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Dr. Susan Meffert [1] knew exactly what she wanted to do a year out of college. As a humanitarian aid worker in southern Sudan, she was compiling statistical data for a sleeping sickness study. The team unveiled that the primary driver of the outbreak was the Sudanese civil war, which pushed unruly soldiers up and down the main roads of the country?s southern towns and villages. Subsequently, civilians moved inland away from roads and towards rivers to escape unpredictable attacks, where they then contracted the parasitic infection (*Trypanosoma brucei*).

?I remember thinking, yes, we have to treat the sleeping sickness, but why don?t we also address the violence and trauma that [drove the circumstances] to their infection?? says Meffert. ?At this point, I knew that I wanted to study trauma and violence. I never seriously considered anything else after that.?

This thinking was corroborated on the first day of her medical school psychiatry rotation, when in witnessing a bipolar patient having a manic episode, it was clear that her colleagues viewed this behavior not as an aberration or something terribly abnormal, but as something that should be approached with compassionate and personalized care.

?People [in psychiatry] were not thrown by extreme things. People were not frightened of strong emotions or abnormal thoughts, and I was moved by that,? explains Meffert. ?Unlike many parts of society where people [with mental illness] are scorned, the field offered a freer atmosphere ? it felt less restrictive than other parts of medicine, not as protocol driven. It was also more social justice oriented, which I was really drawn to,? she adds.

These experiences together created a deep understanding of the need for and importance of mental health services, in addition to a lived comprehension of the exceptionally difficult circumstances and contexts in which many of her future patients were living.

After completing her undergraduate education at Stanford University and her time in southern Sudan, Meffert returned to Iowa, where she grew up, to attend the University of Iowa Carver College of Medicine. Taking a year gap in the midst of her medical degree, she went off to Harvard University for a Master?s in Public Health, with a focus in international health.

?I really wanted an infusion of that broader thinking that public health can give, complementing my medical training,? she explains. ?I knew early on that if I could combine my more social-justice oriented interests in helping those suffering from trauma with my medicine work, both would be more powerful.?

In 2003, it was back to California, where Meffert completed her residency here at UCSF. Now an Associate Professor of Psychiatry at the Langley Porter Psychiatric Institute [2] (LPPI), she serves as the lead attending physician for the telemedicine clinic [3], and as an attending in the women?s clinic and resident continuity clinics. Her time is divided into approximately 60% research and 40% clinical work, and her early projects included task-shifting strategies to treat Posttraumatic Stress Disorder (PTSD) and depression among Sudanese refugees resettling in Cairo and survivors of the 2008 Sichuan China earthquake.

Since 2011, her research has been dominated by the interplay of trauma and HIV in developing countries. Attributing the initial interest to Dr. Paul Volberding [4], she says, ?he was the first person to actually point out to me the levels of trauma that those living with HIV undergo.? This sparked her interest in applying her skills set to HIV+ people in resource-poor settings, particularly women who have experienced gender-based and domestic violence. As she explored this further, it became clear how high gender-based violence (GBV) rates were amongst HIV+ women ? ?it was an incredibly potent trauma marker worldwide,? says Meffert.

Initially, the relationship between mental health and HIV emerged as a problem for clinicians as it impacted the treatment adherence of patients ? the more PTSD and trauma, the less likely one is to take their antiretroviral therapy (ART) with the needed regularity ? subsequently creating even more complicated medical problems.

While common presumptions used to explain the impact of mental illness on HIV outcomes as one almost exclusively of ART adherence, we now know that there are other pathways ? biological ones ? in which mental health impacts the physical health status of those living with HIV, underscoring the need for truly holistic treatment. As Meffert explains, independent of treatment adherence ? regardless of taking medication regularly as prescribed ? those living with trauma and PTSD have higher viral loads than those in better mental health.

One of Meffert?s primary projects, the MIND study in Kisumu, Kenya, showcases how impactful treating mental health issues can be for the overall health status of women and their families. Embedded in FACES [5] (Family AIDS Care and Education Services), the MIND study employs interpersonal therapy (IPT) delivered by non-specialists on a weekly basis for HIV+ women who have been victims of GBV and are suffering from depression and PTSD. Women are assessed at baseline, at the end of the three month intervention, and then again three and six months later.

During a pre-study intervention needs assessment, Meffert and colleagues gleaned a number

of especially important facts: women acknowledged that interpersonal violence had impacted their adherence to medication; women unanimously desired mental health care and asked that treatment be one-on-one (provider-patient, not group) and within the health care facility as they were worried about gossip; and interpersonal psychotherapy tended to align with existing coping skills currently in use by these women.

The work has been life-changing, for both the participants and Dr. Meffert. When asked to describe her greatest achievement thus far in her still young career, Meffert says, ?When I go to our HIV clinic sites in Kenya, care providers come up to me and tell me how glad they are to have mental health treatment and what a difference it?s made for patients. When the value of mental health care is apparent to local HIC care providers, it feels to me like a real accomplishment that can serve as a nidus for broader changes in medical care. It?s been incredibly moving.?

Balancing the intensity of this kind of work is essential ? Meffert runs in her spare time, and says having two little kids is actually a great salve. ?It keeps me away from the commodification of violence. We watch a lot of cartoons,? she says. This includes with her husband, Dr. John Metcalfe [6], a global health physician at UCSF who works extensively on tuberculosis research in Zimbabwe and shares her dedication to solving complex medical challenges in developing regions.

Additionally, Meffert emphasizes that the heart of training for working in trauma is learning how to keep yourself at a safe emotional distance from a patient?s experience, yet go close enough to help heal.

It?s a difficult tension, she admits, though like all in the field of psychiatry, she regularly checks in with mentors to process her own responses to the work.

Processing her work would also be completely different if her focus wasn?t implementation and scale-up of mental health interventions.

?I don?t see anyone in my studies who I don?t have a strategy for helping,? she emphasizes. ?I know we have a great shot at fixing them completely, and if not that, then helping them in really meaningful ways.?

Links
[1] http://profiles.ucsf.edu/susan.meffert#narrative
[2] http://psych.ucsf.edu/lpphc
[3] http://psych.ucsf.edu/telemedicine-project
[4] http://profiles.ucsf.edu/paul.volberding
[5] https://faces.ucsf.edu/
[6] http://profiles.ucsf.edu/john.metcalfe