The Cutting Edge – Trauma, the new frontier of psychiatry

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Editor

The Lotus: newsletter for RESTART

On September 14th I will launch The Lotus, a shorter, more practical version of The Cutting Edge to enhance psychoeducation within our RESTART program. The lotus symbolizes opening (just like what mindfulness practices will promote) and resilience, because beauty can emerge from life struggles, just like the lotus grows on murky waters.

Boundaries

The collision of two people’s personal bubbles is a good illustration of boundaries. And since we are wired to interact with one another, we can be confronted with the necessity to assert our own boundaries on a daily basis. For some, it will be the struggle of a lifetime as new people arrive and seem to “test” our limits. A concept or life skill that has been widely referenced in self-help books and used in the counseling profession since the mid-1980s, personal boundaries are defined as guidelines, rules or limits that a person develops to identify reasonable, safe and permissible ways for other people to behave towards them and how they will respond when someone passes those limits. They are influenced by beliefs, past experiences and social learning

Why are boundaries relevant in everyone but especially survivors of trauma? Because experiencing trauma can affect the development or integrity of our boundaries, or both. It is no coincidence that the terminology “borderline personality disorder” implies issues with boundaries. In the majority of cases, there is a history of boundary violation in childhood or during the formative years that are crucial to the development of a sense of self. Such a violation can be as obvious as sexual abuse or have a more insidious but no less damaging impact on the development of a personality, such as enmeshment, no respect of privacy or parentification (role reversal). As a result, the patients often display unhealthy boundaries.

How do we help patient with blurry or rigid boundaries to develop a more optimal “boundary tone” (a mixture of firmness and flexibility)? First, one must identify the specific dysfunctions. The nature of the boundaries are context- and relationship-specific (in certain situations, the person’s boundaries can be too rigid and in others, too soft).

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<th>Some types of boundaries</th>
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<td>Physical (example: personal space, body/skin)</td>
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In her TED Talk “Good boundaries free you”, Sarri Gilman refers to boundaries as an inner compass, our self-care tool that should be trusted. This compass will be well calibrated if there is an emphasis on self-care (how do you treat yourself to find balance, joy, rest...). Conversely, some maladaptive schemas or tendencies will interfere with the proper functioning of the compass (for instance, the desire to please or the fear of rejection). In people with co-dependent traits, the compass is often silenced by the need to prioritize the caretaking role towards others. As a result, they have weak boundaries\(^2\) that can lead to victimization or enabling behavior. There is often the mistaken notion that self-worth must come from other people.

Self-awareness of one’s own needs is key during that process. Then, learning to say NO more often can lead to a strengthening of boundaries. Gilman explains that it is uncomfortable, even stressful at first, and she compares this transient stress to “sweating”, but eventually it leads to relief and more authentic relationships.

Because of their prominent caretaking roles, some physicians and other health care professionals might struggle with unhealthy boundaries. Again, re-emphasizing self-care will decrease risk of burnout and enabling behaviors towards patients (which could prevent growth and optimal evolution). Mindfulness practices will guide each one of us towards more self-compassion, a de-attachment from the outcomes, less controlling behaviors and better, healthier boundaries.

Source:

**Vicariously**

Vicarious is derived from Latin *vicarius*, meaning “substitute” or “deputy”. Think about “vicarious maternity” and surrogate mothers. Therefore, living or experiencing vicariously when it comes to hearing trauma stories makes sense. Still, there seems to be confusion in the terminology of secondary traumatization. For instance, vicarious trauma (VT) and secondary traumatic stress (STS) are used interchangeably, but the first expression apparently refers more to positive aspects from working with victims of trauma. It seems like it means more vicarious post-traumatic growth (positive, desirable) than the trauma itself (negative, unpleasant). STS, on the other hand, refers to professional workers' subclinical or clinical signs and symptoms of PTSD that mirror those experienced by trauma clients, friends, or family members\(^1\). Another related concept is *vicarious resilience*, which is similar to VT and consists of drawing strength from the patient’s own resilience skills. It is about being inspired and revitalized despite the difficult trauma stories based on our witnessing of their resilience. But just like for happiness,
make sure you don’t exclusively live by proxy, and continue to find your own resilience too...

Source:

Re-enactment

Life is a grand theater. And we are often the privileged spectators of our patients’ enactments and re-enactments. This replay or compulsion repetition is an important concept especially as far as trauma is concerned. According to Freud, the lack of verbal memory is central in trauma: if a person does not remember, he/she is likely to act out\(^1\). People tend to repeat what they haven’t processed or repaired. Also, endorphins secreted in response to stress could play a role in those paradoxical addictions\(^1\). The posttraumatic state is about an inability to integrate a disturbing experience in the person’s life narrative. But deep down, the human nature seeks resolution. By recreating the scenario of a trauma, a person attempts to express that she or he is stuck, and most importantly, is hoping to create a different outcome this time. Additionally, the familiar, even though toxic, is often preferable to a stable situation, because stable might mean unfamiliar, ambiguous, therefore frightening. People who have suffered trauma do not tolerate ambiguity well. Since this all happens at a sub-conscious level, a trigger is often initiating the casting of the trauma. We might even find ourselves in a role similar to the rescuer role but also perpetrator, collaborator or bystander. All of these situations arise when the level of intimacy between therapist and patient rises to the point that triggers the trauma schema, whose function is to reset the boundaries between therapist and patient. It is best for the therapist to consider such enactments as inevitable\(^2\).

In summary, whenever we are in front of a patient who is displaying strong emotions or is acting-out, it is important to depersonalize the encounter and try to rule out a re-enactment. This will allow the clinician to think more clearly about perceived attacks from the patient. Often, it is what we represent more than who we are as a person that triggers the patient. Deconstructing the dynamic and decoding the behavior using “talk therapy” will enhance the patient’s awareness, allow us to be responsive rather than reactive (which could be reminiscent of the initial traumatic interaction) and make a resolution possible by extinguishing the effect of the trigger.

Source:
Concluding reflections...

Physicians are in the frontline when it comes to identify social injustice, a fertile ground for trauma. Often, we oscillate between two states: helpless spectator of our patients’ suffering, and actor in their healing. We go from passive observers to a more active role. However, we still obey certain rules and “scripts” unfortunately not written by us. The corporate interest from the industry (including pharmaceutical and insurance companies) and the heavy bureaucracy of our fragmented, tedious health care system have significantly disempowered our profession, which should have all people’s wellbeing as the main goal. Instead of being puppets on a show that is bound to disintegrate, we’d better re-assert our skills as movie directors, where we can adjust the scenario, maintain a behind-the-scene perspective and deliver a performance (best care) that can change health outcomes for the better.

And we can achieve this without burning-out (remember that you are the main character in your life). I want to commend the newer generations, our residents and medical students, who are quite lucid about the major problems in our health care system and who choose the director’s role by being vocal and proactive in their advocacy effort, by creating committees, sharing stories, inviting a dialogue with their mentors and presenting at meetings. These are the leaders I want to follow...

Speaking of... You have until Thursday, Sept 6th to submit a proposal for a presentation at the 2019 APA annual meeting in San Francisco!!!

NEXT ISSUE: OCTOBER 2018
ANNOUNCEMENTS AND
OTHER SUBMISSIONS WELCOME!