

Agency for Healthcare Research and Quality (February, 2015). ***AHRQ Health Literacy Universal Precautions Toolkit, 2nd Edition***. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2.html>

The AHRQ Health Literacy Universal Precautions Toolkit, 2nd edition, can help primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels.

AMA Council on Ethical and Judicial Affairs. ***Code of Medical Ethics of the American Medical Association***. Chicago Illinois: American Medical Association, 2016. ISBN#: 978-1-62202-553-4. <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/code-medical-ethics.page?>

The Code of Medical Ethics was adopted at the first AMA meeting in 1847. Much in medicine has changed in 169 years, but this founding document—the first uniform code of ethics of its kind—is still the basis of an explicit social contract between physicians and their patients. It is regularly cited as the medical profession's authoritative voice in legal opinions and in scholarly journals. It should be in every medical library and practice office. One of the goals of the modernization was to make the Code simpler to navigate and related opinions easier to find so that physicians could more readily apply the Code to their daily practice of medicine. Changes include: Creating a more intuitive chapter structure so that guidance is easy to find; Implementing a uniform format for opinions so that guidance is easy to read and apply; Consolidating guidance into a single, comprehensive statement on each topic; Harmonizing guidance on related issues; Identifying, updating and retiring guidance that had become significantly outdated over time. The updated Code also includes a new preface to clarify the different levels of ethical obligation in the various ethical opinions.

Ambady N, Koo J, Rosenthal R, Winograd CH (2002). ***Physical Therapists' Nonverbal Communication Predicts Geriatric Patients' Health Outcomes***. *Psychology and Aging* 17(3): 443–452. DOI: 10.1037//0882-7974.17.3.443. <http://web.stanford.edu/group/ipc/pubs/2002AmbadyPhys.pdf>

Two studies explored the link between health care providers' patterns of nonverbal communication and therapeutic efficacy. In Study 1, physical therapists were videotaped during a session with a client. Brief samples of therapists' nonverbal behavior were rated by naive judges. Judges' ratings were then correlated with clients' physical, cognitive, and psychological functioning at admission, at discharge, and at 3 months following discharge. Therapists' distancing behavior was strongly correlated with short- and long-term decreases in their clients' physical and cognitive functioning. Distancing was expressed through a pattern of not smiling and looking away from the client. In contrast, facial expressiveness, as revealed through smiling, nodding, and frowning, was associated with short- and long-term improvements in functioning. In Study 2, elderly subjects perceived distancing behaviors of therapists more negatively than positive behaviors.

American Psychological Association (APA). ***Ethical Principles of Psychologists and Code of Conduct***. Adopted August 21, 2002, effective June 1, 2003 with the 2010 Amendments Adopted February 20, 2010, effective June 1, 2010. <http://www.apa.org/ethics/code/principles.pdf>

PREAMBLE: Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work. This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students and the public regarding ethical standards of the discipline. The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees and colleagues; and to consult with others concerning ethical problems.

Ang S, Van Dyne L, Tan ML (2011). **Cultural Intelligence**, chapter 29 in R.J. Sternberg & S.B. Kaufman (Eds.), *Cambridge Handbook on Intelligence*, New York: Cambridge University Press (pp. 582-602). [http://www.culturalq.com/contents/research/papers/Ang\\_Van%20Dyne\\_Tan%202010%20chapter%20in%20Sternberg.pdf](http://www.culturalq.com/contents/research/papers/Ang_Van%20Dyne_Tan%202010%20chapter%20in%20Sternberg.pdf)

Defines cultural intelligence (CQ) as the capability to function effectively in situations characterized by cultural diversity. CQ is a malleable individual characteristic. Concept of IQ and other non-academic intelligences (social, emotional, practical). Theoretical framework of metacognitive, cognitive, motivational and behavioral factors, all involved in CQ, each important but not sufficient for optimal functioning. Differentiates CQ from nonability traits (e.g., personality). Relationship between certain personality traits (openness to experience) related to CQ. CQ can also be considered a group-level characteristic.

Back AL, Arnold RM, Baile WF, Edwards KA, Tulskey JA (2010). **The Art of Medicine When praise is worth considering in a difficult conversation**. *Lancet*. 2010 Sep 11; 376(9744): 866–867. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4430080/pdf/nihms686201.pdf>

Physicians tend to overlook praise as part of the communication repertoire. Although we acknowledge that praise has received little attention empirically, we think praise deserves special mention because we find that, if used judiciously, praise is a powerful tool that can help deepen conversation and enable physician and patient to move through difficult conversations.

Bair-Merritt MH, Lewis-O'Connor A, Goel S, Amato P, Ismailji T, Jelley M, Lenahan P, Cronholm P (2014). **Primary care-based interventions for intimate partner violence: A systematic review**. *Am J Prev Med* 2014;46(2):188–194. <http://www.ncbi.nlm.nih.gov/pubmed/24439354>

REVIEW: Context: Primary care providers are uniquely positioned to respond to patients' disclosure of intimate partner violence (IPV). However, the research on primary care-based IPV interventions has not been systematically synthesized, making it difficult for providers, policymakers, and researchers to understand how to effectively intervene in the primary care setting. This systematic review summarizes primary care-based interventions for patients experiencing IPV. ...

CONCLUSIONS: The majority of studies demonstrated patient-level benefit subsequent to primary care IPV interventions, with IPV/community referrals the most common positively affected outcome.



Ballon BC, Skinner W (2008). **Attitude is a little thing that makes a big difference: reflection techniques for addiction psychiatry training.** *Acad Psychiatry*. 2008 May-Jun;32(3):218-24. doi: 10.1176/appi.ap.32.3.218.

**OBJECTIVE:** The authors aim to incorporate educational reflection techniques in an addiction psychiatry postgraduate core rotation in order to increase critical self-awareness of attitudes, values, and beliefs related to working with people with substance use and other addictive disorders.

**METHODS:** Reflection discussion times, reflection journaling, and mandatory end-of-rotation reflection papers were embedded into a core addiction psychiatry postgraduate training block. Qualitative analysis of 28 reflection papers was performed to determine key factors and constructs that impacted on the development of attitudes and professionalism.

**RESULTS:** A number of constructs emerged that demonstrated the attitudes, beliefs, stereotypes, and stigmas students have regarding addictive disorders. Some constructs also highlighted that students felt much more comfortable dealing with addictive disorders after the training and would treat individuals with these conditions in a more effective manner.

**CONCLUSION:** Reflection techniques were endorsed as extremely valuable by students, especially in the development of professional attitudes that will help clinicians effectively engage and provide appropriate care for individuals suffering from addictive disorders. The authors suggest that reflective practices be used more extensively in psychiatric training in order to build and establish reflexive self-awareness as a core professional competence essential to work effectively in clinical practice, especially in the most demanding contexts.

Bandstra NF, Camfield CS, Camfield PR (2008). **Stigma of Epilepsy.** *Can J Neurol Sci*. 2008 Sep;35(4):436-40. <http://www.ncbi.nlm.nih.gov/pubmed/18973059>

Epilepsy directly affects 50 million people worldwide. Most can achieve excellent seizure control; however, people living with epilepsy continue to suffer from enacted or perceived stigma that is based on myths, misconceptions and misunderstandings that have persisted for thousands of years. This paper reviews the frequency and nature of stigma toward epilepsy. Significant negative attitudes prevail in the adolescent and adult public worldwide leading to loneliness and social avoidance both in school and in the workplace. People with epilepsy are often wrongly viewed as having mental health and antisocial issues and as being potentially violent toward others. Twenty-five percent of adults having epilepsy describe social stigma as a result of their epilepsy. They fear rejection and often feel shame or loneliness from this diagnosis. The psychosocial and social impact of epilepsy is significant. Yet few specific interventions have been demonstrated to alter this perception. The effect on public education is primarily short-term, while change over the long-term in attitudes and inaccurate beliefs have not presently been proven effective. School education programming demonstrates improved knowledge and attitude a month after a classroom intervention, but persisting change over a longer period of time has not been evaluated. In-depth adult psycho-educational programs for adults with epilepsy improves knowledge, coping skills and level of felt stigma. However these gains have not demonstrated persistence over time. Myths, misconceptions and misunderstandings about epilepsy continue and programs aimed at increasing knowledge and reducing negative public attitudes should be enhanced.

Bell A, Bray, L (2014). **The knowledge and attitudes of student nurses towards patients with sexually transmitted infections: Exploring changes to the curriculum.** *Nurse Education in Practice* 14, 512-517. <http://www.ncbi.nlm.nih.gov/pubmed/24875840>

Evidence suggests that nurses can struggle to care for patients with sexually transmitted infections in a non-judgemental way. It is unknown how targeted education can influence the knowledge and attitudes of student nurses towards caring for patients with sexually transmitted infections. This study aimed to investigate how a change in curriculum influenced the reported sexual health knowledge and attitudes of pre-registration adult student nurses in a University in the UK. A two phase mixed methods study, using a sequential explanatory strategy, collected quantitative questionnaire data (n = 117) followed by qualitative group data (n = 12). Data were collected from one cohort of students before a curriculum change and then from a subsequent cohort of students. Those students who had increased educational

input in relation to sexual health reported higher degrees of knowledge and demonstrated a more positive attitude towards patients with a sexually transmitted infection. Both cohorts of students identified that education in this subject area was essential to challenge negative attitudes and positively influence patient care. Active learning approaches in the curriculum such as small group debates and service user involvement have the ability to allow students to express and challenge their beliefs in a safe and supportive environment.

Best D (2016). **An unlikely hero? Challenging stigma through community engagement.** *Drugs and Alcohol Today* 16(1): 106-116, ISSN 1745-9265. <http://jobsfriendshouses.org.uk/wp-content/uploads/2016/02/Unlikely-hero-paper-published.pdf>

**PURPOSE:** The purpose of this paper is to describe a high-profile social enterprise in Blackpool, England, called Jobs, Friends and Houses (JFH) that has created a visible social identity of recovery and meaningful activity, to assess how stigma is challenged through active and visible community engagement.  
**DESIGN/METHODOLOGY/APPROACH:** Case study based on in-depth individual interview and focus group, supplemented by participant in-depth interviews.  
**FINDINGS:** The paper describes one particular incident in which a worker at JFH intervened in a violent attack, possibly saving a woman's life. The paper describes the experiences of internalised stigma and external exclusion being challenged by the development of a positive social identity and a pro-social community role that has high visibility. Data are presented showing the strong social identity experienced by participants and recognised by external stakeholders.

Bismark MM (2009). **The power of apology.** *NZ Med J* 2009 Oct 9;122(1304):96-106. Epub 2009 Oct 9. <http://www.ih.org/resources/Pages/Publications/PowerofApology.aspx>

In the aftermath of an adverse event, an apology can bring comfort to the patient, forgiveness to the health practitioner, and help restore trust to their relationship. According to the Health and Disability Commissioner: "The way a practitioner handles the situation at the outset can influence a patient's decision about what further action to take, and an appropriate apology may prevent the problem escalating into a complaint to HDC". Yet, for many health practitioners saying "I'm sorry" remains a difficult and uncomfortable thing to do. We can help to bring down this wall of silence by developing a clear understanding of the importance of apologies to patients and health practitioners; appreciating the difference between expressing empathy and accepting legal responsibility for an adverse outcome; knowing the key elements of a full apology and when they should be used; and supporting those who have the honesty and courage to say "I'm sorry" to patients who have been harmed while receiving healthcare.

Blaire E (2011). **Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here?** *Perm J*. 2011 Spring; 15(2): 71-78. <http://www.thepermanentejournal.org/files/Spring2011/HealthDisparities.pdf>

**EXCERPT:** Demands of a busy medical practice leave little time for reflection and the fulfillment of even the best intentions. Biases must be rendered less implicit and unconscious to foster real reflection, analysis and change. Gut reactions to specific individuals or groups may be potential indicators of implicit bias. Identify biases that may be active in the community. Affirm equity of care and diversity as core organizational and institutional values. Disparities in health care are of great concern, with much attention focused on the potential for unconscious (implicit) bias to play a role in this problem. Some initial studies have been conducted, but the empirical research has lagged. This article provides a research roadmap that spans investigations of the presence of implicit bias in health care settings, identification of mechanisms through which implicit bias operates, and interventions that may prevent or ameliorate its effects. The goal of the roadmap is to expand and revitalize efforts to understand implicit bias and, ultimately, eliminate health disparities. Concrete suggestions are offered for individuals in different roles, including clinicians, researchers, policymakers, patients, and community members.

Blatt B, LeLacheur SF, Galinsky AD, Simmens SJ, Greenberg L (2010). **Does Perspective-Taking Increase Patient Satisfaction in Medical Encounters?** *Academic Medicine*, Sept. 2010, 85(9): 1445-1452. [http://journals.lww.com/academicmedicine/Fulltext/2010/09000/Does\\_Perspective\\_Taking\\_Increase\\_Patient\\_Satisfaction\\_in\\_Medical\\_Encounters.15.aspx#](http://journals.lww.com/academicmedicine/Fulltext/2010/09000/Does_Perspective_Taking_Increase_Patient_Satisfaction_in_Medical_Encounters.15.aspx#)

**PURPOSE:** To assess whether perspective-taking, which researchers in other fields have shown to induce empathy, improves patient satisfaction in encounters between student-clinicians and standardized patients (SPs).

**METHOD:** In three studies, randomly assigned students (N = 608) received either a perspective-taking instruction or a neutral instruction prior to a clinical skills examination in 2006–2007. SP satisfaction was the main outcome in all three studies. Study 1 involved 245 third-year medical students from two universities. Studies 2 and 3 extended Study 1 to examine generalizability across student and SP subpopulations. Study 2 (105 physician assistant students, one university) explored the effect of perspective-taking on African American SPs' satisfaction. Study 3 (258 third-year medical students, two universities) examined the intervention's effect on students with high and low baseline perspective-taking tendencies.

**RESULTS:** Intervention students outscored controls in patient satisfaction in all studies: Study 1: P = .01, standardized effect size = 0.16; Study 2: P = .001, standardized effect size = 0.31; Study 3: P = .009, standardized effect size = 0.13. In Study 2, perspective-taking improved African American SPs' satisfaction. In Study 3, intervention students with high baseline perspective-taking tendencies outscored controls (P = .0004, standardized effect size = 0.25), whereas those with low perspective-taking tendencies did not (P = .72, standardized effect size = 0.00).

**CONCLUSIONS:** Perspective-taking increased patient satisfaction in all three studies, across medical schools, clinical disciplines, and racially diverse students and SPs. Perspective-taking as a means for improving patient satisfaction deserves further exploration in clinical training and practice.

Brezing C, Ferrara M, Freudenreich O (2015). **The syndemic illness of HIV and trauma: implications for a trauma-informed model of care.** *Psychosomatics*. 2015 Mar-Apr;56(2):107-18. doi: 10.1016/j.psych.2014.10.006. Epub 2014 Oct 8. <http://www.ncbi.nlm.nih.gov/pubmed/25597836>

**BACKGROUND:** People living with HIV infection are disproportionately burdened by trauma and the resultant negative health consequences, making the combination of HIV infection and trauma a syndemic illness. Despite the high co-occurrence and negative influence on health, trauma and posttraumatic sequelae in people living with HIV infection often go unrecognized and untreated because of the current gaps in medical training and lack of practice guidelines.

**OBJECTIVE:** We set out to review the current literature on HIV infection and trauma and propose a trauma-informed model of care to target this syndemic illness.

**RESULTS:** We confirm high, but variable, rates of trauma in people living with HIV infection demonstrated in multiple studies, ranging from 10%-90%. Trauma is associated with (1) increased HIV-risk behavior, contributing to transmission and acquisition of the virus; (2) negative internal and external mediators also associated with poor health and high-risk HIV behavior; (3) poor adherence to treatment; (4) poor HIV-related and other health outcomes; and (5) particularly vulnerable special populations.

**CONCLUSIONS:** Clinicians should consider using a model of trauma-informed care in the treatment of people living with HIV infection. Its adoption in different settings needs to be matched to available resources.

Brinn F (2000). **Patients with mental illness: general nurses' attitudes and expectations.** *Nursing Standard* 14, 27, 32-36. <http://journals.rcni.com/doi/abs/10.7748/ns2000.03.14.27.32.c2792>

**AIM:** To measure the emotional reactions and expectations of 64 nurses in a general hospital to vignettes describing patients with unstable diabetes and a co-morbid psychiatric diagnosis.

**METHOD:** A small scale questionnaire survey was used in a within-groups design.

**RESULTS:** Findings suggest that the nurses in the sample were fearful of people with a mental health problem. They were wary of possible unpredictable behaviour. Qualified staff generally felt better equipped to cope with such patients, depending on their psychiatric experience.

CONCLUSION: General/adult nurses who have had more exposure to patients with mental health problems during their initial training are more likely to feel adequately prepared for managing people with mental health problems.

Bristowe K, Patrick PL (2014). **'Any questions?'—Clinicians' usage of Invitations to Ask Questions (IAQs) in outpatient plastic surgery consultations.** *Patient Education and Counseling* 97(3), 347–351. <http://www.ncbi.nlm.nih.gov/pubmed/25190641>.

HIGHLIGHTS: •Three types of invitation to ask questions (IAQ) were identified in this study – overt (e.g. 'do you have any questions?'), borderline (e.g. 'was there anything else?') and covert (e.g. 'okay?'). •When IAQs were offered, they almost always occurred in the closing stages of the consultation. •Most consultations did not include an overt IAQ. •When patients were offered an overt or borderline IAQ they always recalled this opportunity after the consultation. •When patients were offered a covert IAQ less than half of them recalled this opportunity after the consultation.

OBJECTIVE: To explore use of 'Invitations to Ask Questions' (IAQs) by plastic surgeons in outpatient consultations, and consider how type of IAQ impacts on patients' responses to, and recollection of, IAQs.

METHODS: Descriptive study: 63 patients were audio recorded in consultation with 5 plastic surgeons, and completed a brief questionnaire immediately after the consultation. Consultation transcripts were analyzed using inductive qualitative methods of Discourse Analysis and compared with questionnaire findings.

RESULTS: A taxonomy of IAQs was developed, including three types of IAQ (Overt, Covert, and Borderline). Overt IAQs were rarely identified, and almost all IAQs occurred in the closing stages of the consultation. However, when an overt IAQ was used, patients always recollected being asked if they had any questions after the consultation.

CONCLUSIONS: Patients are rarely explicitly offered the opportunity to ask questions. When this does occur, it is often in the closing stages of the consultation. Clinicians should openly encourage patients to ask questions frequently throughout the consultation, and be mindful that subtle differences in construction of these utterances may impact upon interpretation. Practice implications: Clear communication, of message and intention, is essential in clinical encounters to minimize misunderstanding, misinterpretation, or missed opportunities for patients to raise concerns.

Browne JL, Ventura A, Mosely K, Speight J (2013). **'I call it the blame and shame disease': a qualitative study about perceptions of social stigma surrounding type 2 diabetes.** *BMJ Open* 2013;3:e003384 doi:10.1136/bmjopen-2013-003384. <http://bmjopen.bmj.com/content/3/11/e003384.short>

CONCLUSIONS: Our study found evidence of people with T2DM experiencing and perceiving diabetes-related social stigma. Further research is needed to explore ways to measure and minimise diabetes-related stigma at the individual and societal levels, and also to explore perceptions and experiences of stigma in people with type 1 diabetes.

Brown L, Macintyre K, Trujillo L (2003). **Interventions to Reduce HIV/AIDS Stigma: What Have We Learned?** *AIDS Education and Prevention: Vol. 15, No. 1*, pp. 49-69. doi: 10.1521/aeap.15.1.49.23844. <http://guilfordjournals.com/doi/abs/10.1521/aeap.15.1.49.23844>

This article reviews 22 studies that test a variety of interventions to decrease AIDS stigma in developed and developing countries. This article assesses published studies that met stringent evaluation criteria in order to draw lessons for future development of interventions to combat stigma. The target group, setting, type of intervention, measures, and scale of these studies varied tremendously. The majority (14) of the studies aimed to increase tolerance of persons living with HIV/AIDS (PLHA) among the general population. The remaining studies tested interventions to increase willingness to treat PLHA among health care providers or improve coping strategies for dealing with AIDS stigma among PLHA or at-risk groups. Results suggest some stigma reduction interventions appear to work, at least on a small scale and in the short term, but many gaps remain especially in relation to scale and duration of impact and in terms of gendered impact of stigma reduction interventions.



Browne JL, Ventura A, Mosely K, Speight J (2014). **'I'm not a druggie, I'm just a diabetic': a qualitative study of stigma from the perspective of adults with type 1 diabetes.** *BMJ Open* 4, e005625-e005625. <http://bmjopen.bmj.com/content/4/7/e005625.full>

**OBJECTIVES** While health-related stigma has been the subject of considerable research in other conditions (eg, HIV/AIDS, obesity), it has not received substantial attention in diabetes. Our aim was to explore perceptions and experiences of diabetes-related stigma from the perspective of adults with type 1 diabetes mellitus (T1DM).

**DESIGN** A qualitative study using semistructured interviews, which were audio recorded, transcribed and subject to thematic analysis.

**RESULTS:** Australian adults with T1DM perceive and experience T1DM-specific stigma as well as stigma-by-association with type 2 diabetes. Such stigma is characterised by blame, negative social judgement, stereotyping, exclusion, rejection and discrimination. Participants identified the media, family and friends, healthcare professionals and school teachers as sources of stigma. The negative consequences of this stigma span numerous life domains, including impact on relationships and social identity, emotional well-being and behavioural management of T1DM. This stigma also led to reluctance to disclose the condition in various environments. Adults with T1DM can be both the target and the source of diabetes-related stigma.

**CONCLUSIONS:** Stigmatisation is part of the social experience of living with T1DM for Australian adults. Strategies and interventions to address and mitigate this diabetes-related stigma need to be developed and evaluated.

Broyles LM, Binswanger IA, Jenkins JA, Finnell DS, Faseru B, Cavaiola A, Pugatch M, Gordon AJ (2014). **Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response.** *Substance Abuse*, 35:3, 217-221, DOI: 10.1080/08897077.2014.930372. <http://dx.doi.org/10.1080/08897077.2014.930372>

Appropriate use of language in the field of addiction is important. Inappropriate use of language can negatively impact the way society perceives substance use and the people who are affected by it. Language frames what the public thinks about substance use and recovery, and it can also affect how individuals think about themselves and their own ability to change. But most importantly, language intentionally and unintentionally propagates stigma: the mark of dishonor, disgrace, and difference that depersonalizes people, depriving them of individual or personal qualities and personal identity. Stigma is harmful, distressing, and marginalizing to the individuals, groups, and populations who bear it. For these reasons, the Editorial Team of Substance Abuse seeks to formally operationalize respect for personhood in our mission, our public relations, and our instructions to authors. We ask authors, reviewers, and readers to carefully and intentionally consider the language used to describe alcohol and other drug use and disorders, the individuals affected by these conditions, and their related behaviors, comorbidities, treatment, and recovery in our publication. Specifically, we make an appeal for the use of language that (1) respects the worth and dignity of all persons ("people-first language"); (2) focuses on the medical nature of substance use disorders and treatment; (3) promotes the recovery process; and (4) avoids perpetuating negative stereotypes and biases through the use of slang and idioms. In this paper, we provide a brief overview of each of the above principles, along with examples, as well as some of the nuances and tensions that inherently arise as we give greater attention to the issue of how we talk and write about substance use and addiction.

Brugel S, Postma-Nilsenová M, Tates K (2015). **The link between perception of clinical empathy and nonverbal behavior: The effect of a doctor's gaze and body orientation.** *Patient Education and Counseling* 98(10):1260-5. doi: 10.1016/j.pec.2015.08.007. Epub 2015 Aug 17. <http://www.ncbi.nlm.nih.gov/pubmed/26320820>

**HIGHLIGHTS:** •A link between a doctor's gaze and body orientation and the viewer's perception of empathy is hypothesized. •A doctor's gaze and body orientation both influence the viewer's perception of empathy. •The effect of a doctor's gaze on the perception of empathy appears to be slightly gender-dependent.

**OBJECTIVES:** Clinical empathy is considered to be one of the most important skills for medical

professionals. It is primarily conveyed by nonverbal behavior; however, little is known about the importance of different types of cues and their relation to engagement and sincerity as possible correlates of perceived clinical empathy (PCE). In this study, we explored the effect of doctor's gaze and body orientation on PCE with the help of 32 video vignettes.

**METHODS:** Actors impersonating medical interns displayed different combinations of gaze and body orientation while uttering an empathetic verbal statement. The video vignettes were evaluated in terms of the perceived clinical and general empathy, engagement and sincerity.

**RESULTS:** A principal component analysis revealed a possible single-factor solution for the scales measuring the two types of empathy, engagement and sincerity; therefore, they were subsumed under general perceived empathy (GPE). An analysis of variance showed a main effect of gaze and body orientation, with a stronger effect of gaze, on GPE. We subsequently performed a linear random effects analysis, which indicated possible gender-related differences in the perception of gaze.

**CONCLUSIONS:** The outcomes of our experiment confirm that both gaze and body orientation have an influence on the GPE. The effect of gaze, however, appears to be gender-dependent: in the experiment, males were perceived as slightly more empathetic with patient-centered gaze, while for females averted gaze resulted in higher GPE scores. **Practice implications:** The findings are directly relevant in the context of medical communication training. Perception of clinical empathy supports medical information transfer, diagnosis quality and other patient outcomes.

Buchman DZ, Ho A, Illes J (2016). **You Present like a Drug Addict: Patient and Clinician Perspectives on Trust and Trustworthiness in Chronic Pain Management.** *Pain Med.* 2016 Jan 11. pii: pnv083. [Epub ahead of print]. <http://www.ncbi.nlm.nih.gov/pubmed/26759389>

**OBJECTIVE:** Past research has demonstrated that trust is central to an effective therapeutic relationship, but the role of trust in chronic pain management is not well understood. The objective of this study was to provide an in-depth examination of how adults living with chronic pain negotiate trust and demonstrate trustworthiness with clinicians in therapeutic encounters.

**METHODS:** This qualitative study focused on adults living in an urban setting in British Columbia, Canada. Semi-structured interviews (N = 27) were conducted with participants with chronic low back pain. The results were triangulated by two feedback groups comprising re-contacted interview participants (n = 4) and physicians with expertise in pain and addiction management (n = 6).

**RESULTS:** Grounded theory analysis of the adult patient interviews and feedback groups yielded four major themes: 1) threats to trustworthiness and iatrogenic suffering; 2) communicating the invisible and subjective condition of chronic pain; 3) motive, honesty, and testimony; and 4) stigmatized identities. The following two themes emerged from the analysis of the physician feedback group: 1) challenges of the practice context, and 2) complicated clinical relationships.

**CONCLUSIONS:** We found that perceived trustworthiness is important in therapeutic encounters as it helps to negotiate tensions with respect to subjective pain symptoms, addiction, and prescription opioid use. An attitude of epistemic humility may help both clinicians and patients cultivate a trustworthy clinical environment, manage the challenges associated with uncertain testimony, place trust wisely, and promote optimal pain care.

Burgess DJ, Warren J, Phelan S, Dovidio J, van Ryn M (2010). **Stereotype threat and health disparities: what medical educators and future physicians need to know.** *J Gen Intern Med.* 2010 May;25 Suppl 2:S169-77. doi: 10.1007/s11606-009-1221-4. <http://www.ncbi.nlm.nih.gov/pubmed/20352514>

Patients' experience of stereotype threat in clinical settings and encounters may be one contributor to health care disparities. Stereotype threat occurs when cues in the environment make negative stereotypes associated with an individual's group status salient, triggering physiological and psychological processes that have detrimental consequences for behavior. By recognizing and understanding the factors that can trigger stereotype threat and understanding its consequences in medical settings, providers can prevent it from occurring or ameliorate its consequences for patient behavior and outcomes. In this paper, we discuss the implications of stereotype threat for medical education and trainee performance and offer

practical suggestions for how future providers might reduce stereotype threat in their exam rooms and clinics.

Burke Harris N (2014). **How childhood trauma affects health across a lifetime**. TED TALK. [https://www.ted.com/talks/nadine\\_burke\\_harris\\_how\\_childhood\\_trauma\\_affects\\_health\\_across\\_a\\_lifetime?language=en](https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en)

Childhood trauma isn't something you just get over as you grow up. Pediatrician Nadine Burke Harris explains that the repeated stress of abuse, neglect and parents struggling with mental health or substance abuse issues has real, tangible effects on the development of the brain. This unfolds across a lifetime, to the point where those who've experienced high levels of trauma are at triple the risk for heart disease and lung cancer. An impassioned plea for pediatric medicine to confront the prevention and treatment of trauma, head-on.

California Department of Mental Health (2010). **California Strategic Plan on Reducing Mental Health Stigma and Discrimination**. <http://calmhsa.org/downloads/aboutus/Strategic-Plan-for-Reducing-Stigma-and-Discrimination.pdf>

Canadian Medical Association (2004, last reviewed 2015). **CMA Code of Ethics**. [https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA\\_Policy\\_Code\\_of\\_ethics\\_of\\_the\\_Canadian\\_Medical\\_Association\\_Update\\_2004\\_PD04-06-e.pdf](https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Code_of_ethics_of_the_Canadian_Medical_Association_Update_2004_PD04-06-e.pdf)

This Code has been prepared by the Canadian Medical Association as an ethical guide for Canadian physicians, including residents, and medical students. Its focus is the core activities of medicine – such as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. It is based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability. The Code, together with CMA policies on specific topics, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians. Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions. Physicians may experience tension between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of other parties. Training in ethical analysis and decision-making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop their knowledge, skills and attitudes needed to deal with these conflicts. Consultation with colleagues, regulatory authorities, ethicists, ethics committees or others who have relevant expertise is also recommended.

Cavayas M (2012) **Stigmatization in Alzheimer's disease, a review [Stigmatisation dans la maladie d'Alzheimer, une revue de la question]**. *Geriatr Psychol Neuropsychiatr Vieil*. 2012 Sep;10(3):297-305. <http://www.ncbi.nlm.nih.gov/pubmed/23015238>

Stigma against chronic disease or mental illness is a well-known phenomenon and results in devastating consequences for individuals who suffer from these diseases and their families. However, few studies have evaluated the stigma and its various processes associated with Alzheimer's disease (AD). The aim of the present review is to discuss the concepts that underlie stigma and its different forms, and then to explain its causes and consequences. Indeed, if the stigma primarily affects individuals with a diagnosis of AD, recent studies have shown that the caregivers of the patients as well as their relatives are also exposed to stigma by association. Moreover, past and current studies on other chronic diseases highlight the importance of using methods issued from experimental social psychology to assess the explicit representations but also the implicit stigma associated with the disease. Finally, several researches and possible interventions are proposed to reduce the stigma associated with AD and related concepts such as MCI.

Carr L, Iacoboni M, Dubeau MC, Mazziotta JC, Lenzi GL (2003). **Neural mechanisms of empathy in humans: a relay from neural systems for imitation to limbic areas.** *Proc Natl Acad Sci USA* 100(9):5497-502. Epub 2003 Apr 7. <http://www.pnas.org/content/100/9/5497.full>

How do we empathize with others? A mechanism according to which action representation modulates emotional activity may provide an essential functional architecture for empathy. The superior temporal and inferior frontal cortices are critical areas for action representation and are connected to the limbic system via the insula. Thus, the insula may be a critical relay from action representation to emotion. We used functional MRI while subjects were either imitating or simply observing emotional facial expressions. Imitation and observation of emotions activated a largely similar network of brain areas. Within this network, there was greater activity during imitation, compared with observation of emotions, in premotor areas including the inferior frontal cortex, as well as in the superior temporal cortex, insula, and amygdala. We understand what others feel by a mechanism of action representation that allows empathy and modulates our emotional content. The insula plays a fundamental role in this mechanism.

Centers for Disease Control and Prevention (2016). **Injury Prevention & Control: Division of Violence Prevention.** <http://www.cdc.gov/violenceprevention/acestudy/>

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.

Chen E, Turiano, NA, Mroczek DK, Miller GE (2016). **Association of Reports of Childhood Abuse and All-Cause Mortality Rates in Women.** *JAMA Psychiatry*. Published online August 17, 2016. doi:10.1001/jamapsychiatry.2016.1786. <http://archpsyc.jamanetwork.com/article.aspx?articleid=2545073>

**IMPORTANCE:** Research has linked childhood abuse to a variety of adult psychiatric problems, but little is known about associations of child abuse with adult mortality.

**OBJECTIVE:** To test associations of retrospective reports of physical and emotional abuse in childhood with all-cause mortality rates in adulthood.

**DESIGN, SETTING, AND PARTICIPANTS:** National sample of 6285 adults (aged 25-74 years at baseline) from the survey of Midlife Development in the United States. Baseline psychosocial data were collected in 1995 and 1996, with follow-up mortality data collected through October 2015.

**MAIN OUTCOMES AND MEASURES:** Participants completed questionnaires at baseline about self-report of childhood emotional abuse, moderate physical abuse, and severe physical abuse. Mortality data during the next 20 years was tracked using the National Death Index.

**RESULTS:** Of the 6285 participants included in the study sample, 2987 were men (48%) and 5581 were white (91%), with a mean (SD) age of 46.9 (12.95) years. Women who reported childhood emotional abuse (hazard ratio [HR], 1.22; 95% CI, 1.01-1.49;  $P = .04$ ), moderate physical abuse (HR, 1.30; 95% CI, 1.05-1.60;  $P = .02$ ), or severe physical abuse (HR, 1.58; 95% CI, 1.20-2.08;  $P = .001$ ) were at increased risk for all-cause mortality during the follow-up period. Reports of more types of childhood abuse were also associated with a greater risk of all-cause mortality in women (all vs none HR, 1.68; 95% CI, 1.24-2.30;  $P = .001$ ; some vs none HR, 1.24; 95% CI, 1.01-1.52;  $P = .04$ ). These effects could not be accounted for by childhood socioeconomic status, personality traits, or adult depression. No associations were observed in men.

**CONCLUSIONS AND RELEVANCE:** These results suggest that in addition to the established psychiatric consequences of abuse, women who report childhood abuse also remain vulnerable to premature mortality into adulthood. Thus, reported childhood abuse may have long-term ramifications for health and longevity in women.



Chin MH, Lopez FY, Nathan AG, Cook SC (2016). **Improving Shared Decision with LGBT Racial and Ethnic Minority Patients.** *Journal of General Internal Medicine* June 2016, Volume 31, Issue 6, pp 591–593.  
<http://link.springer.com/article/10.1007/s11606-016-3607-4>

Series of articles lays the foundation for improving doctor-patient communication for those at the intersection of multiple marginalized populations. Lesbian, gay, bisexual, transgender and queer (LGBTQ) patients who are also racial and ethnic minorities suffer significant health disparities, while facing more complicated challenges than white LGBTQ or racial and ethnic minority patients alone. Now, in a series of three articles published Thursday in the *Journal of General Internal Medicine*, researchers from the University of Chicago Medicine provide a roadmap to help health providers better understand the unique needs of patients with multiple minority identities who face these overlapping health challenges.

Chung AH, Slater MD (2013). **Reducing Stigma and Out-Group Distinctions Through Perspective-Taking in Narratives.** *Journal of Communication* 63 (5): pages 894–911, October 2013.  
<http://onlinelibrary.wiley.com/doi/10.1111/jcom.12050/abstract>

We examine how viewers' narrative involvement is impacted by a character's membership in a highly stigmatized group. In particular, we explore how perspective-taking with a character, a dimension of the identification construct (J. Cohen, 2001), influences in-group/out-group perception. Participants viewed 1 of 2 edited versions of the film *Sherrybaby*, where the main character was manipulated to be relatively more stigmatized (recovering drug addict) or less stigmatized (single mother). As predicted, participants differed with respect to perspective-taking—the highly stigmatized character corresponded to less perspective-taking. Furthermore, the mediation and moderation results lend support to the argument that perspective-taking increases perceptions of in-group belonging and is of particular importance in determining whether a narrative influences in-group/out-group perspectives.

Clair M, Daniel C, Lamont M (2016). **Destigmatization and health: Cultural constructions and the long-term reduction of stigma.** *Social Science & Medicine* Mar 2016.  
<http://www.sciencedirect.com/science/article/pii/S0277953616301216>

Research on the societal-level causes and consequences of stigma has rarely considered the social conditions that account for destigmatization, the process by which a group's worth and status improve. Destigmatization has important implications for the health of stigmatized groups. Building on a robust line of stigma reduction literature in psychology, we develop a sociological framework for understanding how new cultural constructions that draw equivalences and remove blame shape public and structural stigma over time. We examine historical transformations of cultural constructions surrounding three stigmatized groups in the United States: people living with HIV/AIDS, African Americans, and people labeled as obese. By tracing this process across cases, we find that the conditions that account for destigmatization include the credibility of new constructions, the status and visibility of actors carrying these constructions, the conclusiveness of expert knowledge about stigmatized groups, the interaction between new constructions and existing cultural ideologies, and the perceived linked fate of the stigmatized and dominant groups. We also find that the reduction of structural and public forms of stigma often depend on distinct processes and constructions. To conclude, we propose a framework for the comparative study of destigmatization as an essential component of promoting a culture of health.

Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, Morgan C, Rüsch N, Brown JSL, Thornicroft G (2015). **What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies.** *Psychological Medicine* 45, 11-27.  
<http://www.ncbi.nlm.nih.gov/pubmed/24569086>

**BACKGROUND:** Individuals often avoid or delay seeking professional help for mental health problems. Stigma may be a key deterrent to help-seeking but this has not been reviewed systematically. Our systematic review addressed the overarching question: What is the impact of mental health-related stigma on help-seeking for mental health problems? Subquestions were: (a) What is the size and direction of any association between stigma and help-seeking? (b) To what extent is stigma identified as a barrier to help-

seeking? (c) What processes underlie the relationship between stigma and help-seeking? (d) Are there population groups for which stigma disproportionately deters help-seeking?

CONCLUSIONS. Stigma has a small- to moderate-sized negative effect on help-seeking. Review findings can be used to help inform the design of interventions to increase help-seeking.

Cobos B, Haskard-Zolnierok K, Howard K (2015). **White coat hypertension: improving the patient–health care practitioner relationship.** *Psychol Res Behav Manag.* 2015 May 2;8:133-41. doi: 10.2147/PRBM.S61192. eCollection 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4427265/>

White coat hypertension is characterized by the variability of a patient’s blood pressure measurements between the physician’s office and the patient’s home environment. A patient with white coat hypertension has high blood pressure levels in the physician’s office and normal blood pressure levels in their typical environment. This condition is likely caused by the patient’s anxiety within the physician’s office and in the presence of the physician. Research has shown that improving the relationship between a patient and their health care provider can decrease the patient’s anxiety, with the implication of decreasing the patient’s likelihood of demonstrating white coat hypertension. This review provides an overview of the previous literature regarding white coat hypertension, its prevalence, and the consequences for those who develop persistent hypertension. Furthermore, this review discusses the implications of improving patient and health care provider interactions through effective communication, empathy, and trust, as well as the implications for future research studies in improving the patient and health care provider’s relationship.

Cohen M, Quintner J, Buchanan, D Nielsen, M Guy L (2011). **Stigmatization of Patients with Chronic Pain: The Extinction of Empathy.** *Pain Medicine* 12: 1637–1643. <http://www.ncbi.nlm.nih.gov/pubmed/22054062>

OBJECTIVE: To address how health professionals may inadvertently contribute to the stigmatization of patients with chronic pain. SETTING: Formulation and implementation of the Australian National Pain Strategy.

DESIGN: Review of current concepts of stereotyping and stigma, consideration of their relationship to empathy, and how they might impinge upon the clinical encounter.

FINDINGS: The extinction of empathy, which we refer to as “negative empathy,” can overwhelm health professionals, allowing the entry of negative community stereotypes of chronic pain sufferers and add to their stigmatization. Prevailing dualistic frames of reference encourage this process.

CONCLUSION: Greater awareness by health professionals of their own potential, often inadvertent, contribution to the stigmatization of their patients with chronic pain may serve as a basis for an expanded model of clinical engagement.

Committee on Quality of Health Care in America, Institute of Medicine (2001). **Crossing the Quality Chasm: A New Health System for the 21st Century.** Washington DC: National Academy Press. ISBN 0-309-07280-8. <http://nap.edu/10027>

The committee proposes six aims for improvement to address key dimensions in which today’s health care system functions at far lower levels than it can and should. Health care should be: • Safe—avoiding injuries to patients from the care that is intended to help them. • Effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively). • Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. • Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care. • Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy. • Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. A health care system that achieved major gains in these six dimensions would be far better at meeting patient needs. Patients would experience care that was safer, more reliable, more responsive, more integrated, and more available. Patients could count on receiving the full array of preventive, acute, and chronic services from

which they are likely to benefit. Such a system would also be better for clinicians and others who would experience the satisfaction of providing care that was more reliable, more responsive to patients, and more coordinated than is the case today.

Cook JE, Purdie-Vaughns V, Meyer IH, Busch JTA (2014). **Intervening within and across levels: A multilevel approach to stigma and public health.** *Social Science & Medicine* 103, 101-109.  
[http://www.columbia.edu/cu/psychology/vpvaughns/assets/pdfs/Intervening%20Across%20Levels%20\(2014\).pdf](http://www.columbia.edu/cu/psychology/vpvaughns/assets/pdfs/Intervening%20Across%20Levels%20(2014).pdf)

REVIEW: This article uses a multilevel approach to review the literature on interventions with promise to reduce social stigma and its consequences for population health. Three levels of an ecological system are discussed. The intrapersonal level describes interventions directed at individuals, to either enhance coping strategies of people who belong to stigmatized groups or change attitudes and behaviors of the nonstigmatized. The interpersonal level describes interventions that target dyadic or small group interactions. The structural level describes interventions directed at the social-political environment, such as laws and policies. These intervention levels are related and they reciprocally affect one another. In this article we review the literature within each level. We suggest that interventions at any level have the potential to affect other levels of an ecological system through a process of mutually reinforcing reciprocal processes. We discuss research priorities, in particular longitudinal research that incorporates multiple outcomes across a system.

Cooper LA, Roter DL, Carson KA, Beach MC, Sabin JA, Greenwald AG, Inui TS (2012). **The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care.** *Am J Public Health* 2012 May;102(5):979-87.  
<http://www.ncbi.nlm.nih.gov/pubmed/22420787>

OBJECTIVES: We examined the associations of clinicians' implicit attitudes about race with visit communication and patient ratings of care.

METHODS: In a cross-sectional study of 40 primary care clinicians and 269 patients in urban community-based practices, we measured clinicians' implicit general race bias and race and compliance stereotyping with 2 implicit association tests and related them to audiotape measures of visit communication and patient ratings.

RESULTS: Among Black patients, general race bias was associated with more clinician verbal dominance, lower patient positive affect, and poorer ratings of interpersonal care; race and compliance stereotyping was associated with longer visits, slower speech, less patient centeredness, and poorer ratings of interpersonal care. Among White patients, bias was associated with more verbal dominance and better ratings of interpersonal care; race and compliance stereotyping was associated with less verbal dominance, shorter visits, faster speech, more patient centeredness, higher clinician positive affect, and lower ratings of some aspects of interpersonal care.

CONCLUSIONS: Clinician implicit race bias and race and compliance stereotyping are associated with markers of poor visit communication and poor ratings of care, particularly among Black patients.

Corrigan PW, River LP, Lundin RK, Penn DL, Uphoff-Wasowski K, Campion J, Mathisen J, Gagnon C, Bergman M, Goldstein H, Kubiak MA (2001). **Three strategies for changing attributions about severe mental illness.** *Schizophrenia Bulletin*, 27(2), 187-195.  
<http://schizophreniabulletin.oxfordjournals.org/content/27/2/187.full.pdf+html>

The effects of three strategies for changing stigmatizing attitudes--education (which replaces myths about mental illness with accurate conceptions), contact (which challenges public attitudes about mental illness through direct interactions with persons who have these disorders), and protest (which seeks to suppress stigmatizing attitudes about mental illness)--were examined on attributions about schizophrenia and other severe mental illnesses. One hundred and fifty-two students at a community college were randomly assigned to one of the three strategies or a control condition. They completed a questionnaire about attributions toward six groups--depression, psychosis, cocaine addiction, mental retardation, cancer, and AIDS--prior to and after completing the assigned condition. As expected, results showed that education

had no effect on attributions about physical disabilities but led to improved attributions in all four psychiatric groups. Contact produced positive changes that exceeded education effects in attributions about targeted psychiatric disabilities: depression and psychosis. Protest yielded no significant changes in attributions about any group. This study also examined the effects of these strategies on processing information about mental illness.

Corrigan PW, Larson JE, Nicolas Rüsç N (2009). **Self-stigma and the “why try” effect: impact on life goals and evidence-based practices.** *World Psychiatry.* 2009 Jun; 8(2): 75–81.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2694098/>

Many individuals with mental illnesses are troubled by self-stigma and the subsequent processes that accompany this stigma: low self-esteem and self-efficacy. “Why try” is the overarching phenomenon of interest here, encompassing self-stigma, mediating processes, and their effect on goal-related behavior. In this paper, the literature that explains “why try” is reviewed, with special focus on social psychological models. Self-stigma comprises three steps: awareness of the stereotype, agreement with it, and applying it to one’s self. As a result of these processes, people suffer reduced self-esteem and self-efficacy. People are dissuaded from pursuing the kind of opportunities that are fundamental to achieving life goals because of diminished self-esteem and self-efficacy. People may also avoid accessing and using evidence-based practices that help achieve these goals. The effects of self-stigma and the “why try” effect can be diminished by services that promote consumer empowerment.

Corrigan PW, Mittal D, Reaves CM, Haynes TF, Han X, Morris S, Sullivan, G (2014). **Mental health stigma and primary health care decisions.** *Psychiatry Res.* 2014 Aug 15;218(1-2):35-8. doi:

10.1016/j.psychres.2014.04.028. Epub 2014 Apr 18. <http://www.ncbi.nlm.nih.gov/pubmed/24774076>

People with serious mental illness have higher rates of mortality and morbidity due to physical illness. In part, this occurs because primary care and other health providers sometimes make decisions contrary to typical care standards. This might occur because providers endorse mental illness stigma, which seems inversely related to prior personal experience with mental illness and mental health care. In this study, 166 health care providers (42.2% primary care, 57.8% mental health practice) from the Veteran’s Affairs (VA) medical system completed measures of stigma characteristics, expected adherence, and subsequent health decisions (referral to a specialist and refill pain prescription) about a male patient with schizophrenia who was seeking help for low back pain due to arthritis. Research participants reported comfort with previous mental health interventions. Path analyses showed participants who endorsed stigmatizing characteristics of the patient were more likely to believe he would not adhere to treatment and hence, less likely to refer to a specialist or refill his prescription. Endorsement of stigmatizing characteristics was inversely related to comfort with one’s previous mental health care. Implications of these findings will inform a program meant to enhance VA provider attitudes about people with mental illness, as well as their health decisions.

Coulehan MD JL, Platt FW, Egener B, Frankel R, Lin C-T, Lown B, Salazar WH (2001). **“Let Me See If I Have This Right . . .”: Words That Help Build Empathy.** *Ann Intern Med.* 2001 Aug 7;135(3):221-7.

<http://annals.org/article.aspx?articleid=714679>

In clinical medicine, empathy is the ability to understand the patient’s situation, perspective, and feelings and to communicate that understanding to the patient. The effective use of empathy promotes diagnostic accuracy, therapeutic adherence, and patient satisfaction, while remaining time-efficient. Empathy also enhances physician satisfaction. As with any other tool, clinical empathy requires systematic practice to achieve mastery. Certain well-timed words and sentences facilitate empathy during the clinical encounter. These “words that work” are the subject of this paper.



Cross HA, Heijnders M, Dalal A, Sermrittirong S, Mak S (2011). **Interventions for stigma reduction-part 1: Theoretical considerations.** *Disability, CBR and Inclusive Development (DCID) Vol. 22, No. 3.* <http://dcidj.org/article/view/70>

In this article, the discrete components of stigma that should be targeted in stigma intervention programmes are identified. It is also recommended that since stigma affects different levels in society simultaneously, stigma programmes should be multi-targeted and designed with an intention to adjust interactions between groups at different societal levels.

Cross HA, Heijnders M, Dalal A, Sermrittirong S, Mak, S (2012). **Interventions for stigma reduction-part 2: Practical applications.** *Disability, CBR and Inclusive Development (DCID) Vol. 22, No. 3* <http://dcidj.org/article/view/72>

This paper reports the endeavours of the Working Group assigned to develop guidelines for interventions to reduce stigma. The group was comprised of academics and experienced field personnel, all of whom had either investigated stigma, implemented actions to address stigma, and/or had experienced stigma. The group's mandate was to develop an intervention to reduce the stigma of leprosy, but while accepting that there are commonalities relating to stigma that cut across different health conditions, it was hoped that a generic intervention might be developed. This goal proved to be unattainable in the time given: condition-specific peculiarities and the diversity of cultural contexts presented significant challenges. The group agreed, however, that a considerable body of theory and expert opinion does exist, and that general strategies might be developed from this. The Working Group discussed a systematic review of such material. It also discussed other material that was considered to be important but had not met the criteria for the systematic review. One conclusion of the group's deliberations was that a "Stigma Intervention Matrix" could be a useful guide for cross-checking the development of situation-specific stigma interventions. The Stigma Intervention Matrix is presented in this paper.

Curtis V (2011). **Why disgust matters.** *Philosophical Transactions of the Royal Society B: Biological Sciences* 366, 3478-3490. <http://rstb.royalsocietypublishing.org/content/366/1583/3478>

The new synthesis about disgust is that it is a system that evolved to motivate infectious disease avoidance. There are vital practical and intellectual reasons why we need to understand disgust better. Practically, disgust can be harnessed to combat the behavioural causes of infectious and chronic disease such as diarrhoeal disease, pandemic flu and smoking. Disgust is also a source of much human suffering; it plays an underappreciated role in anxieties and phobias such as obsessive compulsive disorder, social phobia and post-traumatic stress syndromes; it is a hidden cost of many occupations such as caring for the sick and dealing with wastes, and self-directed disgust afflicts the lives of many, such as the obese and fistula patients. Disgust is used and abused in society, being both a force for social cohesion and a cause of prejudice and stigmatization of out-groups. This paper argues that a better understanding of disgust, using the new synthesis, offers practical lessons that can enhance human flourishing. Disgust also provides a model system for the study of emotion, one of the most important issues facing the brain and behavioural sciences today.

Davis R, Maul A (2015). Trauma-Informed Care: **Opportunities for High-Need, High-Cost Medicaid Populations.** *Center for Health Care Strategies, Inc. Brief March 2015.* [http://www.chcs.org/media/TIC-Brief-031915\\_final.pdf](http://www.chcs.org/media/TIC-Brief-031915_final.pdf)

Health policymakers and practitioners are increasingly focusing on the harmful effects of trauma on health status for both children and adults. Trauma-informed care acknowledges the role that trauma has played in patients' lives, shifting the question from "What is wrong with you?" to "What happened to you?" This brief provides an introduction to trauma-informed care and describes how it can be adopted to better serve high-need, high-cost Medicaid populations, including examples from three innovative programs across the country. The brief draws from the experiences of organizations in the Center for Health Care Strategies' Complex Care Innovation Lab, made possible by Kaiser Permanente Community Benefit to uncover new ways to improve care for individuals with complex medical and social needs.

De Bellis MD, Keshavan MS, Clark DB, Casey BJ, Giedd JN, Boring AM, Frustaci K, Ryan ND (1999).

**Developmental Traumatology Part II: Brain Development.** *Biol Psychiatry* 45:1271-1284.

<https://www.sacklerinstitute.org/cornell/people/bj.casey/publications/publications/DeBellis.1999.pdf>

**BACKGROUND:** Previous investigations suggest that maltreated children with a diagnosis of posttraumatic stress disorder (PTSD) evidence alterations of biological stress systems. Increased levels of catecholaminergic neurotransmitters and steroid hormones during traumatic experiences in childhood could conceivably adversely affect brain development.

**METHODS:** In this study, 44 maltreated children and adolescents with PTSD and 61 matched controls underwent comprehensive psychiatric and neuropsychological assessments and an anatomical magnetic resonance imaging (MRI) brain scan.

**RESULTS:** PTSD subjects had smaller intracranial and cerebral volumes than matched controls. The total midsagittal area of corpus callosum and middle and posterior regions remained smaller; while right, left, and total lateral ventricles were proportionally larger than controls, after adjustment for intracranial volume. Brain volume robustly and positively correlated with age of onset of PTSD trauma and negatively correlated with duration of abuse. Symptoms of intrusive thoughts, avoidance, hyperarousal or dissociation correlated positively with ventricular volume, and negatively with brain volume and total corpus callosum and regional measures. Significant gender by diagnosis effect revealed greater corpus callosum area reduction in maltreated males with PTSD and a trend for greater cerebral volume reduction than maltreated females with PTSD. The predicted decrease in hippocampal volume seen in adult PTSD was not seen in these subjects.

**CONCLUSIONS:** These data suggest that the overwhelming stress of maltreatment experiences in childhood is associated with adverse brain development.

DeMeester R, Lopez F, Cook S, Chin M (2016). **A Model of Organizational Context and Shared Decision Making: Application to LGBT Racial and Ethnic Minority Patients.** *J Gen Intern Med.* 2016 Mar 17.

<http://www.uchospitals.edu/news/2016/20160317-lgbtq.html>;

<http://www.ncbi.nlm.nih.gov/pubmed/26988980>

Shared decision making (SDM) occurs when patients and clinicians work together to reach care decisions that are both medically sound and responsive to patients' preferences and values. SDM is an important tenet of patient-centered care that can improve patient outcomes. Patients with multiple minority identities, such as sexual orientation and race/ethnicity, are at particular risk for poor SDM. Among these dual-minority patients, added challenges to clear and open communication include cultural barriers, distrust, and a health care provider's lack of awareness of the patient's minority sexual orientation or gender identity. However, organizational factors like a culture of inclusion and private space throughout the visit can improve SDM with lesbian, gay, bisexual, and transgender ("LGBT") racial/ethnic minority patients who have faced stigma and discrimination. Most models of shared decision making focus on the patient-provider interaction, but the health care organization's context is also critical. Context-an organization's structure and operations-can strongly influence the ability and willingness of patients and clinicians to engage in shared decision making. SDM is most likely to be optimal if organizations transform their contexts and patients and providers improve their communication. Thus, we propose a conceptual model that suggests ways in which organizations can shape their contextual structure and operations to support SDM. The model contains six drivers: workflows, health information technology, organizational structure and culture, resources and clinic environment, training and education, and incentives and disincentives. These drivers work through four mechanisms to impact care: continuity and coordination, the ease of SDM, knowledge and skills, and attitudes and beliefs. These mechanisms can activate clinicians and patients to engage in high-quality SDM. We provide examples of how specific contextual changes could make SDM more effective for LGBT racial/ethnic minority populations, focusing especially on transformations that would establish a safe environment, build trust, and decrease stigma.

Derksen F, Bensing J, Lagro-Janssen A (2013). **Effectiveness of empathy in general practice: a systematic review.** *Br J Gen Pract.* 2013 Jan;63(606):e76-84. doi: 10.3399/bjgp13X660814. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3529296/>

**BACKGROUND:** Empathy as a characteristic of patient–physician communication in both general practice and clinical care is considered to be the backbone of the patient–physician relationship. Although the value of empathy is seldom debated, its effectiveness is little discussed in general practice. This literature review explores the effectiveness of empathy in general practice. Effects that are discussed are: patient satisfaction and adherence, feelings of anxiety and stress, patient enablement, diagnostics related to information exchange, and clinical outcomes.

**AIM:** To review the existing literature concerning all studies published in the last 15 years on the effectiveness of physician empathy in general practice.

**DESIGN AND SETTING:** Systematic literature search. **Method:** Searches of PubMed, EMBASE, and PsychINFO databases were undertaken, with citation searches of key studies and papers. Original studies published in English between July 1995 and July 2011, containing empirical data about patient experience of GPs’ empathy, were included. Qualitative assessment was applied using Giacomini and Cook’s criteria.

**RESULTS:** After screening the literature using specified selection criteria, 964 original studies were selected; of these, seven were included in this review after applying quality assessment. There is a good correlation between physician empathy and patient satisfaction and a direct positive relationship with strengthening patient enablement. Empathy lowers patients’ anxiety and distress and delivers significantly better clinical outcomes.

**CONCLUSION:** Although only a small number of studies could be used in this search, the general outcome seems to be that empathy in the patient–physician communication in general practice is of unquestionable importance.

Dikker S, Silbert LJ, Hasson U, Zevin JD (2014). **On the Same Wavelength: Predictable Language Enhances Speaker–Listener Brain-to-Brain Synchrony in Posterior Superior Temporal Gyrus.** *Journal Neurosci.*, 30 April 2014, 34(18): 6267-6272; doi: 10.1523/JNEUROSCI.3796-13.2014. <http://www.jneurosci.org/content/34/18/6267.full.pdf+html>

Recent research has shown that the degree to which speakers and listeners exhibit similar brain activity patterns during human linguistic interaction is correlated with communicative success. Here, we used an intersubject correlation approach in fMRI to test the hypothesis that a listener’s ability to predict a speaker’s utterance increases such neural coupling between speakers and listeners. Nine subjects listened to recordings of a speaker describing visual scenes that varied in the degree to which they permitted specific linguistic predictions. In line with our hypothesis, the temporal profile of listeners’ brain activity was significantly more synchronous with the speaker’s brain activity for highly predictive contexts in left posterior superior temporal gyrus (pSTG), an area previously associated with predictive auditory language processing. In this region, predictability differentially affected the temporal profiles of brain responses in the speaker and listeners respectively, in turn affecting correlated activity between the two: whereas pSTG activation increased with predictability in the speaker, listeners’ pSTG activity instead decreased for more predictable sentences. Listeners additionally showed stronger BOLD responses for predictive images before sentence onset, suggesting that highly predictable contexts lead comprehenders to preactivate predicted words.

Drewcki Brian B (2015). **Education to Identify and Combat Racial Bias in Pain Treatment.** *AMA Journal of Ethics.* March 2015, Volume 17, Number 3: 221-228. <http://journalofethics.ama-assn.org/2015/03/medu1-1503.html>

Most people harbor biases, mostly unconscious, and these are important in healthcare. The most effective method to reduce bias is equal-status contact.

Drwecki BB, Colleen F, Moore CF, Ward SE, Prkachin KM (2011). **Reducing racial disparities in pain treatment: The role of empathy and perspective-taking.** *Pain*: May 2011, Volume 152, Issue 5, pp. 1001–1006.

[http://journals.lww.com/pain/Abstract/2011/05000/Reducing\\_racial\\_disparities\\_in\\_pain\\_treatment\\_The.1.1.aspx?trendmd-shared=0](http://journals.lww.com/pain/Abstract/2011/05000/Reducing_racial_disparities_in_pain_treatment_The.1.1.aspx?trendmd-shared=0)

Epidemiological evidence indicates that African Americans receive lower quality pain treatment than European Americans. However, the factors causing these disparities remain unidentified, and solutions to this problem remain elusive. Across three laboratory experiments, we examined the hypotheses that empathy is not only causing pain treatment disparities but that empathy-inducing interventions can reduce these disparities. The magnitude of the empathy bias experienced predicted the magnitude of the treatment bias exhibited. These findings suggest that empathy plays a crucial role in racial pain treatment disparities in that it appears not only to be one likely cause of pain treatment disparities but also is an important means for reducing racial disparities in pain treatment. An empathy-inducing, perspective-taking intervention reduced racial bias in pain treatment within experimental settings. Empathy may not only cause but can also reduce pain treatment biases.

Duarte J, Pinto-Gouveia J, Cruz B (2016). **Relationships between nurses' empathy, self-compassion and dimensions of professional quality of life: A cross-sectional study.** *Internatl J Nursing Studies* 60:1-11.

DOI: <http://dx.doi.org/10.1016/j.ijnurstu.2016.02.015>.

[http://www.journalofnursingstudies.com/article/S0020-7489\(16\)00083-3/pdf](http://www.journalofnursingstudies.com/article/S0020-7489(16)00083-3/pdf)

**BACKGROUND:** Job stress and burnout are common among healthcare professionals, and nurses in particular. In addition to the heavy workload and lack of recourses, nurses are also confronted with emotionally intense situations associated with illness and suffering, which require empathic abilities. Although empathy is one of the core values in nursing, if not properly balanced it can also have detrimental consequences, such as compassion fatigue. Self-compassion, on the other hand, has been shown to be a protective factor for a wide range of well-being indicators and has been associated with compassion for others.

**OBJECTIVES:** The main goal of this study was to explore how empathy and self-compassion related to professional quality of life (compassion satisfaction, compassion fatigue and burnout). In addition, we wanted to test whether self-compassion may be a protective factor for the impact of empathy on compassion fatigue.

**METHODS AND PARTICIPANTS:** Using a cross-sectional design, 280 registered nurses from public hospitals in Portugal's north and center region were surveyed. Professional quality of life (Professional Quality of Life), empathy (Interpersonal Reactivity Index) and self-compassion (Self-compassion Scale) were measured using validated self-report measures.

**RESULTS:** Correlations and regression analyses showed that empathy and self-compassion predicted the three aspects of professional quality of life. Empathic concern was positively associated with compassion satisfaction as well as with compassion fatigue. Mediation models suggested that the negative components of self-compassion explain some of these effects, and self-kindness and common humanity were significant moderators. The same results were found for the association between personal distress and compassion fatigue.

**CONCLUSIONS:** High levels of affective empathy may be a risk factor for compassion fatigue, whereas self-compassion might be protective. Teaching self-compassion and self-care skills may be an important feature in interventions that aim to reduce burnout and compassion fatigue.

Earnshaw VA, Quinn DM (2011). **The Impact of Stigma in Healthcare on People Living with Chronic Illnesses.** *J Health Psychol* March 2012 vol. 17 no. 2 157-168.

<http://hpq.sagepub.com/content/17/2/157.short>

Approximately half of adults are living with a chronic illness, many of whom may feel stigmatized by their chronic illness in different contexts. We explored the impact of internalized, experienced, and anticipated stigma within healthcare settings on the quality of life of 184 participants living with chronic illnesses (e.g. diabetes, inflammatory bowel disease, asthma). Results of a path analysis demonstrate that participants



who internalized stigma and experienced stigma from healthcare workers anticipated greater stigma from healthcare workers. Participants who anticipated greater stigma from healthcare workers, in turn, accessed healthcare less and experienced a decreased quality of life.

Easter DW, Beach W (2004). **Competent patient care is dependent upon attending to empathic opportunities presented during interview sessions.** *Current Surgery* 61(3), 313-318.

<http://www.ncbi.nlm.nih.gov/pubmed/15165773>

**OBJECTIVE:** Core competencies in surgical education and clinical care rely on effective patient physician communication. We aim to develop quantitative and empirical tools for understanding critical communication tasks during patient interviews.

**METHODS:** Residents in surgical training and attending physicians were separately video recorded during stressful, first visit oncology patient interview sessions. Taped sessions (n = 16) were analyzed in detail to identify and label patient-initiated actions (PIAs), or "empathic opportunities," that call for recognition or action from the caregiver. Doctor-responsive actions (DRAs) were labeled as matching to, or missing from, each empathic opportunity. Missed empathic opportunities occurred when a PIA did not have an associated DRA. Pre-session and post-session surveys queried the patient's perception of how well their health-care needs were met.

**RESULTS:** Resident trainees and attending physicians missed 70% of 160 clearly identified empathic opportunities. There was no clear association with the level of physician training. This pilot study did not have enough power to discern differences in patient satisfaction.

**CONCLUSIONS:** Physicians are often not very attentive to empathic opportunities offered by patients. Individual feedback and training regarding empathic opportunities in recorded patient communication encounters may improve resident and physician core competencies. These improvements may affect patient satisfaction related to these encounters.

Emlet CA, Fredriksen-Goldsen KI, Kim HJ, Hoy-Ellis C (2015). **The Relationship Between Sexual Minority Stigma and Sexual Health Risk Behaviors Among HIV-Positive Older Gay and Bisexual Men.** *J Appl Gerontol.* 2015 Jun 22. pii: 0733464815591210. [Epub ahead of print].

<http://www.ncbi.nlm.nih.gov/pubmed/26100507>

This study investigates how internalized sexual minority stigma and enacted sexual minority stigma in health care settings are associated with sexual health risk behaviors (SRBs) and the mediating role of infrequent routine health care and perceived stress among older gay and bisexual (G/B) men living with HIV disease. Survey responses from 135 sexually active older G/B men living with HIV were analyzed using hierarchical linear regression models. Results indicate that one fifth of G/B older adult men living with HIV are engaged in multiple SRBs. Internalized sexual minority stigma and enacted sexual minority stigma in health care settings are significantly associated with SRBs. The relationship between internalized sexual minority stigma and SRBs are mediated by infrequent routine health care and elevated levels of perceived stress. Improved primary and secondary prevention strategies are needed for the growing number of sexually active older G/B men.

Evans-Lacko S, Little K, Meltzer H, Rose D, Rhydderch D, Henderson C, Thornicroft G (2010). **Development and Psychometric Properties of the Mental Health Knowledge Schedule.** *Can J Psychiatry.* 2010 Jul;55(7):440-8.

<http://www.ncbi.nlm.nih.gov/pubmed/20704771>

**OBJECTIVE:** Stigma has been conceptualized as comprised of 3 constructs: knowledge (ignorance), attitudes (prejudice), and behaviour (discrimination). We are not aware of a psychometrically tested instrument to assess knowledge about mental health problems among the general public. Our paper presents the results of the development stage and the psychometric properties of the Mental Health Knowledge Schedule (MAKS), an instrument to assess stigma-related mental health knowledge among the general public.

**METHODS:** We describe the development of the MAKS in addition to 3 studies that were carried out to evaluate the psychometric properties of the MAKS. Adults aged 25 to 45 years in socioeconomic groups: B, C1, and C2 completed the instrument via face-to-face interview (n = 92) and online (n = 403).

RESULTS: Internal reliability and test-retest reliability is moderate to substantial. Validity is supported by extensive review by experts (including service users and international experts in stigma research).  
CONCLUSION: The lack of a valid outcome measure to assess knowledge is a shortcoming of evaluations of stigma interventions and programs. The MAKES was found to be a brief and feasible instrument for assessing and tracking stigma-related mental health knowledge. This instrument should be used in conjunction with other attitude- and behaviour-related measures.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS (1998). **Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study.** *Am J Prev Med* 1998;14(4).  
<http://www.ncbi.nlm.nih.gov/pubmed/9635069>

BACKGROUND: The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described.

METHODS: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded.

RESULTS: More than half of respondents reported at least one, and one-fourth reported  $\geq 2$  categories of childhood exposures. We found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied ( $P < .001$ ). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health,  $\geq 50$  sexual intercourse partners, and sexually transmitted disease; and 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

CONCLUSIONS: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

Ferlatte O, Hottes TS, Trussler T, Marchand R (2014). **Evidence of a syndemic among young Canadian gay and bisexual men: uncovering the associations between anti-gay experiences, psychosocial issues, and HIV risk.** *AIDS Behav.* 2014 Jul;18(7):1256-63. doi: 10.1007/s10461-013-0639-1.  
<http://www.ncbi.nlm.nih.gov/pubmed/24129844>

Syndemic has become an important theoretical model toward understanding how psychosocial issues may interact to increase HIV acquisition among gay and bisexual men. We measured the extent to which anti-gay experiences are associated with psychosocial issues, which in turn were hypothesized to have an additive effect on HIV risk, in a sample of Canadian young gay and bisexual men. Sixty-eight percent of men reported at least one form of anti-gay experience. For each additional form of anti-gay experience, our data demonstrated increased likelihood of psychosocial issues. Psychosocial issues had an additive effect, increasing the risk of unprotected intercourse in the last 12 months (doubling the risk for those with 3+ issues OR 1.95 [1.39-2.75]). Overall, our findings suggest that a syndemic is occurring among young Canadian gay and bisexual men, highlighting the need to expand HIV prevention efforts beyond sexual risk, to address stigma and gay men's broader health concerns.

Fernandes PT, Snape DA, Beran RG, Jacoby A (2011). **Epilepsy stigma: What do we know and where next?** *Epilepsy & Behavior* 22, 55-62. <http://www.ncbi.nlm.nih.gov/pubmed/21458385>

Stigma is a major issue for people who develop epilepsy. Reducing stigma is a major focus of activity for the epilepsy patient support groups globally. In this paper, we introduce some key ideas and debates about the nature of and drivers for the stigma of epilepsy, including recent arguments about the need to frame

analyses of the nature of epilepsy stigma within sociological debates about conflict and power. We then consider the role of the legislative process for redressing power imbalances that promote or maintain epilepsy stigma; and the value of tailored educational campaigns and programmes directed at stigma reduction. Finally, we consider the nature of 'difference' as experienced by people with epilepsy and how that difference translates into stigma; and provide evidence from a specific targeted intervention to combat epilepsy stigma that its reduction is an achievable goal.

Flickinger TE, Saha S, Roter D, Korthis PT, Sharp V, Cohn J, Egly S, Moore RD, Beach MC (2016). **Clinician empathy is associated with differences in patient-clinician communication behaviors and higher medication self-efficacy in HIV care.** *Patient Educ Couns.* 2015 Sep 3. pii: S0738-3991(15)30070-7. doi: 10.1016/j.pec.2015.09.001. <http://www.ncbi.nlm.nih.gov/pubmed/26395313>

**OBJECTIVE:** We examined associations of clinicians' empathy with patient-clinician communication behaviors, patients' rating of care, and medication self-efficacy. We analyzed 435 adult patients and 45 clinicians at four outpatient HIV care sites in the United States. Negative binomial regressions investigated associations between clinician empathy and patient-clinician communication, assessed using the Roter Interaction Analysis System (RIAS). Logistic regressions investigated associations between clinician empathy and patient ratings of clinician communication, overall satisfaction, and medication self-efficacy. **RESULTS:** Clinicians in the highest vs. lowest empathy tertile engaged in less explicitly emotional talk (IRR 0.79,  $p < 0.05$ ), while clinicians in the middle vs. lowest engaged in more positive talk (IRR 1.31,  $p < 0.05$ ), more questions (IRR 1.42,  $p < 0.05$ ), and more patient activating talk (IRR 1.43,  $p < 0.05$ ). Patients of higher empathy clinicians disclosed more psychosocial and biomedical information. Patients of clinicians in both the middle and highest (vs. lowest) empathy tertiles had greater odds of reporting highest medication self-efficacy (OR 1.80, 95% CI 1.16-2.80; OR 2.13, 95% CI 1.37-3.32).

**CONCLUSIONS:** Clinician empathy may be expressed through addressing patient engagement in care, by fostering cognitive, rather than primarily emotional, processing.

**PRACTICE IMPLICATIONS:** Clinicians should consider enhancing their own empathic capacity, which may encourage patients' self-efficacy in medication adherence.

Flickinger TE, Saha S, Roter D, Korthis PT, Sharp V, Cohn J, Moore RD, Ingersoll KS, Beach MC (2015). **Respecting patients is associated with more patient-centered communication behaviors in clinical encounters.** *Patient Educ Couns.* 2015 Aug 20. pii: S0738-3991(15)30057-4. doi: 10.1016/j.pec.2015.08.020. <http://www.ncbi.nlm.nih.gov/pubmed/26320821>

**OBJECTIVE:** Attitudes towards patients may influence how clinicians interact. We investigated whether respect for patients was associated with communication behaviors during HIV care encounters.

**METHODS:** We analyzed audio-recordings of visits between 413 adult HIV-infected patients and 45 primary HIV care providers. The independent variable was clinician-reported respect for the patient and outcomes were clinician and patient communication behaviors assessed by the Roter Interaction Analysis System (RIAS). We performed negative binomial regressions for counts outcomes and linear regressions for global outcomes.

**RESULTS:** When clinicians had higher respect for a patient, they engaged in more rapport-building, social chitchat, and positive talk. Patients of clinicians with higher respect for them engaged in more rapport-building, social chitchat, positive talk, and gave more psychosocial information. Encounters between patients and clinicians with higher respect for them had more positive clinician emotional tone [regression coefficient 2.97 (1.92-4.59)], more positive patient emotional tone [2.71 (1.75-4.21)], less clinician verbal dominance [0.81 (0.68-0.96)] and more patient-centeredness [1.28 (1.09-1.51)].

**CONCLUSIONS:** Respect is associated with positive and patient-centered communication behaviors during encounters.

**PRACTICE IMPLICATIONS:** Clinicians should be mindful of their respectful attitudes and work to foster positive regard for patients. Educators should consider methods to enhance trainees' respect in communication skills training.

Fook J, Askeland GA (2007). **Challenges of Critical Reflection: 'Nothing Ventured, Nothing Gained'**. *Social Work Education*, 26:5, 520-533, DOI: 10.1080/02615470601118662. <http://dx.doi.org/10.1080/02615470601118662>

This paper arises from the experiences of the authors in providing critical reflection training to social workers and health professionals. It examines the cultural challenges involved in undertaking critical reflection, and how such challenges may contribute to learning. We examine the nature of some of these risks and what might be at stake, and how we as educators might manage these in the interests of better learning. First we discuss the concept of critical reflection and the particular approach we take. We then analyse the nature of some of the risks involved by examining the cultural challenges that are at stake. Lastly we posit some strategies to reduce risk and maximise learning. We outline three major types of cultural assumptions which are challenged by critical reflection. These include assumptions regarding interpersonal communication and dialogue, professional helping and workplace cultures, and regarding knowledge, learning, research and the place of emotions. The implications of these challenges include: the appropriateness of critical reflection for all types of learners; the need for emotional preparation for the critical reflection process; the need to emphasise the professional learning purposes; the need to clarify the use of self-disclosure; and the need to set up an appropriate alternative cultural environment for the purpose of critical reflection.

Ford WS, Snyder OJ (2000). **Customer service in dental offices: analyses of service orientations and waiting time in telephone interactions with a potential new customer**. *Health Communication* 12(2): 149-172. <http://www.ncbi.nlm.nih.gov/pubmed/10938911>

Examined service practices engaged by dental office staff interacting over the telephone with a potential new customer. The goals of the study were to determine whether the staff displayed customer-oriented and control-oriented service communication behaviors and to examine the relation between these service behaviors and waiting time required of customers. Structured observational data were collected in phone encounters with staff in 84 dental offices. Approximately 40% of the staff engaged in the customer-oriented behavior of inviting the customer to share questions or concerns, and 31% exhibited the control-oriented behavior of reciting promotional pitches on behalf of the dental office. Six other communication behaviors were observed with less frequency. Staff who made customers wait on the line longer were more likely to use promotional pitches. The telephone script is appended. **OBJECTIVE:** To determine the extent to which dental office staff engages in communication behaviors with customer orientation / control orientation during initial telephone interactions with potential new customers, and to determine the relationship between staff communication orientation and customer waiting time. **DESIGN:** cross-sectional; the researchers called the dental offices and used a script to engage in a conversation about dental services. **SETTING:** 84 dental offices in a medium metropolitan area in the Midwest. **SUBJECTS:** 84 dental office staff. **DATA COLLECTION:** Calls were recorded and timed. Communication behaviors were coded for 4 types of customer oriented communication behaviors: chit chat, laughter, invitations to speak, and listening responses (reflecting/paraphrase and following (mhm, okay), for 4 types of control-oriented communication behaviors: promotional pitches, commitment prompts, talkovers, and cutoffs, and for 2 types of waiting while on the phone (extra rings, being on hold). **DATA ANALYSIS:** Communication behavior frequencies were calculated using descriptive statistics. **FINDINGS:** 40.5% of the office staff invited customers to speak, a form of customer-oriented communication. Some used laughter (22.6%). Few used chitchat (3.6%) or listening responses (8.3%). Control-oriented behaviors were more frequently used than customer-oriented behaviors: promotional pitches (31%), commitment prompts (10.7%), talkovers (7.1%), and cutoffs (8.3%). Though there were no significant inter-item correlations between any of the two types of behaviors, 27.4% of the staff used both control- and customer-oriented communication behaviors. However, another 27.4% of the staff did not display any of the behaviors at all. Most waiting time occurred during extra rings, though the phone never rang more than 3 times. Only 10.4% of staff put the caller on hold. There was no association between waiting through extra rings and being placed on hold. Only promotional pitches were significantly, positively associated with waiting time. **CONCLUSIONS:** Dental office staff seemed to rely on a communication routine, rather than on customer-oriented communication behaviors, when speaking with potential new patients on the phone. The authors



recommended that receptionist staff in healthcare organizations use more personalized communication behaviors such as asking customers to ask questions or indicating that they are listening by saying “mhm” in order to let customers know they are being paid attention.

Fox FE, Rodham KJ, Harris MF, Taylor GJ, Sutton J, Scott J, Robinson R (2009). **Experiencing “The Other Side”: A Study of Empathy and Empowerment in General Practitioners Who Have Been Patients.** *Qualitative Health Research* 19(11) 1580 –1588. <https://www.ncbi.nlm.nih.gov/pubmed/19843966>

Work-related pressures and susceptibility to health problems mean that many general practitioners (GPs) will, at some stage, experience the role of patient. However qualitative evidence about their experiences of illness and patienthood is sparse. Our study offers an interpretative perspective on GPs’ experiences of illness and the influence that this has had on their practice. Seventeen GPs who had experienced significant illness took part in semistructured interviews. Data were analyzed using interpretative phenomenological analysis (IPA). The findings highlight the relationship between empathy and empowerment and explore the role of self-disclosure of GP status by GPs in consultations. We make suggestions as to how empathy in doctor–patient relationships can be developed through consideration of power and status as well as through interaction with patients from similar backgrounds. Future research should focus on more specific ways to integrate these ideas into medical training.

French H, Greeff M, Watson MJ, Doak CM (2015). **A Comprehensive HIV Stigma-reduction and Wellness-enhancement Community Intervention: A Case Study.** *Journal of the Association of Nurses in AIDS Care* 26, 81-96. [http://www.nursesinaidscarejournal.org/article/S1055-3290\(14\)00073-9/abstract](http://www.nursesinaidscarejournal.org/article/S1055-3290(14)00073-9/abstract)

We describe the implementation of a comprehensive HIV stigma-reduction and wellness-enhancement community intervention that focused on people living with HIV (PLWH), as well as people living close to them (PLC) from six designated groups. A holistic multiple case study design was used in urban and rural settings in the North West Province, South Africa. Purposive voluntary sampling was used to recruit the PLWH group; snowball sampling was used for the PLCs. Data were analyzed by means of open coding and text document analysis. The comprehensive nature of the intervention ensured enhancement in relationships in all groups. The increase in knowledge about stigma, coping with it, and improved relationships led to PLWH feeling less stigmatized and more willing to disclose. PLCs became aware of their stigmatizing behaviors and were empowered to lead stigma reduction in their communities. Many community members were reached through these initiatives.

Friedmann PD, Schwartz RP (2012). **Just call it “treatment”.** *Addiction Science & Clinical Practice* 7:10 DOI: 10.1186/1940-0640-7-10. [http://download.springer.com/static/pdf/869/art%253A10.1186%252F1940-0640-7-10.pdf?originUrl=http%3A%2F%2Fascpijournal.biomedcentral.com%2Farticle%2F10.1186%2F1940-0640-7-10&token2=exp=1473788685~acl=%2Fstatic%2Fpdf%2F869%2Fart%25253A10.1186%25252F1940-0640-7-10.pdf\\*~hmac=50a6fe3f65919cc59ac2529b33d1dcd118ea3fdff2c8ce49aa8d9fd86650f5ac](http://download.springer.com/static/pdf/869/art%253A10.1186%252F1940-0640-7-10.pdf?originUrl=http%3A%2F%2Fascpijournal.biomedcentral.com%2Farticle%2F10.1186%2F1940-0640-7-10&token2=exp=1473788685~acl=%2Fstatic%2Fpdf%2F869%2Fart%25253A10.1186%25252F1940-0640-7-10.pdf*~hmac=50a6fe3f65919cc59ac2529b33d1dcd118ea3fdff2c8ce49aa8d9fd86650f5ac)

Although many in the addiction treatment field use the term “medication-assisted treatment” to describe a combination of pharmacotherapy and counseling to address substance dependence, research has demonstrated that opioid agonist treatment alone is effective in patients with opioid dependence, regardless of whether they receive counseling. The time has come to call pharmacotherapy for such patients just “treatment”. An explicit acknowledgment that medication is an essential first-line component in the successful management of opioid dependence.

Fruh SM, Nadglowski J, Hall HR, Davis SL, Crook ED, Zlomke K (2016). **Obesity Stigma and Bias.** *Journal for Nurse Practitioners* 12(7) July/August 2016. [http://www.npjournal.org/article/S1555-4155\(16\)30188-X/abstract?cc=y=](http://www.npjournal.org/article/S1555-4155(16)30188-X/abstract?cc=y=)

Overweight and obesity are escalating in epidemic proportions in the United States. Individuals with overweight and obesity are often reluctant to seek medical help, not only for weight reduction but also for any health issue because of perceived provider discrimination. Providers who are biased against individuals with obesity can hinder our nation’s effort to effectively fight the obesity epidemic. By

addressing weight bias in the provider setting, individuals affected by obesity may be more likely to engage in a meaningful and productive discussion of weight. Providers need to be the go-to source for obesity-focused information on new and emerging treatments.

Gair S (2013). **Inducing Empathy: Pondering Students' (In)Ability to Empathize with an Aboriginal Man's Lament and What Might Be Done About It.** *Journal of Social Work Education*, 49(1): 136-149, 2013. <http://www.tandfonline.com/doi/abs/10.1080/10437797.2013.755399>

Empathy is a familiar term in social work education, although how to teach and learn empathy is not well documented. Equally, how non-indigenous Australian practitioners learn empathic regard for indigenous peoples living with the crippling legacies of colonialism is not commonly described in the literature. The primary aim of the classroom-based inquiry described here was to explore and reflect on the concept of empathy with social work students at a regional Australian university using selected real-life vignettes. These findings suggest greater cultivation of empathy is needed for respectful social work intervention by non-indigenous practitioners working with Australian Aboriginal and Torres Strait Islander peoples and, by implication, with indigenous peoples worldwide.

Garcia JA, Crocker J, Wyman JF (2005). **Breaking the Cycle of Stigmatization.** *Journal of Wound, Ostomy and Continence Nursing* 32, 38-52. <http://www.ncbi.nlm.nih.gov/pubmed/15718956>

Incontinence is a highly stigmatizing condition. This article explores the dynamics of stigmatization in interpersonal interactions from the perspective of both individuals who are stigmatized and individuals who are not stigmatized. When people who are stigmatized and nonstigmatized interact with each other, both experience threats to self-esteem, but for different reasons. Individuals who are stigmatized may experience self-esteem decrements because they feel that their group is devalued in the eyes of others. Those who are nonstigmatized may fear that their actions will be perceived as biased, thereby threatening their self-image as an unprejudiced person. Individuals who are stigmatized and nonstigmatized act in ways that make their worst fears more than likely come true. Ways that nurses can facilitate ending this cycle with patients who are incontinent are discussed.

Gerdes KE, Segal EA, Jackson KF, Mullins JL (2013). **Teaching empathy: a framework rooted in social cognitive neuroscience and social justice.** *Journal of Social Work Education*, 47:1, 109-131. [http://greatergood.berkeley.edu/images/application\\_uploads/Teaching\\_empathy.pdf](http://greatergood.berkeley.edu/images/application_uploads/Teaching_empathy.pdf)

We propose that a targeted and structured explication of empathy is a useful, if not essential, foundation for social work theory and practice. We outline a social work framework for empathy, one that is rooted in an interdisciplinary context, emphasizes recent findings in the field of social cognitive neuroscience, and yet is embedded in a social work context. The framework lends itself to identifiable education components that social work educators can implement across the curriculum. We can help students understand the basic process of neural pathway development that determines their affective empathic responses and develop and maintain cognitive empathic abilities. In addition, students can learn to use their knowledge, values, and skills, informed by empathy, to take empathic action consciously.

Goleman D (1998). **What Makes a Leader?** *Harvard Business Review* (1998): 93. <https://hbr.org/2004/01/what-makes-a-leader>

Effective leaders possess a high degrees of emotional intelligence. Along with IQ and technical skills, emotional capabilities are the entry-level requirements for executive positions. Emotional intelligence is playing an important role at the highest levels of the company, and is often linked to exceptional performance. Social skill is another key component to successful management. Discussion of the role of self-awareness, self-regulation, achievement motivation, empathy, social skill, in leadership success in business. ..."Globalization is another reason for the rising importance of empathy for business leaders. Cross-cultural dialogue can easily lead to miscues and misunderstandings. Empathy is an antidote." and "Social skill is the culmination of the other dimensions of emotional intelligence. People tend to be very effective at managing relationships when they can understand and control their own emotions and can empathize with the feelings of others." Emotional intelligence is born largely in the neurotransmitters of

the brain's limbic system, which governs feelings, impulses, and drives. Research indicates that the limbic system learns best through motivation, extended practice, and feedback. Consortium for Research on Emotional Intelligence in Organizations. To enhance emotional intelligence, organizations must refocus their training to include the limbic system. They must help people break old behavioral habits and establish new ones. That not only takes much more time than conventional training programs, it also requires an individualized approach.

Gordon J, Sheppard LA, Anaf S (2010). **The patient experience in the emergency department: A systematic synthesis of qualitative research.** *Int Emerg Nurs.* 2010 Apr;18(2):80-8. doi: 10.1016/j.ienj.2009.05.004. Epub 2009 Aug 5. <https://www.ncbi.nlm.nih.gov/pubmed/20382369>

The aim of this study was to systematically review qualitative literature published between 1990 and 2006 exploring the patient experience within the emergency department (ED) with the intent of describing what factors influence the patient experience. Twelve articles were retrieved following combination of key words using five databases. The overarching categories developed from this integration of literature were; emotional impact of emergency, staff-patient interactions, waiting, family in the emergency department, and emergency environment. The patient experience issue given most emphasis by the articles under review was the caring or lack of caring regarding the patients' psychosocial and emotional needs. This was in contrast to the culture of the ED which emphasised "medical-technical" skill and efficiency. Satisfaction studies need to understand many factors and influences, qualitative methodologies have the ability to do so.

Green BL, Saunders PA, Power E, Dass-Brailsford P, Bhat Schelbert K, Giller G, Wissow L, Hurtado-de-Mendoza A, Mete M (2015). **Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers.** *Fam Med.* 2015 Jan; 47(1): 7-14. <http://www.ncbi.nlm.nih.gov/pubmed/25646872>

**BACKGROUND AND OBJECTIVES:** Trauma exposure predicts mental disorders, medical morbidity, and healthcare costs. Yet trauma-related impacts have not received sufficient attention in primary care provider (PCP) training programs. This study adapted a theory-based approach to working with trauma survivors, Risking Connection, into a 6-hour CME course, Trauma-Informed Medical Care (TI-Med), and evaluated its efficacy.

**METHODS:** We randomized PCPs to training or wait-list (delay) conditions; waitlist groups were trained after reassessment. The primary outcome assessing newly acquired skills was a patient-centeredness score derived from Roter Interactional Analysis System ratings of 90 taped visits between PCPs and standardized patients (SPs). PCPs were Family Medicine residents (n=17) and community physicians (n=13; 83% Family Medicine specialty), from four sites in the Washington DC metropolitan area.

**RESULTS:** Immediately trained PCPs trended toward a larger increase in patient-centeredness than did the delayed PCPs ( $p < .09$ ), with a moderate effect size (.66). The combined trained PCP groups showed a significant increase in patient-centeredness pre to post training,  $p < .01$ , Cohen's  $D = .61$ .

**CONCLUSIONS:** This is a promising approach to supporting relationship-based trauma-informed care among PCPs to help promote better patient health and higher compliance with medical treatment plans.

Griffith JL, Kohrt BA (2015). **Managing Stigma Effectively: What Social Psychology and Social Neuroscience Can Teach Us.** *Acad Psychiatry.* 2016 Apr;40(2):339-47. doi: 10.1007/s40596-015-0391-0. Epub 2015 Jul 11. <http://www.ncbi.nlm.nih.gov/pubmed/26162463>

Psychiatric education is confronted with three barriers to managing stigma associated with mental health treatment. First, there are limited evidence-based practices for stigma reduction, and interventions to deal with stigma against mental health care providers are especially lacking. Second, there is a scarcity of training models for mental health professionals on how to reduce stigma in clinical services. Third, there is a lack of conceptual models for neuroscience approaches to stigma reduction, which are a requirement for high-tier competency in the ACGME Milestones for Psychiatry. The George Washington University (GWU) psychiatry residency program has developed an eight-week course on managing stigma that is based on social psychology and social neuroscience research. The course draws upon social neuroscience research demonstrating that stigma is a normal function of normal brains resulting from evolutionary processes in

human group behavior. Based on these processes, stigma can be categorized according to different threats that include peril stigma, disruption stigma, empathy fatigue, moral stigma, and courtesy stigma. Grounded in social neuroscience mechanisms, residents are taught to develop interventions to manage stigma. Case examples illustrate application to common clinical challenges: (1) helping patients anticipate and manage stigma encountered in the family, community, or workplace; (2) ameliorating internalized stigma among patients; (3) conducting effective treatment from a stigmatized position due to prejudice from medical colleagues or patients' family members; and (4) facilitating patient treatment plans when stigma precludes engagement with mental health professionals. This curriculum addresses the need for educating trainees to manage stigma in clinical settings. Future studies are needed to evaluate changes in clinical practices and patient outcomes as a result of social neuroscience-based training on managing stigma.

Grossemann S, Novack DH, Duke P, Mennin S, Rosenzweig S, Davis, TJ, Hojat M (2014). **Residents' and standardized patients' perspectives on empathy: Issues of agreement.** *Patient Educ Couns.* 2014 Jul;96(1):22-8. doi: 10.1016/j.pec.2014.04.007. Epub 2014 Apr 21.  
<http://www.ncbi.nlm.nih.gov/pubmed/24793008>

**OBJECTIVE:** We investigated correlations between residents' scores on the Jefferson Scale of Empathy (JSE), residents' perceptions of their empathy during standardized-patient encounters, and the perceptions of standardized patients.

**CONCLUSION:** The poor correlation between residents' and standardized patients' assessments of residents' empathy raises questions about residents' abilities to gauge the effectiveness of their empathic communications. The study also points to a lack of congruence between the assessment of empathy by standardized patients and residents as receivers and conveyors of empathy, respectively. Practice implications: This study adds to the literature on empathy as a teachable skill set and raises questions about use of OSCEs to assess trainee empathy.

Harris J, Felman K (2012). **A Guide to the Use of Recovery-Oriented Language in Service Planning, Documentation, and Correspondence.** *Mental Health America Allegheny County.*  
<http://content.ementhe.eu/Recovery/Diagnosis-Labeling-stigma/Theuseof.pdf>

Recovery is an ongoing process through which individuals improve their health and wellness and live satisfying self-directed lives. Recovery often begins as a person collaborates with their natural supports and their providers to overcome stigma and identify their own unique strengths, preferences, and support needs. Supporting recovery requires recognizing that the power dynamics of traditional service planning privilege the viewpoints and decision making frameworks of professionals over the individuals served. In order to mitigate this inequality and begin to alleviate the stigma of mental illness, recovery planning utilizes a client-participatory and client-directed approach. Documents that are produced during the recovery process can be important communication tools. Using recovery-oriented language can promote honest and respectful communication which builds trust, facilitates successful therapeutic relationships, and encourages partnerships between individuals who use services and individuals who provide them.

Hasson U, Frith CD (2016). **Mirroring and beyond: coupled dynamics as a generalized framework for modelling social interactions.** *Phil. Trans. R. Soc. B.* 371: 20150366.  
<http://rstb.royalsocietypublishing.org/content/371/1693/20150366>

Hasson, U, Frith, CD (2016). Mirroring and beyond: coupled dynamics as a generalized framework for modelling social interactions. *Phil. Trans. R. Soc. B.* DOI: 10.1098/rstb.2015.0366.  
<http://rstb.royalsocietypublishing.org/content/371/1693/20150366>

Hatzenbuehler ML, McLaughlin KA (2014). **Structural stigma and hypothalamic-pituitary-adrenocortical axis reactivity in lesbian, gay, and bisexual young adults.** *Ann Behav Med.* 2014 Feb;47(1):39-47. doi: 10.1007/s12160-013-9556-9. <http://www.ncbi.nlm.nih.gov/pubmed/24154988>

**BACKGROUND:** Youth exposed to extreme adverse life conditions have blunted cortisol responses to stress.

**RESULTS:** Lesbian, gay, and bisexual young adults who were raised in highly stigmatizing environments as



adolescents evidenced a blunted cortisol response following the TSST compared to those from low-stigma environments.

**CONCLUSIONS:** The stress of growing up in environments that target gays and lesbians for social exclusion may exert biological effects that are similar to traumatic life experiences.

Heaton HA, Campbell RL, Thompson KM, Sadosty AT (2016). **In Support of the Medical Apology: The Nonlegal Arguments** *Journal of emergency medicine*, in press. DOI:

<http://dx.doi.org/10.1016/j.jemermed.2016.06.048>.

<http://www.sciencedirect.com/science/article/pii/S0736467916303766>

**BACKGROUND:** More than 30 million people are affected annually by medical errors. Apologies can heal patients, families, and providers and, if deployed and structured appropriately, can enrich clinical encounters—yet they rarely occur.

**OBJECTIVES:** This article will address the nonlegal arguments in favor of the medical apology and discuss a structure for delivering a meaningful apology. In addition, we will review reasons why some providers feel compelled to apologize while others faced with similar circumstances do not.

**DISCUSSION:** Medical apologies bring value to both patients and providers. Apologies can preserve therapeutic relationships and save careers for professionals by restoring their self-respect and dignity. The four R's of the ideal apology —recognition, responsibility, regret, and remedy—provide a framework to help providers apologize for unintended outcomes. When deployed and structured appropriately, apologies can heal patients, families, and providers and can enrich clinical encounters.

**CONCLUSION:** For providers, forgiving one's self is key to professional wellbeing and continued effective practice. For patients, apologies are desirable and also serve as a conduit for often wanted emotional support from their physician.

Heijnders M, Van Der Meij S (2006). **The fight against stigma: An overview of stigma-reduction strategies and interventions.** *Psychol Health Med.* 2006 Aug;11(3):353-63. *Psychol Health Med.* 2006 Aug;11(3):353-63.

In many health conditions, people are severely affected by health-related stigma and discrimination. A literature review was conducted to identify stigma-reduction strategies and interventions in the field of HIV/AIDS, mental illness, leprosy, TB and epilepsy. The review identified several levels at which interventions and strategies are being implemented. These are the intrapersonal, interpersonal, organizational/institutional, community and governmental/structural level. Although a lot of work has been carried out on stigma and stigma reduction, far less work has been done on assessing the effectiveness of stigma-reduction strategies. The effective strategies identified mainly concentrated on the individual and the community level. In order to reduce health-related stigma and discrimination significantly, single-level and single-target group approaches are not enough. What is required is a patient-centred approach, which starts with interventions targeting the intrapersonal level, to empower affected persons to assist in the development and implementation of stigma-reduction programmes at other levels.

Helitzer DL, Lanoue M, Wilson B, de Hernandez BU, Warner T, Roter D (2011). **A randomized controlled trial of communication training with primary care providers to improve patient-centeredness and health risk communication.** *Patient Educ Couns.* 2011 Jan;82(1):21-9. doi: 10.1016/j.pec.2010.01.021. Epub 2010 Mar 12. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3539754/>

**OBJECTIVE:** to determine the efficacy and effectiveness of training to improve primary care providers' patient-centered communication skills and proficiency in discussing their patients' health risks.

**METHODS:** twenty-eight primary care providers participated in a baseline simulated patient interaction and were subsequently randomized into intervention and control groups. Intervention providers participated in training focused on patient-centered communication about behavioral risk factors.

Immediate efficacy of training was evaluated by comparing the two groups. Over the next 3 years, all providers participated in two more sets of interactions with patients. Longer term effectiveness was assessed using the interaction data collected at 6 and 18 months post-training.

**RESULTS:** The intervention providers significantly improved in patient-centered communication and

communication proficiencies immediately post-training and at both follow-up time points.

**CONCLUSIONS:** this study suggests that the brief training produced significant and large differences in the intervention group providers which persisted 2 years after the training. **PRACTICE IMPLICATIONS:** the results of this study suggest that primary care providers can be trained to achieve and maintain gains in patient-centered communication, communication skills and discussion of adverse childhood events as root causes of chronic disease.

Henderson C, Noblett J, Parke H, Clement S, Caffrey A, Gale-Grant O, Schulze B, Druss B, Thornicroft G (2014). **Mental health-related stigma in health care and mental health-care settings.** *Lancet* (Nov. 2014) 1 (6): p467–482. [http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(14\)00023-6/abstract](http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)00023-6/abstract)

**REVIEW:** This Review considers the evidence for mental-health-related stigma in health-care and mental-health-care settings. Do mental-health-care and other health-care professionals stigmatise people using their services? If so, what are the effects on quality of mental and physical health care? How can stigma and discrimination in the context of health care be reduced? We show that the contact mental-health-care professionals have with people with mental illness is associated with positive attitudes about civil rights, but does not reduce stigma as does social contact such as with friends or family members with mental illness. Some evidence suggests educational interventions are effective in decreasing stigma especially for general health-care professionals with little or no formal mental health training. Intervention studies are needed to underpin policy; for instance, to decrease disparity in mortality associated with poor access to physical health care for people with mental illness compared with people without mental illness.

Herkenhoff L (2004). **Culturally tuned emotional intelligence: an effective change management tool?** *Strategic Change*, March-April 2004. <http://onlinelibrary.wiley.com/doi/10.1002/jsc.666/abstract>

Culture may be national, organizational, professional. In situations that elicit emotions, cultural influences come into play in the interpretation and response. “Reframing emotional intelligence in terms of culture can better support leadership and organization effectiveness.”

Herrick CA, Pearcey LG, Candace Ross C (1997). **Stigma and Ageism: Compounding Influences in Making an Accurate Mental Health Assessment.** *Nursing Forum* 32(3) July-September, 1997. <http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6198.1997.tb00206.x/abstract>

Stigma and ageism are two phenomena that greatly affect the accurate assessment of mentally ill elderly and, ultimately, their health care. Healthcare providers, doctors, nurses and others, including mental-healthcare providers, would benefit from awareness of stigma and ageism and their impact on psychiatric care for the elderly, many of whom also have physical problems. Understanding these influences may assist providers to make more accurate diagnoses and a more appropriate plan of care. This paper defines stigma and ageism and their potential and actual influences on assessment and interventions for the mentally ill elderly. Strategies for overcoming the impact of stigma and ageism are presented to assist healthcare providers to advocate for geropsychiatric clients.

Hocking B (2003). **Reducing mental illness stigma and discrimination-everybody’s business.** *MJA* 2003; 178: S47–S48. <http://www.namigainesville.org/images/Ment%20ill%20stigma%20help.pdf>

The stigma associated with schizophrenia is pervasive, both in the community and among healthcare workers, and forms a real barrier to optimal recovery from the illness. The negative consequences of stigma include discrimination in housing, education and employment, and increased feelings of hopelessness in people with schizophrenia. Health professionals have a responsibility to improve their own attitudes and behaviour towards people with schizophrenia so they do not contribute to the stigma. Educational campaigns aimed at people in the community and media personnel could help to demystify mental illness and reduce the portrayal of offensive stereotypes of people with schizophrenia.

Hoffman Martin L. ***Empathy and Moral Development Implications for Caring and Justice***. Cambridge, UK: Cambridge University Press, 2000. <http://catdir.loc.gov/catdir/samples/cam032/99029669.pdf>

Hojat M, Vergare MJ, Maxwell K, Brainard G, Herrine SK, Isenberg GA, Veloski, J, Gonnella, JS (2009). **The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School**. *Acad Med* 84:1182–1191. <http://www.ncbi.nlm.nih.gov/pubmed/19707055>

**PURPOSE:** This longitudinal study was designed to examine changes in medical students' empathy during medical school and to determine when the most significant changes occur.

**METHOD:** Four hundred fifty-six students who entered Jefferson Medical College in 2002 (n=227) and 2004 (n=229) completed the Jefferson Scale of Physician Empathy at five different times: at entry into medical school on orientation day and subsequently at the end of each academic year. Statistical analyses were performed for the entire cohort, as well as for the “matched” cohort (participants who identified themselves at all five test administrations) and the “unmatched” cohort (participants who did not identify themselves in all five test administrations).

**RESULTS:** Statistical analyses showed that empathy scores did not change significantly during the first two years of medical school. However, a significant decline in empathy scores was observed at the end of the third year which persisted until graduation. Findings were similar for the matched cohort (n = 121) and for the rest of the sample (unmatched cohort, n=335). Patterns of decline in empathy scores were similar for men and women and across specialties.

**CONCLUSIONS:** It is concluded that a significant decline in empathy occurs during the third year of medical school. It is ironic that the erosion of empathy occurs during a time when the curriculum is shifting toward patient-care activities; this is when empathy is most essential. Implications: for retaining and enhancing empathy are discussed.

Itkowitc C (2016). **Unwell and unashamed**. *Washington Post*, June 1, 2016. <http://www.washingtonpost.com/sf/local/wp/2016/06/01/unwell-and-unashamed/>

The stigma of mental illness is under attack by sufferers, who are coming out publicly and defiantly.

Juster R-P, McEwen BS, Lupien SJ (2010). **Allostatic load biomarkers of chronic stress and impact on health and cognition**. *Neuroscience and Biobehavioral Reviews* 35 (2010) 2–16. <http://www.ncbi.nlm.nih.gov/pubmed/19822172>

**REVIEW:** The allostatic load model expands the stress-disease literature by proposing a temporal cascade of multisystemic physiological dysregulations that contribute to disease trajectories. By incorporating an allostatic load index representing neuroendocrine, immune, metabolic, and cardiovascular system functioning, numerous studies have demonstrated greater prediction of morbidity and mortality over and beyond traditional detection methods employed in biomedical practice. This article reviews theoretical and empirical work using the allostatic load model vis-a`-vis the effects of chronic stress on physical and mental health. Specific risk and protective factors associated with increased allostatic load are elucidated and policies for promoting successful aging are proposed.

Kassam A, Williams J, Patten S (2012). **Perceived Discrimination Among People with Self-Reported Emotional, Psychological, or Psychiatric Conditions in a Population-Based Sample of Canadians Reporting a Disability**. *Can J Psychiatry* 2012;57(2):102–110. <http://www.ncbi.nlm.nih.gov/pubmed/22340150>

**OBJECTIVE:** The prevalence of perceived discrimination among people reporting an emotional, psychological, or psychiatric condition in a population of people with a disability has not been studied. Our study evaluated a model that integrated having an emotional, psychological, or psychiatric condition while accounting for age, sex, education, employment, marital status, immigration status, and type of community to estimate the prevalence of perceived discrimination in the population of people with a disability. We hypothesized that higher levels of perceived discrimination would occur in people reporting an emotional, psychological, or psychiatric condition.

**METHOD:** The Participation and Activity Limitation Survey (PALS) by Statistics Canada is a postcensal

survey of community residents reporting health-related impairments. PALS was used to evaluate the interaction between self-reported emotional, psychological, or psychiatric conditions and demographic variables and the odds of experiencing discrimination.

**RESULTS:** In the overall sample, 14.5% perceived discrimination and 18.2% reported having an emotional, psychological, or psychiatric condition. Thirty-five per cent of people with such conditions perceived discrimination. When adjusting for covariates, people reporting an emotional, psychological, or psychiatric condition were 3 times more likely to perceive having been discriminated against than people without such conditions. Across medical conditions, perceived discrimination was higher in people who also reported an emotional, psychological, or psychiatric condition.

**CONCLUSIONS:** The results demonstrate that perceived discrimination and the presence of an emotional, psychological, or psychiatric condition frequently co-occur in people with a disability and therefore programs aimed at reducing the discrimination of emotional, psychological, or psychiatric conditions should take this into account.

Kemp EC, Floyd MR, McCord-Duncan E, Lang F (2008). **Patients Prefer the Method of “Tell Back-Collaborative Inquiry” to Assess Understanding of Medical Information.** *J Am Board Fam Med.* 21(1):24-30. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.527.5770&rep=rep1&type=pdf>

**PURPOSE:** The goal of this study was to determine which approach to assessing understanding of medical information patients most prefer and perceive to be most effective.

**METHODS:** Two videos were shown to participants: (1) a physician explaining a medical condition and its treatment and (2) a physician inquiring about patient understanding of the medical information the patient had been given using 3 different types of inquiry: Yes-No, Tell Back-Collaborative, and Tell Back-Directive.

**RESULTS:** The Tell Back-Collaborative inquiry was significantly preferred over the other 2 approaches.

**CONCLUSIONS:** Patients strongly prefer the Tell Back-Collaborative inquiry when assessing their understanding. We recommend that physicians ask patients to restate what they understand using their own words and that they use a patient-centered approach.

Kim SS, Kaplowitz S, Johnston MV (2004). **The Effects of Physician Empathy on Patient Satisfaction and Compliance.** *Evaluation & the Health Professions,* 27(3): 237-251 DOI:10.1177/0163278704267037. <http://ehp.sagepub.com/content/27/3/237.abstract>

The present study attempted to develop new scales of patient-perceived, empathy-related constructs and to test a model of the relationships of physician empathy and related constructs to patient satisfaction and compliance. Five hundred fifty outpatients at a large university hospital in Korea were interviewed with the questionnaire. The data were analyzed using structural equation modeling. Patient-perceived physician empathy significantly influenced patient satisfaction and compliance via the mediating factors of information exchange, perceived expertise, interpersonal trust, and partnership. Improving physician empathic communication skills should increase patient satisfaction and compliance. Health providers who wish to improve patient satisfaction and compliance should first identify components of their empathic communication needing improvement and then try to refine their skills to better serve patients.

Kinsler JJ, Wong MD, Sayles JN, Davis C, Cunningham WE (2007). **The Effect of Perceived Stigma from a Health Care Provider on Access to Care Among a Low-Income HIV-Positive Population.** *AIDS Patient Care and STDs.* August 2007, 21(8): 584-592. <http://www.ncbi.nlm.nih.gov/pubmed/17711383>

Perceived stigma in clinical settings may discourage HIV-infected individuals from accessing needed health care services. Having good access to care is imperative for maintaining the health, well being, and quality of life of persons living with HIV/AIDS (PLWHAs). The purpose of this prospective study, which took place from January 2004 through June 2006, was to evaluate the relationship between perceived stigma from a health care provider and access to care among 223 low income, HIV-infected individuals in Los Angeles County. Approximately one fourth of the sample reported perceived stigma from a health care provider at baseline, and about one fifth reported provider stigma at follow up. We also found that access to care among this population was low, as more than half of the respondents reported difficulty accessing care at



baseline and follow up. Perceived stigma was found to be associated with low access to care both at baseline (odds ratio [OR] = 3.29; 95% confidence interval [CI] = 1.55, 7.01) and 6-month follow up (2.85; 95% CI = 1.06, 7.65), even after controlling for sociodemographic characteristics and most recent CD4 count. These findings are of particular importance because lack of access or delayed access to care may result in clinical presentation at more advanced stages of HIV disease. Interventions are needed to reduce perceived stigma in the health care setting. Educational programs and modeling of nonstigmatizing behavior can teach health care providers to provide unbiased care.

Klinic Community Health Centres (2013). *Trauma-informed The Trauma Toolkit*, Second Edition, 2013. [http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed Toolkit.pdf](http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf)

A resource for service organizations and providers to deliver services that are trauma-informed.

Korsvold L, Mellblom AV, Lie HC, Ruud E, Loge JH, Finset A (2016). **Patient-provider communication about the emotional cues and concerns of adolescent and young adult patients and their family members when receiving a diagnosis of cancer.** *Patient Educ Couns.* 2016 Mar 31. pii: S0738-3991(16)30150-1. doi: 10.1016/j.pec.2016.03.028 [Epub ahead of print]. [http://www.pec-journal.com/article/S0738-3991\(16\)30150-1/abstract](http://www.pec-journal.com/article/S0738-3991(16)30150-1/abstract)

**OBJECTIVE:** This study aimed to examine how emotional cues/concerns are expressed and responded to in medical consultations with adolescent and young adults (AYA), an understudied patient group, at the time of cancer diagnosis.

**METHODS:** Nine consultations in which AYA patients aged 12-25 years were informed about their cancer diagnosis and treatment plans were audio recorded. Expressions of emotional cues/concerns and physicians' responses were identified and coded using The Verona Coding Definitions of Emotional Sequences (VR-CoDES).

**RESULTS:** A total of 135 emotional cues/concerns (range: 2-26, median: 13) were identified. Cues or concerns that were expressed by patients and relatives following questions from physicians were more often explicit than patient-initiated cues/concerns. Questions about medical and practical issues could often be understood as ways of expressing emotional cues. When patients or relatives expressed less explicit verbal cues about underlying concerns, physicians often responded by presenting medical information without commenting on the emotional aspect indicated by the cue.

**CONCLUSION:** The communication was dominated by information-giving, but the questions from patients and relatives and their responses to the information often had emotional connotations.

**PRACTICE IMPLICATIONS:** Patients' requests for information may include an emotional aspect. These preliminary findings should be tested in a larger sample.

Land H, Linsk, N (2013). **HIV Stigma and Discrimination: Enduring Issues.** *Journal of HIV/AIDS & Social Services* 12, 3-8. <http://www.ncbi.nlm.nih.gov/pubmed/23322536>

A comprehensive understanding of the social and psychological impact of diabetes mellitus is important for informing policy and practice. One potentially significant, yet under-researched, issue is the social stigma surrounding diabetes. This narrative review draws on literature about health-related stigma in diabetes and other chronic conditions in order to develop a framework for understanding diabetes-related stigma. Our review of the literature found that people who do not have diabetes assume that diabetes is not a stigmatized condition. In contrast, people with diabetes report that stigma is a significant concern to them, experienced across many life domains, e.g., in the workplace, in relationships. The experience of diabetes-related stigma has a significant negative impact on many aspects of psychological well-being and may also result in sub-optimal clinical outcomes for people with diabetes. We propose a framework that highlights the causes (attitudes of blame, feelings of fear and disgust, and the felt need to enforce social norms and avoid disease), experiences (being judged, rejected, and discriminated against), and consequences (e.g., distress, poorer psychological well-being, and sub-optimal self-care) of diabetes-related stigma and also identifies potential mitigating strategies to reduce diabetes-related stigma and/or enhance coping and resilience amongst people with diabetes. The systematic investigation of the experiences, causes, and consequences of diabetes-related stigma is an urgent research priority.

Lang F, Floyd MR, Beine KL, Buck P (2002). Sequenced questioning to elicit the patient's perspective on illness: Effects of information disclosure, patient satisfaction, and time expenditure. *Family Medicine* 34(5): 325-30. <http://www.ncbi.nlm.nih.gov/pubmed/12038713>.

**BACKGROUND:** During the medical interview, clinicians frequently overlook the patient's perspective on illness (PPI), i.e., the patient's explanations and concerns about the presenting symptoms and expectations for the encounter. Without special efforts, the PPI surfaces spontaneously in only about one fourth of medical interviews. We determined whether asking the patient a series of sequenced questions would elicit the PPI and what effect such questioning would have on patient and physician satisfaction and on the length of the clinical encounter.

**METHODS:** Fifty-five interviews in a family practice clinic setting were studied by videotape and post interview debriefings. On a random basis, 29 patients were asked sequenced questions at the end of the history, while 26 experienced usual medical interviews. Measures of patient and physician satisfaction were compared by descriptive statistics and the Mann-Whitney test for ordinal data.

**RESULTS:** In response to sequenced questioning, 44% of patients revealed specific, significant concerns that had not been otherwise disclosed. Among patients without prior contact with their provider, satisfaction with the encounter was significantly higher when the sequenced questions were used than when they were not; perception of time spent in discussion with the physician was also higher.

Paradoxically, resident physicians expressed lower confidence that they had helped the patient when the sequenced questions were used to elicit the PPI.

**CONCLUSIONS:** Use of sequenced questions to elicit the PPI results in significant sharing of new information and increased patient satisfaction and requires only a modest investment of time.

Langewitz W, Denz M, Keller A, Kiss A, Rüttimann S, Wössmer B (2002). **Spontaneous talking time at start of consultation in outpatient clinic: Cohort study.** *BMJ* 325: 682-683.

<http://www.bmj.com/content/bmj/325/7366/682.full.pdf>

Examined how long it would take outpatients at a tertiary referral centre to indicate they had completed their story if uninterrupted by their doctors. A sequential cohort of patients from the outpatient clinic of a university hospital participated (n=406; mean age 42.9 yrs). Doctors surreptitiously activated a stop watch at the start of the communication, and pressed it again when the patient indicated they wanted the doctor to take the lead. Mean spontaneous talking time was 92 seconds, and 78% of patients had finished their initial statement in 2 minutes. Seven patients talked for longer than 5 minutes. In all cases doctors felt that the patients were giving important information and should not be interrupted. Implications for patient treatment and doctor-patient communication are discussed.

Lanken PN, Novack DH, Daetwyler C, Gallop R, Landis JR, Lapin J, Subramaniam GA, Schindler BA (2015). **Efficacy of an internet-based learning module and small-group debriefing on trainees' attitudes and communication skills toward patients with substance use disorders: results of a cluster randomized controlled trial.** *Acad Med.* 2015 Mar;90(3):345-54. doi: 10.1097/ACM.0000000000000506.

<http://www.ncbi.nlm.nih.gov/pubmed/25295964>

**PURPOSE:** To examine whether an Internet-based learning module and small-group debriefing can improve medical trainees' attitudes and communication skills toward patients with substance use disorders (SUDs).

**CONCLUSIONS:** This intervention produced improved attitudes and communication skills toward patients with SUDs among residents. Enhanced attitudes and skills may result in improved care for these patients.

LeBel TP (2008). **Perceptions of and Responses to Stigma.** *Sociology Compass* 2, 409-432.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1751-9020.2007.00081.x/abstract>

In the last 10 years, interest in the concept of stigma has grown remarkably throughout the social sciences. Today, stigma is an important topic that bridges many disciplines, including sociology, psychology, social psychology, and public health. This literature review primarily addresses perceptions of and responses to stigma from the insider's or target's perspective. The topics examined in this review include the following:

defining stigma, public opinion and attitudes toward the stigmatized, measurement of perceptions of stigma and discrimination, the coping strategies employed by stigmatized persons to deal with stigma, the impact of stigma in terms of psychological and behavioral outcomes, explanations of coping strategies and outcomes, and strategies and interventions to reduce stigma. As many of the concerns faced by stigmatized persons are universal, what has been learned in research about one stigmatized group can provide insight into another. Promising directions for future stigma-related research are identified and discussed.

Lebel S, Devins GM (2008). **Review: Stigma in cancer patients whose behavior may have contributed to their disease.** *Future Oncol.* October 2008 , 4(5):717-733.

<http://www.futuremedicine.com/doi/abs/10.2217/14796694.4.5.717>

The purpose of the present review is to examine stigma and its consequences among people with cancer, with an emphasis on the situation in which one's behavior may have contributed to the disease. We examine whether voluntarily engaging in behavior that adds to cancer risk leads to increased stigma after cancer onset, as compared with when one's behavior is not considered (by the affected individual or by others) to have contributed to the onset of cancer. We conducted literature searches in PsychInfo and Medline and identified 38 published papers that empirically addressed cancer-related stigma. We found evidence of increased negative attitudes and more severe consequences of stigma among people that have engaged in a behavior that is perceived to have contributed to their cancer, compared with those who are not perceived to have contributed to their disease.

Lee JL, Beach MC, Berger ZD, Pfohd ER, Gallo J, Dya SM, Wu AW (2016). **A qualitative exploration of favorite patients in primary care.** *Patient Educ and Couns.* Published online June 21, 2016,

<http://dx.doi.org/10.1016/j.pec.2016.06.023>

**HIGHLIGHTS:** •The phenomenon of 'favorite patients' is explored. •Many had known their physicians for a long time and 'clicked' with their personalities. •Participants also discussed their challenging patients.

**OBJECTIVE:** To ascertain whether physicians have favorite patients, their experiences with such patients, and how such relationships may influence patients and physicians.

**METHODS:** Semi-structured key informant interviews with 25 primary care internists practicing in several clinic settings at a large academic medical center.

**RESULTS:** The term 'favorite patient' raised concerns regarding boundaries and favoritism. Nevertheless, most participants (22/25) reported having favorite patients. For many physicians, favorite patients were not necessarily the most compliant patients, or those most similar to them. Instead, favorite patients were often very sick patients and/or those who have known their physicians for a long time. Many of these relationships were defined by experiences that strengthened the patient-physician bond. Participants felt that the favorite patient bond had a positive effect on patients and physicians ("it improves my day"). Physicians also discussed their challenging patients unprompted. Participants voiced that being cognizant of having favorite and challenging patients help to prevent favoring the care of certain patients over others.

**CONCLUSIONS & PRACTICE IMPLICATIONS:** Primary care physicians value patient relationships and benefit from deep bonds. A better understanding of how favorite patients affect primary care physicians could help inform and improve relationships with all patients.

Leitner JB, Hehman E, Ayduk O, Mendoza-Denton R (2016). **Blacks' Death Rate Due to Circulatory Diseases Is Positively Related to Whites' Explicit Racial Bias A Nationwide Investigation Using Project Implicit.**

Published online before print August 24, 2016, doi: 10.1177/0956797616658450 *Psychological Science* August 24, 2016. <http://m.pss.sagepub.com/content/early/2016/08/24/0956797616658450.abstract>

Perceptions of racial bias have been linked to poorer circulatory health among Blacks compared with Whites. However, little is known about whether Whites' actual racial bias contributes to this racial disparity in health. We compiled racial-bias data from 1,391,632 Whites and examined whether racial bias in a given county predicted Black-White disparities in circulatory-disease risk (access to health care, diagnosis of a circulatory disease; Study 1) and circulatory-disease-related death rate (Study 2) in the same county. Results revealed that in counties where Whites reported greater racial bias, Blacks (but not

Whites) reported decreased access to health care (Study 1). Furthermore, in counties where Whites reported greater racial bias, both Blacks and Whites showed increased death rates due to circulatory diseases, but this relationship was stronger for Blacks than for Whites (Study 2). These results indicate that racial disparities in risk of circulatory disease and in circulatory-disease-related death rate are more pronounced in communities where Whites harbor more explicit racial bias.

Lelorain S, Brédart A, Dolbeault S, Sultan S (2012). **A systematic review of the associations between empathy measures and patient outcomes in cancer care.** *Psycho-Oncology* 21: 1255–1264.

<http://onlinelibrary.wiley.com/doi/10.1002/pon.2115/full>

**OBJECTIVE:** Despite a call for empathy in medical settings, little is known about the effects of the empathy of health care professionals on patient outcomes. This review investigates the links between physicians' or nurses' empathy and patient outcomes in oncology.

**METHOD:** With the use of multiple databases, a systematic search was performed using a combination of terms and subject headings of empathy or perspective taking or clinician–patient communication, oncology or end-of-life setting and physicians or nurses. Among the 394 hits returned, 39 studies met the inclusion criteria of a quantitative measure of empathy or empathy-related constructs linked to patient outcomes.

**RESULTS:** Empathy was mainly evaluated using patient self-reports and verbal interaction coding. Investigated outcomes were mainly proximal patient satisfaction and psychological adjustment. Clinicians' empathy was related to higher patient satisfaction and lower distress in retrospective studies and when the measure was patient-reported. Coding systems yielded divergent conclusions. Empathy was not related to patient empowerment (e.g. medical knowledge, coping).

**CONCLUSION:** Overall, clinicians' empathy has beneficial effects according to patient perceptions. However, in order to disentangle components of the benefits of empathy and provide professionals with concrete advice, future research should apply different empathy assessment approaches simultaneously, including a perspective-taking task on patients' expectations and needs at precise moments. Indeed, clinicians' understanding of patients' perspectives is the core component of medical empathy, but it is often assessed only from the patient's point of view. Clinicians' evaluations of patients' perspectives should be studied and compared with patients' reports so that problematic gaps between the two perspectives can be addressed.

Levinson W, Gorawara-Bhat R, Lamb J (2000). **A study of patient clues and physician responses in primary care and surgical settings.** *JAMA* 284(8): 1021-1027.

<http://jama.jamanetwork.com/article.aspx?articleid=193022>.

**OBJECTIVE:** To explore the nature and frequency of patient clues during medical encounter and physician response among primary care physicians and surgeons.

**DESIGN:** Descriptive study of audio-taped office visits (data set was part of a larger research project that examined the relationship between physician-patient communication and medical malpractice).

**SETTING:** Community-based practices of primary care physicians and surgeons in Oregon and Colorado.

**SUBJECTS:** 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons (94% male, 91% Caucasian, 67% group practice). Ten patients per physician were selected sequentially from the waiting rooms (54% female, 88% Caucasian, 71% married, average age=54).

**INTERVENTION:** None. **MEASURES:** Audio-taped interactions and transcripts were reviewed to identify and describe segments of the interview in which there were clues about patients' emotional or social concerns. Clues that were initiated by the patient were coded for type and timing and nature of physician response. In addition, physician questions that encouraged patient to discuss a personal topic were also coded as physician-initiated clues. Length of visit was also recorded.

**RESULTS:** Clues occurred in 52% of the primary care visits (mean number of clues =2.6) and in 53% of the surgical visits (mean number of clues = 1.9). Patients initiated approximately 70% of those clues and physicians initiated approximately 30%. Of the patient led clues in primary care visits, 76% were emotional and 60% in the surgical setting. Physicians missed the opportunity to respond to patient led clues 79% of the time in primary care and 62% in the surgical setting. In 50% of those interviews where



the physician missed the opportunity to respond to the patient-led clue, the patient brought up the same issue (clue) a second or third time. In addition, in primary care, visits were longer when there was a missed opportunity to respond by the physician compared with visits where the physician responded with a positive response (mean time, 20.1 min vs. 17.6 min).

**CONCLUSIONS/RECOMMENDATIONS:** Patients offer clues to physicians that provide rich opportunities for empathy and a greater understanding of patients' lives. In primary care and surgery settings, physicians tend to miss these clues and thus overlooking opportunities to strengthen the doctor-patient relationship. Two aspects of the medical encounter uncovered in this study - patient clues and physician responses, should be recognized as being interdependent and necessary in building a trusting relationship between physician and patients and impacting health outcome.

Li L, Liang LJ, Wu Z, Lin C, Guan J (2014). **Assessing outcomes of a stigma-reduction intervention with venue-based analysis.** *Social Psychiatry and Psychiatric Epidemiology* 49, 991-999.  
<http://www.ncbi.nlm.nih.gov/pubmed/24374721>

**CONCLUSIONS:** A matched design and venue-based analysis provide more insight in assessing intervention effects for facility-based intervention trials. The identification of venue-based or hospital characteristics that are associated with intervention efficacy provides additional implications for the adaptation and implementation of future interventions.

Lieberman MD, Eisenberger NI, Crockett MJ, Tom SM, Pfeifer JH, Way BM (2007). **Putting Feelings Into Words Affect Labeling Disrupts Amygdala Activity in Response to Affective Stimuli.** *Psychological Science* 18(5): 421-428, DOI: 10.1111/j.1467-9280.2007.01916.x. <http://pss.sagepub.com/content/18/5/421>

Putting feelings into words (affect labeling) has long been thought to help manage negative emotional experiences; however, the mechanisms by which affect labeling produces this benefit remain largely unknown. Recent neuroimaging studies suggest a possible neurocognitive pathway for this process, but methodological limitations of previous studies have prevented strong inferences from being drawn. A functional magnetic resonance imaging study of affect labeling was conducted to remedy these limitations. The results indicated that affect labeling, relative to other forms of encoding, diminished the response of the amygdala and other limbic regions to negative emotional images. Additionally, affect labeling produced increased activity in a single brain region, right ventrolateral prefrontal cortex (RVL PFC). Finally, RVL PFC and amygdala activity during affect labeling were inversely correlated, a relationship that was mediated by activity in medial prefrontal cortex (MPFC). These results suggest that affect labeling may diminish emotional reactivity along a pathway from RVL PFC to MPFC to the amygdala.

Link BG, Phelan JC (2001). **Conceptualizing stigma.** *Annu. Rev. Sociol.* 27:363-85.  
<http://www.annualreviews.org/doi/abs/10.1146/annurev.soc.27.1.363>

Social science research on stigma has grown dramatically over the past two decades, particularly in social psychology, where researchers have elucidated the ways in which people construct cognitive categories and link those categories to stereotyped beliefs. In the midst of this growth, the stigma concept has been criticized as being too vaguely defined and individually focused. In response to these criticisms, we define stigma as the co-occurrence of its components—labeling, stereotyping, separation, status loss, and discrimination—and further indicate that for stigmatization to occur, power must be exercised. The stigma concept we construct has implications for understanding several core issues in stigma research, ranging from the definition of the concept to the reasons stigma sometimes represents a very persistent predicament in the lives of persons affected by it. Finally, because there are so many stigmatized circumstances and because stigmatizing processes can affect multiple domains of people's lives, stigmatization probably has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health, and life itself. It follows that social scientists who are interested in understanding the distribution of such life chances should also be interested in stigma.

Livingston JD, Milne T, Fang ML, Amari E (2012). **The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review.** *Addiction*. 2012 Jan; 107(1): 39–50.  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3272222/>

**AIMS:** This study provides a systematic review of existing research that has empirically evaluated interventions designed to reduce stigma related to substance use disorders.

**METHODS:** A comprehensive review of electronic databases was conducted to identify evaluations of substance use disorder related stigma interventions. Studies that met inclusion criteria were synthesized and assessed using systematic review methods.

**RESULTS:** Thirteen studies met the inclusion criteria. The methodological quality of the studies was moderately strong. Interventions of three studies (23%) focused on people with substance use disorders (self-stigma), three studies (23%) targeted the general public (social stigma) and seven studies (54%) focused on medical students and other professional groups (structural stigma). Nine interventions (69%) used approaches that included education and/or direct contact with people who have substance use disorders. All but one study indicated their interventions produced positive effects on at least one stigma outcome measure. None of the interventions have been evaluated across different settings or populations.

**CONCLUSIONS:** A range of interventions demonstrate promise for achieving meaningful improvements in stigma related to substance use disorders. The limited evidence indicates that self-stigma can be reduced through therapeutic interventions such as group-based acceptance and commitment therapy. Effective strategies for addressing social stigma include motivational interviewing and communicating positive stories of people with substance use disorders. For changing stigma at a structural level, contact-based training and education programs targeting medical students and professionals (e.g. police, counsellors) are effective.

Luff D, Martin EB Jr, Mills K, Mazzola NM, Bell SK, Meyer E (2016). **Clinicians' strategies for managing their emotions during difficult healthcare conversations.** *Patient Educ Couns*. 2016 Jun 28. pii: S0738-3991(16)30281-6. doi: 10.1016/j.pec.2016.06.017. [Epub ahead of print].  
<http://www.ncbi.nlm.nih.gov/pubmed/27423178>

**OBJECTIVES:** To examine strategies employed by clinicians from different disciplines to manage their emotions during difficult healthcare conversations.

**CONCLUSIONS:** Across disciplines and experience levels, clinicians have developed strategies to manage their emotions when holding difficult healthcare conversations. These strategies support clinicians before, during and after difficult conversations.

**PRACTICE IMPLICATIONS:** Understanding what strategies clinicians already employ to manage their emotions when holding difficult conversations has implications for educational planning and implementation. This study has potential to inform the development of education to support clinicians' awareness of their emotions and to enhance the range and effectiveness of emotion management during difficult healthcare conversations.

Lupien SJ, McEwen BS, Gunnar MR, Heim C (2009). **Effects of stress throughout the lifespan on the brain, behaviour and cognition.** *Nature Reviews Neuroscience* 10, 434-445 (June 2009) | doi:10.1038/nrn2639.  
<http://www.nature.com/nrn/journal/v10/n6/abs/nrn2639.html>

Chronic exposure to stress hormones, whether it occurs during the prenatal period, infancy, childhood, adolescence, adulthood or aging, has an impact on brain structures involved in cognition and mental health. However, the specific effects on the brain, behaviour and cognition emerge as a function of the timing and the duration of the exposure, and some also depend on the interaction between gene effects and previous exposure to environmental adversity.

MacCarthy D, Weinerman R, Kallstrom L, Kadlec H, Hollander MJ, Patten S (2013). **Mental Health Practice and Attitudes Can Be Changed.** *Perm J.* 2013 Summer; 17(3): 14–17. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3783077/>

**OBJECTIVES:** An adult mental health module was developed in British Columbia to increase the use of evidence-based screening and cognitive behavioral self-management tools as well as medications that fit within busy family physician time constraints and payment systems. Aims were to enhance family physician skills, comfort, and confidence in diagnosing and treating mental health patients using the lens of depression; to improve patient experience and partnership; to increase use of action or care plans; and to increase mental health literacy and comfort of medical office assistants.

**METHODS:** The British Columbia Practice Support Program delivered the module using the Plan-Do-Study-Act cycle for learning improvement. Family physicians were trained in adult mental health, and medical office assistants were trained in mental health first aid. Following initial testing, the adult mental health module was implemented across the province.

**RESULTS:** More than 1400 of the province's 3300 full-service family physicians have completed or started training. Family physicians reported high to very high success implementing self-management tools into their practices and the overall positive impact this approach had on patients. These measures were sustained or improved at 3 to 6 months after completion of the module. An Opening Minds Survey for health care professionals showed a decrease in stigmatizing attitudes of family physicians.

**CONCLUSIONS:** The adult mental health module is changing the way participants practice. Office-based primary mental health care can be improved through reimbursed training and support for physicians to implement practical, time-efficient tools that conform to payment schemes. The module provided behavior-changing tools that seem to be changing stigmatizing attitudes towards this patient population. This unexpected discovery has piqued the interest of stigma experts at the Mental Health Commission of Canada.

Machtiger EL, Cuca YP, Khanna N, Rose CD, Kimberg LS (2015). **From Treatment to Healing: The Promise of Trauma-Informed Primary Care.** *Women's Health Issues* May–June, 2015 Volume 25, Issue 3, Pages 193–197. [http://www.whijournal.com/article/S1049-3867\(15\)00033-X/abstract](http://www.whijournal.com/article/S1049-3867(15)00033-X/abstract)

In August 2013, a national strategy group convened in Washington, DC to clarify a framework for trauma-informed primary care (TIPC) for women. The group was motivated by an increasing body of research and experience revealing that people from all races, ethnicities, and socioeconomic backgrounds come to primary care with common conditions (e.g., heart, lung, and liver diseases, obesity, diabetes, depression, substance use, and sexually transmitted infections) that can be traced to recent and past trauma. These conditions are often stubbornly refractory to treatment, in part because we are not addressing the trauma and posttraumatic stress disorder (PTSD) that underlie and perpetuate them. The purpose of the strategy group was to review the evidence linking trauma to health and provide practical guidance to clinicians, researchers, and policymakers about the core components of an effective response to recent and past trauma in the setting of primary care. We describe the results of this work and advocate for the adoption of TIPC as a practical and ethical imperative for women's health and well-being.

MacInnes DL, Lewis M (2008). **The evaluation of a short group programme to reduce self-stigma in people with serious and enduring mental health problems.** *Journal of Psychiatric and Mental Health Nursing* Volume 15, Issue 1, pages 59–65, January 2008. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2850.2007.01212.x/full>

The concept of stigma has been acknowledged as being an important factor in the way that people with mental health problems are viewed and treated. Some authors suggest that stigma should be viewed as a multifaceted rather than a single concept. One part of this multifaceted concept has been called self-stigma which has been defined as the reactions of stigmatized individuals towards themselves. This study examined the impact of a 6-week group programme designed to reduce self-stigma in a group of service users with serious and enduring mental health problems. Twenty participants were assessed prior to the commencement of the group and immediately following its cessation. In addition to self-stigma, assessments for self-esteem, self-acceptance and psychological health measures were also undertaken. The

results record a significant reduction in the stigma following the group and also non-significant increases in the participants' levels of self-esteem, self-acceptance and overall psychological health. However, there was only a negligible correlation recorded between the reduction in self-stigma and the increase in self-esteem, self-acceptance and psychological health. The paper discusses the possible explanations for these findings.

Mahajan AP, Sayles JN, Patel VA, Remien RH, Ortiz D, Szekeres G, Coates TJ (2008). **Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward.** *AIDS*. 2008 Aug; 22(Suppl 2): S67–S79. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835402/>

Outlines conceptual model for stigma. Although stigma is considered a major barrier to effective responses to the HIV/AIDS epidemic, stigma reduction efforts are relegated to the bottom of AIDS program priorities. The complexity of HIV/AIDS related stigma is often cited as a primary reason for the limited response to this pervasive phenomenon. In this paper, we systematically review the scientific literature on HIV/AIDS related stigma to document the current state of research, identify gaps in the available evidence, and highlight promising strategies to address stigma. We focus on the following key challenges: defining, measuring, and reducing HIV/AIDS related stigma as well as assessing the impact of stigma on the effectiveness of HIV prevention and treatment programs. Based on the literature, we conclude by offering a set of recommendations that may represent important next steps in a multifaceted response to stigma in the HIV/AIDS epidemic.

Makoul G, Zick A & Green M (2007). **An evidence-based perspective on greetings in medical encounters.** *Arch Intern Med*, 11;167(11):1172-6. <http://archinte.jamanetwork.com/article.aspx?articleid=412602>.

**BACKGROUND:** Widely used models for teaching and assessing communication skills highlight the importance of greeting patients appropriately, but there is little evidence regarding what constitutes an appropriate greeting.

**METHODS:** To obtain data on patient expectations for greetings, we asked closed-ended questions about preferences for shaking hands, use of patient names, and use of physician names in a computer-assisted telephone survey of adults in the 48 contiguous United States. We also analyzed an existing sample of 123 videotaped new patient visits to characterize patterns of greeting behavior in everyday clinical practice.

**RESULTS:** Most (78.1%) of the 415 survey respondents reported that they want the physician to shake their hand, 50.4% want their first name to be used when physicians greet them, and 56.4% want physicians to introduce themselves using their first and last names; these expectations vary somewhat with patient sex, age, and race. Videotapes revealed that physicians and patients shook hands in 82.9% of visits. In 50.4% of the initial encounters, physicians did not mention the patient's name at all. Physicians tended to use their first and last names when introducing themselves.

Malin AJ, Pos AE (2014). **The impact of early empathy on alliance building, emotional processing, and outcome during experiential treatment of depression.** *Psychotherapy Research* 25(4):1-15. <http://www.tandfonline.com/doi/abs/10.1080/10503307.2014.901572?journalCode=tpsr20>

**OBJECTIVE:** This study examined the relationships among the therapist process of expressed empathy during first sessions, clients' post-session one alliance reports, clients' later working phase emotional processing, and clients' final reductions in depressive symptoms for 30 clients receiving short-term experiential therapy for depression.

**METHOD:** The therapist process of expressed empathy was assessed using a new observer-rated measure: the measure of expressed empathy, which was demonstrated to be valid and reliable.

**RESULTS:** Results indicate that therapist expressed empathy in session one significantly affected the outcome, albeit indirectly. This indirect effect occurred through two direct effects on other important therapy processes that did directly predict client outcomes: (i) Therapist expressed empathy in first sessions directly and positively predicted client reports of first-session alliances; and (ii) therapist expressed empathy directly predicted observer-rated deepened client emotional processing in the working phase of therapy.



CONCLUSIONS: Empirical support was provided for the theorized relationships in experiential theory amongst the variables examined.

Mamede S, Van Gog T, Schuit SCE, Van den Berge K, Van Daele PLA, Bueving H, Van der Zee T, Van den Broek WW, Van Saase JLCM, Schmidt HG (2016). **Why patients' disruptive behaviours impair diagnostic reasoning: a randomised experiment.** *BMJ Qual Saf* doi:10.1136/bmjqs-2015-005065. <http://qualitysafety.bmj.com/content/early/2016/02/09/bmjqs-2015-005065>

BACKGROUND: Patients who display disruptive behaviours in the clinical encounter (the so-called 'difficult patients') may negatively affect doctors' diagnostic reasoning, thereby causing diagnostic errors. The present study aimed at investigating the mechanisms underlying the negative influence of difficult patients' behaviours on doctors' diagnostic performance.

METHODS: A randomised experiment with 74 internal medicine residents. Doctors diagnosed eight written clinical vignettes that were exactly the same except for the patients' behaviours (either difficult or neutral). Each participant diagnosed half of the vignettes in a difficult patient version and the other half in a neutral version in a counterbalanced design. After diagnosing each vignette, participants were asked to recall the patient's clinical findings and behaviours. Main measurements were: diagnostic accuracy scores; time spent on diagnosis, and amount of information recalled from patients' clinical findings and behaviours.

RESULTS: Mean diagnostic accuracy scores (range 0–1) were significantly lower for difficult than neutral patients' vignettes (0.41 vs 0.51;  $p < 0.01$ ). Time spent on diagnosing was similar. Participants recalled fewer clinical findings (mean=29.82% vs mean=32.52%;  $p < 0.001$ ) and more behaviours (mean=25.51% vs mean=17.89%;  $p < 0.001$ ) from difficult than from neutral patients.

CONCLUSIONS: Difficult patients' behaviours induce doctors to make diagnostic errors, apparently because doctors spend part of their mental resources on dealing with the difficult patients' behaviours, impeding adequate processing of clinical findings. Efforts should be made to increase doctors' awareness of the potential negative influence of difficult patients' behaviours on diagnostic decisions and their ability to counteract such influence.

Martin EB, Jr., Mazzola NM, Brandano J, Luff D, Zurakowski D, Meyer EC (2015). **Clinicians' recognition and management of emotions during difficult healthcare conversations.** *Patient Education and Counseling* 98 (2015) 1248–1254. [http://www.pec-journal.com/article/S0738-3991\(15\)30038-0/abstract?cc=y](http://www.pec-journal.com/article/S0738-3991(15)30038-0/abstract?cc=y)

OBJECTIVE: To examine the most commonly reported emotions encountered among healthcare practitioners when holding difficult conversations, including frequency and impact on care delivery.

METHODS: Interprofessional learners from a range of experience levels and specialties completed self-report questionnaires prior to simulation-based communication workshops. Clinicians were asked to describe up to three emotions they experienced when having difficult healthcare conversations; subsequent questions used Likert-scales to measure frequency of each emotion, and whether care was affected.

RESULTS: 152 participants completed questionnaires, including physicians, nurses, and psychosocial professionals. Most commonly reported emotions were anxiety, sadness, empathy, frustration, and insecurity. There were significant differences in how clinicians perceived these different emotions affecting care. Empathy and anxiety were emotions perceived to influence care more than sadness, frustration, and insecurity.

CONCLUSIONS: Most clinicians, regardless of clinical experience and discipline, find their emotional state influences the quality of their care delivery. Most clinicians rate themselves as somewhat to quite capable of recognizing and managing their emotions, acknowledging significant room to grow. Practice implications: Further education designed to increase clinicians' recognition of, reflection on, and management of emotion would likely prove helpful in improving their ability to navigate difficult healthcare conversations. Interventions aimed at anxiety management are particularly needed.

Mason S, Sultzman V, Berger B (2014). **“Like being in a cage”: stigma as experienced by adolescents whose mothers are living with HIV.** *Vulnerable Children and Youth Studies* 9, 32, pp. 323-331. <http://www.tandfonline.com/doi/abs/10.1080/17450128.2014.933941>

Stigma affects not only the person living with HIV, but also, by association, their family members. Stigma-by-association may contribute to adverse outcomes for children of parents living with HIV. We interviewed 27 African-American adolescents, 13–18 years old, who were not HIV-positive but whose mothers were living with HIV. As part of a broader study, adolescents responded to four open-ended questions regarding their experience of HIV stigma-by-association. Their responses were analyzed using ATLAS.ti to identify themes. About half of the teens had not told anyone their mother’s HIV status but had heard peers make fun of or insult people with HIV. Anticipating stigma, teens used a range of strategies from being silent and vigilant to brushing off insults as ignorance and refusing to feel shame. In some instances, these strategies strained peer interactions and reinforced the mother/teen connection. With guidance, mothers may be well positioned to coach children and teens to identify stigma situations, manage those situations, and ultimately reduce stigma’s impact on both adolescent and mother. Group interventions with HIV-affected teens, with or without parental involvement, can ameliorate the strained peer relationships which teens described, reducing their isolation and empowering them with knowledge and decision-making skills.

Mazzi MA, Bensing J, Rimondini M, Fletcher I, van Vliet L, Zimmermann C, Deveugele M (2013). **How do lay people assess the quality of physicians’ communicative responses to patients’ emotional cues and concerns?: an international multicentre study based on videotaped medical consultations.** *Patient Education and Counseling*. 90(3). p.347-353. <https://www.ncbi.nlm.nih.gov/pubmed/21784600>

**OBJECTIVE:** to establish which kind of physician communicative responses to patient cues and concerns are appreciated by lay people.

**METHODS:** A balanced sample (259 people) was recruited in public places to participate in a full day observation of four videotaped standardized medical consultations. In a two-step procedure participants gave their individual quality ratings of the whole consultations and then of a set of four fragments from each consultation. They contained a patient negative emotional expression and the subsequent physician response, according to the VR-CoDES.

**RESULTS:** Higher quality ratings were given to physician responses which provided space to the patient to talk and to the explicit expressions of empathy. The explicit responses were favored above non-explicit responses. Participants’ global evaluation of the whole consultation affected their quality assessments of the fragments (halo-effect). In a multivariate model, lay people’s background characteristics appeared to be relevant: to be female, of lower educational level and living in Belgium or Italy predicted higher ratings.

**CONCLUSIONS:** Providing space to patients is appreciated by all participants, combined with the need for tailor made communication.

**PRACTICE IMPLICATIONS:** To teach physicians listening skills and how to show empathy with distressed patients should be a core element in medical education.

McCauley J, Jenckes MW, McNutt L-A (2003). **ASSERT: The effectiveness of a medical continuing education video on knowledge and attitudes about interpersonal violence.** *Acad. Med.* 2003;78:518–524. <http://www.ncbi.nlm.nih.gov/pubmed/12742790>

**CONCLUSIONS.** The IPV video, using experts from multiple disciplines, improved knowledge and attitudes about child, elder, sexual, and domestic violence, and was rated highly by clinicians. The video was useful for preparing for a JCAHO accreditation visit.

McEwen BS, Seeman T (1999). **Protective and damaging effects of the mediators of stress and adaptation: Elaborating and testing the concepts of allostasis and allostatic load.** *Ann N Y Acad Sci.* 1999;896:30-47. <http://www.ncbi.nlm.nih.gov/pubmed/10681886>

Stress is a condition of human existence and a factor in the expression of disease. A broader view of stress is that it is not just the dramatic stressful events that exact their toll but rather the many events of daily life

that elevate activities of physiological systems to cause some measure of wear and tear. We call this wear and tear “allostatic load,” and it reflects not only the impact of life experiences but also of genetic load; individual habits reflecting items such as diet, exercise, and substance abuse; and developmental experiences that set life-long patterns of behavior and physiological reactivity (see McEwen). Hormones associated with stress and allostatic load protect the body in the short run and promote adaptation, but in the long run allostatic load causes changes in the body that lead to disease. This will be illustrated for the immune system and brain. Among the most potent of stressors are those arising from competitive interactions between animals of the same species, leading to the formation of dominance hierarchies. Psychosocial stress of this type not only impairs cognitive function of lower ranking animals, but it can also promote disease (e.g. atherosclerosis) among those vying for the dominant position. Social ordering in human society is also associated with gradients of disease, with an increasing frequency of mortality and morbidity as one descends the scale of socioeconomic status that reflects both income and education. Although the causes of these gradients of health are very complex, they are likely to reflect, with increasing frequency at the lower end of the scale, the cumulative burden of coping with limited resources and negative life events and the allostatic load that this burden places on the physiological systems involved in coping and adaptation.

McEwen BS (2006). **Protective and Damaging Effects of Stress Mediators: central role of the brain.** *Dialogues Clin Neurosci.* 2006 Dec; 8(4): 367–381. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181832/>

The mind involves the whole body, and two-way communication between the brain and the cardiovascular, immune, and other systems via neural and endocrine mechanisms. Stress is a condition of the mind-body interaction, and a factor in the expression of disease that differs among individuals. It is not just the dramatic stressful events that exact their toll, but rather the many events of daily life that elevate and sustain activities of physiological systems and cause sleep deprivation, overeating, and other health-damaging behaviors, producing the feeling of being “stressed out.” Over time, this results in wear and tear on the body, which is called “allostatic load,” and it reflects not only the impact of life experiences but also of genetic load, individual lifestyle habits reflecting items such as diet, exercise, and substance abuse, and developmental experiences that set life-long patterns of behavior and physiological reactivity. Hormones associated with stress and allostatic load protect the body in the short run and promote adaptation by the process known as allostasis, but in the long run allostatic load causes changes in the body that can lead to disease. The brain is the key organ of stress, allostasis, and allostatic load, because it determines what is threatening and therefore stressful, and also determines the physiological and behavioral responses.

Mehta N, Clement S, Marcus E, Stona AC, Bezborodovs N, Evans-Lacko S, Palacios J, Docherty M, Barley E, Rose D, Koschorke M, Shidhaye R, Henderson C, Thornicroft G (2015). **Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: systematic review.** *Br J Psychiatry.* 2015 Nov;207(5):377-84. <http://bjp.rcpsych.org/content/207/5/377>

CONCLUSIONS: There is modest evidence for the effectiveness of anti-stigma interventions beyond 4 weeks follow-up in terms of increasing knowledge and reducing stigmatising attitudes. Evidence does not support the view that social contact is the more effective type of intervention for improving attitudes in the medium to long term. Methodologically strong research is needed on which to base decisions on investment in stigma-reducing interventions.

Mehu M, Grammer K, Dunbar RIM (2007). **Smiles when sharing.** *Evolution & Human Behav* 18(6): 415-422. DOI: <http://dx.doi.org/10.1016/j.evolhumbehav.2007.05.010>. [http://www.ehbonline.org/article/S1090-5138\(07\)00064-5/fulltext](http://www.ehbonline.org/article/S1090-5138(07)00064-5/fulltext)

One of the proposed functions of human smiling is to advertise cooperative dispositions and thereby increase the likelihood that a social partner would invest resources in a relationship. In particular, smiles involving an emotional component would be honest signals of altruistic dispositions because they are not easy to produce voluntarily. In this study, 60 people were covertly filmed while interacting with a friend in two conditions: control and sharing. Smiles were classified into Duchenne (spontaneous) and non-Duchenne smiles. Participants also completed a series of questionnaires, including the Altruism Scale and a

self-report questionnaire of emotional state. Interestingly, Duchenne smiles were displayed at higher rates in the sharing situation as opposed to the control situation, whereas non-Duchenne smiles were unaffected by the type of interaction. Furthermore, Duchenne smiles in the sharing interaction were positively affected by a measure of altruism. Self-reported emotional states did not vary between conditions and were poorly related to smiling. This study shows that the Duchenne smile is relevant to situations that involve the sharing of material resources because it would reliably advertise altruistic intentions. The Duchenne smile could therefore be an important signal in the formation and maintenance of cooperative relationships.

Menschner C, Maul A (2016). **Key ingredients for successful trauma-informed care implementation.** *Center for Health Care Strategies, Inc. Brief April 2016.*  
[http://www.chcs.org/media/ATC\\_whitepaper\\_040616.pdf](http://www.chcs.org/media/ATC_whitepaper_040616.pdf)

Because of the potentially long-lasting negative impact of trauma on physical and mental health, ways to address patients' history of trauma are drawing the attention of health care policymakers and providers across the country. Patients who have experienced trauma can benefit from emerging best practices in trauma-informed care. These practices involve both organizational and clinical changes that have the potential to improve patient engagement, health outcomes, and provider and staff wellness, and decrease unnecessary utilization. This brief draws on interviews with national experts on trauma-informed care to create a framework for organizational and clinical changes that can be practically implemented across the health care sector to address trauma. It also highlights payment, policy, and educational opportunities to acknowledge trauma's impact. The brief is a product of Advancing Trauma-Informed Care, a multi-site demonstration project supported by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies.

Merrill JO, Rhodes LA, Deyo RA, Marlatt GA, Bradley KA (2002). **Mutual mistrust in the medical care of drug users: the keys to the "narc" cabinet.** *J Gen Intern Med.* 2002 May;17(5):327-33.  
<http://www.ncbi.nlm.nih.gov/pubmed/12047728>

**OBJECTIVE:** Caring for patients who are active drug users is challenging. To better understand the often difficult relationships between illicit drug-using patients and their physicians, we sought to identify major issues that emerge during their interactions in a teaching hospital.  
**DESIGN:** Exploratory qualitative analysis of data from direct observation of patient care interactions and interviews with drug-using patients and their physicians.  
**RESULTS:** Four major themes emerged. First, physicians feared being deceived by drug-using patients. In particular, they questioned whether patients' requests for opiates to treat pain or withdrawal might result from addictive behavior rather than from "medically indicated" need. Second, they lacked a standard approach to commonly encountered clinical issues, especially the assessment and treatment of pain and opiate withdrawal. Because patients' subjective report of symptoms is suspect, physicians struggled to find criteria for appropriate opiate prescription. Third, physicians avoided engaging patients regarding key complaints, and expressed discomfort and uncertainty in their approach to these patients. Fourth, drug-using patients were sensitive to the possibility of poor medical care, often interpreting physician inconsistency or hospital inefficiency as signs of intentional mistreatment.  
**CONCLUSION:** Physicians and drug-using patients in the teaching hospital setting display mutual mistrust, especially concerning opiate prescription. Physicians' fear of deception, inconsistency and avoidance interacts with patients' concern that they are mistreated and stigmatized. Medical education should focus greater attention on addiction medicine and pain management.

Mold F, Forbes A (2013). **Patients' and professionals' experiences and perspectives of obesity in health-care settings: a synthesis of current research.** *Health Expect.* 2013 Jun;16(2):119-42.  
<http://onlinelibrary.wiley.com/doi/10.1111/j.1369-7625.2011.00699.x/abstract>

**AIM:** To undertake a synthesis of studies examining the views and experiences of both obese people in relation to their health-care provision and health-care professionals in providing care to obese patients.  
**FINDINGS:** Thirty studies were identified. All the studies reported obesity impacting on health-care



interactions. Key themes identified were experiences of stigma and feelings of powerlessness, treatment avoidance, psycho-emotional functioning, professional attitudes, confidence and training, variations in health contact time and finally, differences in treatment options and preventative measures.

**CONCLUSION:** Obesity is a stigmatized condition that impacts negatively on the relationship between patients and health-care providers. Given the increasing prevalence of obesity and the range of therapeutic options available, further work is necessary to understand how the presence of obesity affects health-care interactions and decision making.

Montague E, Chen PY, Xu J, Chewning B, Barrett B (2013). **Nonverbal Interpersonal Interactions in Clinical Encounters and Patient Perceptions of Empathy.** *J Participatory Med.* Vol. 5, August 14, 2013. <http://www.jopm.org/evidence/research/2013/08/14/nonverbal-interpersonal-interactions-in-clinical-encounters-and-patient-perceptions-of-empathy/>

**OBJECTIVE:** The relationship between nonverbal behaviors and patient perceptions of clinicians has been underexplored. The aim of this study was to understand the relationship between nonverbal communication behaviors (eye contact and social touch) to patient assessments of clinician (empathy, connectedness, and liking).

**METHODS:** Hypotheses were tested including clinician and patient nonverbal behaviors (eye contact, social touch) were coded temporally in 110 videotaped clinical encounters. Patient participants completed questionnaires to measure their perception of clinician empathy, connectedness with clinician, and how much they liked their clinician.

**RESULTS:** Length of visit and eye contact between clinician and patient were positively related to the patient's assessment of the clinician's empathy. Eye contact was significantly related to patient perceptions of clinician attributes, such as connectedness and liking.

**CONCLUSION:** Eye contact and social touch were significantly related to patient perceptions of clinician empathy. Future research in this area is warranted, particular with regards to health information technology and clinical system design.

**PRACTICE IMPLICATIONS:** Clinical environments designed for patient and clinician interaction should be designed to facilitate positive nonverbal interactions such as eye contact and social touch. Specifically, health information technology should not restrict clinicians' ability to make eye contact with their patients.

National Academies Press (2016). **Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change.** <http://www.nap.edu/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders>

Estimates indicate that as many as 1 in 4 Americans will experience a mental health problem or will misuse alcohol or drugs in their lifetimes. These disorders are among the most highly stigmatized health conditions in the United States, and they remain barriers to full participation in society in areas as basic as education, housing, and employment. Improving the lives of people with mental health and substance abuse disorders has been a priority in the United States for more than 50 years. The Community Mental Health Act of 1963 is considered a major turning point in America's efforts to improve behavioral healthcare. It ushered in an era of optimism and hope and laid the groundwork for the consumer movement and new models of recovery. The consumer movement gave voice to people with mental and substance use disorders and brought their perspectives and experience into national discussions about mental health.

National Association of Social Workers (NASW). **Code of Ethics of the National Association of Social Workers.** Approved by the 1996 NASW Delegate Assembly and revised by the 2008 NASW Delegate Assembly. <http://www.socialworkers.org/pubs/Code/code.asp>

**PREAMBLE:** The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address

problems in living. Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems. The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective: service, social justice, dignity and worth of the person, importance of human relationships, integrity, competence. This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Nazione S, Pace K (2015). **An Experimental Study of Medical Error Explanations: Do Apology, Empathy, Corrective Action, and Compensation Alter Intentions and Attitudes?** *J Health Commun.* 2015;20(12):1422-32. doi: 10.1080/10810730.2015.1018646. Epub 2015 Jul 2. <http://www.tandfonline.com/doi/full/10.1080/10810730.2015.1018646>

Medical malpractice lawsuits are a growing problem in the United States, and there is much controversy regarding how to best address this problem. The medical error disclosure framework suggests that apologizing, expressing empathy, engaging in corrective action, and offering compensation after a medical error may improve the provider-patient relationship and ultimately help reduce the number of medical malpractice lawsuits patients bring to medical providers. This study provides an experimental examination of the medical error disclosure framework and its effect on amount of money requested in a lawsuit, negative intentions, attitudes, and anger toward the provider after a medical error. Results suggest empathy may play a large role in providing positive outcomes after a medical error.

Neumann M, Bensing J, Mercer S, Ernstmann N, Ommen O, Pfaff H (2009). **Analyzing the "nature" and "specific effectiveness" of clinical empathy: A theoretical overview and contribution towards a theory-based research agenda.** *Patient Education and Counseling* 74(3): 339–346. [http://www.pec-journal.com/article/S0738-3991\(08\)00629-0/abstract](http://www.pec-journal.com/article/S0738-3991(08)00629-0/abstract)

**OBJECTIVE:** To establish sound empirical evidence that clinical empathy (abbreviated as CE) is a core element in the clinician–patient relationship with profound therapeutic potential, a substantial theoretical-based understanding of CE in medical care and medical education is still required. The two aims of the present paper are, therefore, (1) to give a multidisciplinary overview of the "nature" and "specific effectiveness" of CE, and (2) to use this base as a means of deriving relevant questions for a theory-based research agenda.

**METHOD:** We made an effort to identify current and past literature about conceptual and empirical work focusing on empathy and CE, which derives from a multiplicity of disciplines. We review the material in a structured fashion.

**RESULTS:** We describe the "nature" of empathy by briefly summarizing concepts and models from sociology, psychology, social psychology, education, (social-)epidemiology, and neurosciences. To explain the "specific effectiveness" of CE for patients, we develop the "Effect model of empathic communication in the clinical encounter", which demonstrates how an empathically communicating clinician can achieve improved patient outcomes. Both parts of theoretical findings are synthesized in a theory-based research agenda with the following key hypotheses: (1) CE is a determinant of quality in medical care, (2) clinicians biographical experiences influence their empathic behavior, and (3) CE is affected by situational factors.

**CONCLUSION:** The main conclusions of our review are twofold. First of all, CE seems to be a fundamental determinant of quality in medical care, because it enables the clinician to fulfill key medical tasks more accurately, thereby achieving enhanced patient health outcomes. Second, the integration of biographical experiences and situational factors as determinants of CE in medical care and medical education appears

to be crucial to develop and promote CE and ultimately ensuring high-quality patient care. Practice implications: Due to the complexity and multidimensionality of CE, evidence-based investigations of the derived hypotheses require both well-designed qualitative and quantitative studies as well as an interdisciplinary research approach.

Nicolaidis C, Touhouliotis V (2006). **Addressing intimate partner violence in primary care: lessons from chronic illness management.** *Violence Vict.* 2006 Feb;21(1):101-15. <http://www.ncbi.nlm.nih.gov/pubmed/16494136>

Though many studies have documented the high prevalence, morbidity, mortality and costs attributable to intimate partner violence (IPV), it is still unclear how our health care system should address this major public health problem. Many have advocated for routine screening, yet there is still insufficient evidence that routine IPV screening can lead to improved outcomes. Though recognition of IPV is very important, a screening paradigm may not be the optimal way to approach IPV within the health care system. For many patients, exposure to violence is a chronic condition, characterized by long-term abusive relationships, histories of childhood and community violence, multiple associated chronic symptoms, and extra barriers to addressing their other chronic illnesses. Thus, there may be important lessons to be learned from work being done in the area of chronic care. We explore how Wagner's Chronic Care model may guide efforts to improve health care for IPV survivors and may serve as a framework for future research studies.

Norfolk T, Birdi K, Walsh D (2007). **The role of empathy in establishing rapport in the consultation: a new model.** *Medical Education* 2007; 41: 690–697. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2007.02789.x/abstract>

**CONTEXT:** Considerable research has been conducted recently into the notion of patient-centred consulting. The primary goal of this approach is to establish a clear understanding of the patient's perspective on his or her problem, and to allow this understanding to inform both the explanation and planning stages of the consultation. The quality of this understanding is largely determined by the empathic accuracy achieved by the doctor; the primary benefit is a therapeutic rapport between doctor and patient.

**METHODS:** To highlight the role of empathy and communication skills in establishing rapport, we initially developed a model which seeks to draw the various motivational and skill elements identified in separate research papers into a comprehensive model of the journey towards shared understanding between doctor and patient. We then conducted an initial validation of the model via qualitative analysis involving general practitioners (GPs) and clinical psychologists.

**RESULTS:** The validation offered encouraging support for the principal elements of the model. Specific suggestions for clarification and extension were then incorporated in a revised model.

**CONCLUSIONS:** The model appears to capture the dynamic process of establishing a therapeutic relationship (rapport) between doctor and patient, defined by the quality of the doctor's understanding of the patient's perspective on his or her problem. Arguably, the most important contribution of the model is to highlight the fact that 'empathy' and consequent 'rapport' are not mystical or exclusive concepts but, rather, involve the use of specific skills accessible at some level by all.

O'Connor MB, Nolan DP, O'Dwyer M, O'Shea S & Phelan MJ (2011). **Doctor-patient introductions: getting it right.** *Irish Journal of Medical Science*, 180(4):935–936. <http://link.springer.com/article/10.1007/s11845-011-0676-6>

The first interaction a doctor has with a patient can often be the foundation on which the doctor-patient relationship blossoms or perishes. Those first few seconds in a medical encounter are pivotal in creating the rapport, making the patient feel comfortable, and setting the tone for a medical consultation. Historically, physicians and medical students are encouraged to shake hands with the patient, address the patient by name, and introduce themselves. This communication process is an important part of a medical consultation and can affect patient satisfaction. Such is the importance of this communication process that it is now recognised as a core clinical skill when practicing in a medical setting. It also needs to be highlighted that nonverbal communication is extremely important and a doctor's attire is to the fore in this

area. From this study, we can conclude that patients, from this cohort, prefer doctors to address them in a friendly personal manner with the use of only first names being very acceptable. This is in direct comparison with how patients prefer doctors to introduce and present themselves, with the use of using of title, full name and formal attire being viewed most appropriate, with the traditional handshake now less acceptable.

Olsen Y, Sharfstein JM (2014). **Confronting the Stigma of Opioid Use Disorder—and Its Treatment.** *JAMA* April 9,2014 Volume 311, Number 14. doi:10.1001/jama.2014.2147.

<http://jama.jamanetwork.com/article.aspx?articleid=1838170>

Four factors contribute to the stigma associated with opioid use disorder and its treatment with medications. First, the understanding of opioid use disorder as a medical illness is still overshadowed by its misconception as a moral weakness or a willful choice. Second, the separation of opioid use disorder treatment from the rest of healthcare has meant that clinicians who treat these patients have not always paid sufficient attention to other substance use, mental health, and physical health conditions. Third, language mirrors and perpetuates the stigma related to treatment of opioid use disorder with medications. Fourth, the criminal justice system often fails to defer to medical judgment in the treatment of opioid use disorders.

Paterson BL, Backmund M, Hirsch G, Yim C (2007). **The depiction of stigmatization in research about hepatitis C.** *International Journal of Drug Policy* 18, 364-373.

<http://www.ncbi.nlm.nih.gov/pubmed/17854724>

In the past decade, there has been an increasing emphasis by researchers regarding the stigmatization of people who are hepatitis C positive as they seek health care. Because the vast majority of people with hepatitis C have a history of injection drug use, they are frequently assumed by practitioners to be injection drug users (IDUs), blamed for acquiring the disease, and viewed as irresponsible, immoral, and unworthy. Such stigmatization may cause people who have hepatitis C to avoid testing, treatment and care, as well as to not disclose their hepatitis C or injection drug use to practitioners. The purpose of this paper is to critically examine the representation of stigmatization in 21 published research reports from 1995 to 2006, with a specific focus on how these depictions have shaped the current understanding of interventions to address stigmatization of people with hepatitis C by health care practitioners. We will identify two themes in this literature: (1) hepatitis C-related stigmatization in health care settings arises primarily from practitioners' negative views of injection drug use, and (2) practitioners' negative attitudes toward people with hepatitis C are the result of their lack of awareness and/or information about the disease and/or about injection drug use. We will illustrate that similar themes have informed anti-stigma initiatives in other diseases, notably HIV/AIDS and mental illness, which have had little sustained effect in changing practitioners' behaviour toward the stigmatized population. In conclusion, we will call for research that considers factors beyond the individual practitioner as contributing to the stigmatization of people with hepatitis C, such as social, structural and institutional forces that shape practitioners' interactions with people with hepatitis C in health care settings.

Patten SB, Remillard A, Phillips L, Modgill, G, Szeto, ACH, Kassam, A, Gardner, DM (2012). **Effectiveness of contact-based education for reducing mental illness-related stigma in pharmacy students.** *BMC Medical Education* 2012, 12:120. <http://bmcmmededuc.biomedcentral.com/articles/10.1186/1472-6920-12-120>

**BACKGROUND:** A strategy for reducing mental illness-related stigma in health-profession students is to include contact-based sessions in their educational curricula. In such sessions students are able to interact socially with a person that has a mental illness. We sought to evaluate the effectiveness of this strategy in a multi-centre study of pharmacy students.

**METHODS:** The study was a randomized controlled trial conducted at three sites. Because it was necessary that all students receive the contact-based sessions, the students were randomized either to an early or late intervention, with the late intervention group not having participated in the contact-based education at the time when the primary outcome was assessed. The primary outcome, stigma, was assessed using an attitudes scale called the Opening Minds Survey for Health Care Providers (OMS-HC).



RESULTS: We initially confirmed that outcomes were homogeneous across study centres, centre by group interaction,  $p = 0.76$ . The results were pooled across the three study centres. A significant reduction in stigma was observed in association with the contact-based sessions (mean change 4.3 versus 1.5,  $t=2.1$ ,  $p=0.04$ ). The effect size (Cohen's  $d$ ) was 0.45. A similar reduction was seen in the control group when they later received the intervention.

CONCLUSIONS: Contact-based education is an effective method of reducing stigma during pharmacy education. These results add to a growing literature confirming the effectiveness of contact-based strategies for stigma reduction in health profession trainees.

Pescosolido BA, Martin JK (2015). **The Stigma Complex**. *Annual Review of Sociology* 41, 87-116. <http://www.annualreviews.org/doi/abs/10.1146/annurev-soc-071312-145702>

Sociological review of stigma; propose ...”a stigma complex, a system of interrelated, heterogeneous parts bringing together insights across disciplines to provide a more realistic and complicated sense of the challenge facing research and change efforts. The Framework Integrating Normative Influences on Stigma (FINIS) offers a multilevel approach that can be tailored to stigmatized statuses.”

Peters R, Lusli M, Zweekhorst M, Miranda-Galarza B, van Brakel, W Joske Bunders J (2015). **Learning from a leprosy project in Indonesia: making mindsets explicit for stigma reduction**. *Development in Practice* 25(8):1105-1119. <http://www.tandfonline.com/doi/abs/10.1080/09614524.2015.1081155?journalCode=cdip20>

International attention for disability recognises that it plays an important role in persistent poverty. Leprosy can cause preventable disability. Stigma associated with leprosy often has greater implications for people affected than physical impairments. The Stigma Assessment and Reduction of Impact (SARI) project in Indonesia employs an action research methodology to develop stigma reduction interventions. By exploring the different mindsets of the stakeholders in the reconnaissance phase of the project, the project identified differences in aspirations, attitudes to research, and conflicting intrinsic models of disability. The differences in mindsets are not symptoms of failure but, rather, should be actively sought out.

Pitrou I, Lecourt AC, Bailly L, Brousse B, Dauchet L, Ladner J (2009). **Waiting time and assessment of patient satisfaction in a large reference emergency department: A prospective cohort study, France**. *European Journal of Emergency Medicine* 16(4): 177-182. <http://www.ncbi.nlm.nih.gov/pubmed/19318959>.

OBJECTIVES: To assess patient satisfaction in a French Emergency Department (ED) and to determine factors associated with dissatisfaction.

METHODS: From July 2003 to February 2004, a prospective cohort study was conducted in an ED (Elbeuf Reference Hospital, Upper-Normandy region). Baseline data collection was performed during individual interview at inclusion. Waiting time in the ED was recorded. Patient satisfaction was assessed by telephone 1 month later. Questions included assessment of overall satisfaction and three different areas of satisfaction: quality of reception, patient-doctor communication, and delays.

RESULTS: One hundred sixty-five patients were included, 146 patients (88.5%) responded to the telephone follow up. We found high levels of satisfaction in the ED (89.7%). Highest satisfaction rate (92.5%) was for reception. Lower satisfaction rates were reported for waiting times (72.6%) and medical information provided by physicians (71.9%). The mean total time spent was 149.9 min (median=133.5). In multivariate analysis, waiting time was the unique independent determinant of patient dissatisfaction: second quartile odds ratio (OR)=0.40; 95% confidence interval (CI)=(0.06-2.66), third quartile OR=1.45; 95% CI=(0.32-6.47), last quartile OR=2.69; 95% CI=(0.65-11.08);  $p$  trend=0.04.

CONCLUSION: Elevated waiting times appeared as the unique independent risk factor of patient dissatisfaction. Information on delays and reasons for this delay could be systematically communicated to patients attending EDs; it could be an effective strategy to reduce perceived waiting times and improve patient satisfaction.

Pollak KI, Ostbye T, Alexander SC, Gradison M, Bastian LA, Namenek Brouwer RJ, Lyna P (2007). **Empathy goes a long way in weight loss discussions: female patients are more likely to step up weight loss efforts when a physician shows empathy and offers support.** *Journal of Family Practice* 56(12): 1031-1036.

<http://static1.1.sqspcdn.com/static/f/995733/19717283/1344045933707/Dia+4.+Empathy+in+weight+loss.pdf?token=C043jQhngaNVC7oc2UY6fHpW1yg%3D>

**PURPOSE:** This study explores how weight-related topics are discussed between physicians and their overweight and obese female patients.

**METHODS:** We surveyed and audiorecorded preventive health and chronic care visits with 25 overweight and obese female patients. We coded both for quantity (content and time) of weight-related discussions and quality (adherence to Motivational Interviewing [MI] techniques). We then tested correlations of these measures with patients' reported attempts to lose weight, change diet, and change exercise patterns 1 month after the visit.

**RESULTS:** Weight was routinely addressed (19 of 25 encounters). Patients usually initiated the topic (67% of time). Physicians' use of MI techniques resulted in patients attempting to lose weight and changing their exercise patterns.

**CONCLUSION:** Physicians may benefit from MI training to help patients lose weight.

Pollak KI, Alexander SC, Tulsy JA, Lyna P, Coffman CJ, Dolor RJ, Gulbrandsen P, Østbye T (2011). **Physician Empathy and Listening: Associations with Patient Satisfaction and Autonomy.** *J Am Board Fam Med* November-December 2011 vol. 24 no. 6 665-67.

[http://selfdeterminationtheory.org/SDT/documents/2011\\_Pollaket\\_al\\_physicianMI\\_JABFM.pdf](http://selfdeterminationtheory.org/SDT/documents/2011_Pollaket_al_physicianMI_JABFM.pdf)

**PURPOSE:** Motivational Interviewing (MI) is used to help patients change their behaviors. We sought to determine if physician use of specific MI techniques increases patient satisfaction with the physician and perceived autonomy.

**METHODS:** We audio-recorded preventive and chronic care encounters between 40 primary care physicians and 320 of their overweight or obese patients. We coded use of MI techniques (e.g., empathy, reflective listening). We assessed patient satisfaction and how much the patient felt the physician supported him or her to change. Generalized estimating equation models with logit links were used to examine associations between MI techniques and patient perceived autonomy and satisfaction.

**RESULTS:** Patients whose physicians were rated as more empathic had higher rates of high satisfaction than patients whose physicians were less empathic (29% vs 11%;  $P = .004$ ). Patients whose physicians made any reflective statements had higher rates of high autonomy support than those whose physicians did not (46% vs 30%;  $P = .006$ ).

**CONCLUSIONS:** When physicians used reflective statements, patients were more likely to perceive high autonomy support. When physicians were empathic, patients were more likely to report high satisfaction with the physician. These results suggest that physician training in MI techniques could potentially improve patient perceptions and outcomes.

Putnam KT, Harris WW, Putnam FW (2013). **Synergistic Childhood Adversities and Complex Adult Psychopathology.** *Journal of Traumatic Stress* August 2013, 26, 435-442.

<http://www.ncbi.nlm.nih.gov/pubmed/23893545>

Numerous studies find a cumulative effect of different types of childhood adversities on increasing risk for serious adult mental and medical outcomes. This study uses the National Comorbidity Survey-Replication sample to investigate the cumulative impact of 8 childhood adversities on complex adult psychopathology as indexed by (a) number of lifetime diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., DSM-IV; American Psychiatric Association, 1994); (b) number of 4 DSM-IV disorder categories (mood, anxiety, impulse control, and substance abuse disorders); and (c) coexistence of internalizing and externalizing disorders. Seven of the 8 childhood adversities were significantly associated with complex adult psychopathology. Individuals with 4 or more childhood adversities had an odds ratio of 7.3, 95% confidence interval [4.7, 11.7] for 4 disorder categories. Additive and multiplicative synergistic effects increasing adult psychopathology were found for specific pairwise combinations of

childhood adversities. Synergistic patterns differed by gender suggesting that women are more impacted by sexual abuse and men by economic hardship. The absence of childhood adversities was protective, in that it significantly decreased an individual's risk for subsequent adult mental illness. The results support the clinical impression that increased childhood adversity is associated with more complex adult psychopathology.

Quill TE, Arnold RM, Platt F (2001). **"I wish things were different": Expressing wishes in response to loss, futility, and unrealistic hopes.** *Annals of Internal Medicine* 135(7) 551-555.

<http://annals.org/article.aspx?articleid=714787>

Physicians who care for patients encounter many powerful and painful emotions, including anger, sadness, fear, grief, loss, hopelessness, and blame. Many studies suggest that physicians should express empathy in response to emotion-laden patient statements to ensure that patients feel listened to and understood. These physician responses usually consist of efforts to comprehend how things feel to the patient and to express that understanding back to the patient. Situations that evoke loss, guilt, or hopelessness are particularly hard for physicians to respond to empathically. Physicians who think that they have failed a dying patient and who fear depriving the patient of hope may respond by avoiding the topic entirely, by overcompensating with overtreatment, or by apologizing for not "saving" the patient. When a patient expresses overwhelming anger or disappointment with limitations in medicine, physicians may be afraid that any explicit response to the patient's emotion may be construed as evidence of their failure, mistake, or inadequacy. In these challenging situations, we have observed that many physicians attempt to respond empathically by stating "I'm sorry." This well-intentioned response, although frequently appropriate, may be misinterpreted and misdirected. We have found that saying "I wish...(things were different)" to the patient and family is a more effective initial response. We explicate some of the challenges of saying "I'm sorry" and explore the potential benefits of joining with patients and families and saying "I wish..." in specific, difficult clinical scenarios.

Raja S, Hasnain M, Hoersch M, Gove-Yin S, Rajagopalan C (2015). **Trauma informed care in medicine: current knowledge and future research directions.** *Fam Community Health*. 2015 Jul-Sep;38(3):216-26.

<http://www.ncbi.nlm.nih.gov/pubmed/26017000>

Traumatic events (including sexual abuse, domestic violence, elder abuse, and combat trauma) are associated with long-term physical and psychological effects. These events may influence patients' health care experiences and engagement in preventative care. Although the term trauma-informed care (TIC) is widely used, it is not well understood how to apply this concept in daily health care practice. On the basis of a synthesis of a review of the literature, the TIC pyramid is a conceptual and operational framework that can help physicians translate TIC principles into interactions with patients. Implications for clinical practice and future research are discussed in this article.

Rakel DP, Hoeft TJ, Barrett BP, Chewning BA, Craig BM, Niu M (2009). **Practitioner Empathy and the Duration of the Common Cold.** *Fam Med* 2009;41(7):494-50.

<http://www.stfm.org/fmhub/fm2009/July/David494.pdf>

**OBJECTIVE:** This study's objective was to assess the relationship of empathy in medical office visits to subsequent outcomes of the common cold.

**METHODS:** A total of 350 subjects  $\geq$  12 years of age received either a standard or enhanced physician visit as part of a randomized controlled trial. Enhanced visits emphasized empathy on the part of the physician. The patient-scored Consultation and Relational Empathy (CARE) questionnaire assessed practitioner-patient interaction, especially empathy. Cold severity and duration were assessed from twice-daily symptom reports. Nasal wash was performed to measure the immune cytokine interleukin-8 (IL-8).

**RESULTS:** Eighty-four individuals reported perfect (score of 50) CARE scores. They tended to be older with less education but reported similar health status, quality of life, and levels of optimism. In those with perfect CARE scores, cold duration was shorter (mean 7.10 days versus 8.01 days), and there was a trend toward reduced severity (mean area under receiver-operator characteristics curve 240.40 versus 284.49). After accounting for possible confounding variables, cold severity and duration were significantly lower in

those reporting perfect CARE scores. In these models, a perfect score also correlated with a larger increase in IL-8 levels.

**CONCLUSIONS:** Clinician empathy, as perceived by patients with the common cold, significantly predicts subsequent duration and severity of illness and is associated with immune system changes.

Rao D, Desmond M, Andrasik M, Rasberry T, Lambert N, Cohn SE, Simoni J (2012). **Feasibility, Acceptability, and Preliminary Efficacy of the Unity Workshop: An Internalized Stigma Reduction Intervention for African American Women Living with HIV.** *AIDS Patient Care and STDs* 26, 614-620.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3462391/>

Observational studies have examined the prevalence and impact of internalized stigma among African American women living with HIV, but there are no intervention studies investigating stigma reduction strategies in this population. Based on qualitative data previously collected, we adapted the International Center for Research on Women's HIV Stigma Toolkit for a domestic population of African American women to be consistent with Corrigan's principles of strategic stigma change. We implemented the intervention, led by an African American woman living with HIV, as a workshop across two afternoons. The participants discussed issues "triggered" by videos produced specifically for this purpose, learned coping mechanisms from each other, and practiced them in role plays with each other. ...The intervention was feasible, enthusiastically accepted by the women, and led to decreased stigma from the start of the workshop to the end ( $p=0.05$ ) and 1 week after ( $p=0.07$ ) the last session of workshop.

Redelmeier DA, Etchells EE (2016). **Unwanted patients and unwanted diagnostic errors.** *BMJ Qual Saf* doi:10.1136/bmjqs-2015-005150. <http://qualitysafety.bmj.com/content/early/2016/02/09/bmjqs-2015-005150>

Editorial. Schmidt et al present two articles testing whether disruptive patient behaviours might provoke unhelpful physician emotions and thereby decrease a physician's diagnostic accuracy.

Reeves E (2015). **A synthesis of the literature on trauma-informed care.** *Issues Ment Health Nurs.* 2015;36(9):698-709. doi: 10.3109/01612840.2015.1025319.

<http://www.ncbi.nlm.nih.gov/pubmed/26440873>

Patients with a history of traumatic life events can become distressed or re-traumatized as the result of healthcare experiences. These patients can benefit from trauma-informed care that is sensitive to their unique needs. However, despite the widespread prevalence of traumatic life experiences such as sexual assault and intimate partner violence, trauma-informed care has not been widely researched or implemented. The purpose of this synthesis of the literature is to examine existing research on trauma-informed care for survivors of physical and sexual abuse. The following themes are discussed: trauma screening and patient disclosure, provider-patient relationships, minimizing distress and maximizing autonomy, multidisciplinary collaboration and referrals, and trauma-informed care in diverse settings. This synthesis also explores implications for trauma-informed care research, practice and policy. The themes identified here could be used as a framework for creating provider and survivor educational interventions and for implementing trauma-informed care across disciplines. The findings of this synthesis support further research on patient and provider experiences of trauma-informed care, and research to test the efficacy of trauma-informed care interventions across healthcare settings. Universal implementation of trauma-informed care can ensure that the unique needs of trauma survivors as patients are met, and mitigate barriers to care and health disparities experienced by this vulnerable population.

Reynolds WJ, Scott B (2000). **Do nurses and other professional helpers normally display much empathy?** *Journal of Advanced Nursing*, 2000, 31(1), 226-234.

<http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2000.01242.x/abstract>

Empathy, the ability to perceive and reason, as well as the ability to communicate understanding of the other person's feelings and their attached meanings, is held to be a core characteristic of a helping relationship. This paper examines some of the observations that motivated the authors' interest in how registered nurses learn how to offer empathy to clients. First, while empathy is crucial to all helping



relationships, professional helpers do not normally offer much empathy. Second, while nurses are meant to provide helping relationships, they do not tend to show much empathy to clients. The relevance of empathy to clinical nursing and the potential consequences of low-empathy nursing for clients is considered. It will be shown that, in the past, a low level of empathy has been reported among the helping professions, including nursing, indicating that many professional helpers are not as helpful as they ought to be. While most studies of empathy in professional relationships are more than a decade old, more recent studies report similar results.

Rhodes KV, Vieth T, He T, Miller A, Howes DS, Bailey O, Walter J, Frankel R, Levinson W (2004). **Resuscitating the physician-patient relationship: Emergency department communication in an academic medical center.** *Annals of Emergency Medicine*, 44(3): 262-267. <http://www.ncbi.nlm.nih.gov/pubmed/15332069>.

**STUDY OBJECTIVE:** We characterize communication in an urban, academic medical center emergency department (ED) with regard to the timing and nature of the medical history survey and physical examination and discharge instructions.

**METHODS:** Audiotaping and coding of 93 ED encounters (62 medical history surveys and physical examinations, 31 discharges) with a convenience sample of 24 emergency medicine residents, 8 nurses, and 93 nonemergency adult patients.

**RESULTS:** Patients were 68% women and 84% black, with a mean age of 45 years. Emergency medicine providers were 70% men and 80% white. Of 62 medical history surveys and physical examinations, time spent on the introduction and medical history survey and physical examination averaged 7 minutes 31 seconds (range 1 to 20 minutes). Emergency medicine residents introduced themselves in only two thirds of encounters, rarely (8%) indicating their training status. Despite physician tendency (63%) to start with an open-ended question, only 20% of patients completed their presenting complaint without interruption. Average time to interruption (usually a closed question) was 12 seconds. Discharge instructions averaged 76 seconds (range 7 to 202 seconds). Information on diagnosis, expected course of illness, self-care, use of medications, time-specified follow-up, and symptoms that should prompt return to the ED were each discussed less than 65% of the time. Only 16% of patients were asked whether they had questions, and there were no instances in which the provider confirmed patient understanding of the information.

**CONCLUSION:** Academic EDs present unique challenges to effective communication. In our study, the physician-patient encounter was brief and lacking in important health information. Provision of patient-centered care in academic EDs will require more provider education and significant system support.

Rhodes KV, Frankel RM, Levinthal N, Prenoveau E, Bailey J, and Levinson W (2007). **“You’re Not a Victim of Domestic Violence, Are You?” Provider-Patient Communication about Domestic Violence.** *Ann Intern Med* 147(9): 620–627. <http://www.ncbi.nlm.nih.gov/pubmed/17975184>

**BACKGROUND:** Women who are victims of domestic violence frequently seek care in an emergency department. However, it is challenging to hold sensitive conversations in this environment.

**OBJECTIVE:** To describe communication about domestic violence between emergency providers and female patients.

**DESIGN:** Analysis of audiotapes made during a randomized, controlled trial of computerized screening for domestic violence. **SETTING:** 2 socioeconomically diverse emergency departments: one urban and academic, the other suburban and community-based. **PARTICIPANTS:** 1281 English-speaking women age 16 to 69 years and 80 providers (30 attending physicians, 46 residents, and 4 nurse practitioners).

**RESULTS:** 871 audiotapes, including 293 that included provider screening for domestic violence, were analyzed. Providers typically asked about domestic violence in a perfunctory manner during the social history. Provider communication behaviors associated with women disclosing abuse included probing (defined as asking  $\geq 1$  additional topically related question), providing open-ended opportunities to talk, and being generally responsive to patient clues (any mention of a psychosocial issue). Chart documentation of domestic violence was present in one third of cases.

**LIMITATIONS:** Nonverbal communication was not examined. Providers were aware that they were being audiotaped and may have tried to perform their best.

**CONCLUSION:** Although hectic clinical environments present many obstacles to meaningful discussions

about domestic violence, several provider communication behaviors seemed to facilitate patient disclosure of experiences with abuse. Illustrative examples highlight common pitfalls and exemplary practices in screening for abuse and response to disclosures of abuse.

Riess H, Kraft-Todd G (2014). **E.M.P.A.T.H.Y.: A Tool to Enhance Nonverbal Communication Between Clinicians and Their Patients.** *Academic Medicine* (August 2014) 89 (8) pp. 1108–1112.

<http://www.ncbi.nlm.nih.gov/pubmed/24826853>

There is a gap in the medical education literature on teaching nonverbal detection and expression of empathy. Many articles do not address nonverbal interactions, instead focusing on “what to say” rather than “how to be.” This focus on verbal communication overlooks the essential role nonverbal signals play in the communication of emotions, which has significant effects on patient satisfaction, health outcomes, and malpractice claims. This gap is addressed with a novel teaching tool for assessing nonverbal behavior using the acronym E.M.P.A.T.H.Y.—E: eye contact; M: muscles of facial expression; P: posture; A: affect; T: tone of voice; H: hearing the whole patient; Y: your response. This acronym was the cornerstone of a randomized controlled trial of empathy training at Massachusetts General Hospital, 2010–2012. Used as an easy-to-remember checklist, the acronym orients medical professionals to key aspects of perceiving and responding to nonverbal emotional cues. An urgent need exists to teach nonverbal aspects of communication as medical practices must be reoriented to the increasing cultural diversity represented by patients presenting for care. Where language proficiency may be limited, nonverbal communication becomes more crucial for understanding patients’ communications. Furthermore, even in the absence of cultural differences, many patients are reluctant to disagree with their clinicians, and subtle nonverbal cues may be the critical entry point for discussions leading to shared medical decisions. A detailed description of the E.M.P.A.T.H.Y. acronym and a brief summary of the literature that supports each component of the teaching tool are provided.

Ross CA, Goldner M (2009). **Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature.** *Journal of Psychiatric and Mental Health Nursing* 16(6):558–567 <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2850.2009.01399.x/full>

The aim of this paper was to review the existing literature pertaining to stigma, negative attitudes and discrimination towards mental illness, specifically as viewed through the lens of the nursing profession. The results of the literature review were synthesized and analysed, and the major themes drawn from this were found to correspond with Schulze’s model identifying three positions that healthcare workers may assume in relation to stigma of mental illness: ‘stigmatizers’, ‘stigmatized’ and ‘de-stigmatizers’. In this paper, the nursing profession is examined from the perspectives of the first two major themes: the ‘stigmatizers’ and ‘stigmatized’. Their primary sub-themes are identified and discussed: (1) Nurses as ‘the stigmatizers’: (a) nurses’ attitudes in general medical settings towards patients with psychiatric illness and (b) psychiatric nurses; (2) Nurses as ‘the stigmatized’: (a) nurses who have mental illness and (b) stigma within the profession against psychiatric nurses and/or psychiatry in general. The secondary and tertiary sub-themes are also identified and reviewed.

Rowbotham SJ, Hollerd J, Wearden A, Lloyd DM (2016). **I see how you feel: Recipients obtain additional information from speakers’ gestures about pain.** *Patient Education and Counseling* 99 1333–1342.

<http://www.ncbi.nlm.nih.gov/pubmed/26996051>

**OBJECTIVE:** Despite gestures frequently add information about pain that is not contained in the accompanying speech. We explored whether recipients can obtain additional information from gestures about the pain that is being described.

**METHODS:** Participants (n = 135) viewed clips of pain descriptions under one of four conditions: 1) Speech Only; 2) Speech and Gesture; 3) Speech, Gesture and Face; and 4) Speech, Gesture and Face plus Instruction (short presentation explaining the pain information that gestures can depict). Participants provided free-text descriptions of the pain that had been described. Responses were scored for the amount of information obtained from the original clips.

**FINDINGS:** Participants in the Instruction condition obtained the most information, while those in the

Speech Only condition obtained the least (all comparisons  $p < 0.001$ ).

**CONCLUSIONS:** Gestures produced during pain descriptions provide additional information about pain that recipients are able to pick up without detriment to their uptake of spoken information. Practice implications: Healthcare professionals may benefit from instruction in gestures to enhance uptake of information about patients' pain experiences.

Ruberton PM, Huynh HP, Millera TA, Krusec E, Chancellor J, Lyubomirskya S (2016). **The relationship between physician humility, physician-patient communication, and patient health.** *Patient Education and Counseling* 99 (2016) 1138–1145. <http://www.ncbi.nlm.nih.gov/pubmed/26830544>

**OBJECTIVE:** Cultural portrayals of physicians suggest an unclear and even contradictory role for humility in the physician-patient relationship. Despite the social importance of humility, however, little empirical research has linked humility in physicians with patient outcomes or the characteristics of the doctor-patient visit. The present study investigated the relationship between physician humility, physician-patient communication, and patients' perceptions of their health during a planned medical visit.

**METHODS:** Primary care physician-patient interactions (297 patients across 100 physicians) were rated for the physician's humility and the effectiveness of the physician-patient communication. Additionally, patients reported their overall health and physicians and patients reported their satisfaction with the interaction.

**RESULTS:** Within-physician fluctuations in physician humility and self-reported patient health positively predicted one another, and mean-level differences in physician humility predicted effective physician-patient communication, even when controlling for the patient's and physician's satisfaction with the visit and the physician's frustration with the patient.

**CONCLUSIONS:** The results suggest that humble, rather than paternalistic or arrogant, physicians are most effective at working with their patients. Practice implications: Interventions to improve physician humility may promote better communication between health care providers and patients, and, in turn, better patient outcomes.

Rutledge SE, Whyte J, Abell N, Brown KM, Cesnales NI (2011). **Measuring Stigma Among Health Care and Social Service Providers: The HIV/AIDS Provider Stigma Inventory.** *AIDS Patient Care and STDs* 25, 673-682. <http://www.ncbi.nlm.nih.gov/pubmed/21967495>

Initial validation of the HIV/AIDS Provider Stigma Inventory (HAPSI), piloted on a sample of 174 nursing students, supported the psychometric qualities of a suite of measures capturing tendencies to stigmatize and discriminate against people living with HIV/AIDS (PLHA). Derived from social psychology and mindfulness theories, separate scales addressing awareness, acceptance, and action were designed to include notions of labeling, stereotyping, outgrouping, and discriminating. These were enhanced to capture differences associated with personal characteristics of PLHA that trigger secondary stigma (e.g., sexual orientation, injection drug use, multiple sex partners) and fears regarding instrumental and symbolic stigma. Reliabilities were strong (coefficients  $\alpha$  for 16 of 19 resulting measures ranged from 0.80 to 0.98) and confirmatory factor analyses indicated good model fit for two multidimensional (Awareness and Acceptance) and one unidimensional (Action) measure. Evidence of convergent construct validity supported accuracy of primary constructs. Implications for training and professional socialization in health care are discussed.

Ryan R, Grolnick WS (1986). **Origins and Pawns in the Classroom: Self-Report and Projective Assessments of Individual Differences in Children's Perceptions.** *J Personality and Soc Psych*, Vol. 50, No. 3, 550-558. [http://selfdeterminationtheory.org/SDT/documents/1986\\_RyanGrolnick\\_IPSP.pdf](http://selfdeterminationtheory.org/SDT/documents/1986_RyanGrolnick_IPSP.pdf)

Two studies examined the significance of children's perceptions of their classroom environment along autonomy versus external control dimensions. Study 1 related a self-report measure of the perceived classroom climate to other self-related constructs. In a sample of 140 elementary children, it was found that the more "origin" the children perceived in their classroom, the higher their perceived selfworth, cognitive competence, internal control, and mastery motivation, and the lower their perceived control by unknown sources or powerful others. These relationships were primarily due to individual differences

within classrooms rather than average classroom differences. Children also wrote projective stories about an ambiguous classroom scene. Ratings of these stories indicated that, within children's fantasy, origin-like behavior of students was associated with autonomy-oriented teachers and low aggression. Self-report and projective methods converged, particularly for children whose self-reported perceptions were extreme. In a second study (N = 578), relative contributions of classroom and individual difference effects were further examined. Results are discussed in terms of the importance of perceived autonomy and issues in assessment strategies.

Sayles JN, Ryan GW, Silver JS, Sarkisian CA, Cunningham WE (2007). **Experiences of Social Stigma and Implications for Healthcare Among a Diverse Population of HIV Positive Adults.** *J Urban Health.* 2007 Nov;84(6):814-28. Epub 2007 Sep 2. <http://www.ncbi.nlm.nih.gov/pubmed/17786561>

Stigma profoundly affects the lives of people with HIV/AIDS. Fear of being identified as having HIV or AIDS may discourage a person from getting tested, from accessing medical services and medications, and from disclosing their HIV status to family and friends. In the present study, we use focus groups to identify the most salient domains of stigma and the coping strategies that may be common to a group of diverse, low-income women and men living with HIV in Los Angeles, CA (n = 48). We also explore the impact of stigma on health and healthcare among HIV positive persons in our sample. Results indicate that the most salient domains of stigma include: blame and stereotypes of HIV, fear of contagion, disclosure of a stigmatized role, and renegotiating social contracts. We use the analysis to develop a framework where stigma is viewed as a social process composed of the struggle for both internal change (self-acceptance) and reintegration into the community. We discuss implications of HIV-related stigma for the mental and physical health of HIV-positive women and men and suggestions for possible interventions to address stigma in the healthcare setting.

Schabert J, Browne JL, Mosely K, Speight J (2013). **Social stigma in diabetes: a framework to understand a growing problem for an increasing epidemic.** *Patient.* 2013;6(1):1-10. doi: 10.1007/s40271-012-0001-0. <http://www.ncbi.nlm.nih.gov/pubmed/23322536>

A comprehensive understanding of the social and psychological impact of diabetes mellitus is important for informing policy and practice. One potentially significant, yet under-researched, issue is the social stigma surrounding diabetes. This narrative review draws on literature about health-related stigma in diabetes and other chronic conditions in order to develop a framework for understanding diabetes-related stigma. Our review of the literature found that people who do not have diabetes assume that diabetes is not a stigmatized condition. In contrast, people with diabetes report that stigma is a significant concern to them, experienced across many life domains, e.g., in the workplace, in relationships. The experience of diabetes-related stigma has a significant negative impact on many aspects of psychological well-being and may also result in sub-optimal clinical outcomes for people with diabetes. We propose a framework that highlights the causes (attitudes of blame, feelings of fear and disgust, and the felt need to enforce social norms and avoid disease), experiences (being judged, rejected, and discriminated against), and consequences (e.g., distress, poorer psychological well-being, and sub-optimal self-care) of diabetes-related stigma and also identifies potential mitigating strategies to reduce diabetes-related stigma and/or enhance coping and resilience amongst people with diabetes. The systematic investigation of the experiences, causes, and consequences of diabetes-related stigma is an urgent research priority.

Schmidt HG, van Gog T, Schuit SCE, Van den Berge K, Van Daele PLA, Bueving H, Van der Zee T, Van den Broek WW, Van Saase JLCM, Mamede S (2016). **Do patients' disruptive behaviours influence the accuracy of a doctor's diagnosis? A randomised experiment.** *BMJ Qual Saf* doi:10.1136/bmjqs-2015-004109. <http://qualitysafety.bmj.com/content/early/2016/02/09/bmjqs-2015-004109>

**BACKGROUND:** Literature suggests that patients who display disruptive behaviours in the consulting room fuel negative emotions in doctors. These emotions, in turn, are said to cause diagnostic errors. Evidence substantiating this claim is however lacking. The purpose of the present experiment was to study the effect of such difficult patients' behaviours on doctors' diagnostic performance.

**METHODS:** We created six vignettes in which patients were depicted as difficult (displaying distressing



behaviours) or neutral. Three clinical cases were deemed to be diagnostically simple and three deemed diagnostically complex. Sixty-three family practice residents were asked to evaluate the vignettes and make the patient's diagnosis quickly and then through deliberate reflection. In addition, amount of time needed to arrive at a diagnosis was measured. Finally, the participants rated the patient's likability. RESULTS: Mean diagnostic accuracy scores (range 0–1) were significantly lower for difficult than for neutral patients (0.54 vs 0.64;  $p=0.017$ ). Overall diagnostic accuracy was higher for simple than for complex cases. Deliberate reflection upon the case improved initial diagnostic, regardless of case complexity and of patient behaviours (0.60 vs 0.68,  $p=0.002$ ). Amount of time needed to diagnose the case was similar regardless of the patient's behaviour. Finally, average likability ratings were lower for difficult than for neutral-patient cases.

CONCLUSIONS: Disruptive behaviours displayed by patients seem to induce doctors to make diagnostic errors. Interestingly, the confrontation with difficult patients does however not cause the doctor to spend less time on such case. Time can therefore not be considered an intermediary between the way the patient is perceived, his or her likability and diagnostic performance.

Sengupta S, Banks B, Jonas D, Miles M, Smith S (2011). **HIV interventions to reduce HIV/AIDS stigma: a systematic review.** *AIDS Behav.* 2011;15:1075–87.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128169/>

We reviewed the literature to determine the effectiveness of HIV-related interventions in reducing HIV/AIDS stigma. Studies selected had randomized controlled trial (RCT), pretest–posttest with a non-randomized control group, or pretest–posttest one group study designs in which HIV-related interventions were being evaluated, and in which HIV/AIDS stigma was one of the outcomes being measured. Only 2 of these 14 effective studies were considered good studies, based on quality, the extent to which the intervention focused on reducing HIV/AIDS stigma, and the statistics reported to demonstrate effectiveness.

Shah S, Diwan S (2010). **Methadone: Does Stigma Play a Role as a Barrier to Treatment of Chronic Pain?** *Pain Physician* 13:289-293, ISSN 1533-3159. <http://www.ncbi.nlm.nih.gov/pubmed/20495594>

INTRODUCTION: The synthetic opioid methadone is a promising analgesic for the management of chronic neuropathic pain. Methadone therapy is increasing as its advantages are being realized over other opioids. Methadone's lack of known active metabolites, high oral bioavailability, low cost, and its additional receptor activity as an antagonist of N-methyl-D-aspartate receptors make it an attractive analgesic. METHODS: We surveyed 550 pain physicians to determine their prescribing practices of methadone. The study was approved by our Institutional Review Board. A list of 550 pain physicians, which included practitioners in private practice, university settings, and community hospitals, were obtained and surveys sent via mail. The list was obtained through the American Pain Society's membership list. Out of 550 surveys sent, 124 replies were returned.

RESULTS: The 124 surveys that were returned included pain physicians from various settings: 20 responses from physicians practicing at a university setting, 16 responses from a community setting, 54 responses from a private setting, one from university and community settings, 7 from community and private settings, 3 from university and community and private settings; 23 did not specify. Of the 124 physicians, 111 prescribe methadone in their pain practice. Of the 13 physicians who do not prescribe methadone, the main reason for not using the drug for 5 physicians was because of social stigma, 2 because of minimal experience with the drug, 2 because the drug was not effective, one because of lack of knowledge, and one because of potential adverse effects. Of the 111 physicians who use methadone, 55 stated that social stigma was the most common reason patients refuse to take methadone for the treatment of pain, 44 because of adverse effects, and 5 stated "other" as the reason patients refuse to take methadone. Of 111 physicians who prescribe methadone, 100 prescribed it for neuropathic pain, 101 for somatic pain, 80 for visceral pain, 78 for cancer pain, and 34 for sickle cell pain. Also, 21 stated that methadone was the primary opioid they prescribed. Of the 111 physicians who prescribe methadone, 86 start methadone at low dose and titrate up to minimize side effects. Fourteen clinicians load methadone and titrate down to minimize adverse effects while maintaining analgesia.

CONCLUSION: The majority of survey responders (90%) prescribed methadone in their pain practice, but on a very limited basis; 59% state <20% of their patients are on methadone. Three times a day dosing schedule was the most typical regimen (57%) while 77% prefer to titrate up on the dosage. It seems interesting that many clinicians do not prescribe methadone as a primary analgesic. One reason for this is due to the social stigma of its use in treatment of heroin addicts. Also, a lack of widely recognized treatment algorithms or guidelines to assist clinicians with opioid conversions and maintenance might be playing a role. The role of stigma as a barrier to adequate treatment of chronic pain among pain physicians prescribing practices is a fundamental, yet unexplored issue.

Sharples A, Page-Gould E (2016). Web blog post, *How to Avoid Picking Up Prejudice from the Media* Greater Good Science Center, University of California, Berkeley, September 7, 2016.

Although stereotypes are still broadcast to us through media, we can resist their influence when we acknowledge that they exist and that they are a problem. Moreover, we can use media as a tool to come into contact with different social groups that we may otherwise not have contact with and to learn about their experiences.

Sheehan L, Nieweglowski K, Corrigan P (2016). **The Stigma of Personality Disorders.** *Curr Psychiatry Rep* (2016) 18: 11. <http://www.ncbi.nlm.nih.gov/pubmed/26780206>

This article reviews the recent literature on the stigma of personality disorders, including an overview of general mental illness stigma and an examination of the personality-specific stigma. Overall, public knowledge of personality disorders is low, and people with personality disorders may be perceived as purposefully misbehaving rather than experiencing an illness. Health provider stigma seems particularly pernicious for those with borderline personality disorder. Most stigma research on personality disorders has been completed outside the USA, and few stigma-change interventions specific to personality disorder have been scientifically tested. Limited evidence suggests that health provider training can improve stigmatizing attitudes and that interventions combining positive messages of recovery potential with biological etiology will be most impactful to reduce stigma. Anti-stigma interventions designed specifically for health providers, family members, criminal justice personnel, and law enforcement seem particularly beneficial, given these sources of stigma.

Shepherd MA, Gerend MA (2014). **The blame game: Cervical cancer, knowledge of its link to human papillomavirus and stigma.** *Psychology & Health* 29, 94-109. <http://www.ncbi.nlm.nih.gov/pubmed/24006882>

This two-study paper examined stigma toward women with cervical cancer. Cervical cancer is caused by human papillomavirus (HPV), a sexually transmitted infection (STI). ...Consistent with Study 1, participants in the cause-specified condition rated the patient as more unwise, and reported feeling more moral disgust and 'grossed out' than participants in the cause-unspecified condition. These effects were mediated by attributions of blame toward the patient. Findings suggest that women with cervical cancer may be stigmatised and blame may play a role in this process.

Sibley A, Latter S, Richard C, Lussier MT, Roberge D, Skinner TC, Cradock S, Zinken KM (2011). **Medication discussion between nurse prescribers and people with diabetes: An analysis of content and participation using MEDICODE.** *Journal of Advanced Nursing* 67(11): 2323-2336. <http://www.ncbi.nlm.nih.gov/pubmed/21592189>.

AIM: This paper is a report of a study to identify the content of, and participation in, medicine discussion between nurse prescribers and people with diabetes in England.

BACKGROUND: Diabetes affects 246 million people worldwide and effective management of medicines is an essential component of successful disease control. There are now over 20,000 nurse independent prescribers in the UK, many of whom frequently prescribe for people with diabetes. With this responsibility comes a challenge to effectively communicate with patients about medicines. National guidelines on medicines communication have recently been issued, but the extent to which nurse prescribers are facilitating effective medicine-taking in diabetes remains unknown.

**METHODS:** A purposive sample of 20 nurse prescribers working with diabetes patients audio-recorded 59 of their routine consultations and a descriptive analysis was conducted using a validated coding tool: MEDICODE. Recordings were collected between January and July 2008. The unit of analysis was the medicine.

**RESULTS:** A total of 260 instances of medicine discussion identified in the audio-recordings were analysed. The most frequently raised themes were 'medication named' (raised in 88.8% of medicines), 'usage of medication' (65.4%) and 'instructions for taking medication' (48.5%). 'Reasons for medication' (8.5%) and 'concerns about medication' were infrequently discussed (2.7%). Measures of consultation participation suggest largely dyadic medicine discussion initiated by nurse prescribers.

Sikveland R, Stokoea E, Symonds J (2016). **Patient burden during appointment-making telephone calls to GP practices.** *Patient Education and Counseling* 99 (2016) 1310–1318.  
<http://www.ncbi.nlm.nih.gov/pubmed/27055769>

**OBJECTIVE:** This study addresses, for the first time, the effectiveness of receptionists handling incoming calls from patients to access General Practice services.

**METHODS:** It is a large-scale qualitative study of three services in the UK. Using conversation analysis, we identified the issue of 'patient burden', which we defined based on the trouble patients display pursuing service. We quantified instances of 'patient burden' using a coding scheme.

**RESULTS:** We demonstrate how 'patient burden' unfolds in two phases of the telephone calls: (i) following an initial rejection of a patient's request; and (ii) following a receptionist's initiation of call closing. Our quantitative analysis shows that the three GP services differ in the frequency of 'patient burden' and reveals a correlation between the proportion of 'patient burden' and independent national satisfaction scores for these surgeries.

**CONCLUSION:** Unlike post-hoc surveys, our analysis of live calls identifies the communicative practices which may constitute patient (dis)satisfaction. Practice implications: Through establishing what receptionists handle well or less well in encounters with patients, we propose ways of improving such encounters through training or other forms of intervention.

Sinclair S, Beamer K, Hack TF, McClement S, Bouchal SR, Chochinov HM, Hagen NA (2016). **Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences.** *Palliat Med* August 17, 2016 026921631666349.  
<http://pmj.sagepub.com/content/early/2016/08/17/0269216316663499.1.abstract>

**BACKGROUND:** Compassion is considered an essential element in quality patient care. One of the conceptual challenges in healthcare literature is that compassion is often confused with sympathy and empathy. Studies comparing and contrasting patients' perspectives of sympathy, empathy, and compassion are largely absent.

**AIM:** The aim of this study was to investigate advanced cancer patients' understandings, experiences, and preferences of "sympathy," "empathy," and "compassion" in order to develop conceptual clarity for future research and to inform clinical practice.

**DESIGN:** Data were collected via semi-structured interviews and then independently analyzed by the research team using the three stages and principles of Straussian grounded theory. Setting/participants: Data were collected from 53 advanced cancer inpatients in a large urban hospital.

**RESULTS:** Constructs of sympathy, empathy, and compassion contain distinct themes and sub-themes. Sympathy was described as an unwanted, pity-based response to a distressing situation, characterized by a lack of understanding and self-preservation of the observer. Empathy was experienced as an affective response that acknowledges and attempts to understand individual's suffering through emotional resonance. Compassion enhanced the key facets of empathy while adding distinct features of being motivated by love, the altruistic role of the responder, action, and small, supererogatory acts of kindness. Patients reported that unlike sympathy, empathy and compassion were beneficial, with compassion being the most preferred and impactful.

**CONCLUSION:** Although sympathy, empathy, and compassion are used interchangeably and frequently

conflated in healthcare literature, patients distinguish and experience them uniquely. Understanding patients' perspectives is important and can guide practice, policy reform, and future research.

Sinclair S, Norris JM, McConnell SJ, Chochinov HM, Hack TF, Hagen NA, McClement S, Raffin Bouchal S (2016). **Compassion: a scoping review of the healthcare literature.** *BMC Palliative Care* 15:6 DOI: 10.1186/s12904-016-0080-0. <http://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-016-0080-0>

**BACKGROUND:** Recent concerns about suboptimal patient care and a lack of compassion have prompted policymakers to question the preparedness of clinicians for the challenging environment in which they practice. Compassionate care is expected by patients and is a professional obligation of clinicians; however, little is known about the state of research on clinical compassion. The purpose of this scoping review was to map the literature on compassion in clinical healthcare.

**METHODS:** Searches of eight electronic databases and the grey literature were conducted to identify empirical studies published over the last 25 years. Eligible studies explored perceptions or interventions of compassionate care in clinical populations, healthcare professionals, and healthcare students. Following the title and abstract review, two reviewers independently screened full-texts articles, and extracted study data. A narrative approach to synthesizing and mapping the literature was used.

**RESULTS AND DISCUSSION:** Of 36,637 records, 648 studies were retrieved and 44 studies were included in the review. Less than one third of studies included patients. Six themes emerged from studies that explored perceptions of compassionate care: nature of compassion, development of compassion, interpersonal factors related to compassion, action and practical compassion, barriers and enablers of compassion, and outcomes of compassion. Intervention studies included two compassionate care trials with patients and eight educational programs that aimed to improve compassionate care in clinicians and students.

**CONCLUSIONS:** This review identifies the limited empirical understanding of compassion in healthcare, highlighting the lack of patient and family voices in compassion research. A deeper understanding of the key behaviors and attitudes that lead to improved patient-reported outcomes through compassionate care is necessary.

Sinclair S, Torres M-B, Raffin-Bouchal S, Hack TF, McClement S, Hagen, NA Chochinov HM (2016). **Compassion training in healthcare: what are patients' perspectives on training healthcare providers?** *BMC Medical Education* 16:169 DOI: 10.1186/s12909-016-0695-0, Published: 11 July 2011. <https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-016-0695-0>

**BACKGROUND:** The purpose of this qualitative study was to investigate advanced cancer patients' perspectives on the importance, feasibility, teaching methods, and issues associated with training healthcare providers in compassionate care.

**METHODS:** This study utilized grounded theory, a qualitative research method, to develop an empirical understanding of compassion education rooted in direct patient reports. Audio-recorded semi-structured interviews were conducted to obtain an in-depth understanding of compassion training from the perspectives of hospitalized advanced cancer patients (n = 53). Data were analyzed in accordance with grounded theory to determine the key elements of the underlying theory.

**RESULTS:** Three overarching categories and associated themes emerged from the data: compassion aptitude, cultivating compassion, and training methods. Participants spoke of compassion as an innate quality embedded in the character of learners prior to their healthcare training, which could be nurtured through experiential learning and reflective practices. Patients felt that the innate qualities that learners possessed at baseline were further fashioned by personal and practice experiences, and vocational motivators. Participants also provided recommendations for compassion training, including developing an interpersonal relationship with patients, seeing the patient as a person, and developing a human connection. Teaching methods that patients suggested in compassion training included patient-centered communication, self-reflection exercises, and compassionate role modeling.

**CONCLUSIONS:** This study provides insight on compassion training for both current and future healthcare providers, from the perspectives of the end recipients of healthcare provider training – patients.



Developing a theoretical base for patient centred, evidence-informed, compassion training is a crucial initial step toward the further development of this core healthcare competency.

Smith R (2007). **Media depictions of health topics: challenge and stigma formats.** *Journal of Health Communication* 12, 233-249. <http://www.ncbi.nlm.nih.gov/pubmed/17497378>

This article explored the notion that media depictions of health concerns come in one of two formats: challenge and stigma. After explicating the five features that should appear in challenge format and the seven features of stigma formats, we analyzed the content of health messages in magazines, brochures, and posters ... Some health topics appeared most often in challenge formats (including cancer, heart disease, and scoliosis), while others appeared in stigma formats (including tuberculosis, hepatitis, smoking, and sexually transmitted diseases [STDs]). Findings suggest that media depictions of health differ, and the implications of stigma and challenge formats are discussed.

Smith RA (2007). **Language of the Lost: An Explication of Stigma Communication.** *Communication Theory* 17:10.1111/comt.2007.17.issue-4, 462-48. <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-2885.2007.00307.x/abstract>

Although stigmas appear throughout history, even in present-day virtual communities, an explanation of stigma communication has yet to be offered; this essay attempts to do just that. This essay argues that stigma communication includes specific content: marks, labels, responsibility, and peril, in order to induce affective and cognitive responses to create stigma attitudes, to generate protective action tendencies, and to encourage the sharing of these messages with others. Stigma messages bear the following attributes: they provide cues (a) to distinguish people, (b) to categorize distinguished people as a separate social entity, (c) to imply a responsibility for receiving placement within this distinguished group and their associated peril, and (d) to link this distinguished group to physical and social peril. Different qualities of stigma messages, moreover, evoke different emotions (disgust, fear, and anger) that motivate people to access relevant social attitudes, form or bolster stigma attitudes, and to remove the stigmatized threat. Stigma attitudes encourage the sharing of stigma messages with others in a network, which may, subsequently, bond in-group members.

SmithBattle LI (2013). **Reducing the stigmatization of teen mothers.** *MCN Am J Matern Child Nurs.* 2013 Jul-Aug;38(4):235-41; quiz 242-3. <http://www.ncbi.nlm.nih.gov/pubmed/23571424>

Teen mothers are stigmatized by stereotypes that they are unmotivated, irresponsible, and incompetent parents. In spite of the pervasiveness of these stereotypes, stigma is rarely described as a contributing factor to teen mothers' difficulties and their health and social disparities. After tracing how teen mothers have been misrepresented and stereotyped over the last half century, I describe what is known about the stigma associated with teen mothering, reasons for its persistence, efforts to reduce it, and its potentially harmful effects. Stigma should be of concern to nurses because stigmatizing practices impede effective clinical care, contribute to teen mothers' many challenges, and violate the nursing ethic that patients be treated with respect and dignity. Recommendations for restoring dignity and reducing stigma in healthcare focus on developing recognition practices that are predicated on respect and concern for the teen's well-being and her capacity as a mother. Nurses are also urged to advocate for services and policies that reduce the stigmatization and marginalization of teen mothers.

Stephens GJ, Silbert LJ, Hasson U (2010). **Speaker-listener neural coupling underlies successful communication.** *Proc Natl Acad Sci U S A.* 2010;107:14425-14430. <http://www.pnas.org/content/107/32/14425.full>.

An MRI study recording brain activity during verbal communication found that the speaker's activity was spatially and temporally coupled with the listener's activity, but that this coupling vanishes when participants fail to fully comprehend one another.

**ABSTRACT:** Verbal communication is a joint activity; however, speech production and comprehension have primarily been analyzed as independent processes within the boundaries of individual brains. Here, we applied fMRI to record brain activity from both speakers and listeners during natural verbal

communication. We used the speaker's spatiotemporal brain activity to model listeners' brain activity and found that the speaker's activity is spatially and temporally coupled with the listener's activity. This coupling vanishes when participants fail to communicate. Moreover, though on average the listener's brain activity mirrors the speaker's activity with a delay, we also find areas that exhibit predictive anticipatory responses. We connected the extent of neural coupling to a quantitative measure of story comprehension and find that the greater the anticipatory speaker-listener coupling, the greater the understanding. We argue that the observed alignment of production and comprehension-based processes serves as a mechanism by which brains convey information.

Stolka A, Verhagena L, Schoffelen J-M, Oostenveld R, Blokpoela M, Hagoorta P, van Rooija I, Tonia I (2013). **Neural mechanisms of communicative innovation.** *Proc Natl Acad Sci.* 110(36):14574-14579, doi: 10.1073/pnas.1303170110. <http://www.pnas.org/content/110/36/14574.abstract>

Human referential communication is often thought as coding-decoding a set of symbols, neglecting that establishing shared meanings requires a computational mechanism powerful enough to mutually negotiate them. Sharing the meaning of a novel symbol might rely on similar conceptual inferences across communicators or on statistical similarities in their sensorimotor behaviors. Using magnetoencephalography, we assess spectral, temporal, and spatial characteristics of neural activity evoked when people generate and understand novel shared symbols during live communicative interactions. Solving those communicative problems induced comparable changes in the spectral profile of neural activity of both communicators and addressees. This shared neuronal up-regulation was spatially localized to the right temporal lobe and the ventromedial prefrontal cortex and emerged already before the occurrence of a specific communicative problem. Communicative innovation relies on neuronal computations that are shared across generating and understanding novel shared symbols, operating over temporal scales independent from transient sensorimotor behavior.

Street RL, Makoul, G, Arora, NK, Epstein, RM (2009). **How does communication heal? Pathways linking clinician-patient communication to health outcomes.** *Patient Educ Couns.* 2009 Mar;74(3):295-301. doi: 10.1016/j.pec.2008.11.015. Epub 2009 Jan 15. <https://www.ncbi.nlm.nih.gov/pubmed/19150199>

**OBJECTIVE:** Although prior research indicates that features of clinician-patient communication can predict health outcomes weeks and months after the consultation, the mechanisms accounting for these findings are poorly understood. While talk itself can be therapeutic (e.g., lessening the patient's anxiety, providing comfort), more often clinician-patient communication influences health outcomes via a more indirect route. Proximal outcomes of the interaction include patient understanding, trust, and clinician-patient agreement. These affect intermediate outcomes (e.g., increased adherence, better self-care skills) which, in turn, affect health and well-being. Seven pathways through which communication can lead to better health include increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment, and better management of emotions.

**CONCLUSION:** Future research should hypothesize pathways connecting communication to health outcomes and select measures specific to that pathway.

**PRACTICE IMPLICATIONS:** Clinicians and patients should maximize the therapeutic effects of communication by explicitly orienting communication to achieve intermediate outcomes (e.g., trust, mutual understanding, adherence, social support, self-efficacy) associated with improved health.

Swift JA, Tischler V, Markham S, Gunning I, Glazebrook, C, Beer, C, Puhl R (2013). **Are Anti-Stigma Films a Useful Strategy for Reducing Weight Bias Among Trainee Healthcare Professionals? Results of a Pilot Randomized Control Trial.** *Obes Facts* 2013;6:91-102. <http://www.karger.com/article/FullText/348714>

**BACKGROUND:** Weight bias is an important clinical issue that the educators of tomorrow's healthcare professionals cannot afford to ignore. This study, therefore, aimed to pilot a randomized controlled trial of the effects of educational films designed to reduce weight stigmatization toward obese patients on trainee dietitians' and doctors' attitudes.

**METHODS:** A pre-post experimental design with a 6-week follow-up, which consisted of an intervention

group (n = 22) and a control group (n = 21), was conducted to assess the efficacy of brief anti-stigma films in reducing weight bias, and to test whether future, larger-scale studies among trainee healthcare professionals are feasible.

**RESULTS:** Participants at baseline demonstrated weight bias, on both implicit and explicit attitude measures, as well as strong beliefs that obesity is under a person's control. The intervention films significantly improved explicit attitudes and beliefs toward obese people, and participant evaluation was very positive. The intervention did not significantly improve implicit anti-fat bias.

**CONCLUSION:** The current study suggests both that it is possible to conduct a substantive trial of the effects of educational films designed to reduce weight stigma on a larger cohort of trainee healthcare professionals, and that brief educational interventions may be effective in reducing stigmatizing attitudes in this population.

Szeto AC, Dobson, KS (2013). **Mental Disorders and Their Association with Perceived Work Stress.** *J Occup Health Psychol.* 2013 Apr;18(2):191-7. <http://www.ncbi.nlm.nih.gov/pubmed/23458060>

The economic repercussions of mental disorders in the workplace are vast. Research has found that individuals in high-stress jobs tend to have higher prevalence of mental disorders. The current cross-sectional study examined the relationships between work-related stress and mental disorders in a recent representative population-based sample—the 2010 Canadian Community Health Survey by Statistics Canada (CCHS; 2010a; Retrieved from [http://www23.statcan.gc.ca/imdb-bmdi/instrument/3226\\_Q1\\_V7-eng.pdf](http://www23.statcan.gc.ca/imdb-bmdi/instrument/3226_Q1_V7-eng.pdf)). Respondents in the highest level of perceived work stress had higher odds of ever being treated for an emotional or mental-health problem and for being treated in the past 12 months. These high-stress respondents also had higher odds of being diagnosed for mood and anxiety disorders than their nonstressed counterparts. These associations highlight the continued need to examine and promote mental health and well-being in the workplace.

Szeto ACH, Luong D, Dobson KS (2013). **Does labeling matter? An examination of attitudes and perceptions of labels for mental disorders.** *Soc Psychiatry Psychiatr Epidemiol* (2013) 48:659–671. <http://www.ncbi.nlm.nih.gov/pubmed/22711063>

**PURPOSE:** Labeling research in various domains has found that attitudes and perceptions vary as a function of the different labels ascribed to a group (e.g., overweight vs. obese). This type of research, however, has not been examined extensively in regards to labels for mental disorders. The present study examined whether common psychiatric labels (i.e., mental disease, mental disorders, mental health problems, and mental illness) elicited divergent attitudes and perceptions in a group of participants. These labels were also compared to the specific label of depression.

**METHODS:** Undergraduate psychology students (N = 124) were given identical questionnaire packages with the exception of the label used. That is, each participant received a set of questionnaires that referred to only one of the five labels. The questionnaire package contained various quantitative measures of attitudes and social distance, in addition to a short qualitative measure.

**RESULTS:** Analyses demonstrated equivalence among the four general psychiatric labels on measures of attitudes, social distance, and general perceptions. However, results also suggested that the general labels diverged from the depression label, with the latter being generally more negatively perceived. Some analyses demonstrated that participants' understanding of the terminology might be incorrect. The results of the investigation are discussed with a focus on its relationship with current research in stigma.

**CONCLUSION:** Within the current sample, general psychiatric labels did not appear to distinguish themselves from each other on measures of attitude and social distance but did so when compared to a relatively more specific term. Future research should examine the underlying mechanism driving this finding, with the ultimate goal of reducing the stigma faced by those with mental disorders.

Tamblyn R, Abrahamowicz M, Dauphinee D, Wenghofer E, Jacques A, Klass D, Smee S, Egualé T, Winslade N, Girard N, Bartman I, Buckeridge DL, Hanley JA (2010). **Influence of Physicians' Management and Communication Ability on Patients' Persistence With Antihypertensive Medication.** *Arch Intern Med* 170(12): 1064-1072. <http://archinte.jamanetwork.com/article.aspx?articleid=416089>

**BACKGROUND:** Less than 75% of people prescribed antihypertensive medication are still using treatment after 6 months. Physicians determine treatment, educate patients, manage side effects, and influence patient knowledge and motivation. Although physician communication ability likely influences persistence, little is known about the importance of medical management skills, even though these abilities can be enhanced through educational and practice interventions. The purpose of this study was to determine whether a physician's medical management and communication ability influence persistence with antihypertensive treatment.

**METHODS:** This was a population-based study of 13 205 hypertensive patients who started antihypertensive medication prescribed by a cohort of 645 physicians entering practice in Quebec, Canada, between 1993 and 2007. Medical Council of Canada licensing examination scores were used to assess medical management and communication ability. Population-based prescription and medical services databases were used to assess starting therapy, treatment changes, comorbidity, and persistence with antihypertensive treatment in the first 6 months.

**RESULTS:** Within 6 months after starting treatment, 2926 patients (22.2%) had discontinued all antihypertensive medication. The risk of nonpersistence was reduced for patients who were treated by physicians with better medical management (odds ratio per 2-SD increase in score, 0.74; 95% confidence interval, 0.63-0.87) and communication (0.88; 0.78-1.00) ability and with early therapy changes (odds ratio, 0.45; 95% confidence interval, 0.37-0.54), more follow-up visits, and nondiuretics as the initial choice of therapy. Medical management ability was responsible for preventing 15.8% (95% confidence interval, 7.5%-23.3%) of nonpersistence.

**CONCLUSION:** Better clinical decision-making and data collection skills and early modifications in therapy improve persistence with antihypertensive therapy.

Tang B, Jamieson E, Boyle M, Libby A, Gafni A, MacMillan H (2006). **The influence of child abuse on the pattern of expenditures in women's adult health service utilization in Ontario, Canada.** *Soc Sci Med.* 2006 Oct;63(7):1711-9. Epub 2006 Jun 21. <http://www.ncbi.nlm.nih.gov/pubmed/16793185>

Childhood maltreatment is a common and serious problem for women, particularly in relation to impairment in adulthood. To our knowledge, no system-wide study has addressed the influence of childhood maltreatment on the cost of these women's adult health service utilization. This paper examines this relationship. The 1990 Ontario Health Survey (OHS) gathered information regarding determinants of physical health status and the use of health services. The 1991 Ontario Mental Health Supplement (OHSUP) examined a variety of childhood experiences as well as the prevalence of psychiatric disorders from a sample of OHS respondents. These were province-wide population health surveys of a probability-based sample of persons aged 15 years and older living in household dwellings in Ontario. The OHSUP randomly selected one member from each participating OHS household to be interviewed regarding personal experiences and mental health. This analysis used data from women aged 15-64 who participated in both the OHS and OHSUP. Self-reported health service utilization was collected in four groups of women--those who reported no history of child abuse, those with a history of physical abuse only, those who reported sexual abuse only, and those who reported both physical and sexual (combined) abuse. We hypothesized that a history of child abuse would result in greater adult health care costs. The results indicated that having a history of combined abuse nearly doubles mean annual ambulatory self-reported health care costs to 775 dollars (95% CI 504 dollars-1045 dollars) compared to a mean cost of 400 dollars with no abuse (95% CI 357 dollars-443 dollars). Median annual ambulatory self-reported health care costs were also increased in the combined abuse group, to 314 dollars (95% CI 220 dollars-429 dollars), compared to 138 dollars (95% CI 132 dollars-169 dollars) in those with no abuse. We conclude that child abuse in women is significantly associated with increased adult self-reported health care costs.



Tervalon M, Murray-Garcia J (1998). **Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education.** *J Health Care Poor Underserved.* 1998 May;9(2):117-25. <http://www.ncbi.nlm.nih.gov/pubmed/10073197>

Researchers and program developers in medical education presently face the challenge of implementing and evaluating curricula that teach medical students and house staff how to effectively and respectfully deliver health care to the increasingly diverse populations of the United States. Inherent in this challenge is clearly defining educational and training outcomes consistent with this imperative. The traditional notion of competence in clinical training as a detached mastery of a theoretically finite body of knowledge may not be appropriate for this area of physician education. Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

Thompson-Brenner H, Satir DA, Franko DL, Herzog DB (2012). **Clinician reactions to patients with eating disorders: a review of the literature.** *Psychiatr Serv.* 2012 Jan;63(1):73-8. <http://www.ncbi.nlm.nih.gov/pubmed/22227763>

**OBJECTIVE:** The delivery of psychiatric services may be affected by clinicians' negative reactions to treatment-resistant or stigmatized patient groups. Some research has found that clinicians across professional disciplines react negatively to patients with eating disorders, but empirical data related to this topic have not been systematically reviewed. The authors sought to review all published empirical studies of clinician reactions to patients with eating disorders in order to characterize negative reactions to these patients and identify patient or clinical factors associated with negative reactions.

**RESULTS:** Twenty studies, published between 1984 and 2010, were found. Clinician negative reactions in regard to patients with eating disorders typically reflected frustration, hopelessness, lack of competence, and worry. Inexperienced clinicians appeared to hold more negative attitudes toward patients with eating disorders than toward other patient groups, but experienced psychotherapists did not experience strong negative reactions to patients with eating disorders. Medical practitioners consistently reported strong feelings of lack of competence in treating eating disorders. Negative reactions to patients with eating disorders were associated with patients' lack of improvement and personality pathology and with clinicians' stigmatizing beliefs, inexperience, and gender.

**CONCLUSIONS:** Research about the impact of negative clinician attitudes toward patients with eating disorders on psychiatric service delivery, including multivariate analyses using larger samples, comparison groups, validated instruments, and experimental methods, is much needed.

Thornicroft G, Rose D, Kassam A (2007). **Discrimination in health care against people with mental illness.** *International Review of Psychiatry,* April 2007; 19(2): 113–122. <https://meded.duke.edu/practice/wp-content/uploads/2012/05/ainstPeoplewithMentalHealthIllness-IntlReviewofPsych20071.pdf>

This paper discusses factors associated with low rates of help-seeking and poorer quality of physical healthcare among people with mental illnesses. Evidence is reviewed on the associations between low rates of mental health literacy, negative attitudes towards people with mental illness, and reluctance to seek help by people who consider that they may have a mental disorder. People with mental illness often report encountering negative attitudes among mental health staff about their prognosis, associated in part with 'physician bias'. 'Diagnostic overshadowing' appears to be common in general health care settings, meaning the misattribution of physical illness signs and symptoms to concurrent mental disorders, leading to underdiagnosis and mistreatment of the physical conditions.

Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D, Koschorke M, Shidhaye R, O'Reilly C, Henderson C (2016). **Evidence for effective interventions to reduce mental-health-related stigma and discrimination.** *The Lancet* Volume 387, No. 10023, p1123–1132, 12 March 2016.  
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00298-6/fulltext?rss%3Dyes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00298-6/fulltext?rss%3Dyes)

Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves. Most medical literature in this area of research has been descriptive and has focused on attitudes towards people with mental illness rather than on interventions to reduce stigma. In this narrative Review, we summarise what is known globally from published systematic reviews and primary data on effective interventions intended to reduce mental-illness-related stigma or discrimination. The main findings emerging from this narrative overview are that: (1) at the population level there is a fairly consistent pattern of short-term benefits for positive attitude change, and some lesser evidence for knowledge improvement; (2) for people with mental illness, some group-level anti-stigma inventions show promise and merit further assessment; (3) for specific target groups, such as students, social-contact-based interventions usually achieve short-term (but less clearly long-term) attitudinal improvements, and less often produce knowledge gains; (4) this is a heterogeneous field of study with few strong study designs with large sample sizes; (5) research from low-income and middle-income countries is conspicuous by its relative absence; (6) caution needs to be exercised in not overgeneralising lessons from one target group to another; (7) there is a clear need for studies with longer-term follow-up to assess whether initial gains are sustained or attenuated, and whether booster doses of the intervention are needed to maintain progress; (8) few studies in any part of the world have focused on either the service user's perspective of stigma and discrimination or on the behaviour domain of behavioural change, either by people with or without mental illness in the complex processes of stigmatisation. We found that social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes in the short term. However, the evidence for longer-term benefit of such social contact to reduce stigma is weak. In view of the magnitude of challenges that result from mental health stigma and discrimination, a concerted effort is needed to fund methodologically strong research that will provide robust evidence to support decisions on investment in interventions to reduce stigma.

Trauma Informed Oregon (2015). **Standards of Practice for Trauma Informed Care.** Portland State University, October 2015. <http://traumainformedoregon.org/wp-content/uploads/2014/10/Standards-of-Practice-for-Trauma-Informed-Care.pdf>

The following Standards of Practice for Trauma Informed Care in Oregon are based on nationally recognized principles of trauma informed care (TIC) and are in alignment with SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL (2013). **Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review.** *Drug and Alcohol Dependence* July 1, 2013 Volume 131, Issues 1-2, Pages 23–35.  
[http://www.drugandalcoholdependence.com/article/S0376-8716\(13\)00067-7/abstract?cc=y](http://www.drugandalcoholdependence.com/article/S0376-8716(13)00067-7/abstract?cc=y)

**BACKGROUND:** Healthcare professionals are crucial in the identification and accessibility to treatment for people with substance use disorders. Our objective was to assess health professionals' attitudes towards patients with substance use disorders and examine the consequences of these attitudes on healthcare delivery for these patients in Western countries.

**METHODS:** Pubmed, PsycINFO and Embase were systematically searched for articles published between 2000 and 2011. Studies evaluating health professionals' attitudes towards patients with substance use disorders and consequences of negative attitudes were included. An inclusion criterion was that studies addressed alcohol or illicit drug abuse. Reviews, commentaries and letters were excluded, as were studies originating from non-Western countries.

**RESULTS:** The search process yielded 1562 citations. After selection and quality assessment, 28 studies were included. Health professionals generally had a negative attitude towards patients with substance use disorders. They perceived violence, manipulation, and poor motivation as impeding factors in the

healthcare delivery for these patients. Health professionals also lacked adequate education, training and support structures in working with this patient group. Negative attitudes of health professionals diminished patients' feelings of empowerment and subsequent treatment outcomes. Health professionals are less involved and have a more task-oriented approach in the delivery of healthcare, resulting in less personal engagement and diminished empathy.

**CONCLUSIONS:** This review indicates that negative attitudes of health professionals towards patients with substance use disorders are common and contribute to suboptimal health care for these patients.

However, few studies have evaluated the consequences of health professionals' negative attitudes towards patients with substance use disorders.

van Dulmen S, van den Brink-Muinen A (2004). **Patients' preferences and experiences in handling emotions A study on communication sequences in primary care medical visits.** *Patient Educ Couns.* 2004 Oct;55(1):149-52. <https://www.ncbi.nlm.nih.gov/pubmed/15540370>

Varas-Díaz N, Neilands TB, Rodríguez-Madera SL, Padilla M (2016). **The role of emotions in the reduction of HIV/AIDS stigma among physicians in training.** *AIDS Care.* 2016 Mar;28(3):376-83. doi: 10.1080/09540121.2015.1090537. Epub 2015 Oct 7. <http://www.ncbi.nlm.nih.gov/pubmed/26444133>

Scientific literature has systematically documented the negative effects of social stigma for people living with HIV/AIDS (PLWHA). HIV/AIDS stigma has the potential to negatively impact self-care strategies for those already affected, and simultaneously hinder prevention efforts to deter the emergence of new infections. When health professionals manifest these negative attitudes access to quality health-care and prevention strategies can be seriously affected. Scientifically tested interventions to reduce HIV/AIDS stigma among health professionals are still scarce. Although the number of tested interventions has increased over the past decade, few of them target Latino health professionals or Spanish-speaking populations. Furthermore, although some of those interventions have been reported as effective for stigma reduction, more work is needed to better understand the underlying variables that account for the reduction of stigma attitudes in those efforts. The SPACES intervention has been documented as an effective HIV/AIDS stigma-reduction intervention focusing on health-care professionals in training. The intervention, which is delivered in Spanish, has been previously tested with medical students in Puerto Rico and shown significant results in addressing negative attitudes toward PLWHA. The main objective of this study was to document the underlying variables that fostered reduction of HIV/AIDS stigma due to participation in the SPACES intervention. Results evidence that health professionals in training who participated in the intervention (n = 507) had less stigmatizing attitudes toward PLWHA due to an increase in their positive emotions toward this population. In light of these results, we discuss the importance of engaging health professionals in HIV/AIDS stigma-reduction interventions that go beyond the provision of information and skills for interacting with PLWHA, and address the emotional component of HIV/AIDS stigma.

Verheul W, Sanders A, Bensing J (2010). **The effects of physicians' affect-oriented communication style and raising expectations on analogue patients' anxiety, affect and expectancies.** *Patient Educ Couns.* 2010 Sep;80(3):300-6. doi: 10.1016/j.pec.2010.06.017. Epub 2010 Jul 17. [http://www.pec-journal.com/article/S0738-3991\(10\)00379-4/abstract](http://www.pec-journal.com/article/S0738-3991(10)00379-4/abstract)

**OBJECTIVE:** Patients' affect and expectancies can set off placebo effects and thus impact patients' health. We assessed the relative effects of physicians' affect-oriented communication style and raising expectations on patients' affective state and outcome expectancies.

**METHOD:** Thirty healthy women presented severe menstrual pain in a scripted consultation with a general practitioner (GP). In a 2x2 randomized controlled trial, the GP communicated in a warm, empathic or cold, formal way and raised positive or uncertain expectations. Effects on subjects' state anxiety, affective state and outcome expectancies were assessed.

**RESULTS:** Only warm, empathic communication combined with positive expectations led to a significant and relevant decrease in state anxiety. Subjects' positive and negative affects were influenced by GPs affect-oriented communication style. Negative affect and outcome expectancies are influenced by GP suggestions about outcomes.

**CONCLUSION:** Manipulations in physicians' affect-oriented and expectancy-related communication can have a large impact on patients' affective state and outcome expectations. A combination of a warm, empathic communication style and raising positive expectations resulted in optimal subject outcomes. **PRACTICE IMPLICATIONS:** Physicians should take into account that communicating in warm, empathic way combined with raising positive expectations seems to lead to the most favorable effects on patients' state anxiety and outcome expectancies.

Vickers MH (2012). **"For the Crime of Being Different..."**. *Employee Responsibilities and Rights Journal* 24, 177-195. <http://link.springer.com/article/10.1007%2Fs10672-011-9186-y#/page-1>

The literature is largely silent on how workers with Multiple Sclerosis (MS), or any disability or stigmatising trait, might experience working in teams. It is argued here that working in a team sharpens the likelihood and experience of the stigmatisation process because of uncritical assumptions made in workplaces about the benefits of teams and team processes, combined with managerialist pressures on team members to perform. I theorise a single phenomenological case study: one woman's lived experience of working in a team as a process of stigmatisation after her diagnosis of MS. It is recommended that workplaces rethink their expectations and approaches to working in teams, especially for those with MS or any other stigmatising trait, to ensure a more comfortable and constructive workplace environment for all, and to reduce the potential for premature departures from work for those stigmatised.

Wakeman S (2016). **Words matter: The language of addiction and life-saving treatments**. *Harvard Health Blog*, Aug. 15, 2016. <http://www.health.harvard.edu/blog/words-matter-language-addiction-life-saving-treatments-2016081510130>.

News articles, radio, and television frequently report on the current opioid crisis. As the death toll has mounted, the media has importantly covered many aspects of the crisis. Unfortunately, this coverage often focuses on the very visible individuals who continue to struggle with active addiction. What is missing is a narrative of hope for a chronic disease which is as treatable as diabetes or high blood pressure.

Wariki WMV, Nomura S, Ota E, Mori R, Shibuya K (2013). **Interventions for reduction of stigma in people with HIV/AIDS**. *Cochrane Database of Systematic Reviews* 2013, Issue 6. Art. No.: CD006735. DOI: 10.1002/14651858.CD006735.pub2. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006735.pub2/full>

This is the protocol for a review and there is no abstract. The objectives are as follows: 1. To assess the effectiveness of interventions to reduce stigma towards people living with HIV/AIDS, improve coping strategies and increase tolerance, compared with a control group. 2. To assess the most effective form of interventions to reduce stigma towards people living with HIV/AIDS, improve coping strategies and increase tolerance, compared with a control group.

Werner A, Malterud K (2005). **"The pain isn't as disabling as it used to be": How can the patient experience empowerment instead of vulnerability in the consultation?** *Scandinavian Journal of Public Health*, 33(Suppl 66): 41-46. [http://sjp.sagepub.com/content/33/66\\_suppl/41](http://sjp.sagepub.com/content/33/66_suppl/41)

**AIM:** This study explores how doctors can help patients transform vulnerability into strength, instead of increasing a feeling of disempowerment.

**METHODS:** The authors analysed their findings from four previously written articles based on qualitative interviews with 10 women with chronic pain, comparing the reported negative consultation experiences with the beneficial effects of good treatment experiences, in order to identify potentials for change.

**RESULTS:** Altering the way in which the women are encountered may empower and help them deal with a painful life. Doctors can challenge stereotyped macrostructures of women's "unexplained" pain as hysteria by admitting the shortcomings of medical knowledge. The blame is then put on the medical discipline instead of the individual patient who presents bodily symptoms or reveals help-seeking behaviour that does not fit with biomedical expectations of what illness is and how it should be performed. Thus, the vulnerable position described by the patients can be converted or transformed into strength or resources in spaces that promote empowerment through recognition.



CONCLUSION: Although doctors may feel helpless or puzzled in the consultation, they must take the responsibility for turning the consultation into a space for empowerment of the patient.

White Hughto JM, Reisner SL, Pachankis JE (2015). **Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions.** *Soc Sci Med.* 2015 Dec;147:222-31. <http://www.sciencedirect.com/science/article/pii/S0277953615302185>

This review demonstrates that transgender stigma limits opportunities and access to resources in a number of critical domains (e.g., employment, healthcare), persistently affecting the physical and mental health of transgender people. The applied social ecological model employed here elucidates that transgender stigma operates at multiple levels (i.e., individual, interpersonal, structural) to impact health. Stigma prevention and coping interventions hold promise for reducing stigma and its adverse health-related effects in transgender populations.

Wolitski RJ, Pals SL, Kidder DP, Courtenay-Quirk C, Holtgrave DR (2009). **The Effects of HIV Stigma on Health, Disclosure of HIV Status, and Risk Behavior of Homeless and Unstably Housed Persons Living with HIV.** *AIDS Behav* 13:1222–1232. <http://www.ncbi.nlm.nih.gov/pubmed/18770023>.

Stigma was strongly associated with poorer self-assessed physical and mental health, and perceived external stigma was associated with recent nonadherence to HIV treatment. Perceived external stigma was associated with decreased HIV disclosure to social network members, and internal stigma was associated with drug use and non-disclosure to sex partners.

Yagil D, Shnapper-Cohen M (2016). **When authenticity matters most: Physicians' regulation of emotional display and patient satisfaction.** *Patient Educ Couns.* 2016 Apr 11. pii: S0738-3991(16)30155-0. doi: 10.1016/j.pec.2016.04.003. [Epub ahead of print]. <http://www.ncbi.nlm.nih.gov/pubmed/27085519>

OBJECTIVE: The emotions expressed by physicians in medical encounters have significant impact on health outcomes and patient satisfaction. This study explored how physicians' regulation of displayed emotions affects patients' satisfaction, under low and high levels of patient distress and length of physician-patient acquaintance.

METHODS: Questionnaires were administered to 46 physicians and 230 of their patients (before and after the medical encounter) in outpatient clinics of two hospitals.

RESULTS: Data were analyzed with hierarchical linear modeling which takes the nested data structure into account. We found a significant interaction effect of physician regulation of displayed emotions and patient distress on satisfaction: When distress was high, physician regulation of emotions was negatively related to patient satisfaction. The results also show a significant interaction effect of physician regulation of displayed emotions and length of physician-patient acquaintance: With a longer acquaintance, physician regulation of emotions was negatively related to patient satisfaction.

CONCLUSION: The effect of the physicians' emotional display on patient satisfaction depends on contextual factors, such as patient distress and length of physician-patient acquaintance, which affect patients' emotional needs and expectations.

PRACTICAL IMPLICATIONS: When patients have high emotional involvement in the encounter it is suggested that physicians consider presenting genuine emotions to patients.