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Volume 2, Issue 1&2
January/February/March 2022
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Learning Objectives
After reading these articles, you should be able to:

1. Understand best practices for court testimony and a clinician's "duty to warn."
2. Identify verbal de-escalation techniques to use with agitated patients.
3. Utilize Good Psychiatric Management principles to improve interactions with patients with borderline personality disorder.
4. Summarize some of the current research findings on psychiatric treatment.

Tarasoff: Making Sense of the Duty to Warn or Protect

Ahmad Adi, MD, MPH. Senior Instructor, Department of Psychiatry, University of Colorado, Anschutz Medical Campus. Victoria Hendrick, MD, Editor-in-Chief of the Carlat Hospital Psychiatry Report. *Chief, Inpatient Psychiatry, Olive View UCLA Medical Center.*

Dr. Adi and Dr. Hendrick have disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Highlights From This Issue

- Tarasoff warnings are more complex than they might seem, argues Dr. Ahmad Adi.
- How can we provide effective testimony in court? Dr. Ashley VanDercar gives us tips.
- Dr. Victor Hong shares approaches to working with patients with borderline personality disorder.
- We review strategies to verbally de-escalate agitated patients.

Your hospitalized patient tells you that he is angry with his sister and intends to "bash her brains in." He tells you she is sending him messages through the television that say she is going to kill him. Nurses note the patient has been tense and irritable and has been observed talking to himself.

Tarasoff ruling: Background

We often hear about the "Tarasoff warning" and the "duty to protect," but what do these mean, and who was Tarasoff?

Tatiana Tarasoff was a student at Merritt College in Oakland. In 1968, when she was 18, she met

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Q&A With the Expert

A Primer for Psychiatrists on Court Hearings
Ashley H. VanDercar, MD, JD

Psychiatrist, Northcoast Behavioral Healthcare, Northfield, OH.

Dr. VanDercar has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CHPR: Please tell us about yourself; you have a background in both law and psychiatry, right?

Dr. VanDercar: Correct. I practiced law in Florida for a couple of years, working as in-house counsel and risk manager for a medical practice. I then remained in Florida for medical school before moving to Cleveland for psychiatry residency and a forensic psychiatry fellowship. I am now a psychiatrist at a state hospital in Ohio.

CHPR: Can you start by telling us some key points that we should know about testifying?

Dr. VanDercar: It's important to remember that the American legal system is adversarial. It is a boxing match dressed up to look like a boardroom. When you testify, one side will be "against" your position. Your treatment decisions and diagnostic impressions will be questioned and

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challenged. You might feel attacked. It's not personal—it's how the justice system works. As psychiatrists, we know how to remain calm when we deal with acutely ill patients whom we need to de-escalate, or hostile patients who disagree with our treatment recommendations. It's important to maintain that same professional calm when we testify, especially during cross-examination. Don't get flustered. Don't become argumentative. If you feel your cool fading, switch to the approach that you use when dealing with a hostile or agitated patient.

CHPR: What other tips can help us in court hearings?

Dr. VanDercar: It's important to remember your role. As a treating psychiatrist at a civil commitment hearing, you are there as a fact witness as opposed to an expert witness. You are there to testify as to what you have seen with your patient and how that led to your decision to request involuntary civil commitment. So, you need to know the specific legal standard—for example, the standard for civil commitment—that your testimony is being used to support.

CHPR: Can you say a little more about the legal standards?

Dr. VanDercar: It's not enough to describe your patient's symptoms, even if they are acutely psychotic. Being mentally ill is not a sufficient reason for a patient to be committed. State commitment statutes have specific standards; for example, their criteria may require a mental illness to present an imminent risk of harm (to self or others) or grave disability. You are there to share the clinical information that supports your belief that a patient meets the specific legal criteria for commitment. If the patient's commitment request is based on suicidality, don't just say that they "have suicidal thoughts." Provide verbatim descriptions of what the patient has said, and how their specific history and current symptoms support your assessment of a high suicide risk. Be ready for questions. Know the details of the hospitalization, such as when and why a patient required emergent medications.

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists, and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

The Carlat Hospital Psychiatry Report (ISSN 2768-3877)

POSTMASTER: Send address changes to *The Carlat Psychiatry Report,* P.O. Box 626, Newburyport, MA 01950

CHPR: In Los Angeles, some details regarding a patient's behavior, like information we receive from nurses or other staff, are not admissible in our testimony as they're considered "hearsay." Is this a common limitation on psychiatrists' testimony?

Dr. VanDercar: Hearsay is tricky. Although it sounds like a simple concept, in practice it can be pretty amorphous. Hearsay is a statement made out of court that is being introduced into court to prove its truth. The legal system doesn't like hearsay because the witness is not in court—and thus cannot be cross-examined or confronted. So, for example, if a patient's mother told me about the patient's statements regarding a suicide plan, and I then cite the mother's comments during my testimony to support the notion that the patient was suicidal at admission, that would technically be hearsay. Hearsay is, at baseline, inadmissible. However, there are many exceptions to the hearsay rule.

CHPR: Such as?

Dr. VanDercar: Using this same example, the mother's comments might fall into one of several exceptions. For example, the comments might be admissible if they were offered for the purpose of facilitating her son's treatment when he was unable to speak for himself. Different states have different varieties, and interpretations, of hearsay and its exceptions. In California, there was a 2016 case called *People v. Sanchez* (63 Cal.4th 665) that resulted in a substantial tightening up on the use of hearsay. But other states handle hearsay differently. Some allow you to rely on statements documented in the medical record—whether they be by the patient's family or by nursing—in addition to your own observations of the patient.

CHPR: Earlier you referred to the concept of imminent harm. How do courts usually interpret the term "imminent"?

Dr. VanDercar: That is a good question. There's no agreed-upon definition for the term within our profession (Simon R, *U Cin L Rev* 2006;75:631–644). Practically speaking, the way that the court interprets the phrase is going to depend on the state statute on civil commitment (and whether, for example, that statute requires a recent overt act), the case law in your jurisdiction, and often the specific magistrate or judge. Judges have a lot of latitude, especially with terms that are as amorphous as "imminent." As long as there is no on-point statute or case law stating otherwise, a judge can interpret "imminent" as meaning within the next day, within the next month, or some other foreseeable time in the future. Talk to colleagues to find out how the phrase tends to be interpreted in your specific courtroom or area.

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CHPR: But is there generally a basic understanding of what constitutes imminent harm?

Dr. VanDercar: The Merriam-Webster dictionary describes the term "imminent" as meaning "ready to take place" or "happening soon." But finding a basic understanding, or applying this, is more challenging when you are dealing with the potential discharge of someone from an inpatient unit. The unit is a controlled setting. So, if their behavior has been appropriate while in the inpatient setting, you need to explain to the court why their suicide or violence risk still remains active and *imminently* elevated. Again, in the context of a civil commitment order, this is ultimately a judicial decision. If you, as the clinician, view it as imminently elevated, explain why you think so. Be ready to explain the lack of certainty associated with suicide and violence risk assessments (including as it pertains to the prediction of a time course), and then leave the decision up to the court.

CHPR: How else should we prepare for commitment hearings?

Dr. VanDercar: Focus your time on knowing the patient's clinical history and hospital course. You should know the reason for the patient's initial admission and what has transpired since their arrival. Be able to explain how the patient's current status supports your state's legal criteria for commitment. Also, if you are arguing for a hold based on a patient's inability to care for themselves, make sure you have reached out to, or at least considered, potential support systems in the community (for example, willing family members who have agreed to care for the patient on discharge). When possible, talk with the attorney who will be doing your direct examination ahead of time. That will let you discuss your planned testimony. And present yourself appropriately—this is important if you want to be effective at conveying your opinion. Dress appropriately, in conservative business attire. Remember that you are in the courtroom as a guest; wait until you are asked questions to talk, and stop talking if the judge intervenes.

CHPR: In many states, there are two hearings associated with commitment. The first decides whether the patient is committable, followed by a hearing on whether the patient can be given involuntary medication. Can you say more about the involuntary medication standard?

Dr. VanDercar: Sure. Legal standards vary by state, but they have many similarities. In my state of Ohio, for example, the legal standard is from the 2000 case *Steele v. Hamilton Cty. Comm. Mental Health Bd* (90 Ohio St.3d 176) and requires that 1) the patient lacks capacity to give or withhold consent, 2) the medication is in the patient's best interest, and 3) no less-intrusive treatment will be as effective. In any state, psychiatrists need to be able to explain why they believe the patient fulfills each of the specific criteria of their state's legal standards, as the judge uses these standards to evaluate the content of the testimony and make a ruling.

"As psychiatrists, it's important to maintain that same professional calm we use when we deal with acutely ill patients when we testify, especially during cross-examination. Don't get flustered. Don't become argumentative. If you feel your cool fading, switch to the approach that you use when dealing with a hostile or agitated patient."

Ashley H. VanDercar, MD, JD

CHPR: Can you review reasons why we might lose a hearing, whether it's a hearing for medication capacity or civil commitment?

Dr. VanDercar: Yes. State statutes for commitment and forced medication orders often have very specific requirements regarding each step of their specified process, from the emergency hold, to the involuntary admission, to the commitment. If the clinical criteria or procedural details of the statutory requirements are not met—for example, the length of time that a clinician has to file paperwork for commitment, the notice requirements, etc—the court will often rule contrary to what the psychiatrist is recommending.

CHPR: And also, of course, a judge may rule against our wishes if we don't adequately demonstrate evidence that meets the legal standard. We sometimes lose hearings for patients who are, for example, homeless and floridly psychotic—to the point they were wandering through traffic a few days earlier—but we can't demonstrate evidence for imminent self-harm as they haven't experienced any self-injurious thoughts or exhibited self-injurious behaviors on the unit.

Dr. VanDercar: Right. Although a strong case can often be made that if they were unable to manage their needs and find their way on the inpatient unit, they continue to be imminently at risk of grave disability and resultant harm upon discharge (based on the combination of their clinical status and their predischarge behavior).

CHPR: Does a forced medication order allow us to prescribe any medication?

Dr. VanDercar: In general, no. If a forced medication order is granted, the specifics of what you can prescribe will depend on the exact language of the court order. Therefore, the medications you are requesting should be detailed in your written opinion that is submitted to the court and reiterated during your testimony. Some court orders, particularly those involving forensic patients, can be quite broad; they may even state that the patient is to take whatever medication the doctor recommends as medically appropriate. Other court orders allow categories of medications. Conversely, there are court orders that specify exact medications, dosages, and routes—even requiring that oral versions be attempted

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before injections. It is thus helpful to consider your treatment plan before submitting a request for a forced medication order.

CHPR: Is it best to list all possible medications that you might envision using, just in case some of them are ineffective or cause side effects?

Dr. VanDercar: Yes—however, some opposing attorneys, and even some magistrates or judges, will push back on this. When you request a long list of medications, it can create a perception that you are going to overmedicate a patient or want carte blanche to make judicially imposed medication decisions. You should thus be prepared to explain to the court what your primary treatment plan is, and why you are listing alternative treatment plans.

CHPR: Some medications don't have intramuscular versions. How do you handle refusals of medication in those cases?

Dr. VanDercar: This is a reason to request alternative medications. For example, a refusal of oral Abilify can often be managed with an intramuscular injection of Zyprexa or Haldol. Your electronic or written orders can clearly specify this to ensure the patient receives necessary antipsychotic medications despite their refusal (eg, "medication is court ordered; administer olanzapine 5 mg IM in case of oral Abilify refusal").

CHPR: Can the involuntary medication order be used to forcibly administer a long-acting medication, like Invega Sustenna, even when a patient is willing to take the oral form of the medication?

Dr. VanDercar: That would be dependent on the wording of the court order, and the clinical need for a long-acting rather than a short-acting medication.

CHPR: One of the toughest situations we encounter is when a patient reaches the end of their hold and is still unwell, but we cannot legally commit them any longer.

Dr. VanDercar: That is a tough situation. You can offer the patient voluntary admission. If, however, they refuse and are no longer committable, you need to release them. You can then document their refusal and provide the best discharge plan that is practically feasible.

CHPR: What about patients who are released by the court but then decide that they don't want to leave the unit after all? Can they sign in as voluntary patients?

Dr. VanDercar: Yes. The question would then be whether they in fact still need to be hospitalized, and if so, whether insurance would cover their ongoing stay.

CHPR: You've mentioned that states vary in their regulations around psychiatric commitments. How much variability is there?

Dr. VanDercar: There are a lot of differences from state to state. The duration of emergency holds can vary; there are also differences in who is authorized to initiate a psychiatric hold. A useful article comparing differences between states was published a few years ago (Hedman LC et al, *Psychiatr Serv* 2016;67(5):529–535). The same types of differences exist with the actual commitment process. Interestingly, when I've talked to colleagues from other states, even when we've had similar-sounding commitment statutes, we've noticed substantial differences in the types of patients who tend to be considered committable, in particular regarding the issue of imminence and the concept of "grave disability."

CHPR: Thank you for your time, Dr. VanDercar.

Disclaimer: The information in the interview transcript is for educational purposes only. It should not be construed as, and does not constitute, legal advice.

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Tarasoff: Making Sense of the Duty to Warn or Protect

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22-year-old Prosenjit Poddar, a graduate student at UC Berkeley. They dated, but Tarasoff told Poddar that she was seeing other men, and he was crushed, becoming increasingly depressed. He eventually began therapy with Lawrence Moore, a psychologist at the student health service. Poddar told Moore that he intended to kill Tarasoff by stabbing her. In response, Moore informed campus police and recommended that Poddar be civilly committed for treatment of paranoid schizophrenia. Police detained Poddar but released him because he appeared rational. Neither Tarasoff nor her parents received any warning directly. A few months later, Poddar stabbed and killed Tarasoff, carrying out the plan he had confided to his therapist.

The family sued the university, leading eventually to two important California Supreme Court decisions, referred to as *Tarasoff I* and *Tarasoff II*. In *Tarasoff I,* the court ruled that doctors and psychotherapists have a legal obligation to warn a patient's intended victim if that person is in foreseeable danger from the patient. Warning the police or other authorities is not good enough. This is a concept known as the "duty to warn."

In *Tarasoff II,* a rehearing of the case, the court added the concept of "duty to protect." This duty requires providers to take whatever steps are necessary to protect the intended victim. You can warn them, but you can also protect the intended victim by, for example, placing the patient

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on an involuntary psychiatric hold. This option has the advantage of not breaching patient confidentiality.

Still, many clinicians continue to warn intended victims in addition to placing patients on involuntary psychiatric holds, from a belief that the Tarasoff ruling requires this warning—but in 2013, California courts clarified that the current duty is solely to protect and disregarded the previous duty to warn (Weinstock R et al, *J Am Acad Psychiatry Law* 2014;42(4):533).

Do you have a duty to warn anyone if a patient makes nonspecific threats to the general public? Most state legislatures have adopted "Tarasoff-limiting statutes" that provide specific criteria for Tarasoff warnings, including the requirement that the threat be made against an identifiable intended victim (Knoll JL, *CNS Spectr* 2015;20(3):215–222). Of course, in those situations, if you believe the threat to be associated with a mental illness, you would place the patient on an involuntary hold on the grounds of danger to others, thereby keeping the public safe.

Applicability by state

If you don't work in California, does Tarasoff apply to you? Most states have adopted similar or modified versions of Tarasoff. In 26 states and Puerto Rico, Tarasoff applies much the same way as it does in California (see map of" Implementations of Tarasoff in the U.S.": www.thecarlatreport.com/duty) in that the duty is mandatory—ie, you may face civil liability, fines, or other penalties if you fail to warn/protect a potential victim.

You can find each state's laws here: www.tinyurl.com/mves5y29

Evaluating risk

Even if you live in a state with a clear-cut Tarasoff ruling, you will still face legal ambiguity: How do you decide whether a patient's threats are serious enough to warrant action? Your patient might express violent fantasies but have no intention of following through with them. In a 12-month study of patients who made explicit and clear violent threats, 23% of the threats resulted in a violent act by the threatening party (Warren LJ et al, *Behav Sci Law* 2011;29(2):141–154). Here are some ways you can hone your risk appraisals:

1. Look for red flags that increase the likelihood of a threat leading to actual violence: prior violence, substance use, and untreated mental illness (Warren et al, 2011).
2. Ask yourself the following questions:
   - Is the threat clear and imminent?
   - Is the patient able to carry out the threat?
   - Has the patient engaged in preparatory actions, such as buying a weapon or rehearsing a planned attack?
   - Is the intended victim identifiable?
3. Consider the difference between a patient with dementia who threatens to "hurt people who want to hurt me" versus a patient with psychosis who informs you that they plan to stab a specific family member later that day as they exit their home because they believe that family member is trying to poison them. The second patient presents a far more urgent scenario, warranting immediate action to warn/protect.

Steps to follow when you believe a third party is in danger

You gently attempt to obtain more information about the seriousness of your patient's threat. He tells you, "I know my sister is plotting to kill me. Once I'm discharged from the hospital, I'll wait for her outside of her job so I can finish her off as soon as she leaves the building."

When you have a compelling reason to believe that a third party is in danger, you must take steps to protect that person (see "Duty to Protect Options" table). If you're unable to place the patient on an involuntary psychiatric hold, you'll need to warn the intended victim and notify the police.

Duty to Protect Options
Hospitalize the patient.
Warn the police.
Warn the intended victim.
Ask the patient to warn the intended victim.

Source: Knoll JL, *CNS Spectr* 2015;20(3):215–222

If you don't have any contact information for the intended victim, you can try to reach out to the patient's family members who might have the intended victim's contact information, or you can conduct an online search. Let the police department know if you are still unable to reach the intended victim. Document all of these efforts in an accurate and timely manner, and be clear as to your reasoning and actions. Describe the threat using verbatim quotes. If you contact the police, take down the name and badge number of the officer you speak with.

You prescribe an antipsychotic for your patient, but he refuses to take it, so you seek a court order to treat the patient involuntarily. Once this is granted, the patient takes his meds twice daily, and you note his behavior has become increasingly calm and appropriate. He is no longer seen talking to himself, and his paranoid delusions resolve. He denies any intention of harming his sister. You discharge him as he no longer appears to pose a threat of imminent violence. He agrees to follow up with outpatient treatment.

CHPR VERDICT: Ultimately, our clinical judgment and our good faith efforts to protect potential victims are the most important tools in preventing harm to a third party. Most states have adopted statutes concerning a duty to warn or protect, like California's Tarasoff rule. While we risk breaching confidentiality, our overriding principle is to make good faith efforts to protect intended victims. By involuntarily hospitalizing and treating a patient so they no longer pose an imminent threat, we can fulfill our obligation to protect third parties without needing to contact the intended victim and thereby breach confidentiality. But check your state's laws, and keep in mind that the most prudent course of action is to protect *and* warn.

Q&A With the Expert

Borderline Personality Disorder in the ED

Victor Hong, MD

Clinical Assistant Professor, Department of Psychiatry, University of Michigan, Ann Arbor, MI.

Dr. Hong has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CHPR: What are some common issues that you encounter with patients with borderline personality disorder (BPD) in the psychiatric emergency department (ED)?

Dr. Hong: First, we should remember that individuals with BPD are prevalent in every psychiatric setting, but especially the ED. About 10%–15% of all psychiatric ED patients have BPD, and these patients often present repeatedly (Pascual JC et al, *Psychiatr Serv* 2007;58(9):1199–1204). That can be very frustrating for clinicians, who might have the attitude of "Wait, didn't I just see you? You're here again? You made another suicide attempt?" Adding to the frustration, there's the issue of chronic suicidality and self-harm behaviors. We worry about patients killing themselves if we discharge them. There's typically a lot of drama surrounding individuals with BPD. And the frenetic nature of EDs adds to the challenge of working with these patients, since they're interpersonally hypersensitive and easily triggered emotionally.

CHPR: So how can we best work with these patients in EDs?

Dr. Hong: It helps to think of patients with BPD as a special population who require a distinct, organized approach. Good Psychiatric Management principles, based on APA guidelines, are particularly useful in the emergency setting (Hong V, *Harv Rev Psychiatry* 2016;24(5):357–366). Do these principles solve all the problems? Definitely not, but if clinicians and staff have a better understanding about why the patients behave the way they do and how to proactively mitigate that behavior, everyone benefits.

CHPR: Can you review the fundamental points of Good Psychiatric Management?

Dr. Hong: There are several evidence-based treatments for BPD, the most well known being dialectical behavior therapy. There's also mentalization-based therapy, transference-focused psychotherapy, and other evidence-based treatments. But these modalities are time intensive and require lengthy training, and few practitioners are adequately trained in them. They're difficult to implement in acute care settings like inpatient units or EDs. John Gunderson and his team at McLean Hospital developed the Good Psychiatric Management modality (Gunderson J et al, *Curr Opin Psychol* 2018;21:127–131). It's intended to be a generalist model that can be easily taught in an eight-hour training. There are several principles that are relevant for the ED *(Editor's note: For more information, see the "Good Psychiatric Management Fundamentals" table on page 7).*

"The minds of patients with borderline personality disorder tend to wander toward negative thoughts. If you take a neutral approach and don't say much, they will often interpret that behavior negatively. But if you sit forward and make it very clear that you're interested and engaged, asking about their lives and their relationships, that approach helps develop rapport and trust."

Victor Hong, MD

CHPR: Which are the main principles?

Dr. Hong: The most essential principle is that the core attribute of individuals with BPD is interpersonal hypersensitivity, and most crises come out of interpersonal stressors. For example, the patient has an argument or there's a breakup or a perceived breakup, and in response the individual self-harms or threatens or attempts suicide, ending up in the ED. To help these patients, we need to get straight to the heart of the issue and explore their interpersonal stressors.

CHPR: What's another important principle?

Dr. Hong: A second key principle is that you want to provide psychoeducation, including a review of evidence-based treatments. The acute care setting provides an opportunity to review the diagnosis if it is already established, and to bring up the possibility of BPD if it is suspected. You can review the DSM criteria together and see if the patient thinks the diagnosis fits. Another way, if the patient is frustrated that medications don't seem to be helpful, is to ask, "Might something else be going on? Has anyone ever mentioned BPD?" And then a third key principle is to quickly work to develop rapport with a patient with BPD.

CHPR: How do you do that?

Dr. Hong: One effective way is to be more active and engaged than you might otherwise be. There was a study that took patients with BPD and control subjects and told them to let their minds wander. It showed that the minds of patients with BPD, compared to controls, tended to wander toward negative thoughts (Kanske P et al, *Psychiatry Res* 2016;242:302–310). So, if you take a neutral approach to a patient and sit back in our chair and don't say much,

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patients with BPD will often interpret that behavior negatively and think, "This person is being dismissive and doesn't care about me." But if you sit forward and make it very clear that you're interested and engaged, asking about their lives and their relationships, that approach helps develop rapport and trust.

CHPR: So, it helps to be highly engaged in our interviewing. And back to your comment about patients' self-harming behavior: How do you distinguish between chronic self-harming behaviors and real suicidality?

Dr. Hong: This is one of the most stressful aspects of managing patients with BPD. Yes, these patients do carry an elevated risk of suicide compared to the general population. But too often we use that chronic risk to guide us in our clinical decision making, and that can lead to unnecessary hospitalizations. It helps to look at the patient's acute risks. For patients with BPD, to hammer home the point, the triggers are typically interpersonal stressors, like real or perceived abandonment. There are patients who will attempt suicide after they lose a therapist or after their significant other threatens a breakup. So, we need to be attuned to those specific risk factors for suicidality in patients with BPD.

CHPR: Anything else we should be mindful of?

Dr. Hong: No matter how many times the patient has threatened suicide, it's important to provide validation and hope, and maintain and exhibit a genuine concern about their safety. Even though you might be seeing a patient for suicidality for, say, the 20th time, from the patient's perspective their suicidality is very fresh. And if they're coming to the ED or inpatient unit as a last line of defense and they're met with a hostile or dismissive attitude, that can increase their suicide risk. So, no matter how frustrated you might be with the patient, you need to remember that they're in crisis. Additionally, patients with BPD often need us to interpret what they're saying. So, if somebody says "I'm suicidal" or "I want to die," or cuts themselves or takes pills, they may be communicating: "I'm lonely. I feel abandoned. I'm upset and I don't know what to do about it."

Good Psychiatric Management Fundamentals

Fundamental	Essential Elements
Conservative psychopharmacology	• Adjunctive to psychosocial treatments • No one medication is uniformly or dramatically helpful
Coordination of care	• Family psychoeducation is importnat • Use adjunctive treatments (eg, dialectical behavior therapy skills groups) when resources allow • Collaboration among providers is essential
Diagnostic disclosure	• Provides validation and hope • Withholding diagnosis blocks patient from receiving appropriate treatment, can cause iatrogenic harm
Getting a life	• Primary goal: Build a meaningful life • Secondary goal: Symptom reduction, self-control
Psychoeducation	• Useful treatment in and of itself • Symptoms are rooted in interpersonal hypersensitivity • Prognosis is cautiously hopeful
Suicidality and self-harm management	• Suicidality and self-harm are reactions to interpersonal distress • Response: Expression of concern and clear-headed evaluation of level of risk • Collaboration with patient, clinicians to make a safety plan

Source: Finch EF et al, J College Stud Psychother *2019;33(2):163–175*

CHPR: It must be very reassuring for a patient to hear someone put their feelings into words. By helping patients develop greater self-awareness, does that help reduce their visits to the psych ED?

Dr. Hong: Over time, if patients can gain a sense of what triggers emotional reactions, understand how they can self-soothe, and remember that whatever they are feeling will likely pass, they'll have a better chance of avoiding an ED visit. This is an important point because for a lot of patients with BPD, recurrent visits to the psych ED and hospitalizations can be harmful. Some patients develop a dependence on the hospital system to the point that they run to the ED whenever they're in distress, and this can handicap them in developing self-soothing techniques.

CHPR: Is there anything else we can do to minimize recurrent visits to psych EDs?

Dr. Hong: For somebody who is coming to the ED time after time, it's important to collaborate with everyone involved in the patient's care—the outpatient therapist, the outpatient psychiatrist, and the patient. Everyone should understand when the patient should call the therapist or psychiatrist, when they should go to the ED, and when they should use self-regulation and self-soothing techniques. And if they do come to the ED, everyone should be on the same page regarding the expectations of an ED visit, the criteria for hospitalization, and the goals for discharge if the patient is hospitalized.

CHPR: In these collaborative meetings, do you include family members?

Dr. Hong: Yes, whenever possible. These families are often desperate for help. Sometimes they don't have a good understanding of BPD; sometimes they're terrified that they're going to lose their loved one to suicide. So, it is crucial to engage families in the care. It's also a good liability risk reducer to involve families in the care, but this isn't always easy. BPD often runs in families, so family members themselves might have BPD or other cluster B traits, which obviously can complicate family meetings. There are also a lot of cases, given BPD's ties to trauma, where family members have engaged in overt abuse of the patient. But as much as possible, I try to have the families engaged.

CHPR: Do you provide any psychoeducation to family members?

Dr. Hong: We hand out educational material for families in the ED, which I think is very helpful. These materials include tips like being aligned as a family unit to avoid splitting *(Editor's note: See "Tips for Family Members"*

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Principles of Verbal De-Escalation

Victoria Hendrick, MD. Editor-in-Chief of the Carlat Hospital Psychiatry Report. *Chief, Inpatient Psychiatry, Olive View UCLA Medical Center. Janet Richmond, MSW. Clinician at VA Boston Healthcare System and McLean Hospital, MA. Associate Clinical Professor of Psychiatry, Tufts University School of Medicine.*

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When our patients become agitated and threatening, we often think first about chemical or physical restraints—especially when staff's physical safety seems at imminent risk. But it's important to remember that coercive interventions can be humiliating and may lead to more agitation and violence. In fact, research indicates that restraints are correlated with worse patient outcomes, including lengthier hospitalizations (Gopalakrishna G et al, *Int J Psychiatry Clin Pract* 2015;19(4):238–244). In this article we will review verbal de-escalation techniques that can calm a patient and potentially preclude the need for coercive interventions.

Surprisingly little research exists on the effectiveness of verbal de-escalation methods, and many of the data originate from low-quality studies (Du M et al, *Cochrane Database Syst Rev* 2017; 4(4):CD009922). One reassuring finding is that we can reduce the use of coercive interventions without increasing the incidence of violent behaviors (Fernández-Costa D et al, *J Clin Med* 2020;9(9):2791). Our recommendations are based on the consensus guidelines from Project BETA (**B**est Practices for the **E**valuation and **T**reatment of **A**gitation), established by the American Association for Emergency Psychiatry.

A fundamental goal in verbal de-escalation is to move away from the concept of "calming the patient," which implies a dominant/submissive relationship, to the collaborative concept of "helping the patient calm himself" (Richmond JS et al, *West J Emerg Med* 2012;13(1):17–25).

Here are 10 principles you can use in your efforts to de-escalate agitated patients (Fishkind A, *Current Psychiatry* 2002;1(4):32–39).

1. **Respect the patient's personal space.** Stay at a distance of two leg lengths—this keeps you far enough away that the patient will not feel hemmed in and you will be safe from punches or kicks. You and the patient should have room to quickly exit the encounter if either of you feels uncomfortable.
2. **Don't be provocative.** Remain calm and unruffled. If you cannot, you might need to take a break or ask a colleague to join you or take over. Judicious self-disclosure helps humanize you: "I can't help you if you're screaming at me." "I need help and I'm going to ask Dr. X to join us." If you threaten to use coercive interventions or say anything that the patient might perceive as humiliating—for example, telling them that you are extending their psychiatric hold without providing a clear explanation—you will only escalate the situation. Watch your body language: Are your arms crossed? Does your voice sound tense? Patients will notice these behaviors. Stand with your arms uncrossed, keep your hands visible—showing you aren't concealing a weapon—and speak in a relaxed tone. Use friendly eye contact but not so much that the patient feels stared at.
3. **Establish verbal contact.** Introduce yourself and ask the patient's name. Consider addressing the patient by their last name, as using their first name might appear overly personal or insincere. Let the patient know you are there to help. Identify one staff member to speak to the patient. Whoever engages best with the patient should conduct the de-escalation, even if that person is not the team leader.
4. **Be concise.** Use simple phrases and repeat your message as often as necessary until the patient has heard it. "You seem upset. How can I help you?" and "Let's work together to get you what you want" are simple and effective phrases.
5. **Identify wants and feelings.** What does the patient want? Reassure them that even if you can't get them what they want right away, you will work with them to obtain it. Attend to the patient's real-life needs. Questions like "Is there something I can get for you?" and "Would you like a snack?" show the patient that you are trying to help.
6. **Listen closely to what the patient is saying.** Convey that you are genuinely paying attention. Use echoing statements like "So what I think you're saying is…" Do not argue with the patient, even if they insult you or use profanities or slurs. Tell the patient that you understand they are frustrated, but that the unit does not tolerate rude and inappropriate comments.
7. **Agree to disagree.** Find things you can agree on. For example, if the patient says, "The staff mistreats me," you can agree in principle by saying, "I believe everyone should be treated respectfully." Explore why patients feel a certain way. If they believe staff are ignoring them, acknowledge this by saying something like, "Sometimes we get really busy and don't have as much time as we'd like for each patient, but I promise that we will never deliberately ignore you." If the patient tells you that they are angry because the government installed a chip in their brain, you can agree that no one should have things done to their body against their will. If there is no way to honestly agree with the patient, agree to disagree. We find it helpful to say, "You have a right to disagree with me, and I respect that, but I need to do what I think is best for you while you're under my care."
8. **Lay down the law and set clear limits.** Provide clear information about acceptable behaviors and inform the patient of both the positive and negative consequences, depending on their choices. Tell the patient that it is unacceptable to inflict self-injury or to injure others. We say, "Our job is to keep you and everyone else safe, and we need to take whatever steps are necessary for that. We don't want you to be placed in restraints, but that might need to happen if it's the only

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Minimizing PTSD From Workplace Trauma

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Mr. Jacobowitz has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

For staff on inpatient psychiatric units, the rate of posttraumatic stress disorder (PTSD) is around 9%, which is two to three times higher than the national prevalence rate of 3%–5%. Rates are higher if you work with forensic patients or if you're a nurse. Nearly all (96%) psychiatric nurses have been directly or indirectly exposed to a critical event, and over half have been physically assaulted by a patient (Hilton NZ et al, *Psychiatr Serv* 2020;71(3):221–227).

Typical manifestations of workplace PTSD include disengagement from patient care, frequent absenteeism, and a tendency to self-isolate. Over half of workers who meet PTSD criteria also meet criteria for depression or anxiety (Seto MC et al, *Can J Psychiatry* 2020;65(8):577–583).

How can we mitigate our risk of developing PTSD after a traumatic event? Debriefing sessions help, especially if they take place soon after the event—within 10 hours. Be careful, however, as a single debriefing can be retraumatizing if it is not followed with individual counseling, which staff can seek through their workplace's employee assistance program.

Here are some additional tips to help you decrease your chances of developing PTSD after workplace trauma:

- Try to carry on with your usual work activities—in effect, you'll be practicing exposure therapy, a common psychological intervention in treating PTSD.
- Talk to people and spend time with others.
- Practice mindfulness—which includes muscle relaxation, meditation, and frequent self-assessment of stress level.
- Make as many daily decisions as possible, even about minor things—like what to make for dinner—as they will give you a feeling of control over your life.
- Understand that you might experience recurring thoughts, dreams, or flashbacks; they are normal and will decrease over time.

Here are some ways that you can help co-workers who have been exposed to trauma:

- Offer them assistance and a listening ear even if they have not asked for help.
- Don't pressure them to recount the incident if they don't want to. Respect their privacy.
- Don't tell them they are "lucky it wasn't worse." Instead, affirm that you are sorry such an event has occurred, and you want to understand and help them (Mitchell JT. *Critical Incident Stress Management (CISM): Group Crisis Intervention,* 4th ed. Ellicott City, MD: International Critical Incident Stress Foundation; 2006).

Also, consider scheduling routine monthly staff meetings, as they help reduce the risk of PTSD by enhancing employee cohesion and providing opportunities to express concerns and receive support (Jacobowitz W, *Issues Ment Health Nurs* 2013;34(11):787–795).

CHPR VERDICT: Many of us experience or witness traumatic incidents on inpatient psychiatric units, so it's no surprise that rates of PTSD are high. Practical tips can help reduce the risk, but be careful about debriefing sessions as they can be retraumatizing if not done correctly.

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Principles of Verbal De-Escalation

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way to keep everyone safe." Communicate this in a matter-of-fact way and not as a threat. Have security on standby if there is any question as to whether the patient can contain their anger. It can be helpful to say, "Our hospital policy requires us to call security when there's a big disagreement between patients and staff" so that the patient won't see the call to security as a personal affront.

9. **Offer choices and optimism.** Offer things that will show the patient you are trying to help, such as a cup of water, a blanket, or access to a phone. If a time-out or a medication might be helpful, give the patient a choice, and if they choose medication, give them options: eg, "Do you want the pill form or a shot?" Express optimism and let the patient know that things will get better. If the patient doesn't want to take medication, tell them, "I realize you don't think this medication will help you, but I've seen a lot of people who've come in for similar reasons as you, and they've gotten better with it." If the patient states they want to get out of the hospital, give them clear goals—eg, appropriate impulse control and adherence to treatment—and assure them that, if they reach those goals, they will be discharged.
10. **Debrief the patient and staff.** Sometimes, despite every effort to de-escalate, patients will end up receiving intramuscular medications or being placed in seclusion or restraints. Following an involuntary intervention, work to restore the therapeutic relationship. Explain why the intervention was necessary and let the patient explain events from their perspective. Help the patient think of more appropriate ways to express anger. Give the staff an opportunity to suggest what went well during the episode and what did not.

CHPR VERDICT: These techniques of verbal de-escalation will help calm at least some of your challenging patients.

Research Update IN PSYCHIATRY

DEPRESSION

The Role of rTMS in Poststroke Depression

Susan L. Siegfreid, MD

Dr. Siegfreid has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

REVIEW OF: Hordacre B et al, *J Neurol* 2021;268(4):1474–1484

STUDY TYPE: Randomized controlled trial

Poststroke depression is common, disabling, and often treatment refractory. We know repetitive transcranial magnetic stimulation (rTMS) is effective for treatment-resistant depression. Might it offer a safe and effective treatment for poststroke depression? Two previous small randomized controlled trials of rTMS (using high-frequency [10 Hz] delivery of 1,000 pulses per session to the left dorsolateral prefrontal cortex for 10 sessions) demonstrated both safety and efficacy in poststroke depression (Gu SY and Chang MC, *Brain Stimul* 2017;10(2):270–274; Jorge RE et al, *Biol Psychiatry* 2004;55(4):398–405). Researchers in the current study hypothesized that delivery of a higher dose—3,000 pulses per session—would increase clinical benefit without compromising safety.

The study recruited 11 patients with moderate (baseline PHQ-9 score > 5) poststroke depression and no change in antidepressant medication for the prior six months. Most of the patients (n = 9) were male, ages 44–78 years, with predominantly right hemispheric strokes occurring one to 11 years prior to enrollment. Participants were randomized to either active (n = 6) or sham (n = 5) rTMS groups using an identical figure-8 coil. They received 10 treatment sessions, occurring over five weekdays for two consecutive weeks. The primary outcome measure for depression severity was the Beck Depression Inventory-II (BDI), which was assessed at baseline, immediately after treatment, and at one month follow-up.

From baseline to one-month follow-up, the BDI scores in the treatment group decreased significantly more than in the sham group, with an average change of 12 points (p = 0.04). Adverse effects were transient and comparable between the treatment and sham groups.

CHPR'S TAKE

This study was small and only followed moderately depressed patients for one month after treatment, but it provides additional evidence that higher-dose rTMS is a safe and effective treatment option for poststroke depression in patients who do not fully respond to antidepressant medication.

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Expert Interview—Borderline Personality Disorder in the ED
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table at right). And if families need more assistance, there's a program called Family Connections offered through the National Education Alliance for BPD, and they provide education and support groups for families *(Editor's note: For more information, see www.borderlinepersonalitydisorder.org/family-connections).*

CHPR: You mentioned liability concerns. Are there any other thoughts you have about reducing liability risk?

Dr. Hong: In terms of reducing liability, an important point is to appropriately manage countertransference reactions. These reactions are often born out of a sense that the patient is intentionally trying to cause problems. We hear terms like, "They're being manipulative." Patients may seem like they're being overly dramatic to get attention, but often the truth is that they don't know how to express their emotions in a more regulated way. I highly value the process of venting with a trusted colleague. These patients create stressful situations, and venting can help you have a cooler head when you interact with them.

CHPR: Those are good tips.

Dr. Hong: And going back to the question of liability, you don't want the first time you're meeting a family to be in the ICU after a patient has taken an overdose. You will want to have met them before that to say, "I'm concerned about your family member. There is a real risk of suicide in this illness. We're going to do the best we can. These are the evidence-based practices." If somebody does die by suicide and you have that connection with the family, then an honest, frank appraisal of the situation can reduce liability. And the last thing I'll say about reducing liability involves conversations with supervisors and colleagues. Many of us don't do these consultations enough, especially if you're a more experienced clinician. But we can all use a second opinion, no matter how many times we've dealt with a

Tips for Family Members

- Set short-term, feasible goals
- Keep things cool
- Maintain family routines
- Schedule times to talk
- Don't get defensive
- Maintain concern about self-harming thoughts and behaviors but don't panic
- Involve the patient with BPD in identifying what needs to be done
- Make sure all family members are on the same page
- Express your expectations in simple, clear language
- Don't protect the patient with BPD from the consequences of their actions
- Set limits but be cautious about ultimatums
- Don't tolerate abusive treatment

Adapted from: https://dev.borderlinepersonalitydisorder.org/wp-content/uploads/2011/08/Family-Guidelines-standard.pdf

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CME Post-Test

To earn CME or CE credit, log on to www.TheCarlatReport.com with your username and password to take the post-test. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be completed within a year from each issue's publication date. The Carlat CME Institute is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Carlat CME Institute maintains responsibility for this program and its content. The Carlat CME Institute designates this enduring material educational activity for a maximum of two (2) *AMA PRA Category 1 Credits*™. Physicians or psychologists should claim credit commensurate only with the extent of their participation in the activity.

For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Learning Objectives (LO) are listed on page 1.

1. According to the clarification provided by California courts in 2013, clinicians have what required duty to an intended victim (LO #1)?
   - [ ] a. A duty to warn and protect
   - [ ] b. A duty to protect
   - [ ] c. A duty to warn
   - [ ] d. Neither a duty to warn nor a duty to protect

2. During a conversation with an agitated patient, how far away should you be (LO #2)?
   - [ ] a. Across the room
   - [ ] b. One arm length away
   - [ ] c. Seated next to the patient
   - [ ] d. Two leg lengths away

3. According to Dr. Hong, which psychopharmacological management option is most optimal for addressing mood dysregulation, paranoia, and dissociation symptom clusters in patients with borderline personality disorder (BPD) (LO #3)?
   - [ ] a. Low-dose antipsychotics
   - [ ] b. High-dose antipsychotics
   - [ ] c. Low-dose SSRIs
   - [ ] d. High-dose SSRIs

4. In a 2021 study of moderate poststroke depression, what was concluded about the efficacy and safety of higher-dose repetitive transcranial magnetic stimulation (rTMS), compared to the sham group (LO #4)?
   - [ ] a. Higher-dose rTMS significantly reduced Beck Depression Inventory-II (BDI) scores but produced significantly higher rates of adverse events
   - [ ] b. Higher-dose rTMS significantly reduced BDI scores and produced adverse events comparable to the sham group
   - [ ] c. Higher-dose rTMS did not separate from sham and produced adverse events comparable to the sham group
   - [ ] d. Higher-dose rTMS did not separate from sham but produced significantly fewer adverse events

5. According to Dr. VanDercar, there's no agreed-upon definition for "imminent harm" regarding a threat posed by a patient against an intended victim, and courts will interpret this phrase based on the state statute on civil commitment (LO #1).
   - [ ] a. True
   - [ ] b. False

6. Which of the following is the best response for de-escalating an agitated patient who tells you that "all of the staff hate me" (LO #2)?
   - [ ] a. "I think everyone should be kind and compassionate to others."
   - [ ] b. "What did they do to you?"
   - [ ] c. "No, they don't hate any patient."
   - [ ] d. "We are trying to help you."

7. According to Dr. Hong, what is the core attribute of BPD (LO #3)?
   - [ ] a. Impulsivity
   - [ ] b. Disproportionately intense anger responses
   - [ ] c. Interpersonal hypersensitivity
   - [ ] d. Feelings of loneliness

8. If a clinician has a compelling reason to believe that a third party is in imminent danger but cannot place their patient on an involuntary psychiatric hold, which of the following must they do (LO #1)?
   - [ ] a. Inquire about their patient's specific plans
   - [ ] b. Contact their patient to prevent them from following through with their plans
   - [ ] c. Warn the intended victim and notify the police
   - [ ] d. Warn the intended victim's family about the threat

THE CARLAT REPORT
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patient with BPD or how many years of experience we have. We all have blind spots. That is a very important liability risk reducer.

CHPR: If you get to the point where you need a medication, do you have any tips for psychopharmacology management?

Dr. Hong: There are no FDA-approved medications for BPD or any other personality disorder, so everything we're using is off label. Try to focus on specific symptom clusters, like psychosis or agitation. Low-dose antipsychotics win out for most symptom clusters, like mood dysregulation, paranoia, and dissociation. For patients with comorbid anxiety disorders or a concurrent major depressive episode, SSRIs rise to the forefront. SSRIs sometimes need to be pushed to higher-than-usual doses, whereas for antipsychotics, high doses have not been shown to help more—but of course, they can lead to more side effects (Black DW et al, *Am J Psychiatry* 2014;171(11):1174–1182).

CHPR: What about benzodiazepines?

Dr. Hong: It's important to be careful with benzodiazepines. They work well, almost too well, and for a patient who is often distressed and can be easily calmed by a benzodiazepine, that's a setup for dependence. So, if you use a benzodiazepine, you must be strict about it being very short term.

CHPR: Thank you for your time, Dr. Hong.

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