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Editor

Wellness

As the theme of the APA meeting “Building Well-Being through Innovation” implied, there was a collection of talks on burnout and resilience. After sharing the recent, tragic news of a 4th-year female medical student who died by suicide, the speaker mentioned that upon entering medical school, students are considered more resilient than other fields. Six months later, they are far less resilient (whatever that means...?). What happened during those 6 months? According to the speaker, it could have something to do with grieving the ego ideal when confronted with talented, competitive classmates. I am wondering also how do they measure such resilience in medical students, and how do they define its decline? As a buffer to stress, the attendees were reminded of the importance of community to reconnect with what drew us to medicine. Creating a support group for physicians who are also mothers was given as a successful example by another speaker.

Matrescence

A very profound panel addressed the topic of “matrescence”, this multidimensional process of becoming a mother. Daniel Stern wrote about “the Motherhood Constellation”, the mother-related themes that emerge during pregnancy. The pregnant woman’s past and present relationship with her own mother, and also her idealized version or fantasies about motherhood become prominent themes. But if the woman’s own mother was absent or inadequate, her becoming pregnant or matrescence can be filled with conflict, not to say post-traumatic reactivation. She must face the reality of the demands of her changing body and role and might feel unprepared for that developmental transition. Difficulties in bonding with her own child often finds roots in her past, and if there was trauma (especially sexual), one can easily imagine how breastfeeding can be interfered with. Shifting her own view of the breast from prematurely sexualized to functional might be challenging. Understanding
the complexity of each woman’s matrescence is not only trauma-informed but adds an important psychodynamic perspective during the therapy process.

**Psychotherapies**

Otto Kernberg, the Viennese psychoanalyst who is famous for his objects relation theory and his work on narcissism, is still incredibly sharp at 89. He and his team revisited the borderline personality organization, a much broader concept than borderline personality and that reflects a very much needed trans-diagnostic treatment of patients with personality disorders. Within that framework, relationships are viewed in terms of need fulfillment. There is a question of abolishing each individual category and viewing personality pathology as part of a continuum of severity (bringing the obsessive-compulsive to conscientious, the narcissistic to self-confident, and the paranoid to vigilant). And Dr. Yeomans explained that the hybrid model in the DSM is a choice. The audience was also reminded of the importance of the transferential and countertransferential aspects. Transference-focused psychotherapy (TFP)* is evidence-based for borderline personality disorder and consists of 4 phases:

1. Comprehensive evaluation
2. Establishment of goals
3. Defining the structure (treatment contract) to attain behavioral control
4. Exploration (of the here and now and the transference).

*TFP does not focus on the past.

Identity integration and affect regulation are part of a “virtuous cycle” which TFP and other approaches are meant to enhance. Dr. Kernberg listed four other aspects of the approach:

a) Interpretation of dominant conflict
b) Transference analysis (to liberate the patient who is reenacting and stuck in patterns)
c) Technical neutrality (the therapist’s effort in staying out of the reenactment)
d) Counter-transference utilization (experiencing reactions about patient without acting on them).

**Treating Self and Interpersonal functioning**

Mother-child interventions

As we know, being raised by a parent with mental illness is an adverse childhood experience and can have lifelong impact of the person’s health by creating insecure or chaotic attachment styles. Borderline personality disorder is 35-70% “heritable”. Having a parent with borderline personality interferes also with the child’s development of emotion regulation (ER) skills because the signature of such a personality pathology (just like so many others) is emotional dysregulation. Not only the child
witnesses abnormal coping, but his/her intense affect can’t be regulated effectively and his/her own ER skills cannot be developed/reinforced by the dysregulated parent. So it is important to be aware of the transgenerational mechanism of risk for ER.

Four elements of ER presented by Dr. Stephanie Stepp:

- regulation of arousal
- labeling of emotions
- attentional and inhibitory control
- recognition and implementation of ER strategies

**Beyond exposure therapy for PTSD**

Even though exposure therapy (imaginal) is the first-line psychotherapy for PTSD, its attrition rate is 31%. Other options have been presented as acceptable, such as a combination of STAIR (Skills Training in Affective and Interpersonal Regulation) and narrative therapy developed by Marylene Cloitre, and interpersonal therapy (IPT), which domains (such as loss, transition etc) can intersect with the impact of trauma. Dr. Cloitre used the “resources loss model” by listing the 3 levels of losses associated with trauma:

1. Social: sense of connection to others
2. Emotional: ability to manage affective responses

In addition to the resolution of fear and the meaning-making, resource loss must be dealt with (it is a realistic component to address, especially when the patient doesn’t want to talk about trauma). IPT will help with the creation and/or utilization of a social network.

**Seclusion and restraints on trial**

Most of us would feel diminished or humiliated placed in seclusion and restraints. Imagine a patient with a history of trauma. One complained to a hospital administrator who, in turn, invited the patient to speak to a group of residents about how the experience made him feel. As a result, the patient felt empowered (and hopefully, the staff felt motivated to be more trauma-informed).

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You wrote an article, book review, QI project or a description of an innovative program? The Community Mental Health Journal might be interested in publishing your paper. And its acceptance rate is 49%.

https://link.springer.com/journal/10597
Trauma is prevalent and is at the core of a multitude of disease processes. Thinking about your career path, it is highly likely that you will be faced with the clinical impact of adverse life experiences, and research will need to expand to match the needs of our ill society. Therefore, to what capacity can you make a difference? Even though the extensive media coverage about natural or large scale disasters bring images a lot of people will associate with trauma, eliciting horror, a deep sense of hopelessness and also compassion, a lot of traumatic experiences happen in homes that might appear functional from the outside, and most of these trauma are preventable. Where will your contribution lie within such a broad field? Prevention, early identification, increasing mental health literacy (parenting support groups...), research, activism? For instance, we know that homelessness is both a consequence and a cause of sexual violence. How are we addressing social determinants of health such as poverty and access to care?

**Career-building reflections:**

In this newsletter, I will continue to mention various areas that could be of potential interest and where there is definitely a need.

**Did you know...**

You can advocate for the appropriate clinical availability and reimbursement of psychotherapy by joining the **Coalition for Psychotherapy Parity**:

https://www.coalitionforpsychotherapyparity.org/

**NEXT ISSUE: JUNE 2018**

**ANNOUNCEMENTS AND OTHER SUBMISSIONS WELCOME!**