The top of the book pile

This very scholarly work provides a thorough analysis and useful framework to address the “suburban housewife syndrome”. Various forces conspired to interfere with the development of women the generation of my grandmothers. The author correlates sexual harassment/trauma with the hostility from men towards women as a result of corporate downsizing. Men were editors of women’s magazines. Girls were encouraged to look prettier than smart, and to make their quest of a good husband their life goal. Teenage girls were encouraged to marry early as the “occupation: housewife” was glorified; but their education and emancipation suffered. Advertisement creating the image of a “happy housewife” has been driven by the corporate world (for instance, the appliances industry). Freud’s perception of women as “infantile” didn’t encourage women development (and in my mind, it perpetuated oppressive attitudes and micro-aggressions). Written over 50 years ago, it is quite topical. According to Betty Friedan, self-fulfillment is the remedy to a lot of our stay-at-home mothers’ despair, emptiness and disempowerment. I am concerned about the stay-at-home mother who feels trapped to keep her abusive spouse’s health insurance... (another reason to advocate for universal health care instead of tying health benefits to the capricious fluctuations of certain employment situations). Offspring also benefits from parents who do not live vicariously through them. The author even states that self-realized women have a more satisfying sexual life! Which also means happier partners... A powerful, enlightening read. For all women. And men.


The masks of PTSD

How many patients did you have with the chief complaint of ADD this past week? How many of them screened positive for past trauma? Has ADHD become an idiom of distress, a script to express a need for care while at the same time a convenient way to avoid broaching the topic of trauma? While there are certainly legitimate cases of this complex neurodevelopmental disorder, the differential of seemingly ADD symptoms should include the following:
• Dissociation (freeze response) and hyperarousal look like ADHD or defiance.¹

• Aggression and impulsivity (fight or flight response) could present as ODD or ADHD¹; belligerence could also look like mania or hypomania.

Remember: stress in general can interfere with proper executive function. Toxic stress in childhood affects the developing architecture of the brain, subsequent disorganization in brain systems, and can cause chronic difficulties in mood regulation or even executive functioning with lifelong consequences for mental health.²

Source:

Life review

Aging and solitude seem to be intertwined. But socialization is an important ingredient to brain health (it decreases risks of depression and dementia or delays their onset). But friends do not always appear at the strike of a magical wand. What is left for people whose network is shrinking during the cycle of life?

After a small randomized control trial, authors concluded that an 8-week MBSR program may reduce perceptions of loneliness in older adults, which is a well-known risk factor for morbidity and mortality in aging populations (Hawkley and Cacioppo, 2010). Second, consistent with previous reports (Cole et al., 2007, 2011), the authors found that loneliness is associated with up-regulated expression of pro-inflammatory genes in circulating leukocytes, and that MBSR can significantly down-regulate the expression of inflammation-related genes in parallel with reductions in loneliness.

In other words, it seems like mindfulness can make the loneliness more bearable by developing intra-personal attunement, a useful tool as people grow older and accumulate interpersonal losses (become your own best friend !). As we all know, mindfulness can be practiced in any situation; even reminiscing should be practiced mindfully to prevent overwhelming nostalgia.

Source:
Wellness

As a profession, physicians are at equal risk for depression and higher risk for suicide than that of the general population. Roughly a quarter to a third of physicians in retaining reported experiencing significant depressive symptomatology at any point in time. The prevalence is unacceptably high in our helping profession. Studies among medical students and residents have demonstrated that burnout, a different but closely related construct to depression, is associated with:

- More cheating on examinations
- Lying about clinical data
- Medical errors
- Ethical lapses
- Less altruistic and compassionate care.

The author listed three categories of proposed solutions:

1. Provide appropriate medical and mental health care to all members of the medical profession.
2. Modify the training environment and system thought to contribute to poorer mental health.
3. Consider the possibility that the medical training system needs more fundamental change.

It seems like the structure and expectations of training programs need to take into account the dramatic transformations, not to say aberrations of our modern medical system. I agree with the author who listed the following features:

- Life-prolonging and life-creating technologies that lead to unsolvable ethical dilemmas;
- Risk-based reimbursement strategies that limit the opportunities for patient engagement;
- EMR and documentation requirements that lead to inaccurate and sometimes dangerous shortcuts;
- Malpractice exposure;
- Short hospital lengths of stay and protocol-driven procedural care limiting opportunity for thinking and learning;
- Direct-to-consumer advertising that causes patients to demand medications for conditions they sometimes do not even have;
- On-line ratings of physician performance;
- Training system for residents and fellows disconnected from that of the medical students, interfering with a continuum of progressive learning objectives and professional growth;
- Clinical productivity pressures incompatible with processing and healing from traumatic experiences.

Source: Schwenk TL, Resident Depression – The Tip of a Graduate Medical Education Iceberg. JAMA. 2015;314:2357-2358
**Dr Grandma’s trauma-informed toolkit**

Since patients who have suffered trauma have hyperreactive stress response systems, their sensitivity can also apply to interoceptive stimuli (such as body sensations, or symptoms) just like exteroceptive triggers (noise, bright lights, strong smells…) can create a seemingly disproportioante knee-jerk reaction. Therefore, it is indicated to start a new medication at a lower dose (I usually cut the starting dose from Stahl in half, even if only for a few days. It is more gradual, and gentler on the body). Some patients can experience traumatic reactivation if the side effects are too intense (nausea, dizziness, tremor can me reminiscent of panic attacks, and they might misinterpret such reactions as signals of threat). Remember, being sensitized makes them more sensitive to and vigilant about side effects, just like with other (environmental) triggers.

**Career-building opportunities:**

We are pleased to announce a new elective for third-year residents while at BHC:

**Recovery program for survivors of trauma**

Supervisors: Caroline Giroux/Andrés Sciolla

Availability: 1 resident for 2018-2019, half a day per week (potentially 2 thereafter)

Application: interest letter (about 500 words)

Submission deadline: April 30th 2018

(Questions? Contact Dr Giroux, Dr Sciolla or Dr Pakyurek)