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These could be submitted as regular articles, reviews or brief reports. This journal specifically solicits brief reports, which may involve preliminary results of ongoing research, clinical hypotheses, and front-line perspectives on rehabilitative care and treatment delivery.

Editor: J. D. Mendonça PhD, CPsych

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Manuscripts submitted for publication must follow the rules of APA Style® detailed in the *Publication Manual of the American Psychological Association.* For more details visit the **APA website.**

Regular articles (not to exceed 4000 words) should contain the following sections: 1) Title page 2) Structured Abstract with Clinical Implications and Limitations, and Key Words 3) Body Text with Tables / Figures, References (as per APA style) and 4) Funding Support / Acknowledgements.

Brief reports (not to exceed 1500 words) may be submitted in the usual APA style or in two additional variations given below (while observing the APA citing and referencing style).
1) *Front Line Perspectives*
The submission would consist of a description of actual or prototypical cases (n < 5, from hospital or community settings, de-identified, with patient consent placed in the clinical file).
Sections: Abstract with key words, Introduction, Case Review, Commentary, Conclusions.
2) *Clinical Hypotheses*
A hypothesis should include an organized structure of known facts and their real world impacts that are observable.
Sections: Abstract with key words, Introduction, Hypothesis/Theory, Evaluation Pilot Data (if applicable), Clinical and Research Implications, Conclusions.

The editor may be approached for any unique manuscript variations required by the subject matter.

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Research Insights

Team-Based Assessment of Violence Risk

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Implementation of a Team-Based Violence Risk Assessment Process: An Interdisciplinary Analysis

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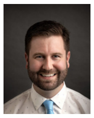

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Structured professional judgement tools, such as the HCR-20 V3, are widely used in violence risk assessment in Canadian forensic programs. The HCR-20 V3 can be scored by interdisciplinary teams, although its utility is debated in the literature. In the present study, perceptions of team-based risk assessment were explored at a forensic hospital in Ontario. Semi-structured interviews were conducted with 10 inpatient, interdisciplinary forensic clinicians. Interview transcripts were interpreted via inductive thematic analysis conducted by three interdisciplinary forensic professionals. Participants reported that engaging in a consensus-based process for risk assessment was clinically useful, especially in developing case formulations and a common risk language. There was consensus around barriers to implementation, including access to education and the availability of therapeutic programming to address identified modifiable risk factors. Interdisciplinary engagement in risk assessment was perceived as valuable when implementation facilitators and barriers were considered, with implications for program development.

Keywords: violence, risk assessment, forensic psychiatry, inpatient, HCR-20, structured professional judgment, risk factors, dynamic risk, team-based, interdisciplinary, consensus, mental health

Forensic mental health systems are tasked with balancing the recovery of patients under their care with the protection of public safety (Pinals, 2021). Striking the right balance between risk assessment and recovery has been described as a key goal for forensic clinicians (Chaimowitz, 2018; Simpson & Penney, 2011). Evidence-based violence risk assessment is thus a core competency for forensic clinicians.

Violence risk assessments help determine patient treatment and trajectory through the forensic system. They guide important decisions from formulating individualized risk management strategies to advising Review Boards on the appropriate level of liberty to grant forensic patients (Glancy et al., 2021b; Quinn et al., 2022).

Historically, violence risk assessments were generated by forensic professionals solely using their clinical judgment (Glancy et al., 2021b; Levin et al., 2018; Quinn et al., 2022). However, risk assessment has moved on from unstructured approaches considerably. Today, evidence-based structured professional judgment (SPJ) tools, such as the Historical Clinical Risk Management-20, Version 3 (HCR-20 V3; Douglas, et al., 2013), are often used. SPJ tools systematically consider both historical and dynamic (i.e., modifiable) risk factors (Douglas et al., 2013). They may be favored over other evidence-based approaches (such as using actuarial tools) in clinical forensic settings because dynamic risk factors serve as both a metric to evaluate how the patient is progressing and a guide for clinical interventions that may reduce risk (Carroll, 2007; Doyle & Dolan, 2002, 2007; Schuringa et al., 2018).

Although SPJ tools are traditionally administered by forensic psychologists or psychiatrists, they may benefit from multidisciplinary input. Consensus-based structured risk assessments (i.e., risk assessments completed with input from nursing and allied health staff) are less susceptible to personal biases, less likely to miss important risk factors, and ultimately lead to better judgment (Department of Health, National Risk Management Programme, 2007).

Despite the empirical validity of using SPJ tools in a consensus-based, multidisciplinary context, past literature indicates a disconnect between that validity and perceived clinical utility by the multidisciplinary teams tasked with scoring them (Carroll, 2007; Chaimowitz, 2018; Levin et al., 2016). In search of why such disconnect exists, previous literature has mainly focussed on barriers and facilitators to implementing team-based SPJ procedures – the rationale being that even psychometrically sound instruments can be perceived as having little utility by the clinician if not implemented properly (De Beuf et al., 2020; Glancy et al, 2021b, Levin et al., 2016, 2018).

A review by Levin et al. (2016) analyzed SPJ implementation and highlighted critical barriers and facilitators (i.e., implementation determinants). The implementation determinants they found were organized into four different categories: characteristics of the tool itself, characteristics of the user, characteristics of the setting the tool is being implemented in, and characteristics of the process of implementation.

The present study aims to explore this disconnect further from an interdisciplinary perspective. We review the implementation of an SPJ tool in a multidisciplinary forensic mental health setting, wherein the implementation was mindful of the framework described by Levin et al. (2016). Uniquely, our work does not only include data collection from participants of different health disciplines, but our data analysis is also conducted by researchers from different health disciplines (including psychiatry, social work, and occupational therapy). We hypothesized that having team members from multiple disciplines conduct an analysis of staff's views of implementation of an SPJ tool would reveal more about the culture, attitudes, and perceptions within forensic mental health teams regarding implementation of a consensus-based violence risk assessment procedure, and more broadly about how therapeutic teams see their role in violence risk assessment. Such an analysis may inform future implementation of risk assessment procedures in forensic programs. We further hypothesized that a process of multidisciplinary risk assessment using a SPJ approach represents a viable means of assessing violence risk if barriers and facilitators are carefully considered.

Methods

Study Type

A prospective, qualitative research design using semi-structured interviews was adopted to collect data. Thematic analysis was used to interpret data.

Setting

This study was completed at the Southwest Centre for Forensic Mental Health Care (the Centre). The Centre is a medium-secure forensic psychiatric hospital serving forensic inpatients and outpatients in Southwestern Ontario, Canada. The inpatient treatment program has 72 beds across four units, where patients receive multidisciplinary rehabilitation prior to community living. Patients in the program are typically individuals found Not Criminally Responsible on Account of a Mental Disorder and are supervised by the Ontario Review Board.

Context

In the 18 months prior to the study, three inpatient units began incorporating aspects of structured violence risk assessment into their multidisciplinary care planning rounds ("MDPs"). MDPs are typically one-hour meetings which occur quarterly for each forensic inpatient to discuss clinical progress, active issues, and create plans and goals moving forward. MDPs are attended by the staff involved in each patient's active clinical care, including their primary nursing organizer, unit lead, treating psychiatrist, occupational therapist, social worker, and therapeutic recreationist.

The HCR-20 V3 was chosen as the SPJ tool to guide the team-based risk assessment. The HCR-20 V3 is a widely used SPJ tool with strong inter-rater reliability and predictive validity and is suitable for scoring with multidisciplinary input (Brookstein, 2021; Douglas et al., 2013). It involves scoring 10 historical/static factors (including historical problems with violence, personality disorder, and substance use) and 10 dynamic factors. The dynamic factors are further divided between five clinical items (recent problems with insight, instability, and symptoms of major mental disorder, for example) and five risk management items (likelihood of having difficulties in the coming supervisory period with housing, personal support, stress and coping, for example).

The goal was to score all 20 items for a patient at each MDP meeting throughout the clinical year in anticipation of an annual Review Board hearing (such that the risk assessment could inform the hospital recommendations to the Review Board for a given patient's disposition). The items were divided between MDP meetings and between team members, scored prior to MDPs, and reviewed by the team at the MDP itself, where the presence and relevance of a given risk item would be determined by consensus between team members. The entire 20 items were reviewed and updated as required at the final meeting prior to a given patient's Review Board hearing to create an up-to-date risk assessment and maintain fidelity with the manual (Douglas et al., 2013).

In implementing the risk assessment procedures, the implementing team (including authors SL, CM, and JQ) was mindful of the factors described by Levin et al. (2016). For example, tool selection was informed by staff familiarity; the HCR-20 V3 is used routinely by the psychology service at the hospital and is routinely discussed at Review Board hearings attended by staff. It is relatively easy to score, with 20 items, which were divided between disciplines with relevant expertise (e.g., "History of Problems with Mental Disorder" was scored by psychiatry staff, "History of Problems with Relationships" by social worker, clinical items by nursing staff, and so on). The procedures were built into pre-existing workflows (the MDP meetings), as opposed to the creation of a new rounds to reduce perceived complexity and workload demands. Units had the flexibility to experiment with the process of the scoring procedures (e.g., which items were reviewed at which MDP meeting, and which staff reviewed which item) and the pace of implementation over the 18 months prior to data collection for the present study in an attempt to encourage a sense of ownership and professional pride over the process. Leadership, including hospital coordinators, physician leadership, and nurse educators were engaged in the process and attempted, where possible, to respond to unit concerns (e.g., increasing staff education on request, modifying documentation procedures, and delaying aspects of implementation when other clinical or staffing challenges arose). Routine educational rounds for risk assessment, which reviewed the HCR-20 V3 tool and scoring procedures, were held on the participating units.

Participants

Clinical staff members from forensic inpatient units at the Centre were recruited through email. To be eligible, staff must have been involved in the care planning and SPJ tool scoring process in the last one year and could be clinicians of any discipline. The participants consisted of 10 staff from nursing, occupational therapy, recreational therapy, social work, psychology, and psychiatry. Specific numbers of each discipline were not reported to enhance anonymity of the participants in the small sample size from a single hospital. However, the sample reflected approximate ratios of staff from different disciplines and levels of experience on forensic inpatient units at the Centre.

Procedure

Informed consent was obtained from all individual participants included in the study. Interviews were conducted by the first author (DT), in-person, at the Centre and were approximately 40 minutes in length. DT had no prior relationship with the participants.

The semi-structured interviews consisted of six open-ended questions to elicit attitudes about the clinician's role in violence risk assessment and participation in team-based risk assessment procedures in light of the recent implementation of the HCR-20 V3 during MDP meetings. Despite being guided by these questions, each interview was largely driven by the participant and their responses in order to allow themes to emerge naturally. The interviewer posed a question from a short list of prompts (see Appendix for the list of prompts). The interviewee's response led to further questions by the interviewer.

Interviews were manually transcribed verbatim by DT and then reviewed by DT to ensure fidelity. Data analysis occurred concurrently with interview transcription so that the team was able to identify when saturation had been achieved – that is, when the themes expressed in interviews became repetitive, and few or no new ideas were expressed in subsequent interviews (Hennink et al., 2017). No further interviews were completed after saturation had been achieved.

Data Analysis

De-identified interview transcripts were analysed and coded by three researchers with front-line forensic experience from different professional backgrounds (CM, an occupational therapist; SL, a social worker; and JQ, a forensic psychiatrist) via thematic analysis. Thematic analysis is a flexible and effective method of identifying and analysing qualitative data (Braun & Clarke, 2006). Thematic analysis is often used to capture participants' candid opinions, making it suitable for this project.

To carry out the thematic analysis and coding, three coding researchers individually reviewed transcripts line-by-line to identify keywords or ideas (codes). Initial codes were refined by re-reading and re-coding interviews as key patterns began to emerge. After individual researchers had identified codes in the interview data set, the coding researchers met to compare codes and further refine them, before grouping codes into overall themes through a consensus-based discussion, a process otherwise known as triangulation. For example, the three coders all had the impression that there were multiple overarching themes emerging from the data, which was a signal that participants had positive feelings towards engaging in the HCR-20 V3 scoring process, but also a sense that different factors made the process more (or less) useful, or professionally fulfilling. After discussing the topics and specific examples in the data, the coders settled on organizing sub-themes under "utility and value" and "barriers and facilitators to implementation."

The research team recognises that although qualitative data analysis software exists, the limited number of interviews and the potential benefits of manual coding made it a more appropriate option (Brod et al., 2009).

Ethical Approval

Ethical approval was granted by the Western University Health Sciences Research Ethics Board (project ID: 118607). All procedures were in accordance with the ethical standards of the Western University Health Sciences Research Ethics Board and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Results

Analysis of participants' perceptions of implementing a team-based SPJ risk assessment process revealed two overarching themes. First, participants spoke to the utility and value of using a team-based process of risk assessment using an SPJ tool. Second, they discussed perceived barriers and facilitators to implementing a team-based SPJ tool process. Within each overarching theme, there were several sub-findings. Excerpts from the interviews are provided to contextualize these themes.

Theme 1: Utility and Value of Interdisciplinary Risk Assessment

Participants felt, near unanimously, that engaging in a structured, consensus process for risk assessment was clinically useful. Participants spoke about both the relevance of risk assessment to care planning and the benefits to applying an interdisciplinary lens to risk assessment. Embedding structured risk assessment in care planning meetings facilitated better team communication. Finally, participants believed including patients in future risk assessment discussions would further enhance the value of MDP meetings.

Risk Assessment is Relevant to Care Planning

Participants valued having risk assessment as part of a care planning process. In particular, they felt the process focused the team on shared treatment goals, and assisted in tracking patient progression through the forensic system.

> *"[The HCR-20] gives us a better direction on what we're doing... [it] focuses us on certain aspects."*

> *"It shows whether there is progression happening with that person, with their risk factors as well."*

Risk Assessment Benefits from an Interdisciplinary Lens

Participants often alluded to the benefits of an interdisciplinary approach to assessing violence risk. Having multiple lenses was perceived as increasing the quality of risk assessment and validating staff feelings of professional expertise.

> *"Different disciplines have different lenses, and they see things in different ways... risk is dynamic and multifaceted... a team-based [assessment] provides a richness."*

Embedding Structured Risk Assessment in Team Meetings Improves Communication

The process of incorporating team-based structured risk assessment into care planning meetings was thought to engage the full team in discussion. More specifically, the HCR-20 V3 as embedded in multidisciplinary meetings was viewed as helping the team develop a common risk language and the shared patient formulation as allowing the team to be more focused in their approach.

> *"The HCR-20... once you're familiar with it... it's a common language, common foundation."*

> *"There is value added when we know the facts and know the realities, and share that vision, or that understanding."*

Including Patients in Risk Assessment would Further Enhance Value

Notably, although participants felt that the instrument was useful clinically, they expressed that team-based violence risk assessment could be further enhanced. Staff believed there would be further value in incorporating patients in their own risk discussions. Staff reported that this added value would be in the domain of addressing fairness and transparency.

> *"I think the main advantage [of including patients in risk assessment discussions] is transparency. Patients should know what's going on with their treatment, what's expected of them, what they need to work on – those types of things. And I think they should have an input in that. Their perspective should also be captured in that."*

> *"Patient perspective is so important... having patients be part of their own treatment is crucial."*

Theme 2: Facilitators and Barriers to Implementation

Despite the perceived value of team-based violence risk assessment, participants varied in their experiences of successful implementation of the process. There was consensus around the determinants that worked as facilitators (and conversely, as barriers) to successful implementation. Access to education and training, human resource challenges, program consistency across the hospital, issues of leadership and organizational culture, and connecting risk assessment to risk management were frequently cited as facilitators or as barriers to implementation.

Access to Education and Training

Lack of access to formal education and training in the HCR-20 V3 tool and how it was integrated into team meetings were seen as barriers. Staff education sessions, which occurred during the day shift, were not accessible to all staff. For example, this posed a particular challenge for new staff, part-time staff and those working exclusively on night shifts. Regular training sessions, accessible to all staff, were recommended by multiple participants.

> *"We have a lot of staff that work night shifts that don't get to see some of the in-service tools and a lot of it falls to full-time staff. And we do have a lot of part-time staff that are nearly full-time, and I don't know if they always have access to a lot of the training."*

> *"Having regular training sessions, just like we do for CPR and everything else – this is the equivalent... Regular training sessions, held yearly or twice a year, where it's available to staff online or on site, I think would be an excellent idea."*

Human Resource Challenges

Human resource issues, including high staff turnover and a lack of access to psychological and behavioural therapy assessments, were seen as barriers to successful team-based risk assessment by many staff. Some staff also struggled with their shift timing or time constraints, limiting their ability to contribute to the care planning process.

> *"We've had retirements and turnover and stuff. So, we don't have a consistent full-time, gelled team anymore – we used to. So that's been tough."*

> *"The hope is that whoever the organizer [primary nurse] is would be present at that actual [MDP] meeting so we can have that discussion with them there, too. But we know some of those staff work straight nights and aren't able to attend those meetings."*

Program Consistency Throughout the Hospital

Having a consistent approach across the Centre seemed to influence participants' perception of risk assessment implementation. Although different units were encouraged to experiment with the specifics of risk assessment procedures (the organization of the MDP meetings, or divisions of tasks between disciplines, for example), many staff ultimately felt a standardized process between units would be helpful, for both staff and patients, as both staff and patients may move between units.

> *"I think a consistent approach, across the hospital, across wards, would be really important – that patients have an understanding from the beginning about what our obligation is to society and what our obligation is to them."*

Leadership and Organizational Culture

Several participants noted the culture of specific units, and the hospital organization at large had a significant impact on the uptake of the risk assessment process. Leadership – from both hospital administrators and physician staff in particular – was seen as an important factor in whether risk assessment was perceived as successful.

> *"Interestingly, the culture… changes from each unit to unit. It changes because of the team members; it changes because of the leaders on the unit."*

> *"If the doctor values that tool and finds it useful, I think that may lead to more successful implementation."*

Participants not only valued support from individual leaders, but also spoke of the importance of an overarching organizational philosophy into which risk assessment fits.

> *"I think [the process will reach its fullest potential] when there's a philosophy of care… We give our patients dedicated time for a robust understanding of their history and their risk factors, and how we're going to manage them. And that includes group work and individual work and supporting their progress and having families as partners in care… And we should all have that shared purpose and feel invigorated that we're doing meaningful work."*

Related to organizational and leadership factors, participants noted that inertia within teams or the organization was a barrier to implementation. Some participants spoke of the implementation of the risk assessment process taking longer than it needed to and feeling frustrated with resistance to change.

> *"You just ask your coordinator 'when is this going to happen' or 'should it be happening' and [the response is] 'we need to postpone it', 'we're not ready yet'."*

Connecting Risk Assessment with Risk Management

Participants reported that the availability of risk management resources was important to the process of risk assessment. They reflected on a perceived lack of intervention resources available to address the risk factors the SPJ tool identified (e.g., anger management, substance-use, and other psychotherapeutic interventions). When such a disconnect came up in participant interviews, they tended to take a more pessimistic view towards participating in violence risk assessment.

> *"We complete the tool, but then I wonder how we implement our discussion on risk – how that's translated into our care plan and do we reflect that enough in our care planning and our treatment. So, I'm not really sure we do that enough here."*

> *"We're not even offering what we can to meet those identified risk factors."*

> *"I think that there needs to be more [treatment] groups… And I think we're working on that; however, I think that needs to be developed far faster than it is."*

Discussion

This study's aim was to explore forensic mental health clinicians' perspectives on the implementation of an interdisciplinary risk assessment process using an SPJ tool in a forensic hospital. Several previous qualitative studies have looked at similar implementations (De Beuf et al., 2020; Glancy et al., 2021b; Levin et al., 2016). However, our study is the first, to our knowledge, to use an interdisciplinary team to analyze staff perceptions of implementation as part of its methodology. Including multiple perspectives in the analysis of descriptive qualitative data has been shown to provide valuable insights in the past (Gale et al., 2013).

The first major theme that was prevalent in the interviews was that clinicians found completing risk assessments as a team, using an SPJ tool, both clinically useful and valuable – a finding is consistent with other research (Carroll, 2007; Glancy et al., 2021b; Schuringa et al., 2018). When clinicians spoke of its utility, comprehensiveness was a common theme. Staff mentioned how the instrument forms a complete picture of the patient and gives clinicians a sense of where patients are at in their recovery. The instrument's validity and reliability have been well-established (Brookstein et al., 2021) and staff seem to recognize this; they appreciated having an evidence-based tool to guide their team-based risk assessments.

Consensus scoring of SPJ tools has previously been found to enhance team communication around risk (Gerace et al., 2013). This study reported similar findings: participants spoke of the "common language" and "common foundation" that the SPJ tool facilitated when communicating with one another, thereby ensuring a mutual understanding among team members. Given that risk assessments are highly weighted in influencing legal or clinical decisions, effective communication around risk issues is especially important in the forensic context (Heilbrun et al., 1999).

Another reason consensus scoring of the HCR-20 V3 was seen as valuable was because it fostered a sense of professionalism. When the SPJ tool was scored at multidisciplinary meetings, staff from different disciplines used their expertise to score different sections of the instrument. Other research suggests that mental health care workers generally enjoy working in multidisciplinary teams and that job satisfaction is higher when professional roles are maintained (Scanlan et al., 2021). Distributing the scoring of specific items on the HCR-20 V3 to suitable professional staff (for example, "history of problems with employment" to an occupational therapist), followed by a team meeting to review and achieve consensus, may help strike a balance between team collaboration and validating individual professionals' expertise.

On a separate note, when discussing clinical utility, multiple staff commented that they would like to see patients involved in their own risk assessment discussions, although no specific proposals were brought forward. The idea of involving patients in their own risk assessments has been explored conceptually, to some extent, in the literature (Markham, 2020). For example, Levin et al. (2016) noted that there was a lack of patient involvement in risk assessment that "might reflect... the attitudes of services, clinicians and researchers about the appropriateness of participation of the consumer population and their ability to participate and contribute to care and knowledge development" (pp. 613-614). However, in the present study, clinicians generally viewed the idea of including patients in their own risk assessment as a positive and believed that it may increase patient insight while addressing the issue of fairness/transparency. Of note, tools that use patients' self-assessment of risk do exist (e.g., the Self-Assessment Questionnaire or SAQ) and have been found to be effective predictors of recidivism (Mills, 2003). Though they are not widely used at present, these tools may represent an opportunity for future development of assessment processes.

The other major theme derived from the interviews is that even though staff varied in their experience with implementation of the process, there was consensus around which factors served as implementation determinants. Overall, most factors staff reported as determinants in the present study were consistent with the existing literature (Levin et al., 2016). These factors included access to education/training, lack of staff or high turnover of staff, having a consistent approach to implementation across units, leadership, and organizational philosophy and culture.

Unique to our study was the finding that staff identified the lack of availability of risk management resources as a barrier to implementing the team-based risk assessment process. Otherwise optimistic views of violence risk assessment became more pessimistic when staff considered the lack of treatment resources to address certain modifiable risk factors they were identifying. This finding may reflect underlying ethical tension experienced by staff, between their roles as therapeutic clinicians and

and risk assessors.

The so-called dual-role conflict has been described in the psychology and psychiatry literature in some detail in the context of independent psycho-legal assessments (Glancy et al., 2021a). We speculate that staff may be experiencing a similar conflict in reconciling their roles as therapeutic agents and risk assessors in the clinical context of inpatient forensic mental health care. Assuming most mental health staff enter their professions to "help" patients, being asked to provide third parties (such as the Review Board) with risk-related information that then may be used "against" their patients may be consciously or unconsciously jarring. This phenomenon, if present, may explain some of the disconnect between the positive literature on the clinical utility of SPJ tools in the team context and their reportedly low uptake. If so, our study provides a possible avenue to reduce that tension: provide staff and patients with the resources (e.g., psychotherapies and other supportive interventions) to help patients address their modifiable risk factors, while engaging patients in a transparent discussion of their current risk formulation.

Our study has some limitations. The relatively small sample size from a single forensic centre may not be representative of forensic clinicians in general. Staff that chose to engage in the interview process may reflect a biased sample (e.g., night staff may have been less likely to participate, given that the interviews were conducted during daytime hours). Coding researchers involved in data analysis may hold inherent biases, as they work on the inpatient units at the Centre and were partly involved in the implementation of the team-based risk assessment program.

Our research holds implications for program development and SPJ integration, highlighting the importance of taking a multifactorial approach to SPJ implementation and the need for interventional resources to address identified risk factors. Our findings are consistent with many of the determinants described in previous literature on the subject, with some additional emphasis on patient engagement and risk management. If patient outcomes are to be improved, care needs to be provided in a manner that matches patients' readiness to change, and an integral part of this is having the right resources and programs available (CFIR Research Team-Center for Clinical Management Research, n.d.). We recommend enhanced staff training opportunities and supporting staff on the delivery of validated patient interventions (e.g., cognitive behavioural therapy for psychosis, dialectical behaviour therapy). Simultaneously, we recommend increased support for community-based interventions (e.g., for addictions, vocational, and recreational resources) as our inpatients transition through the forensic mental health care system and are reintegrated into the community setting.

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Appendix

Interview Prompts

1.Can you describe how your team typically assesses risk for violence on forensic inpatients?

2.Can you describe your exposure to the HCR-20 V3 instrument? For example: formal or informal training sessions on the HCR-20 V3, personally scoring patients on the HCR-20 V3, attending meetings where patients were scored.

3.What are your views on having the clinical team assess violence risk via consensus using a structured tool (such as the HCR-20 V3), as opposed to having risk assessed by a single consulting professional?

4.What are your views on integrating violence risk assessment using the HCR-20 V3 into regular multidisciplinary care planning meetings (MDPs)?

5.How has participating in consensus-based violence risk assessment using the HCR-20 V3 altered your clinical practice?

6.How could multidisciplinary violence risk assessment be improved?

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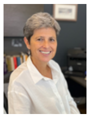
Language Deprivation in Deaf Individuals



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Children typically acquire a first language through consistent linguistic exposure and interaction. The process of language acquisition can be much different for deaf children, and they may miss the critical period of exposure to a natural language. Resulting language delays or deprivation may have serious clinical implications for deaf children and adults with deficits in cognitive activities and psychosocial skills. Uninformed clinicians may mistakenly diagnose psychiatric disorders when the etiology is more related to linguistic impoverishment or the absence of a first language. Clinician education is critical to ensure accurate and equitable assessment and treatment of deaf children and adults.

Keywords: deaf individuals, language acquisition, language deprivation, clinical decisions

Background

All babies (hearing and deaf) are born with an innate ability to learn language.Language acquisition is a subconscious instinctive process which is both amazingly simple and amazingly complex. The simplicity is that barring catastrophic events or genetic anomalies, babies are born with brains hardwired and structured for language acquisition.The complexity is that this acquisition is very much dependent on the successful and necessary connections made between brain cells. These connections are highly impacted by experiences provided by the child's environment. Furthermore, the linguistic experiential exposure needs to happen during a neuro-developmentally critical period of time, which is approximately the first five years of development (Hall, 2017). Lack of or delays in language exposure during this early time of brain development affects neurolinguistic structures resulting in an irreversible biological impact on both the brain and healthy development (Hall, 2017; Skotara et al., 2012; Penicaud et al., 2013).

Children are not taught language but rather learn it through repeated and frequent exposure to and interaction with their parents, other adults, and children around them (Clark, 2009). It is during these sensitive developmental years that the brain is most primed for language acquisition and after which the plasticity of the brain cells responsible for learning language begin to gradually decrease (Humphries et al., 2012).Due to this change in brain structure and function as a child ages, children who have not acquired a first language during their early years have a much more difficult time mastering any language later in life.

Language formation is so important during the critical period of development that missing early exposure to a natural language may adversely affect cognitive activities that rely on a first language such as literacy, memory organization, number manipulations (Humphries et al., 2012, Cheng et al., 2019), language abilities (Yoshinaga-Itano,1998) and mental health (Glickman & Hall, 2018). Furthermore, delays in language acquisition affect future development of other neuro-linguistic brain structures and as Glickman and Hall (2018) wrote "Altogether, a fundamental and irreversible biological impact—on the brain and on healthy development—appears to occur when an accessible language is not provided by a certain early time period in brain development" (p. 962).

Clinical Implications

There are significant clinical implications when a child does not acquire language. Language deprivation is the term used when a child has been deprived of full exposure to an accessible language during the critical period of language development.This is rarely seen in hearing children unless in situations where a child has been reared in extreme social isolation and stimulus deprivation such as "feral" children who have been reportedly raised by wild animals or lived entirely alone in the wilderness. One example is the case of Genre in

California who was an adolescent girl subjected to severe social isolation and experiential deprivation (Curtiss et al.,1974). Other examples of language deprivation in hearing children include Viktor, the wild boy of Aveyron, the Ukranian girl named Oxana and others summarized by Dombrowski et al., (2011) who all showed similar negative mental health outcomes tied to early language deprivation and lack of nurturing.

The mental health effects of language deprivation in these tragic cases supports the importance of early language learning in sensitive developmental periods. This same concept is also applicable to deaf and hard of hearing children albeit for vastly different sociocultural reasons. Deaf and hard of hearing children are typically born to hearing parents who then face many difficult decisions about how to raise their child.Du Feu & Chovaz (2014) describe this often as a grieving period for parents as they struggle to accept the reality of their child which is far different from their own, overlaid by pressing and often conflicting opinions of professionals about how best to parent their child, teach their child, bond with their child, play with their child and what language to use to communicate with their child. Quitnner et al. (2010) concluded that context-specific measures of parenting stress were elevated in this population reflecting the unique challenges facing these families. Embedded in these stressors are the fact that many hearing professionals strongly advocate for spoken language while other professionals (and the Deaf community) advocate for sign language. Ironically, both languages are considered full forms of language (i.e. grammar, syntax etc.) and just use different forms of expression or modalities (Snoddon & Weber, 2021).

Identification of Deafness

Du Feu & Chovaz (2014) described how in the past many children were not identified with deafness until they began attending school (around age 4-5 years). Children were frequently misidentified, overlooked or ignored. Often parents would conduct rudimentary tests such as banging pots together and when the child responded (to the vibrations!), parents concluded their child could hear.

In 2002 the Infant Hearing Program was implemented in Ontario with a goal to promote early intervention in terms of language development. In 1992 the average age of identification for children born in Ontario with permanent hearing loss was two and a half years. By 1993 and after ten years of Infant Hearing Screening, the average age of identification was less than four months of age (Ministry of Children, Community and Social Services, 2017).

Although helpful, early identification through infant screening has not necessarily solved the issues of early language acquisition in deaf and hard of hearing children. Although the intention of the programs is to provide evidence-based options to new parents following screening of their baby, parents have often shared confusion as to how to decide what language is optimal for development (spoken or sign?). The emphasis, largely driven by the medical professionals, has been on auditory technology such as hearing aids, cochlear implants, and bone anchored hearing aids (BAHA) with the goal of promoting spoken language whereas deaf communities and scholars have advocated for sign language as the most natural accessible language.

Language impoverishment may occur in environments where the chosen language has not been accessible. Not all deaf children benefit in the same ways from auditory technology even with advanced technology and thus, spoken language may not be fully accessible. By the time the parents or someone (often teachers) realize the child has not developed a first language, the child has potentially missed the window of developmental linguistic opportunity. Then, the negative and irreversible trajectory of language deprivation with its corresponding implications is set in place.

Clinical Effects of Language Deprivation

Gulati (2018) applied the term language deprivation to deaf and hard of hearing children who experienced less than necessary/sufficient access to a first language (either spoken or signed). A deaf individual who is linguistically deprived will typically suffer many serious maladaptive mental health effects (cognitive, emotional, and social) in addition to negative societal implications (cost to medical system and loss of potential productive participation in society (Humphries et al., 2012).

Language deprivation may be associated with low levels of psychosocial functioning and independent living, poor emotional social-regulation skills, emotional, and behavioural problems (Glickman & Hall, 2018; Pollard & Fox, 2018). Hall (2017) noted that psychiatric health is often affected by social factors such as poverty, discrimination, social distress, and that language development (or lack thereof) is essentially another social factor that contributes to significant mental health issues in the deaf population. Gulati (2018) has suggested that early language deprivation is a recognizable constellation of social, emotional, intellectual, and psychiatric consequences proposing the term *language deprivation syndrome*. In this context then, language deprivation syndrome is considered a possible neurodevelopmental disorder with sociocultural origins.

Gulati (2018) listed the following characteristics of language deprivation syndrome:

- May superficially appear to use sign language fluently, but on closer examinations shows characteristic linguistic deficits.
- Struggles with the concept of time.
- Struggles with cause-and-effect.
- Lacks "theory of mind."
- Struggles with abstract concepts.
- Has difficulty learning.
- Struggles with emotional regulation.
- Struggles in relationships.
- Shows reduced fund of information but may be quite "streetwise."
- Acts feelings out.

Conclusions

Deaf individuals, like hearing individuals, may present clinically with symptoms suggestive of serious mental health disorders. This brief article, however, highlights the necessity of considering language deprivation as either a cause of mental health distress or contributing to it. Psychiatric symptoms may be wrongly diagnosed as disorders such as schizophrenia, psychosis, or ADHD when the etiology is linguistic impoverishment or the absence of a first language. In this sense, language deprivation syndrome may well be best understood as a neurodevelopmental disorder of sociocultural origins with tragically very few options for successful interventions. Prevention is optimal.

For the clinician who is not fluent in American Sign Language (ASL) nor knowledgeable about mental health and deafness, it is imperative to seek appropriate supervision as well as utilize an ASL interpreter with an expertise in mental health. Chovaz (2013) examined the multiple complex contributions that the ASL sign language interpreter, the clinician, and the deaf client bring to the mental health context proposing that the optimal intersection of these factors will positively affect mental health outcomes. Accurately assessing the clinical presentation in deaf individuals to better understand the symptoms/effects of language deprivation, mental health disorders or a combination thereof, is potentially a powerful predictor for efficacious interventions.

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Lithium as an Often Overlooked or Delayed Augmentation Strategy for Treatment-Resistant Depression: Insights and Case Reports

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Treatment resistant depression presents a challenge for clinicians due to insufficient evidence on effective treatment strategies. This report presents three cases of patients with treatment-resistant depression and chronic suicidal ideation who showed marked improvement following lithium augmentation. Side-effects were observed in two patients. These findings highlight the potential benefits of lithium as an adjunct treatment for treatment resistant depression. However, further research is needed to compare lithium to other augmentation agents both in terms of efficacy and side-effect profiles.

Keywords: Lithium, Treatment resistant depression, chronic suicidality

Introduction

Depression is a significant challenge to both patients and healthcare systems in Canada, with an estimated economic burden of 12 billion dollars per year (Tanner, 2020). The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) defines Unipolar Major Depressive Disorder (MDD) as five or more symptoms of depression with at least one being anhedonia or low mood (American Psychiatric Association, 2013).

Although there is no official DSM-5 definition for treatment resistant depression (TRD), the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines define TRD as the inadequate response to two or more antidepressants (Kennedy, 2016). TRD can be especially difficult for clinicians to manage due to lack of clear evidence for subsequent treatment strategies. A comparative effectiveness review conducted by the United States Agency for Healthcare Research and Quality in 2012 showed insufficient evidence to differentiate between switching strategies and low-quality evidence to differentiate between augmentation strategies (Santaguida, 2012).

Systematic reviews have shown the efficacy of lithium as an adjunct in TRD, with some suggesting improved effectiveness when compared to modern antipsychotics (Vázquez, 2021). Yet CANMAT has listed lithium as a second line augmentation agent behind first line agents, aripiprazole, quetiapine and risperidone, citing issues with extant lithium studies using tricyclic antidepressant combinations and using small sample sizes (Kennedy, 2016).This is reflected in physician prescribing practices. One study of 244,859 veteran patients diagnosed with depression found that 53,807 (22%) required augmentation and only 1106 (0.5%) receiving lithium (Valenstein, 2006). Over the last two years we have seen marked improvement in three cases of TRD with suicidal ideation after the addition of lithium as an adjunct. This report aims to shed light on the potential of lithium as an adjunctive treatment for TRD through the lens of three cases seen in the outpatient setting.

Case Reviews

Patient A

Initial Presentation: A 53-year-old single male with no past psychiatric history presented to the emergency room with debilitating depressive symptoms, anxiety, insomnia, and chronic suicidal ideation. He endorsed a 12-year history of depressive symptoms following the diagnosis of a parent with dementia and a yearlong acute exacerbation in the context of worsening parental health, pandemic-related social isolation, and the suicide of a close friend. This patient screened negative on multiple occasions for mania and hypomania. He was diagnosed with major depressive disorder with anxious distress and admitted.

Interventions: Upon discharge he had been initiated on sertraline 100 mg for depression, lorazepam for anxiety, and numerous sleep medications including levomepromazine, pregabalin and quetiapine. At follow up, sertraline was up-titrated and buspirone was added. Shortly after this appointment, he attempted suicide by self-strangulation and was readmitted. Over the next twelve months he was up-titrated on previously mentioned medications with little benefit. Sertraline was replaced with bupropion and uptitrated. This was later augmented with brexpiprazole and venlafaxine. Unfortunately, the patient experienced very little improvement in his mood, anxiety, and SI. He received 8 sessions of ECT before deciding to discontinue due to lack of response and side effects.

Augmentation with Lithium: Fourteen months after his initial presentation and after carefully assessing the risks and benefits, the patient began lithium 150 mg daily in addition to his then current medications venlafaxine 150 mg, bupropion 300 mg, lemborexant 5 mg, propranolol 10 mg TID, and lorazepam 2 mg BID PRN. He was admitted within the month for worsening suicidal ideation and his lithium was up-titrated to 750 mg daily as an inpatient, at which time his serum lithium concentration was 0.5 mmol/L. Following discharge, the patient has been doing well, endorsing an 80-90% improvement in his mood,

Patient B

Initial Presentation: A 42-year-old married female with a history of major depressive disorder, posttraumatic stress disorder, chronic pain, and chronic suicidal ideation that were precipitated by a car accident. There was no history of mania or hypomania. Prior to involvement with psychiatry, sertraline, bupropion, and duloxetine had all been trialed unsuccessfully with the patient still having chronic passive suicidal ideation and low mood. At the time of consultation, she was receiving venlafaxine 150 mg BID and pregabalin 150 mg BID.

Interventions: Over the course of 15 months the patient was taking total daily doses of brexpiprazole 4 mg, clonazepam 2mg, venlafaxine 337.5mg, prazosin 15mg, pregabalin 600mg, and amitriptyline 100mg. With the previously mentioned pharmacotherapies as well as 12 sessions of psychotherapy she was still experiencing depressive symptoms and ongoing passive suicidal ideation that prevented her from being able to work or complete household tasks.

Lithium Augmentation: Lithium was added to her current medications of brexpiprazole, clonazepam, venlafaxine, prazosin, pregabalin, and amitriptyline, after the risks and benefits were carefully assessed, and was titrated to a dose of 900 mg daily. Within 4 weeks of initiation, there were substantial enhancements in positive mood and the complete resolution of suicidal ideation. Her serum lithium concentration was most recently measured at 0.44 mmol/L. She had some concerns with agitation following the initiation of lithium that improved with the addition of risperidone 0.5mg TID as well as gabapentin 100 mg TID.

Patient C

Initial Presentation: A 30-year-old single male with a long history of major depressive disorder, chronic suicidality with two previous suicide attempts, ADHD, and a failure to respond adequately to several antidepressants and psychotherapy was seen in the outpatient setting. He had no history of mania, hypomania, or mood lability. At the time of consultation, the patient was struggling with worsening depressive symptoms and increasing suicidal ideation while on sertraline 100mg, Vyvanse 50mg, along with having received 12 weeks of psychotherapy. Additionally, he had previously been trialed on escitalopram, venlafaxine, and quetiapine.

Interventions: After the initial consultation, the patient was started on brexpiprazole 2mg as an adjunctive antipsychotic, but minimal change in his low mood and frequent suicidal ideation was seen after 2 months. This was followed by addition of bupropion 300mg and increase of sertraline to 150mg and Vyvanse to 80mg, which also did not cause significant change in depressive symptoms.

Lithium Augmentation: At this point, after carefully assessing the risks and benefits, the patient was started on Lithium as an adjunct with initially tapering up to 600mg. Within 4 weeks, the patient endorsed a 40% decrease in suicidal ideation frequency. Over the following 4 months, lithium was slowly tapered up to 1350 mg daily, sertraline was discontinued, while being maintained on his other medications of Bupropion 300mg and Vyvanse 80mg. This has resulted in a significant increase in positive mood and reduced frequency of suicidal thought from 5-7 times per day to once per week on average. At his most recent appointment his serum lithium levels measured 0.67 mmol/L. At this time, it was also found that the patient had developed hypothyroidism likely secondary to lithium use. Given the efficacy of lithium augmentation in reducing his suicidal ideation and improving his mood, the patient was agreeable to continue lithium, and receive appropriate thyroid replacement.

Commentary

The presented cases show three patients with similar presentation and treatment courses. Each patient presented with symptoms of unipolar major depressive disorder and chronic suicidal ideation. Patients were appropriately screened for evidence of mania or hypomania, and in each instance, screening was negative. All patients failed to respond to standard antidepressant regimens and psychotherapy. They were subsequently trialed on numerous medications and treatment modalities (e.g., ECT, psychotherapy) with no benefit. Upon initiation of lithium and titration of serum lithium levels to within therapeutic range, the three patients all experienced a clinical improvement of their depressive symptoms and chronic suicidal ideation.

In terms of side effects, two of the three patients experienced symptoms that can be reasonably attributable to the initiation of lithium. Patient B experienced agitation after the initiation of lithium, which did not require hospitalization and improved with risperidone and gabapentin. Patient C developed clinical and biochemical evidence of hypothyroidism. Patient A was admitted under psychiatry for suicidal ideation shortly after initiation of lithium. Although he had been clinically worsening for some time, it is possible that the initiation of lithium exacerbated his symptoms and led to his admission.

Conclusions

Though limited by their anecdotal nature, these reports offer a valuable perspective on the potential of lithium augmentation in patients with TRD and chronic suicidal ideation. While side effects were observed, the clinical improvements suggest that the benefits of lithium should not be overlooked. Future studies should further investigate comparative efficacy between lithium and other augmentation agents, as well as factors predisposing to serious side effects.

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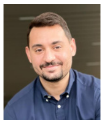
Evaluating Psychoeducation Material for Borderline Personality Disorder: Case Series



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Borderline Personality Disorder (BPD) is a complex mental disorder, with about 1 in 5 patients admitted to mental health facilities diagnosed with the disorder. Good Psychiatric management (GPM, Gunderson & Links, 2014) for BPD was designed as a flexible and pragmatic approach for patients with BPD in different settings. This brief report aims to assess the acceptability and inclusiveness of the excerpt provided in the GPM handbook for diagnostic disclosure. Three patients with different BPD severity and comorbidity profile participated in this case series. Some of the feedback provided highlights the need for further research to assess whether the educational material is inclusive and revisions are needed to better adapt the educational material to the inpatient setting.

Keywords: Borderline Personality Disorder, Good Psychiatric Management, GPM, Psychoeducation

Introduction

Borderline Personality Disorder (BPD) is a complex mental disorder characterized by interpersonal hypersensitivity, identity disturbance and emotional dysregulation, culminating in impulsive and potentially dangerous behavior, and dysfunction in multiple domains of life (American Psychiatric Association, 2022). The prevalence of BPD in the general population is around 1.6%, increasing to 10-12% in ambulatory mental health settings and 20-22% in inpatient psychiatric settings (Ellison et al., 2018).

Dialectical Behavioral Therapy (DBT) is an outpatient treatment structure developed for the management of BPD, and incorporates skills training groups, individual psychotherapy, telephone consultation, and therapist consultation(May et al., 2016).The resource-intensive nature of specialized modalities for managing BPD such as DBT, and the requirements for specialized training render such management options inaccessible for most patients. As well, they encourage a reluctance in clinicians to manage patients with BPD. General, or Good Psychiatric Management for BPD (GPM, Gunderson & Links, 2014) was consequently developed as a more flexible and pragmatic modality to help clinicians deliver a more structured and stepped-care model that is not as resource-intensive and does not require specialized training. GPM perceives interpersonal hypersensitivity as the core of BPD symptoms, and offers guiding principles for clinicians that incorporate elements of DBT and mentalization-based therapy. These principles focus on psychoeducation, being proactive, by fostering an anticipation that patients will improve and that clients are ultimately accountable for their decisions (Gunderson & Links, 2014).

Recently, principles of GPM were adapted to different settings, including inpatient psychiatric units. With the premise that unstructured environments can be harmful for patients with BPD, GPM emphasizes the following: importance of providing diagnostic disclosure via psychoeducation and a structure which includes goal-setting, multiple-hours of daily group activities, focusing on patients' life stressors alongside safety and discharge planning, particularly in the first week after discharge (Choi-Kain & Gunderson, 2019).

For psychoeducation, the same excerpt (see Appendix I) for diagnostic disclosure in ambulatory care is recommended for inpatient settings. The purpose of this case series was to assess the acceptability of the information provided in the excerpt as well as suggest possible adaptations for diagnostic disclosure.

Case Series

Participants. Three patients diagnosed with BPD admitted in different inpatient units at Finch Family Mental Health Building at Parkwood Institute agreed to take part in this case study and provided written consent.

Measures and Methods. Each patient completed the Borderline Symptom List (BSL-23) questionnaire. BSL-23 requires patients to indicate whether or not they experienced 23 possible problems or symptoms in the past week or on average, on a scale of 0-4 (0 = not at all, 4 = very strong). The 24th component of BSL-23 then asks participants to rate their overall personal state from 0-100% (0 = very bad, 100 = excellent, Bohus et al., 2007). Based on the average score of items, respondents' BPD symptom burden is classified into Non/Low (0 - 0.3), Mild (0.3 - 1.1), Moderate (1.1-1.9), High (1.9 - 2.7), Very High (2.7-3.5), and Extremely High (3.5 - 4) (Kleindienst et al., 2020).

Participants were then asked to indicate whether they agree or disagree with the following statements (S), on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree):

S1. The excerpt improved my level of knowledge and understanding of BPD

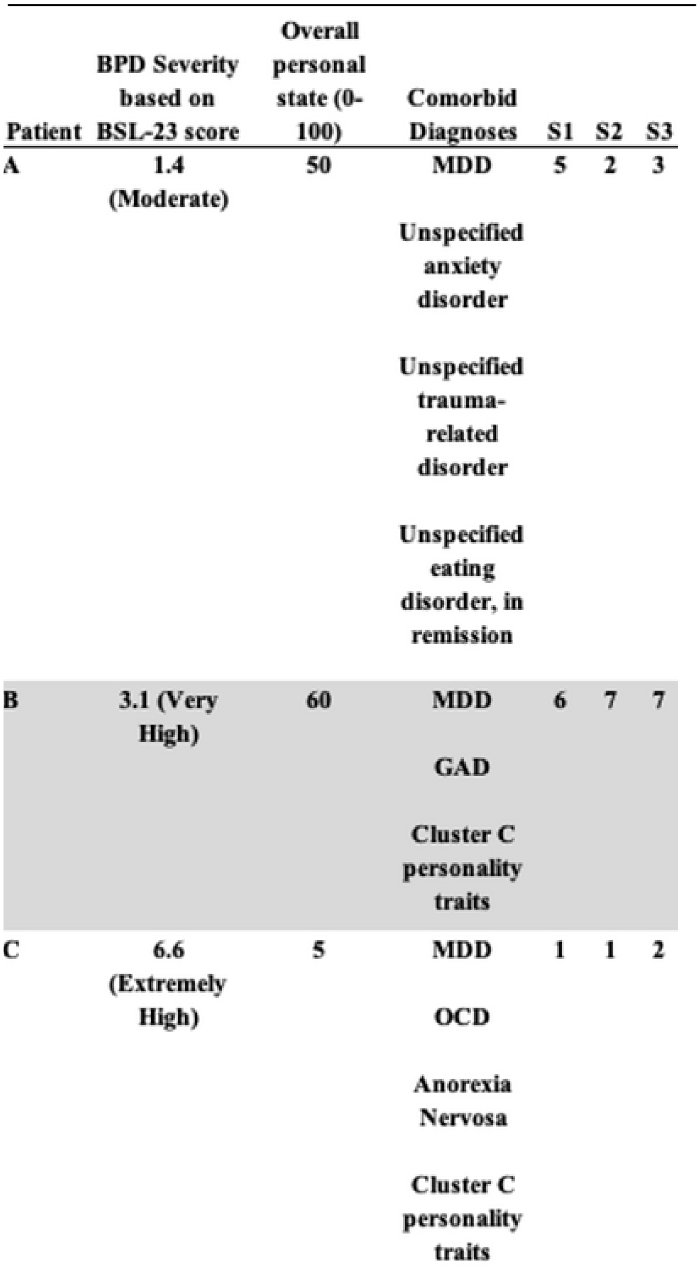
S2. The excerpt validates and accurately reflects my previous and/or my current interactions and experiences with my care takers

S3. The excerpt validates and accurately reflects my previous and/or current interactions and experiences with my friends and/or intimate partners

Patients finally provided recommendations to improve the excerpt as an educational material for clients with BPD.

Results. Table 1 lists patients' BPD severity based on BSL-23 average score, overall personal state, comorbid diagnoses, and responses to the three statements pertaining to the psychoeducational material provided.

***Table 1.* Participants' BSL score and BPD severity, overall personal state, comorbid diagnoses and responses to statement pertaining to excerpt**



Patient	BPD Severity based on BSL-23 score	Overall personal state (0-100)	Comorbid Diagnoses	S1	S2	S3
A	1.4 (Moderate)	50	MDD Unspecified anxiety disorder Unspecified trauma-related disorder Unspecified eating disorder, in remission	5	2	3
B	3.1 (Very High)	60	MDD GAD Cluster C personality traits	6	7	7
C	6.6 (Extremely High)	5	MDD OCD Anorexia Nervosa Cluster C personality traits	1	1	2

***Note:* GAD = Generalized Anxiety Disorder, MDD = Major Depressive Disorder, OCD = Obsessive Compulsive Disorder**

Below are verbatim responses from participants and their reflections on the material provided:

Patient A:

Discuss or include how experiences as a child are valid, and although they have a genetic disposition to react or behave, there could be some instances where their experiences have triggered these behaviors.

Patient B:
What would excerpt need? More educational information regarding the ups and downs and what to accept when this happens and this is normal to go through when the person has BPD.

Patient C:
Why "attribute" rather than "experience" parental anger and rejection? Similarly, why "feeling" versus "experiencing"? The current verbiage places all responsibility on the young person and doesn't place any on their caretakers. It also trivializes what can be serious maltreatment from caretakers. It is just resentment or has it caused them attachment trauma (among others)? How does the author know that their expectations are unrealistic?! Is it unrealistic to hope for safe, predictable, loyal, love/care/support (received and given)? Is it not reasonable the attachment is going to cause stress, fears, and insecurity in future close attachments? Again places all responsibility on the person with BPD.
Yeah, this whole excerpt feels filled with stigma and negative perceptions of the individual with BPD, not to mention rife with victim-blaming considering how many people with BPD have experienced abuse.

Commentary

Psychoeducation has been shown to reduce impulsivity, psychopathology burden, and enhance psychosocial functioning among clients with BPD (Zanarini et al., 2018). The first phase of inpatient management of BPD according to GPM entails safety planning and psychoeducation. The purpose of this brief report was to ask rather than answer questions. Should we continue to adopt the excerpt provided in disclosing the BPD diagnosis in the inpatient setting or introduce changes based on patient feedback? Is the excerpt inclusive or does it devalue or minimize traumatic childhood experiences? Is the material fit for patients on the more severe end of the BPD spectrum, and does it actually place all the responsibility on the person with BPD, or are some patients with BPD unlikely to accept their responsibility for their own behavior and that of their caretakers?

Conclusions

Further research is needed to assess the acceptability and inclusiveness of the psychoeducational material provided by GPM for disclosing the BPD diagnosis. On a broader perspective, efforts should be directed towards incorporating and adapting GPM as the standard model of inpatient management for patients with BPD.

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Appendix

Excerpt for diagnostic disclosure of Borderline Personality Disorder

“People with BPD are born with a genetic disposition to be highly sensitive and reactive to their caretakers. They are more apt to attribute rejection or anger to parental behaviors than are other children. They have usually grown-up feeling that they were unfairly treated and that they did not get the attention or care they needed. They resent this and, as young adults, they hope to establish a relationship with someone who can make up to them for what they feel is missing. The desired relationship is exclusive, setting in motion intense reactions to real or perceived slights, rejections, or separations. Predictably, both their unrealistic expectations and their intense reactions cause such relationships to fail. When this happens, people with BPD will feel rejected or abandoned, and they cannot resolve their anger about being treated unfairly and their fear that they are bad and deserved the rejection. Both conclusions can lead them to become self-destructive. Their anger about being mistreated or their shame about being bad or their self-destructive behaviors can evoke guilty or protective feelings in others. Such guilt or rescuing responses from others validate the borderline person’s unrealistically negative perceptions of mistreatment and sustain their unrealistically high expectations of having their needs met. Thus, the cycle is apt to repeat itself.”

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The Childhood Maladaptive Daydreaming Scale and the Childhood Maladaptive Daydreaming Checklist: A Case-Control Study

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Maladaptive daydreaming, or excessive daydreaming (ED), is a recently identified condition characterized by complex cognitive acts of fantasy that interfere with daily functioning. In children, similar maladaptive cognitive acts have been documented and are commonly associated with stereotypic movement behaviours, collectively referred to as Intense Imagery Movement (IIM). There is limited understanding of the natural history and long-term outcomes for IIM, with no validated screening and diagnostic tools currently. Through a case-controlled cohort study, we assess the feasibility of two newly developed assessment tools, one for children with IIM or ED and one for their caregivers. Our preliminary data is shared below, along with a discussion of the clinical implications of IIM or ED.

Keywords: intense imagery movement, maladaptive daydreaming, stereotypies, diagnostic tools, screening

Introduction

Maladaptive daydreaming, or excessive daydreaming (ED), is a condition that was first described in adults whereby affected individuals engage in complex cognitive acts of fantasy that are time-consuming, difficult to control, and interfere with daily activities, hence the term ‘maladaptive’ (Somer, 2002; Bigelsen et al., 2016). The condition is not well characterized in children, though case reports have suggested that it occurs in association with stereotypic movement disorders (SMD).

Stereotypic movement disorders present with repetitive non-functional complex movements that typically begin in early childhood and can lead to significant interference with normal daily function. Motor stereotypies are linked to overactive fronto-striatal dopaminergic pathways and underactive cholinergic and GABAergic inhibitory pathways (Katherine, 2018). One of the few empirical SMD papers presented evidence showing that 35 out of 42 children with SMD reported that daydreaming was associated with the onset of movements (Freeman, Soltanifar & Baer, 2010). Intense Imagery movement (IIM) is a term in the literature that describes children with SMD who engage in intense imagery or daydreaming when engaged in stereotypies. These children report consciously engaging in complex cognitive acts as the stereotypic movements occur (Robinson et al., 2014; Schimmenti, Somer & Regis, 2019).

While classic SMDs are believed to be a benign childhood disorder without long-term consequence (Freeman, Soltanifar & Baer, 2010), IIM can negatively impact a child’s ability to sustain attention and respond to external stimuli and subsequently lead to impairment in daily function. Further, ED in adulthood has been described to have a negative impact on those affected as it leads to social withdrawal, social isolation, and self-consciousness (Somer, Somer & Jopp, 2016). Adults with ED almost invariably report a childhood onset of their condition, with many recalling an antecedent vivid fantasy life often involving an engagement with imaginary friends (Bigelsen & Schupak, 2011). Therefore, if IIM is a precursor of ED, early recognition for these children can allow for better informed support and will lead to an improved understanding of the natural history of this condition.

Theory / Hypothesis

In adults, ED has been reliably diagnosed using a structured interview format and the 16-item Maladaptive Daydreaming Scale (MDS-16) (Somer, Soffer-Dudek, Ross & Halpern, 2017). In children, the Stereotypy Severity Scale has been used to characterize stereotypies in a standardized way (Leckman et al. 1989). However, these scales do not capture the intense imagery described by children with IIM. A validated screening and diagnostic tool is needed. This is particularly important when considering a diagnosis of IIM, as make-believe play is a common developmental behavior in children and is typically not pathological. To address this gap, Somer developed a caregiver report: Child Maladaptive Daydreaming Checklist (CMDC) (Somer, 2017). More recently Theodore-Katz's group modified the adult MDS-16 to create a childhood self-report scale: the Childhood Maladaptive Daydreaming Scale (CMDS) (Theodore-Katz, in preparation). However, there is a lack of clinical experience in the use of these tools and, they have not been formally validated in a paediatric population.

With our clinical population of IIM and ED patients at the Child and Parent Resource Institute (CPRI) in London, Ontario, we have designed a case-controlled cohort study to assess the feasibility of these two new assessment tools; the Childhood Maladaptive Daydreaming Scale (C-MDS) and the Child Maladaptive Daydreaming Checklist (CMDC). A secondary objective is to determine whether these tools distinguish between two age and sex-matched cohorts of children with and without a clinical diagnosis of IIM and ED. We hypothesize that children with IIM and ED will score higher than the control group in both assessment tools and that the assessment tools will be consistent with each other.

Evaluation of Preliminary Data

To date, we have administered the C-MDS and the CMDC to a population of nine patients with IIM and ED, ranging from ages 6 to 18. Our control group is made up of age and sex-matched patients who visited the local paediatric emergency department in London, Ontario and received a Canadian Triage and Acuity Scale (CAEP, 2012) score of 4 or 5. We currently have a control group of eight patients with further data collection ongoing.

Out of a maximum score of 64 for the child self-reported C-MDS, the study group's score (M = 27.1, SD = 7.5), was significantly greater than the control group (M = 6.0, SD = 6.2), which was computed as t (15) = 6.27, p<.0001. Out of a maximum score of 45 for the caregiver reported CMDC, the study group's score (M = 20.2, SD = 8.0), was significantly greater than the control group (M = 3.0, SD = 1.9), which was computed as t (15) = 5.91, p<.0001. Initial results of our feedback form show that 67% of our study group and 100% of our control group rated the assessment tools as "very easy" or "easy" to complete. When asked how well the tools captured the child's life experience, 78% of patients with IIM/ED gave ratings of "well" or "very well".

Clinical and Research Implications

ED has been linked to comorbidities such as attention deficit hyperactivity disorder, substance use disorders, childhood trauma, anxiety, and depressive disorders along with a history of suicide attempts (Somer, Abu-Raya & Nsairy Simaan, 2019). Similarly, children with IIM have been found to have comorbidities of ADHD, tics, autism spectrum disorder, and obsessive-compulsive disorder (Robinson et al., 2014). Children with IIM have been described to have a distinct intellectual functioning profile, when compared to children without IIM including significant impairments in processing speed, attention, and inhibition with strengths in memory and oral expression (Robinson, Woods, Cardona & Hedderly, 2016). It has also been theorized that cognitive profile contributes to the propensity for IIM and the complexity of the cognitive acts (Robinson, Woods, Cardona & Hedderly, 2016). Thus, the importance of early recognition of IIM is critical for establishing appropriate supports and initiating therapeutic interventions to minimize the longterm negative sequelae of ED.

SMD treatment has been largely behavioral in nature (Miller, Singer, Bridges & Waranch, 2006). ED has been treated through its proposed etiological pathways as a dissociative disorder, obsessive-compulsive disorder, or a behavioral addiction. (Somer, 2018; Pietkiewicz, Necki, Banbura & Tomalski, 2018). Therapies have included cognitive-behavioral therapy, motivational interviewing, and mindfulness training (Somer, 2018). There is limited evidence supporting antidepressants in helping reduce symptoms of ED (Ross, West & Somer, 2020; Rebello, Johnson, D'Souza, Rao & Malarmathi, 2019). Therapeutic interventions in IIM have not been formally studied. Habit reversal training and other strategies commonly used in tic disorders have been suggested (Robinson, Woods, Cardona & Hedderly, 2016).

Conclusions

Intense imagery movement and excessive daydreaming are newly described disorders and, as such, there remain many unknowns including prevalence, natural history, risk factors for adverse outcomes, and treatment strategies. Whether these are separate disorders or the same disorder presenting at different points across the lifespan is also not known. Continued work on assessment tools like the C-MDS and CMDC is needed to improve identification, diagnosis, and monitoring for this phenomenon.

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