Resilience in Women Physicians

Saving Your Sanity Without Losing Your Soul

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Objectives

- Prevalence of Major Depression in Women Physicians
- Prevention & Early Intervention
- Treatment Strategies to Optimize Recovery & Remission
Resilience

- “The capacity to tolerate the effects of trauma exposure or successfully manage following a challenge or setback”
- An effective response to situational demands
- Ability to recover from negative/stressful experiences
- Ability to find positive meaning in seemingly adverse situations

(Green et al, J Clin Psych 2010)
Is the resilience model appropriate for physicians?
What is the lifetime prevalence of MDD in men?

A. 2-5%
B. 5-10%
C. 10-20%
D. 20-40%
E. 40-60%
What is the lifetime prevalence of MDD in male physicians?

A. 2-5%
B. 5-10%
C. 10-20%
D. 20-40%
E. 40-60%
Major Depression in Male Physicians

- Lifetime prevalence 10-20% (vs. 8-10% in non-MDs)
- Suicide risk approximately equal to non-physician men (36:100,000)

Kaplan & Sadock, 6th edition, 1995
JAMA Consensus Statement 2003: “Confronting Depression and Suicide in Physicians”
Levine & Bryant, 2000
What is the lifetime prevalence of MDD in women?

A. 2-5%
B. 5-10%
C. 10-15%
D. 15-20%
E. 20-40%
What is the lifetime prevalence of MDD in female physicians?

A. 2-5%
B. 5-10%
C. 10-15%
D. 15-20%
E. 20-50%
Major Depression in Female Physicians

- Lifetime Prevalence 20-50% (vs. 15-20% in non-MDs)
- Suicide Risk (41:100,000) is 3x greater than in non-MD women (12:100,000) and approximately equal to that of male MDs

Kaplan & Sadock, 6th edition, 1995
JAMA Consensus Statement 2003: “Confronting Depression and Suicide in Physicians”
North & Ryall 1997
Frank & Dingle, 1999
JAMA Consensus Statement 2003

- 19.5% self-identified depression from Women Physicians’ Health Study (ages 30-70, n=1500)
- 51% in Welner study of 111 female MDs in St. Louis in late 1970s (73% of female psychiatrists, 46% other female physicians) compared to 32% of the 103 female PhDs
Factors in Physician Depression

- Family History
- Work Hours/Demands
- Sleep deprivation is normal
- Culture in training and practice equating illness, asking for help, or taking time off with weakness
- Frequent “self-medication” with alcohol, other drugs
- Financial strain
- Relationship loss
- Job loss/malpractice threat/retirement
Challenges to Performance

- Level 1: Burnout
- Level 2: Distress
- Level 3: Illness
  - Major Depression (in unipolar MDD, or Bipolar II)
  - PTSD
  - Relapse of well-controlled OCD, GAD, Panic, ADD
  - Worsening of comorbid medical conditions
Level 1: Daily Burnout

- Mentally fatigued at the end of the day
- Feeling unappreciated, frustrated, bored, tense, or angry as a result of contact(s) with patients, colleagues, superiors, assistants, or others
- Physical symptoms
- Pace of day and/or requirements of present tasks seem greater than personal/professional resources available
- Required job tasks feel repetitious, beyond your ability, or require unsustainable continuous intensity

(Wicks, 2008)
Level 3: Major Depression

- Depressed or irritable mood most days (dread, decreased frustration tolerance) for at least 2 wks, more often months
- Anhedonia (loss of ability to feel pleasure)
- Low energy, Low interest, low motivation, low libido
- Cognitive impairment: slowed (executive functions/confidence/decision-making/multi-tasking)
- Changes in sleep & appetite, esp. early morning awakening, inability to sleep even when you’re exhausted, or inability to get up even when you’ve slept enough
- Negative & pessimistic view of self, people, and the future
- Thoughts of death or suicide (escape)
A Resilience/Threshold Model

- Resilience does not equal inability to get sick
- Genetic vulnerabilities or stress thresholds exist beyond which even highly resilient individuals may become ill
- Resilience should also include the ability to identify when you may be ill, get correct diagnosis, access aggressive treatment, and invest the time and resources needed to get remission from symptoms
- Don’t blame the physician with major depression for failing to be resilient
Fostering Resilience
Primary Prevention: Healthy

- Keep up your good habits.
- Maintain a healthy support network and spiritual life.
- Prepare for transitions.

www.AuthenticHappiness.org

- Martin Seligman PhD at Penn: Positive Psychology
- Do the 240-question VIA scale (10 min.)
  - Identifies your top character strengths; goal is to find a way to use them more often
Prevention if Burnout looms

- Correct cognitive errors: recognize when you exaggerate or personalize situations in an inappropriate/negative way
- Have a variety of activities in your daily schedule
- Get enough rest, good nutrition, exercise
- Incorporate meditation/quiet reflection in daily schedule
- Interact with supportive friends regularly
- Be assertive
- Know and use professional/self-help literature on stress management

(Wicks, 2008)
Common Therapy Themes in Women Physicians

- Clarifying priorities
- Change job/hours/commitments
- Re-evaluate relationships
- Assertiveness training
- Learning to say NO
- Grief and loss
- Coming to terms with strengths and vulnerabilities
If Illness Strikes (or Strikes Back)

- Major Depression, Bipolar I or II, OCD, GAD?
  - Identify your resources
  - Find a smart and friendly psychiatrist
  - Be honest, not stoic
  - Target remission, then maintain remission
  - Don’t quit medications or psychotherapy unilaterally: stay the course
Barriers to Treatment

- Difficulty of getting/receiving/affording appropriate & confidential psychiatric care
- Fears about licensure
- Fears about insurability
- Time
- Denial
- Curbside consults/colleague prescribing
- Self-treatment/samples
Aggressive Treatment for MDs

- Don’t self-medicate with meds or alcohol/drugs.
- Get a good psychiatrist. Higher doses, target remission, evaluate for other psychiatric or medical disorders.
- Regular sleep at consistent times matters.
- Don’t forget psychotherapy:
  - Individual: meds don’t change habits or stuck patterns of thought & behavior, don’t resolve grief or trauma
  - Couples/Family: repairing damage done during the depression, changing unhealthy relationships
Med Suggestions

- Consistent schedule with insomnia?
  - Paroxetine, nortriptyline, mirtazapine
- Rotating schedules?
  - Fluoxetine (very long half-life)
  - Buproprion SR, sertraline, citalopram at morning equivalent
- Partial remission with max dose SSRI?
  - Augment with buproprion, l-methylfolate, atypicals
- Failed multiple SSRI trials?
  - Try buproprion unless severe anxiety or panic attacks
  - Try nortriptyline (NRI)
  - Try an SNRI
- Recurrent 3x+?
  - Augment with lithium (12-hr level 0.4-0.8)
Special Challenges for Women

- Pregnancy
- Postpartum Period
- Breastfeeding
- Perimenopause

www.womensmentalhealth.org (MGH Center for Women’s Mental Health)
The Working Woman’s Pregnancy Book (Greenfield)
Pregnancy and Antidepressants

- High risk of relapse if meds are stopped
  - 68% vs. 26%
- Possible risk with 1st trimester exposure
  - Paroxetine, bupropion (cardiac)
- Possible PPHN risk with SSRI exposure 20+ weeks
  - 0.3% vs. 0.12%
- Possible neonatal adaptation syndrome in 20-25%
  - SSRIs, SNRIs (but Prozac has long half-life)
- Doubtful increased risk of autism spectrum disorders compared to high genetic risk
Postpartum Depression

- PPD rates
  - 20% of first-time moms
  - 33% if prior hx of major depression
  - 50% if prior hx of postpartum depression

- Prevention Strategies
  - Sleep! Goal at least 4h uninterrupted stretches ASAP
  - Supportive partner, confidante may be protective
  - Identify support group BEFORE delivery
Breastfeeding

- Safety in breastfeeding
  - SSRIs appear safe
  - Consider short half-life meds ie sertraline, paroxetine
- Pump & Dump Strategies
  - Stay flexible. Some breastfeeding may be better than no breastfeeding; formula can be your friend!
- Consider psychotherapy (CBT, IPT)
- Challenges with return to work: you need support to continue to pump/breastfeed
Perimenopause

- Mood, anxiety, cognitive, vasomotor symptoms
- Prior premenstrual or peripartum mood symptoms may be associated with increased risk of perimenopausal mood symptoms (ie “hormone-responsive mood disorders”)
- Please don’t rule out HRT
- Sleep disruption from vasomotor sx may contribute to psychiatric symptoms
- SSRIs, SNRIs may reduce all of the above sx
- Stimulants may contribute to irritability & mood cycling – ADD does not have adult onset!
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