The minute of gratitude

For this festive season, I would like to take this opportunity to thank all of you, dear residents, for your role within our department. With your alert and inquisitive minds, you energize us, “oldies”, and you help maintain the flame alive. Thank you to all my colleagues and our support staff whose dependability and diligence allow us to provide excellent care and to engage in scholarly projects.

Saying “thank you” feels good and practicing gratitude on a regular basis is a form of auto-therapy. I invite you to find that space of gratitude throughout the winter as you celebrate whatever is meaningful to you and your loved ones. Dear readership, I am thankful for participating in your training.

Happy Thanksgiving!

Dissociative mechanisms (or life on “pause”)

Dissociative disorders, characterized by loss of sensations and motor control are often related to sexual abuse, emotional neglect or abuse. Severe trauma would be an important mechanism underlying somatoform and psychoform dissociation. Nijenhuis referred to somatoform dissociation as dissociative symptoms that involve the body and comprise reduction up to complete loss of sensory perception and/or loss of motor control (negative somatoform dissociation) as well as involuntary perception of sensory (e.g., prickling), motor (e.g., tremor) and/or pain (positive somatoform dissociation). Psychoform dissociation phenomenologically involves the mind and pertains to disrupted mental processes such as consciousness, memory, identity and emotion and manifests in amnesia, depersonalization, derealization or out-of-body experiences. Peri-traumatic (mainly psychoform) dissociation and physiological components (e.g., fainting) may foster later PTSD development. The authors explain a defense cascade:
1- Existential threat prompts excessive physiological arousal ("fight/flight" responses);
2- Lack of escape options turns into a "freeze", or shutdown, response.

Fainting and immobility (freeze response) are manifestations of vagal dominance and can represent a somatoform type of dissociation. Alexithymia, the inability to perceive and verbally express emotions, was reported to be a predictor of adult psychoform dissociation. It was also found to predict suicidal attempt in veterans diagnosed with PTSD. Among the patients with PTSD who were part of the study, alexithymia was also positively related to somatoform dissociative symptoms, which might reflect the learned attribution of feelings to somatic sensations. Recent research found evidence for a depressive subtype of PTSD that is associated with greater dissociative experience.

In sum, dissociation is an adaptive response to trauma. It also demonstrates how neglect can be as traumatic (if not more) as abuse. For instance, ignoring or invalidating the distress in a child might make him/her switch to vagal responses (freeze or dissociation) which will later become the preferred mode of coping with stress. Because of the diversity of its presentations (neurological, awareness, memory...) and systems affected (positive or negative somatoform, versus psychoform), dissociation is frequently missed. Somatization tendencies in our patients who have suffered trauma could very well be dissociative manifestations. Keeping this in mind at all times will likely transform our approach of many medical symptoms and make sure we remain trauma-informed.

Source:


Dr Grandma’s trauma-informed toolkit

Trauma is an event that shatters an individual’s sense of safety and overwhelms his/her adaptation mechanisms. Elder abuse is insufficiently discussed in the literature despite the disproportionate risks for (poly)victimization that many older adults may face. Thus far, research in young people has revealed that:

1- The impact of trauma is cumulative;
2- Victims of interpersonal violence are disproportionately likely to be re-victimized.

Hence, the statistical likelihood for re-victimization grows for older adults. Work with older adults must also consider historical trauma; slavery, colonialism (e.g., the boarding school experiences of Native North Americans), genocide (e.g., the Holocaust), racism, ableism create lasting ripple effects for individuals, families and communities. Older adults may carry victim-blaming attitudes due to early
socialization experiences. Also, when harmed by loved ones, they may experience more psychosocial trauma than peers harmed by strangers or paid care providers.

Signs of trauma can be confused with physical and mental health conditions or the PTSD symptoms may be masked by other diagnoses.

Hospitalizations and illness have been observed to precipitate traumatic responses in older adults\(^1\). Also, being given the wrong or excessive medications is often perceived as a severe trauma by elderly adults (My rule of thumb: cut Stahl’s recommended starting dose in HALF in all patients, even if only for a couple of days. I found this to be gentler on the body!).

Here are some additional suggestions for providing victim-centered care\(^1\):

1. Spend time with the alleged victims before involved providers, family members, alleged perpetrators etc.
2. Listen before you speak.
3. Honor the older adult’s “no”.
4. Reflect the language an older adult uses
5. Ask older adults about their goals and strengths before asking about their challenges.
6. Acknowledge abuse disclosures without expressing horror, disbelief or opinions about the perpetrator.
7. Be prepared to have victims miss or forget appointments as trauma interferes with sense of time.
8. Follow the sensory details the person remembers; the body remembers trauma where the brain cannot.
9. Do not push for details if the victim cannot remember or find language for certain elements. Inability to remember can have a protective function.
10. Reframe maladaptive coping as normal and hardwired responses to recurrent toxic stress and signs of adaptability and survival skill. Offer tools to develop beneficial coping skills.
11. Recognize that physical, mental, emotional and spiritual safety for providers is the foundation of trauma-informed care for victims.

Source:


**Did you know...**

Withdrawal, agitation, memory loss, difficulty with problem-solving, disorientation, aggression, insomnia and clingy or childlike behavior may all be signs of both dementia and trauma in older adults.
Your input matters

Your direct patient care experience on a daily basis is a gold mine of scenarios to continue to improve practices. I am sure many of you have witnessed unideal clinical encounters within our field or while interacting with other specialties. Since there are educational activities currently developed to facilitate the integration of trauma-informed principles, I would welcome ideas of situations that could be used to continue to educate ourselves and the future generations of doctors. This week, I will leave a suggestion box at BHC, in room 120 (on the black file folder) and I will check it on a weekly basis. You can use it for any feedback you have regarding this leaflet. Alternatively, you can email me your suggestions (announcements or submissions of summaries of articles are always appreciated) or let me know in person.

Be a trauma-informed care ambassador!

- Emulate patient-centered care by practicing universal trauma precautions;

- Disseminate the knowledge about this strength-based framework within our institution and in the community.

With the ongoing threat that gun violence poses on the wellbeing of all people living on this soil, I would like to address this issue in our next edition. If you would like to share your reflections or a commentary, please email: cegiroux@ucdavis.edu

What is the solution:
More stringent gun laws? Deep culture shift? Both?