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Editorial

Società Italiana di Psichiatria

SIP Virtual Congress Next Generation Psychiatry: "Lezioni della-dalla pandemia"

Massimo di Giannantonio[1], Enrico Zanalda[2]

[1] Presidente Eletto SIP; [2] Presidente SIP

Massimo di Giannantonio

Enrico Zanalda

The lifestyle changes imposed by the pandemic have profoundly affected us as individuals and as health professionals involved in the emergency. The rapid spread of vaccination practices finally means that precautionary anti-pandemic restrictions have been overcome. Starting in the summer, autumn 2021, we will gradually return to our pre-COVID lifestyle, and we look forward to a return to normality without masks and without the fear of physical contact with others that has affected us so much during these long months of pandemic and lockdown. What will remain in our memories of this trauma and how much have we changed internally from our previous lives? Nice used to say that whatever doesn't kill you makes you stronger! Will this really be true for everyone? Psychiatric professionals question the personal changes as therapists, the changes in their patients and society in general, brought about by the experience since March 2020. What is the value of overcoming this experience and what are the challenges it leaves us as individuals and in the practice of our profession? The serious problems that were already affecting mental health services before the pandemic, partially mitigated by the health emergency, must now be tackled with determination. We need to be able to assert in public opinion and institutions the rights of our patients and their families and to raise awareness of the importance of investment in mental health in the post-COVID era.

With this in mind, the Italian Society of Psychiatry encouraged the establishment of the Coordination of Italian Mental Health Department (DSM) Directors, which met four times between December 2020 and June 2021 on a zoom platform. Eighty percent of the DSM directors participated in these meetings, representing all the people who work there, as well as patients and their families. The fourth conference, held on 23 June 2021, was attended by representatives of all categories of workers in the DSM. The proposal coming from the conferences is the need to promote a new "Progetto Obiettivo Tuela Salute Mentale 2021/30". Italian mental health urgently needs economic, cultural and organisational investments, which have been summarised in a document sent to the Ministry of Health and which will be supported as a concrete proposal with all the decision-makers, summarised in three key words: Resources, Integration, Innovation.

In addition to this proposal, the organisation of the 2021 SIP National Congress entitled: "Next Generation of Progress: Lezioni della-dalla Pandemia" will be held in virtual mode from 23 to 25 November 2021. The decision to keep the virtual mode stems from investors' uncertainty about organising a large national congress in presence without overcoming COVID-19 limitations. One of the lessons from the pandemic experience is the possibility of organising relevant scientific events in virtual mode. As summarised in the title, the negative and positive legacy of this traumatic and prolonged experience will be discussed in the various fields of psychiatry: the social, the psychodynamic and the biological. Registration will be open from 15 September and is free of charge for members who have paid their 2021 subscription.

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Correspondence:
Massimo di Giannantonio
digiannantonio@unich.it

Enrico Zanalda
enrico.zanalda@yahoo.it

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Evidence based Psychiatric Care
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Original article

Società Italiana di Psichiatria

Psychomotor agitation, anxiety disorders, trauma-related disorders: a review of clinical manifestations in COVID-19

Patrizia Moretti, Valentina Pierotti, Francesca Brufani, Giorgio Pomili, Eleonora Valentini, Micaela Bozzetti, Laura Lanza, Luigi Maria Pandolfi, Giulia Menculini, Alfonso Tortorella

Department of Psychiatry, University of Perugia, Italy

Patrizia Moretti

Summary

Introduction. The aim of our study is to highlight psychiatric clinical features due to the SARS-CoV-2 infection, providing insights from the new environmental circumstances resulting from the global pandemic.

Materials and Methods. We conducted a review of the most recent literature involving psychiatric consequences of COVID-19, particularly focusing on psychomotor agitation, anxiety disorders, trauma-related disorders and the main guidelines for the treatment of such consequences.

Results. A great variety of psychiatric correlates is involved in the present pandemic, with a relatively wide distribution.

Discussion and Conclusions. We believe that promoting studies that could explore the epidemiological distribution of psychiatric and psychological dysfunctional responses to the global situation may be useful. Furthermore, the possible influence that SARS-CoV-2 may exert on specific psychiatric diseases claims further attention. Future research with this specific focus may help a more timely and correct management of the infection, as well as the implementation of actions to protect public health.

Key words: COVID-19 pandemic, SARS-CoV-2 infection, ACE2 receptor, Psychomotor agitation, Anxiety Disorders, and Trauma-Related Disorders

Introduction

Coronavirus disease (COVID-19) is an infectious disease caused by the Coronavirus Severe Acute Respiratory Syndrome - CoronaVirus - 2 (SARS-CoV-2) that belongs to the family of Coronaviridae, genus Betacoronavirus and is a virus with a single-stranded RNA genome with positive polarity [1].

SARS-CoV-2, despite having a possible different origin, has a similarity to SARS-CoV for over 70% of the genome, since both use spike glycoprotein to bind to the ACE2 receptor (present in large quantities in the respiratory tract and also in the gastrointestinal tract) and infect the host, but SARS-CoV-2 possesses a 10-20 times greater binding affinity, justifying the high infectivity compared to its predecessor SARS-CoV, which caused an epidemic in 2002, of much more limited geographical and temporal extent [1].

The virus has human-to-human transmission capacity through droplets (respiratory droplets generated by coughing or sneezing, with a journey of 1-2 meters which then deposits on surfaces) or by direct or indirect contact with secretions [2]. If there are favorable conditions, the virus can remain on surfaces for few days but is destroyed in a minute by commonly used disinfectants such as sodium hypochlorite or hydrogen peroxide [2,3].

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Correspondence:
Patrizia Moretti
patrizia.moretti@unipg.it

Conflict of interest
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Clinical manifestations of COVID-19 may encompass different levels of severity, with a variable course ranging from mild symptoms to an acute respiratory distress syndrome (ARDS), also causing in some cases Multi-Organ Failure Syndrome (MOFS) leading to death [4,5]. Among possible presentations of COVID-19, psychiatric symptoms were also reported, e.g. psychotic symptoms [6], anhedonia [7], anxiety [8], psychomotor agitation [9]. Furthermore, psychiatric manifestations that may be reactive to the current pandemic and to the SARS-CoV-2 infection are in fact increasingly widespread in our daily practice in hospital and at local level, and currently represent one of the greatest challenges in the medical field. Among these an increase of symptoms relate to anxiety, including pandemic fear and ruminations about this, severe insomnia and suicidal thoughts, has been highlighted [10]. Noteworthy, mental health was pointed out as a priority during the current emergency situation by the World Health Organization (WHO), with a call for a comprehensive approach to this issue in order to address mental health needs [11]. As a consequence, in this review we will outline the main clinical aspects of the infection caused by Coronavirus (COVID-19) in the field of mental health, also evaluating the possible impact on psychiatric services and evaluating possible intervention strategies.

Materials and Methods

We carried out a research on Pubmed/MedLine using the main keywords “COVID-19” and/or “SarS-Cov 2” variously combined with “Psychomotor Agitation”, “Anxiety”, “Anxiety Disorders”, “Post-traumatic Stress Disorder”, ”Trauma-related disorders”.

Results

We present our results divided into chapters of interest concerning major psychiatric aspects highlighted during the pandemic: Psychomotor Agitation, Anxiety Disorders, Stress-related or trauma-related disorders.

Psychomotor agitation

Psychomotor agitation is a heterogeneous concept, mainly defined a set of non-specific, unconnected behaviors that can endanger the safety of the patient or caregivers and hinder the treatment process [12,13].
It is generally considered to be a cognitive and motor state characterized by excessive or inappropriate motor or verbal activity, marked emotional arousal, very marked internal restlessness or tension, high reactivity to internal and external stimuli, and irritability, which can lead to aggression and violence [14]. While it is difficult to estimate the overall prevalence of agitation episodes in subjects affected by psychiatric disorders due to the lack of epidemiological studies, it is widely recognized that agitation is a common phenomenon in both medical and psychiatric emergencies [15].

In a patient suffering from COVID-19, agitation, confusion or both may result from the underlying clinical condition, from medical complications, from treatment or from the medical environment, e.g. intensive care [12]. Possible causes are pain and discomfort from endotracheal intubation, fever, electrolyte imbalances, acidosis, hypoxia, hypotension, sepsis and shock, organ failure, sedative use, sleep deprivation, fear of dying, anxiety about unpleasant medical procedures, mechanical ventilation, the presence of a genitourinary catheter, and the possible establishment of delirium [12]. Additional triggers for the development of psychomotor agitation can be accidental rupture of ventilators, shortness of breath, loneliness, immobilization [12].
In such circumstances, it is appropriate to set up pharmacological therapy with psychotropic drugs to avoid the appearance of behavioral disorders induced by psychomotor agitation, which can complicate the treatment of SARS-CoV-25 infection. Many psychotropic drugs share the same metabolism with cytochrome P450 of antiviral drugs, therefore the choice of the drug must be made considering these possible interactions. Sedatives and hypnotics such as oxazepam and lorazepam are not metabolized by cytochrome P450 and are therefore quite safe when used in combination with antivirals, althoughtit is to consider that their use is contraindicated during respiratory distress. The same is true for some antipsychotics such as olanzapine and mood stabilizers such as valproic acid, which are thus considered safe [16].

Anxiety Disorders

We will examine anxiety disorders starting from the assumption that psychological factors play a vital role in the success of public health strategies (risk communication, hygiene practices and social distancing, antiviral therapy and, where possible, vaccination) used to manage epidemics and pandemics. Health anxiety is indeed important in influencing the success or failure of each of these strategies. Pandemics include not only the spread of physical disease, but also the spread of what is perhaps the real pathogen of mass reactions: anxiety, which at times, if also propagated through social media, can become “viral” [17].
This great epidemiological impact is evidenced by a study where a sample of 1,210 adults from 194 cities in China during the SARS-CoV-2 pandemic was interviewed to asses he psychological impact of the virus spread. Among those, 53.8% declared a moderate or severe psychological impact of the pandemic, 28.8% reported moderate to severe anxiety symptoms, and 8.1% disclosed moderate to severe stress levels [17].
When facing a major emergency like the present one, personal reactions may be heterogeneous, as well as the defense mechanisms that can be implemented: at one end of the spectrum, some people may deny the risks, sometimes not following health-related behavioral recommendations (hygiene practices, social distancing, vaccination,

when available), whilst on the other end of the spectrum many people may react with intense anxiety or fear that are sometimes even exagerrated [18].

Excessive health anxiety, as present in psychiatric disorders such as Hypochondria, Illness Anxiety Disorder and Somatic Symptom Disorders is common, with an estimated lifetime prevalence of 6% in the general population [18]. It is therefore easy to understand how subjects are prone to excessive worries concerning health risks, thus becoming particularly anxious during a pandemic period [19].

Additionally, patients with already known psychiatric conditions are at increased risk of developing comorbid anxiety exacerbations; this phenomenon is especially accentuated if such patients are already being treated for anxiety disorders [20].

In a psychodynamic context, anxiety can be defined as "fear without an object", even though the object of anxiety "exists, but it is indefinite and indefinable"[16]. It is perhaps possible to hypothesize that, in such situation, the anxious subject could try to link his or her mood to some representation or idea with a pessimistic content, which could find an easy expression, in this historical moment, in anxiety about an "indefinite and indefinable", apparently invisible pathogen, possibly threatening his or her health [21].

In order to provide an overview of possible scenarios, we drew up the following list of behaviors, possibly being the obvious sign of clinically relevant anxiety:

- resorting to repetitive medical checks and seeking excessive reassurance, which could lead to management problems by the healthcare system [22], e.g., in the early stages of the swine flu pandemic, a British government diagnostic website was unable to keep up with the demand for information, crashing as thousands of people simultaneously attempted to access it [23];
- excessive avoidance, with social withdrawal, of stimuli / sources related to infection, including people, places, things, animals. Emblematic are the cases of abandonment / killing of domestic dogs and cats, sometimes brutally killed, on the occasion of the SARS virus pandemic and the fear of being avoided by others if one becomes ill [24-26];
- extreme attempts at "decontamination", with the risk of more extreme behaviors than simple hand washing. As evidenced from the news of 44 people who died and 218 hospitalized for industrial alcohol poisoning in the provinces of Khuzestan and Alborz in Iran, after the news was spread that drinking alcohol could fight COVID-19 [27];
- civil unrest, riots, mass panic, looting sometimes occur during pandemics although the most common behaviors are of a solidarity type, as the threat of the disease evokes acts of mutual aid among the members of a community in crisis. Even in our country (Italy), after the first weeks of the first lockdown, there was a growing fear that the emergency situation and the stress secondary to isolation, and in general to the restrictions in place, could lead to riots and civil revolts, especially in some areas characterized by worse socio-economic status [28,29];
- tendency to excessive buying, which taken to an extreme can have negative consequences for the individual and his community [30];
- sleep disturbances, which can be both a consequence of stress and risk factors for the development of PTSD. In a study conducted on 170 individuals in self-isolation, low levels of "social capital", as defined by Portes and Lynch, ("a collection of actual or potential resources that include social trust, belonging and social participation") were associated with increased levels of anxiety and stress [30]. Anxiety was associated with stress and reduced sleep quality, and the combination of anxiety and stress reduced the positive effects of social capital on sleep quality. Similarly, out of 180 healthcare professionals involved in the treatment of COVID-19 patients, anxiety levels were significantly associated with stress, and negatively influenced work efficiency and sleep quality [31-33].

In order to reduce the social impact of the current environmental stressor and reduce the impact of anxiety disorders, it would be appropriate to pay greater attention to vulnerable groups, including psychiatric patients, to strengthen and improve accessibility to medical resources of the public health system, also establishing a strategic national coordination plan for psychological first aid services, which could be potentially provided through telemedicine [34].

Trauma-related disorders

In the DSM-5, a traumatic or stressful event means a serious threat to the psychophysical integrity of the person [32]. Exposure can be direct or indirect, therefore the individual can experience the threat firsthand or be in physical or emotional proximity to the victim; those who are exposed to repetitive observation of raw details of the event are also included. Post-Traumatic Stress Symptoms (PTSS) are considered as such because their first manifestation in the individual is temporally related to the event and had not manifested before it [35].

The two disorders differ in the temporal criterion, respectively for the persistence of symptoms beyond one month from the event (they tend to present themselves about three months later), and for the onset of the same between three days and within the month following the event. It should not be underestimated that this diagnostic category includes Adjustment Disorders, psychic manifestations characterized mainly by marked suffering, disproportionate to the severity of the stressful event, which produce a significant impairment in social, work or family functioning of the individual, and which may cause a deflection of mood and / or anxious symptoms [35,36].

Simplifying a lot, we could say that patients affected by the SARS-CoV-2 virus, in particular those who have been

in the Intensive Care Units (ICU), should be considered directly exposed to a traumatic or stressful event, which was a threat to psychophysical integrity. The general population is exposed to psychological distress, not only for measures of social distancing, but also for the variable perception of risk [36,37].

Contradictory information (easily accessible on social media) exposes subjects to greater distress, because it increases uncertainty about the future and the consequent fear of the unknown and leads to greater levels of anxiety both in the "healthy" population and in those with previous mental health problems [37,38].

Qualitative and quantitative data on the impact of mental health is currently available, despite limitations due to research being carried out in the short period of time from the beginning of the epidemic until today, whilst literature relating to previous Coronavirus infections, as well as other epidemics and experiences in the Intensive Care Unit, offers numerous contributions to be referred to by analogy of circumstance [39-42].

The following individuals should be considered more vulnerable and exposed to the risk for developing emotional responses(to quarantine or isolation, to the perceived risk of getting sick, or to the spread of the disease with its consequences: (1) infected individuals (hospitalized and/or quarantined), their families and their colleagues; (2) individuals with previous morbidity (organic or psychic); (3) healthcare professionals, especially doctors and nurses, who directly worked with affected patients [39].

In various studies conducted following an epidemic, the incidence of PTSD varies from 14% to 59% of survivors in the Intensive Care Units (ICU); in line with the literature supporting the classification systems, PTSD can occur up to three years later (on average) after the traumatic event [38]. Some studies highlight its appearance even in those who have been in quarantine, with an increasing incidence according to the longer duration of quarantine. In the general population, the incidence is between 4% and 41% [20-43].

Additional risk factors can be the following: female gender, low socioeconomic status, interpersonal conflicts, frequent use of social media and decreased resilience and social support. Fear of getting infected, frustration, boredom, inadequate support and information, economic losses, and stigma can also contribute to the onset of PTSD. Therefore, variables that should be taken into account are both the ones that were present prior to the epidemic (not least, the existence of previous trauma), and the ones related to the disease (severity, hospital or home treatment, quarantine and / or isolation), as well as psychosocial variables [44,45].

The absence of a support system for mental health, as well as the shortage of properly trained professionals, may amplify the risk of persistent psychological distress and progression of psychopathology [46,47].

In the short term, first-line psychological help should be provided to patients: interventions must be aimed at assessing the most critical needs, reducing stress and reactions to pain, supporting positive thoughts about the future and teaching mindfulness-based techniques to reduce stress levels and hyperarousal (e.g. deep breathing, progressive muscle relaxation, and guided imagery). Coping with anger and reducing anger-driven behaviors are also important therapeutic goals. The global picture relating to mental health is inevitably influenced not only by local culture, political and economic factors, but also by the presence of previous and / or concomitant traumatic events [48].

Addressing the psychological aspects of social distancing likely offers benefits in the long term, through a lower incidence of PTSD, anxiety, depression, or substance abuse, but it could also motivate participation and promote adherence to treatment [49].

Another major aspect that should be considered concerns health professionals, towards whom preventive measures may be represented by the support from supervisors and colleagues, such as clear communication about decisions, directives, and risks [49]. It is important to encourage the transmission of skills by means ofwith mentoring systems, which also promote a sense of support and interconnectedness, while reducing stigma [49]. It may also be useful to promote work in groups and moral-building activities, as it would be useful to promote shared moments of gratification and appreciation in which the efforts that the whole staff is carrying out should be verbally acknowledged [49]. It would be adequate to reduce overtime shifts, encourage shifts that allow rest and temporary relief from obligations (also preventing burnout) [49]. Mindfulness and relaxation techniques can prove to be self-help tools that health professionals could pass on to patients. For those who have religious communities of reference, ad hoc initiatives by the guides of these realities are protective and supportive [50,51].

As for PTSD treatment, where diagnosed, it should be timely and, based on the evidence available to date, the first choice should be Trauma-Foucsed Cognitive-Behavioral Therapy (TF-CBT) to reduce pessimistic and catastrophic thoughts about the future. An alternative is represented by Eye Movement Desensitization and Reprocessing (EMDR) therapy [52]. If these therapeutic modalities are not available, pharmacological treatment may consist of Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin-Norepineprhine Reuptake Inhibitors (SNRIs), which should be maintained for 6-12 months to prevent recurrence and relapse of symptoms [53]. Quetiapine may also be considered, either as monotherapy or as adjunctive therapy. Alpha-adrenergic antagonists such as prazosin can be used for sleep abnormalities and nightmares, either alone or in combination with an antidepressant [52].

Discussion and Conclusions

Although only some of the psychopathological manifestations that were most highlighted during the pandemic have been reviewed in this paper, we can assert that most populations of subjects suffering from psychiatric diseas-

es can potentially present an increased risk of relapse in this particular historical moment [20]. From a psychopathological point of view, the current COVID-19 pandemic represents a new form of trauma. It has been compared to natural disasters such as earthquakes or tsunamis but, in these cases, the emergency was localized, limited to a specific area and to a specific time, and people could escape if they had the chance. In all of these circumstances the enemy was easily recognizable, while in the pandemic the "threat" can be anywhere and can be carried by the person close to us. This destabilizing environmental condition has led to some psychiatric patients an alteration in reactive judgment skills, with the assumption of risky behaviors and great difficulty in following the measures aimed at mitigating the spread of the epidemic [20].

It is therefore useful to promote initiatives aimed at acquiring epidemiological information: adequate knowledge of the distribution of risk allows for the implementation of preventive actions in terms of public health, including the protection of mental health [46,47].

In fact, it is crucial to increase the resources dedicated to mental health services and facilitate access to them, also by exploiting the use of telepsychiatry [53], which makes it possible to overcome the obstacles caused by fiduciary isolations or ascertained patient's infection, thus removing the geographical barriers between patients and operators [54]. Through the use of telepsychiatry, the effectiveness of which has now been widely proven [55], the number of patients that can be reached increases, as can be guessed, and with it the possibility of making early diagnoses and promptly setting appropriate therapies. In a period like this, opening up and relying on alternative ways of doing and building treatment paths means knowing how to respond to the concrete adversities of the moment and thus also encourage the patient to adhere to a reality plan [55].

Moreover, providing educational materials that inform the public of common stress reactions can help scale reactions and emphasize hope, resilience, and healing [49]. Recommendations for the development of positive coping strategies should be readily accessible (e.g., a dedicated website describing the warning signs of pandemic-related mental health problems). Social media, despite of the previously mentioned risks, can play a useful role in helping to share and disseminate information sources [50].

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Original article

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Early psychopathology: arrival to first aid

Claudia Palumbo[1], Clara Locatelli[1], Alessandra Massaro[1], Daniele La Barbera[2], Emi Bondi[1]

[1] ASST Papa Giovanni XXIII-Bergamo; [2] Università di Palermo

Claudia Palumbo

Summary

Adolescence has been identified as a phase of transition and destabilization in which risk behaviors for oneself or for others can emerge. These behaviors are characterized by an increased search for novelty, impulsiveness and preference for reward, which can give rise to an increased risk of using drugs. Beyond this alcohol and/or drug abuse, among the so-called "risk behaviors" typical of this age group, there are bullying, "cyberbullying", "sexting", soliciting online, violent behavior against objects, animals or people, as well as self-harm and suicide attempts.

This work aims to evaluate the psychopathological needs of adolescents arriving for the first time at an emergency room. This work also aims to emphasize the importance of untreated disease duration as a negative prognostic factor, particularly in mental disorders. The number of first aid visits for teenagers appears to be on the rise. Teens arrive to the emergency room with various symptoms that can range from suicidal ideation to self-harm, substance abuse, social psychological problems resulting from childhood sexual abuse, or family psychiatric history.

Today it is important to implement early intervention programs whose goal is to reduce latency times latency of psychiatric assistance intended to intervene in the best possible way on those sources of discomfort that are not part of the diagnoses structured by the DSM 5 manual.

Key words: adolescence, first aid, psychopathological onset

Introduction

The term "Adolescence" generally refers to the transition phase from childhood to adulthood whose duration is quite variable. During this phase, it is possible to note that the typical characteristics of late adolescents (12 and 18 years) are often found also in young adults (18 and 25 years) such as the lack of economic independence and the long stay in the origin family.

In the adolescent phase we witness the maturation of the analysis and introspection skills and the definition one's own identity with a progressive personological reorganization. Several authors study the deep emotional disturbances, considering the adolescent crisis "physiological", mostly correlated to the biological changes typical of this period [1].

In this experience, the body pays the highest price. In fact, the mistreatment of it by the adolescent in crisis denounces the collapse of the psychic container and the need to affirm one's own omnipotence, challenging the limit between life and death.

Adolescence brings with it a basic depressive potential but also a drive increase such as to determine an increase in aggression and impulsivity. This can result in transgressive and risky behaviors with often lethal consequences on the individuals health who practice them [2].

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Correspondence:
Claudia Palumbo
clapal82@gmail.com

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Among behaviours at risk for health and psycho-physical well-being, there are for example unprotected sexual activities, school leaving, escaping from home, high-speed motorcycle travelling without a helmet and driving under the influence of alcohol and/or other psychoactive substances. These behaviors also include the so-called "death games" and dangerous sports such as extreme skiing, "bungee jumping" and free canoe descents.
More recently the "Blue Whale Challenge", a "deadly" challenge that adolescent can take part in via social media chat groups, has taken hold in the world of young people. The conducts implemented in this "game" could constitute "suicidal equivalents" as they endanger the life of the subject or his physical integrity but, unfortunately, escape the epidemiological findings. Recent research suggests that these phenomena, show an incidence that varies between 15% and 20% among adolescents and young adults, with an onset between 13 and 14 years of age and are often associated with psychopathology but also with substance abuse, dysfunctional family relationships, social isolation and low academic achievement [3].
During this identity crisis, the adolescent ideas range from the willingness to be independent and the acknowledgement of dependence on one's own parents. The adolescent sometimes take refuge in the community, in other situations they find comfort in their own families. However, this is multiple reaction the right way for the adolescent to advance into the adult world [4].
The adaptation to the somatic and psychosocial evolution, typical of this period, takes place today more and more in advance and in an environment characterized by sensory "hyperstimulation" by the mass media, by different family organizations from the traditional ones and by the increased alcohol and drugs availability.
It is precisely in this difficult period that psychopathological onset can occur. In fact, in literature there are numerous clinical studies relating to adolescent psychopathology but they were hardly comparable to each other for both methodological and conceptual reasons.
Recent studies have shown an average prevalence of 21.8% of psychiatric disorders in adolescence. The most frequent disorders seem to be the Use of Substances (12.1%), Anxiety Disorders (10.7%) and Depressive Disorders (6.1%) [5].
Among all psychopathologies, Major Depressive Disorder (MDD) is one of the most frequently disorders in adolescence. It is associated with social disability and suicidal risk, affecting approximately 5% of adolescents of both gender. After puberty, MDD in girls shows a double incidence while Bipolar Disorder occurs in 20% of cases.
The recent great socio-cultural change of latest decades has significantly influenced the course of adolescence.
Furthermore, in an increasing number of cases, psychopathological distress in adolescence occurs in the form of an acute psychiatric crisis, sometimes catching the Emergency Departments unprepared for adequate and effective intervention.
However, the data relating to access to the Emergency Area for mental health problems are probably underestimated if one takes into account that, on frequent occasions, adolescents arrive at the emergency room with symptoms unsuitable for specific psychopathological diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 and with signs of non-acute psychiatric suffering. In fact, patients often come to the emergency room with symptoms related to mental suffering linked to the family and/or socio-working environment, physical and/or psychological abuse, psychosomatic manifestations, post-traumatic stress and suicidal fantasies.
Since most of the causes of illness and death in this age group seem to be closely related to risk behaviors, implementing preventive interventions is considered necessary so that adolescence can attribute meaning to their actions and achieve their development goals without endangering their own's integrity and psychophysical health.
Nowadays mental health operators are facing with new difficulties, both organizational and managerial, relating to the safety of the patient and their own healthcare, with a growing profile of ethical, deontological and medico-legal responsibilities.
The work we carried out is an epidemiological, observational, retrospective study, which aims at analyzing the psychiatric consultations required for adolescent patients (18-25 years) who arrive, in a defined period of time and for the first time, in the emergency room manifesting or reporting an emerging symptomatic or psychopathological manifestation.
Then we compared the results obtained with those emerged from the most recent scientific literature and we identified the factors most predisposing to psychopathological distress at a young age, underlining possible primary prevention interventions, including rehabilitation techniques in the field of empowerment and psychosocial well-being of the most young people. The paper is also aimed at emphasizing the importance of the duration of untreated illness as a negative prognostic factor, particularly in mental disorders.

Materials and Methods

We examined psychiatric consultations carried out on patients with range age of 18 and 25 years old who, in a period of 2 years (January 2018-January 2020), accessed to the Emergency Department of the Papa Giovanni XXIII Hospital in Bergamo, in need of a first psychiatric evaluation. The useful data was filtered through the "Opera" computer system.
Anamnestic information were collected, the onset symptoms and the most predisposing risk factors were analyzed in order to promote early identification and interventions.
In order to conduct the study a database was created by collecting the necessary information related to the psychiatric consultations. The datapoints were subsequently

divided into 3 different groups of variables, respectively defined as socio-demographic, personal and clinical features. Among the socio-demographic variables, attention was paid to:

- gender (male or female);
- age, in terms of range age (18-21 years or 22-25 years) and punctual age;
- country of origin;
- employment.

The personal variables taken into consideration were those relating to family history, previous stressful life events, presence of any childhood abuse, finding of neurodevelopmental disorders and organic comorbidities.

Among the clinical variables, the main symptomatic manifestations causing the young patient to the Emergency Area were identified, such as:

- behavioral disturbances (psychomotor agitation, verbal aggression or heterodirect agitation);
- suicidal ideation with or without suicidal attempts or even only self-harm;
- psychotic decompensation;
- acute intoxication from alcohol and/or other drugs of abuse;
- depressive symptoms;
- manic or hypomanic episode;
- anxiety rates with or without panic attacks;
- somatic symptoms of various kinds;
- escapes from home;
- DCA;
- extra-pyramidal symptoms (EPS);
- dissociative phenomena;
- sleep disturbances;
- obsessive brand symptoms;
- other symptoms such as catatonia or mutacism.

Clinical variables also include the "Duration of Untreated Illness" (DUI), the pharmacological treatment proposed by the specialist during the consultation, the indications provided by the latter in the Emergency Room (ER) and any subsequent accesses to the ER by the same young person patient. These are very important parameters above all when taking into account that the highest risk of suicide in people with schizophrenia occurs during the first five years of illness ("the critical period") and interventions are most fruitful during this time [6].

At the end of the psychiatric evaluation, a specific therapeutic and management indication for each patient were provided such as a voluntary or coercive hospitalization in the Psychiatric Care; an admission to the Psycho-Social Center (CPS) or to the clinic dedicated to the management of the psychopathology in adolescence (Varenna Clinic) offering them a strong clinical-therapeutic care; a link to the Addiction Service (Ser.D), aimed at dealing with both subjects with problems of use, abuse or dependence on legal and / or illegal substances and those who manifest forms of behavioral addiction.

Results

Statistical analyses were performed using the SPSS v. 26, taking into consideration 233 psychiatric consultations, 134 (57.5%) reported in 2019, 99 (42.5%) in the previous year.

The socio-demographic variables investigated gave the following results:

- the percentage of female patients was higher (N=129, 55.4%) than males (N = 104, 44.6%);
- the age range of patients was predominantly between 18 and 21 years (126, 54.1%) rather than that of 22-25 years (107, 45.9%), with a mean age of 21 years and a standard deviation of 2;
- compared to the country of origin, 159 (68.2%) patients were Italian, 56 (24%) non-European and 18 (7.7%) non-Italian but in any case European;
- in relation to employment, it was found that 63 (45.7%) were students, 47 (34.1%) workers and 28 (20.3%) unemployed.

The psychiatric family history has been investigated and we found:

- anxiety disorders (N = 9, 3.9%);
- mood disorders (N =7 , 3%);
- neurodevelopmental disorders (N = 3, 1.3%);
- substance abuse (N = 2, 0.9%);
- suicide (N = 1, 0.4%);
- In 90.6% of cases (N = 211) there was negative psychiatric history.

Subsequently, the presence of previous stressful life events was also examined:

- intra-family problems (N = 42, 18%),
- socio-economic difficulties (N = 38, 16.3%),
- bereavement (N = 11, 4.7%)
- transfers to another city and/or sentimental breakdowns (N = 29, 12.4%).

Many patients declared not have any previous stressful life events (N = 113, 48.5%).

Child abuse was also investigated (N = 23; 9.9%. Physical abuse in 3.9% (N = 9) of cases, sexual abuse in 2.6% (N = 6) of cases, other type in 3.4% (N = 8).

The anamnestic data showed the presence of:

- neurodevelopmental disorders (N = 38; 16.3%; Tab. I);
- organic comorbidities (N = 37; 16%; Tab. II);
- drug abuse (N = 76; 33%; Tab. III).

Table I. Neurodevelopmental Disorders.

	Count	N %
Intellectual disability	16	6.9%
ADHD	8	3.4%
Specific learning disability	6	2.6%
Autism spectrum disorders	5	2.1%
Communication disorders	2	0.9%
Movement disorders	1	0.4%
None	195	83.7%

Table II. Organic comorbidities.

	Count	N %
Epilepsy	9	3.9%
Headache	6	2.6%
Thyropathies	3	1.3%
Do not specify	3	1.3%
Bronchial asthma	2	0.9%
Genetic syndromes	2	0.9%
Deaf mute	1	0.4%
Spastic diplegia	1	0.4%
Food allergy	1	0.4%
Pancreatitis	1	0.4%
Diabetes mellitus	1	0.4%
Obesity	1	0.4%
MICI	1	0.4%
Celiac disease	1	0.4%
Gastritis	1	0.4%
Prolactinoma	1	0.4%
TB	1	0.4%
Rheumatoid arthritis	1	0.4%
None	196	84.1%

Table III. Drug abuse.

	Count	N %
Cannabinoids	40	17.2%
Alcohol	16	6.9%
Psychostimulating	13	5.6%
Do not specify	5	2.1%
Opioids	2	0.9%
None	157	67.4%

Regarding the symptomatic manifestations in the Emergency Area, it was documented:

- suicidal ideation and/or suicidal attempts and/or self-injurious gestures: 58 (24.9%);
- anxiety symptoms and/or panic attacks: 47 (20.2%);
- behavioral disturbances (agitation, aggression): 41 (17.6%);
- acute psychotic episode: 23 (9.9%);
- somatic symptoms: 12 (5.2%);
- depressive episode: 12 (5.2%);
- escapes from home: 8 (3.4%);
- acute alcohol and / or drugs intoxication 8 (3.4%);
- sleep disorders: 6 (2.6%);
- manic or hypomanic episode: 5 (2.1%);
- dissociative symptoms: 4 (1.7%);
- eating disorders: 4 (1.7%);
- other symptoms (catatonia, mutacism): 3 (1.3%);
- EPS: 2 (0.9%).

DUI was equal to an average of 51 days with a standard deviation of 64 and the outliers of 540 and 720 days were excluded from the analysis. The most prescribed therapy in the emergency room was represented by benzodiazepines (113, 48.5%), antidepressants (21, 9%), atypical antipsychotics (19, 8.2%), mood stabilizers (11, 4, 7%). In 29.6% (69) of the cases no therapy was prescribed.

In line with the literature data, it was possible to see how the different psychopathological pictures presented by the young patient in the emergency room were linked to some of the socio-demographic variables considered such as sex and country of origin. The male gender, in fact, presented mainly externalizing behaviors linked to aggression and a provocative attitude, while the female gender presented greater problems related to internalization and, therefore, characterized by a tendency to act self-injurious and/or anti-conservative as well as an alteration of the timism towards the depressive attitude (Tab. IV).

Clinincal manifestation of symptoms are split according to with the place of birth of the young patients examined:

- group of Italian patients: anxious symptoms (41, 25.8%), suicidal ideation (37, 23.3%) and behavioural disorders (30, 18.9%);
- group of immigrant patients: suicidal ideation (28.4%), behavioural disorders (14.9%) and psychotic decompensation (13.5%);
- only group differences related to anxiety symptoms were statistically significant, present in 8.1% of immigrant patients.

The anamnestic variable relating to the usage of substances, crossed with the variable relating to the onset symptomatology, gave the following results:

Table IV. Variable "Onset symptoms" in relation to "Gender".

Clinical symptomatology	Male	Female
Behavioral disturbances	24 (23.1%)	17 (13.2%)
Suicidal ideation and / or TS	19 (18.3%)	39 (30.2%)
Psychotic break	14 (13.5%)	9 (7%)
Acute substance intoxication	3 (2.9%)	5 (3.9%)
Depressive episode	4 (3.8%)	8 (6.2%)
Manic or hypomanic episode	3 (2.9%)	2 (1.6%)
Anxiety and / or panic attacks	17 (16.3%)	30 (23.3%)
Somatic symptoms	6 (5.8%)	6 (4.7%)
Escape from home	6 (5.8%)	2 (1.6%)
DCA	0 (0%)	4 (3.1%)
EPS	1 (1%)	1 (0.8%)
Dissociative symptoms	1 (1%)	3 (2.3%)
Sleep disorders	4 (3.8%)	2 (1.6%)
Obsessive symptoms	0 (0%)	0 (0%)
Others (catatonia, mutacism)	2 (1.9%)	1 (0.8%)
Total	104 (100%)	129 (100%)

- patients with a history of cannabinoid use arrived in the Emergency Area complaining of behavioural disorders in 27.5% of cases, psychotic decompensation in 22% of cases and suicidal ideation in the same percentage;
- patients who had a positive history of usage of psychostimulant substances such as cocaine and amphetamines were referred to the Emergency Room for acute intoxication or behavioural disorders in 23.1% of cases and for psychotic decompensation or flight from home in 15.4 % of cases;
- patients with a history of alcohol experienced behavioural disorders in 43.8% of cases, acute intoxication in 18.8% of cases and psychotic or depressive decompensation in 12.5% of cases.

The present work also shows that cannabinoid users at the time of psychotic onset belonged to the lower age range (18-21 years) in 55.6% of cases and to the higher age range (22-25 years) in the remaining percentage of cases (44.4%). People who did not abuse cannabis were 18-21 years old in 28.6% of cases and 22-25 years old in the remaining percentage of cases (71.4%).

Discussion

The results obtained appear to be in line with those emerging from the most recent data in the scientific literature relating to access to the Emergency Area by young adolescents at their psychopathological onsets.

Our research shows that the familiarity of patients admitted to ER was generally positive from a psychiatric point of view. Among the anamnestic data there were various stressors such as bereavement events and socio-economic problems but also stories of childhood abuse, organic comorbidities or neurodevelopmental disorders of different severity degrees.

Comparing the results of the cases relating to 2018 with those of 2019, a significant increase in access to the emergency room by the younger population was a clear evidence. These results appear in line with the data emerging from the most recent literature showing a trend in gradual and constant growth of young people who arrived at the emergency room with an emerging symptomatology and underwent to an initial psychiatric evaluation.

At the same time, a slight decrease in hospital admissions was observed from 2018 to the following year (20.2% in 2018 versus 17.1% in 2019), in contrast to the most recent literature data which show worldwide an increase in the hospitalization rates of younger patients at their psychopathological onset. Our data could refer to a solid and profitable connection of the patient to the Lombard territorial services. Of course, these data would need further confirmation, extending the study object of this thesis work to subsequent years.

The attention was subsequently placed on a possible relationship between the DUI of the patients examined and the probability that these, after their first access to the ED, have made further ones.

From the analysis of the data carried out using the Column Means Test, a statistically significant difference emerged between patients who had only one access to the ER (mean DUI of 42 days) and patients who had multiple accesses to the hospital emergency room (mean DUI of 71 days).

The extent of the DUI also appears to be directly linked to the average length of hospitalization of those patients who, once arrived in the ER and underwent the evaluation of the psychiatrist specialist, were admitted for hospitalization in the SPDC.

Furthermore, as already pointed out, the age between 18 and 21 years was more frequently observed than the age between 22-25 years. This underlines the earlier onset of symptoms attributable to psychopathological pictures of a different nature. However, observing the average ages of patients evaluated in the emergency room in 2018 in comparison with those who arrived in 2019, there is no difference in the average age within the sample (22 years in 2018 versus 21 years in 2019).

As we have seen, our data confirm what emerges in the global epidemiological scenario. Evidences show that main symptomatic manifestations in male patiens are behavioral disorders such as psychomotor agitation and/or auto or heterodirect aggression (23.1%), followed by suicidal ideation and/or suicidal attempts rather than self-injurious (18.3%) and anxiety symptoms with or without panic attacks (16.3%). In the female patients, on the other hand, suicidal ideation prevails (39, 30.2%), anxious symptoms (23.3%) and behavioral abnormalities (13.2%).

The “Column Proportions Test” (Z-test, parametric statistical test) shows that the percentage of women with behavioural disorders and suicidal ideation at the onset is significantly different from the percentage of men. Contrarily, the percentage of women who suffer from anxiety and/or panic attacks at the onset does not appear to be significantly different from the percentage of men with the same symptom at the onset.

With reference to the country of origin, however, it seems that the status of “immigrant” considerably increases the possibility that younger subjects manifest some form of psychopathological distress and that this is in most cases of a psychotic type. In fact, we found a statistically significant difference for anxiety symptoms of immigrant patients.

In line with literature data, our results show a correlation between the psychotic onset and the patient’s ethno-anthropographic conditions as well as cannabis use. This use seems to be associated with an earlier symptom onset and associated with a greater severity of productive symptoms.

Finally, analysing the regulation of the thymic axis, important scientific evidence highlights the relationships between child sexual abuse with early suicide attempts; ADHD as a risk factor for the onset of manic or hypomanic episodes and positive familiarity for Affective Disorders as

a predisposing factor to a depressive symptomatology at the onset.
We also noticed that half of the people who reported having suffered sexual abuse in the past performed self-harming gestures.
Referring to neurodevelopmental disorders as potential factors capable of triggering psychopathological conditions among the younger, it was noted that those who had already received a diagnosis of ADHD in childhood subsequently presented to the emergency room for probable expansion of the tone of the mood (12.5%). However, the main symptom manifestation of ADHD patients were behavioral disturbances (62.5%) [7]. Furthermore, those who had a positive family history for Affective Disorders then developed depressive symptoms characterized by suicidal ideation or self-harm (28.6%).
Our research obviously has limits and problems. They must be taken into account for a more adequate evaluation of the results, that is, patients aged between 18 and 25 years who needed a first psychiatric evaluation during the psychopathological acuity were examined. It is possible that some potential cases have escaped this examination as they are younger than the considered range and, therefore, of NPI competence.
Literature data show that the prevalence of psychiatric disorders at onset- progressively increases over the years and with the age of the adolescent and that the prevalence of mood disorders and neurotic, stress-related and somatoform disorders increased particularly in young ages over the years [8].
Future studies should be cross-conducted on young people in both adult psychiatric and NPI services, looking at a wider age range. Similarly, it appears useful to continue the work already started in order to assess the trend and prevalence of psychopathological disorders over time.

Conclusions

Adolescence is considered a period of multiple evolutionary changes but also a phase of particular vulnerability to stressful and traumatic events that can lead to discomfort or psychopathological disorders. This period has been called “the adolescent crisis” to emphasize its intrinsic complexity. It involves some aspects such as:

- biological factors that include physical and psychic transformations;
- psychological factors enabling new cognitive abilities, communication skills to relate and to make new experiences;
- social factors among which personal interests and emotional and relational connections.

Therefore, it is easy to understand why the interest in clinical research regarding this difficult phase of life has progressively intensified.
Moreover, treatments of severe discomfort and mental states at risk reduce and counteract the evolution into mental illness.
However, adolescents are difficult to treat and motive to seek for help. This fact has delayed the establishment of specific counseling and care programs.
It is known, for example, that the highest incidence of psychopathological onset (75%) occurs in late adolescence and early adulthood and that the prodrome is often faded and can last up to 6 years.
In fact, different pathologies have often overlapping symptomatic patterns, characterized by non-specific symptoms such as cognitive, neuropsychological and psychosocial deficits. Therefore in many cases, it is difficult to define the diagnosis [9]. It must be taken into account also that the accessibility to territorial not emergency services for such users is very limited.
According to estimates, only a small part of these young people (less than 1 out of 6) asks for and receives appropriate care also because the current model is only partially capable of intercepting the serious discomfort that characterizes this young age group.
As a consequence, adolescents first come to the attention of doctors in emergency areas mainly for reasons such as self-harm, accidents and suicide attempts. At this regard, it was demostrated that there is a dramatic increase in the number of young people who come to the emergency room for psychiatric care, making the Emergency Area a privileged place for the possibility of welcoming these children and implementing a first diagnostic screening.
In conclusion, to avoid the onset and progression of the disease, primary prevention practices and interventions should be implemented for population at risk and for subjects with psychopathological onset [10]. The integration between UONPIA, Primary Medicine and Ser.Ds is fundamental to guarantee the continuity of care especially during the transition from psychiatric services for children to those for adults. Moreover, especially for adolescents, adherence to treatments, access to psychotherapeutic treatments and interventions dedicated to the entire family context are very relevant.
It is important to remember also that there are effective mental health promotion programs that provide practical skill development and, at the same time, a cognitive-educational approach to specifically address issues such as abuse, nutrition and related disorders, risk, interpersonal relationships including those of a sexual nature, the assumption of a healthy lifestyle. The ultimate goals is to implement integrated and interinstitutional strategies (school, social and health services) in order to promote processes of personal and social empowerment and to leverage values such as self-esteem and resilience.
Intervention programs aimed at reducing the latency time of psychiatric assistance could be very useful, since having a prolonged DUI exposes more frequently to greater severity and chronicity of the clinical picture.

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Pierluigi Politi

Original article

Creating a new space for people with autism spectrum disorders in the Mental Health Department

Pierluigi Politi[1,2], Marta Nola[1], Stefano Damiani[1], Cecilia Guiot[1], Elena Farinella[2], Miriam Olivola[2], Umberto Provenzani[1], Matteo Rocchetti[2], Natascia Brondino[1,2]

[1] Dipartimento di Scienze del Sistema Nervoso e del Comportamento, Università di Pavia;
[2] Dipartimento di Salute Mentale e Dipendenze, Azienda Socio Sanitaria Territoriale di Pavia

Summary

In this paper we will epitomize and share the internal and unofficial guidelines for the clinical management of people with Autism Spectrum Disorders (ASD) at the Mental Health and Addiction Department of Pavia, Italy. We will provide suggestions to implement our approach in other Mental Health and Addiction Departments, as ASD is a common but highly specific condition that psychiatrists need to consider in their daily clinical practice.

Introduction

Considering the recent "autism epidemic" [1], treating people with autism spectrum disorder (ASD) in general psychiatry practice has gradually become more common in the last decade. Therefore, as psychiatrists we cannot anymore tell our adult patients with ASD: "it's not my job/I do not know how to treat you". Nevertheless, professional competences and expertise encompassing the whole life span of ASD are still quite uncommon among Italian adult psychiatrists. This could probably be ascribed to the legacy of the DSM III and ICD-9 training, when ASD was described only as "infantile", confined to childhood [2,3] and totally ignored in terms of healthcare when people with autism grew up.

It is well known that the word "autism" was firstly created by Eugen Bleuler, as a core symptom of schizophrenia. Bleuler defined it as the "detachment from reality together with the relative and absolute predominance of the inner life" [4]. For decades, autism and schizophrenia have been strongly interconnected, even after the seminal papers of Leo Kanner [5] and Hans Asperger [6,7]. Of note, the two first editions of DSM (DSM-I 1952, DSM-II 1963) [8,9] mention "autism" and "autistic" only when describing schizophrenia and/or schizoid personality. Autism as a diagnostic entity for itself first appeared in the DSM III (1980) [2] and moved to be a subtype of the Pervasive Developmental Disorders Cluster from the DSM IV onwards. The concept of an autism spectrum was introduced systematically only with the DSM 5 [10].

In any case, autism is a strange kind of illness, full of controversies. Firstly, it is still debatable if it is a disease and not only a peculiar human condition [11] in which the individual/environment relationship follows rules different from Aristotle's assumption of man as a "social animal". People with autism often behave breaking unwritten social rules in their everyday life, both because of their own peculiarities and because of others' reaction to their social hindrance. Secondly, dealing with any kind of environment, not only the mental health one [12], can be particularly challenging for people with ASD when their unique communication, sensory, and safety/behavioral needs are unaddressed [13]. Understanding

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Correspondence:
Pierluigi Politi
pierluigi.politi@unipv.it

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these needs is hence the starting point to deal with them successfully. We will approach this topic by retracing the recent history of our service, which has been constructed in an "autism friendly" way, since the end of the last century.

Materials and Methods

Sample

All subjects with a diagnosis of ASD followed-up by our clinical-academic (Azienda Socio-Sanitaria di Pavia and Università di Pavia) centre were included in the present analysis.

Outcome variables

The present study reported the results of two main outcomes: diagnosis of ASD in a clinical setting and clinical management of subjects with ASD.
The first outcome will be presented as a description of the catchment area (number of referrals, psychometric assessment, differential diagnosis and prevalence of comorbid diagnoses in our catchment area). The second outcome will point out the available options for the treatment of ASD patients (case management, focused interventions, personalized approach), which could be implemented in a general psychiatric setting.

Catchment area

The Department of Mental Health and Addiction of Pavia provides mental health treatment for half a million inhabitants over an area of 3.000 km^2, partly urban and partly rural, located in northwestern Italy. The province of Pavia and consequently the Mental Health Department includes three subregions, namely Lomellina, Oltrepo and Pavese. Each region has a child and adolescent unit, an adult outpatient service, an addiction ambulatory, a psychiatric ward and some rehabilitation facilities. As a legacy of autism history, each child and adolescent psychiatry unit has good expertise in ASD and at least one MD or one psychologist trained in the administration of the standardized interview for ASD, the Autism Diagnostic Observation Schedule (ADOS) and the Autism Diagnostic Interview-Revised (ADI-R). The adult units of the service are supported by a clinician expert in ASD and ADOS/ADI-R trained.
Referrals are accepted by mail or telephone and could be done by the subject, relatives or health professionals.

Results

Number of referrals

In the last three years, the outpatient service has received some 321 referrals from psychiatrists, GPs as well as self-referral from the Pavia area, but also from other provinces in Lombardy or from other Regions (Tab. I).

Table I. Characteristics of referral to the Pavia ASD (n = 321) team in the last three years (2018-2020)

Variables	Mean ± Standard Deviation or % (counts)
Age, years	36.11 ± 17.71
Gender, male	75.7% (n = 243)
Referral	
Self	22.1% (n = 71)
Relatives or friends	44.8% (n = 144)
Health professional	33.1% (n = 106)
Origin	
Lombardy Region	87.8% (n = 282)
Other Regions	12.2% (n = 39)
Medication, yes	54.2% (n = 174)
Cognitive impairment, yes	33.9%(n=109)

The assessment of referrals consists of two/three sessions in which subjects will undergo a clinical interview, ADOS (and ADI-R if caregivers are available), IQ and/or adaptive abilities evaluation and sensory assessment. If necessary, more specific evaluations will be conducted to investigate specific areas of functioning (for instance, cognitive functioning, empathy, social cognition). If a psychiatric comorbidity/primary diagnosis is suspected, a DSM 5 interview will be conducted. The overall assessment process is quite time consuming, lasting for three to four hours.

Diagnosis and psychometric assessment

Diagnostic criteria for ASD have changed dramatically over the past 70 years. However, the gold standard for ASD diagnosis is still the clinical interview conducted by a clinician expert in autism: the clinical judgment should be supported by standardized tests which may rely on direct observation of the subject such as the ADOS or on caregiver-reported symptoms in infancy such as the ADI-R. This protocol (standardized tests plus expert judgment) is aimed at improving diagnostic sensitivity/specificity in every mental health service.

Differential Diagnosis

In fact, autism can be both under- and over-diagnosed, especially in selected populations [14,15], mainly because of the overlapping of clinical symptoms or conditions and because of a suboptimal instrument reliability [16,17]. For instance, it could be difficult to distinguish a person with a schizotypal personality disorder from a person with ASD, especially when there are no trustable informants about the early childhood of the subject. Moreover, the diagnostic process becomes even more difficult when ASD co-occurs with a psychiatric diagnosis (i.e. psychosis, depression, obsessive-compulsive disorder), especially in adulthood, as prevalence of psychiatric conditions in an ASD adult sample is higher than in the general population. In the last three years, we observed a vast majority of appro-

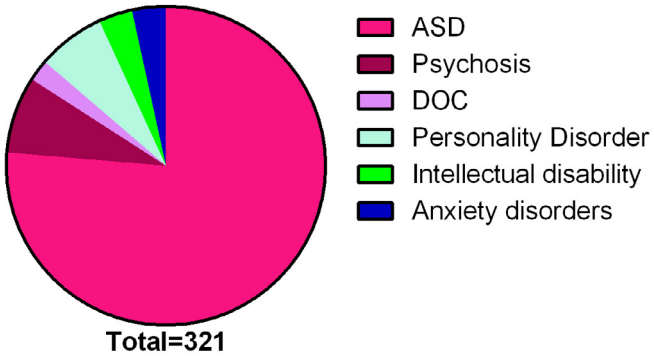

Figure 1.
Diagnosis types after referral to ASD service.

priate referral while in a small number of cases a no-ASD diagnosis was made (Fig. 1).

Comorbid Conditions

The assessment of comorbidities is crucial, since along the whole life circle, individuals with ASD have been found to have higher rates of various psychiatric as well as medical conditions [12,18] and are thus subjected to higher healthcare utilization. Additionally, comorbid conditions could trigger problem behaviors, unresponsive to medications. In our centre, medical comorbidities are usually investigated by a specialized team of physicians, using prioritized pathways to care and a dedicated nurse. Psychiatric comorbidities are of difficult detection, as questionnaires and interviews are usually not validated in an ASD sample and therefore the training of psychiatrists should be a turning point in the timely detection and treatment of these conditions.

Diagnosis communication

After assessment, ASD people will receive a formal diagnosis during a specific session. This usually represents the first step of a brief psychoeducational program for both the ASD people and their loved ones. If the subjects do not have a referring mental health service, they are taken on by the team composed by the psychiatrist and a clinical psychologist at a sustainable frequency determined by their clinical needs.

Therapeutic options

Case Management

The appointed clinicians will maintain close relationships with patient's relatives, monitor emergent therapeutic targets (distress, anxiety, depression, etc) and develop a life project for the patient according to the predefined level of functioning and expectations for the future.

Psychoeducational Interventions

Our Community Mental Health Centre provides psychoeducation group interventions (twice a week according to level of functioning) which are focused on social skills training as well as emotional management in different contexts. Additionally, single psychoeducation sessions are provided if needed. All people with ASD are accompanied in their acquisition of insight about their condition. Parent training is also offered through group training as well as self-mutual help groups. We offer a coaching service to support people with ASD through the identification of their strengths, promoting soft skills and work-related abilities that can facilitate job placement. A special focus is also helping people with ASD dealing with their sexuality.

Pharmacological management

Despite the absence of medications effective on ASD core symptoms (social impairment as well as restrictive and repetitive behaviors), appropriate pharmacological management appears a priority in the management of problem behaviors associated with ASD. A large majority of ASD subjects are on psychotropic medications [19], but the response to these drugs is quite different from the one which general psychiatrists are used to. In fact, efficacy of almost all psychotropic compounds is lower in subjects with ASD with higher levels of side effects. Despite this evidence, people with ASD are usually treated with complex pharmacological strategies with a higher risk of interaction effect. Additionally, subjects with ASD usually use multiple complementary and alternative methods, which should be always investigated and which sometimes could be extremely deleterious.

Emergency services

Explosive, uncontrolled, aggressive behavioral crises may also concern people with ASD and normal cognitive functioning. Such eventualities are quite unusual but may potentially cause important distress as usual psychiatric interventions are ineffective. The Mental Health Department of Pavia received specific fundings by Regione Lombardia for the management of such crises (project EARL: Emergenze Autismo in Regione Lombardia). Three lines of intervention were designed and implemented:

- a telephone helpline available 10 hours/six days per week;
- the possibility to provide a bedplace in a "autism friendly" psychiatric ward with a dedicated trained staff member 24/7 (eg. for acute phase with the need of hospitalization);
- the possibility to provide a dedicated room with trained staff in a sheltered house (eg. for post-acute phase or acute phase with no need of hospitalization).

At the present day, this service is available for the whole region and will last till October 2021.

Residential and semi-residential services

While a small percentage of all people with ASD could reach independence, almost half of our sample will be still

requiring various levels of support, ranging from supported living to residential or semi-residential services. This is particularly true for patients with ASD and comorbid cognitive impairment. A recent survey of the 15 semi-residential facilities (Day Centers for the Disabled, DCD), located inside the Mental Health Department catchment area re-evaluated patients (N = 344) present at the time of the site visit. Of the 344 patients screened, 47 (14%) were registered with a diagnosis of autism, which was confirmed; one, despite having a diagnosis of autism, did not meet the expected criteria (false positive); 38 (11%) were evaluated as having ASD (false negatives). Thus, overall, one in four people present in accredited DCDs in our province has a validated diagnosis of Autism Spectrum Disorder.
Two independent, specialized facilities for ASD young adults are located among the same catchment area. Both facilities follow several principles which have inspired their development (i.e. structured ecological environment; contact with nature; favor natural circadian and seasonal rhythms; active involvement of people with ASD in farming activities). Cascina Rossago (frazione San Ponzo Semola, Pontenizza, PV) is the first farm-community for people with ASD in Italy and welcomes 24 adults with severe ASD and comorbid cognitive impairment. The semi-residential centre "Il Tiglio" (Sant'Alessio con Vialone, PV) is a DCD welcoming 20 subjects with ASD. Both facilities are constructed according to the knowledge of the autistic mind and activities and spaces are tailored as the most tolerable for patients. Specific training in all unspecialized DCD and residential facilities is also being conducted in order to provide more specific information and help the healthcare professionals in constructing a more personalized life plan for each subject.

Supporting talents

According to Happè and Frith expertise [20], one in three people with autism have some kind of talent, irrespectively of IQ. Our approach to disability is to focus on unsuspected talents, to foster and train special abilities, avoiding any "circus freak" phenomenon and improving self esteem. Changing perspective represents a crucial point when taking care of people with ASD. An evocative example of this is, for instance, the discovery of the undetected non-compositions of a gifted piano player transcribed and edited in Playing with Autism 1.1 [21,22].

Academic support for ASD

ASD students are particularly at risk of career interruption. Approaching university studies, with a less restricted and constant environment, introduces uncontrollable variables in their lives, causing deep discomfort, performance problems, or even actual psychopathological decompensation. For this reason, the SAISD (Assistance and Integration Service for Disabled Students) center at the University of Pavia has undertaken a collaboration with our clinical center to support undergraduate and postgraduate students with high-functioning autism. Assistance is delivered by a team composed of a psychiatrist and a clinical psychologist who are experienced both in autism and learning disabilities. Following an evaluation of personal educational needs and potential, our team will formulate a sustainable, individualized project designed to enhance study skills. During 2020, for example, the SAISD center served a total of approximately 380 students with motor impairment, ASD, and learning disabilities. In addition, our clinical center has followed dozens of other cases, although not yet certified, providing support with difficulties encountered during their academic journey.

Networking

As constructing a constant and coherent environment is the key for a successful management of ASD, we have developed a network with other local healthcare services which do not pertain to the Mental Health Department of Pavia but are currently dealing with people with ASD. All these local healthcare services are periodically reached for staff training, clinical support and development of research projects. This interaction has been fundamental to avoid fractures in the therapeutic continuum of people with ASD and to involve these individuals and their families in shared activities to avoid isolation.

Research

Knowledge on ASD is still limited: a better characterization and phenotyping are thus crucial to tailor individualized and effective interventions. In addition to the clinical level, our research unit is involved in several projects with the aim to shed new light on the neurobiological substrates of ASD [23-25]. This is particularly true when considering the impact of the recent Covid19 pandemic on the life of people with ASD [26].
In any case, research concerning ASD is still lacking a solid methodology. In particular we need affordable, specific measurement tools in order to evaluate the supposed variations in symptoms, behavior, or function. The available outcome measures remain highly heterogeneous and non specific, while a significant number of studies about ASD lacks a clear primary aim [27].

Discussion and Conclusions

To conclude this extensive survey, we believe that, considering an approximate prevalence of 1:100 of ASD among the general population, any Mental Health Departments should be aware of:

- the possibility of detecting hidden or misunderstood autistic patients among service users;
- the importance of facilitating the transition of ASD people from childhood into adolescence and from adolescence into adulthood;
- the relevance of preventing behavioral complications among ASD people who have never been treated and who lived a more or less normal life

- the significance of a program for job support dedicated to people with ASD.

What did we learn from taking care of this peculiar population, moving from the original and creative work of Francesco Barale and Stefania Ucelli di Nemi [28]? There are, in our opinion, two major issues. ASD needs in any case a paradigm shift. Autism was firstly identified as a symptom (1911), then we recognized the syndrome (1943), only later we detected the spectrum (1980). We believe that this timeline prevented us, for such a long time, from understanding and appreciating the "positive" elements in ASD. It will be challenging for the future generation of clinicians and researchers to learn how positive could be cooperating and interacting with neurodiverse people, being conscious of the point of strength and weaknesses of belonging to both populations, the neurotypical and the neurodiverse. Secondly, we learnt that treating a person with ASD, without taking care at the same time of her environment (family, school, job place, community, etc), is always frustrating and hopeless. The communication difficulties grow in the middle of the relationship between a person with ASD and her environment, involving the two members. Therefore, the therapeutic work with the environment is, at least, as important as the therapeutic work with the individuals. In this light, multiple and continuous levels of assessment and treatment on both sides of the intervention are crucial to provide effective therapeutic strategies.

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Review

Società Italiana di Psichiatria

Rethinking ecmnesia and ecmnesic delirium: "pièce oubliée" in psychopathology

Domenico De Berardis[1-2]*, Federica Vellante[2], Michele Fornaro[3], Giulia Gianfelice[1], Carmine Tomasetti[4], Alessandro Valchera[5], Alessandro Carano[6], Antonio Ventriglio[7], Giampaolo Perna[8-11], Mauro Pettorruso[2], Giovanni Martinotti[2], Silvia Fraticelli[2], Massimo di Giannantonio[2], Enrico Mancini[12]

[1] NHS, Department of Mental Health, Psychiatric Service of Diagnosis and Treatment, Hospital "G. Mazzini," ASL 4 Teramo, Italy; [2] Department of Neurosciences and Imaging, Chair of Psychiatry, University "G. D'Annunzio," Chieti, Italy; [3] Federico II University, Department of Psychiatry, Naples; [4] NHS, Department of Mental Health, Psychiatric Service of Diagnosis and Treatment, Hospital "SS. Annunziata," Giulianova, Italy; [5] Villa S. Giuseppe Hospital, Hermanas Hospitalarias, Ascoli Piceno, Italy; [6] Department of Mental Health, Psychiatric Service of Diagnosis and Treatment, Hospital "Madonna Del Soccorso," NHS, San Benedetto del Tronto, Ascoli Piceno, Italy; [7] Department of Psychiatry, University of Foggia, Italy; [8] Humanitas University Department of Biomedical Sciences, Milan, Italy; [9] Department of Clinical Neurosciences, Villa San Benedetto Menni Hospital, Hermanas Hospitalarias, Como, Italy; [10] Department of Psychiatry and Neuropsychology, Faculty of Health, Medicine and Life Sciences, Maastricht University, Maastricht, The Netherlands; [11] Department of Psychiatry and Behavioral Sciences, Leonard Miller School of Medicine, Miami University, Miami, USA; [12] Private Psychiatrist, Ancona, Italy

Domenico De Berardis

Summary

The article presents a historical survey of studies in Neuropsychiatry, that focus on the topic of ecmnesia ecmnesic and delirium, from the earliest description by Pitres to the 1970's (with special emphasis on the French School). The decline of Pitres' concept of ecmnesia is related both to a change in psychiatric hermeneutics and to the fact that hysteria lost its autonomous status as a nosographic entity, two to the emergence of international classifications. Consequently, the notion of ecmnesia is more likely to be dealt with in the domain of aesthetics rather than in the field of psychopathology.

Key words: ecmnesia • ecmnesic delirium • ecmnesic hallucinations • ecmnesic paroxysmes • ideo-ecmnesic zones • ecbiosis

Introduction

It is a fact that from the descriptive psychopathology and from actual psychiatric semeiotic the "ecmnesia" is almost disappeared, relegated at most in the mnemic disturbances of organic mental disorders. It can be found still sometimes in neurology and especially in epileptology, as an obsolete and curious legacy of literature rather than as an expression of a current clinical entity. Moreover, the absence of the term from the intenrnational nosographical repertoires is to witness that the classic psychopatology was a bit neglected in the last half a century, whereas in the most important treatise of psychiatry italian, that of Bini and Bazzi's (v.a.), it was critically discussed placement categoriale of similar conditions as the "ecmnesie" and "illusion of the doppelganger", and in the latter experience frenzied Danilo Cargnello did not fail to detect the "ecmnesiche productions" [1].

A historical survey of significant passages in which the ecmnesia is explicitly being treated in neuropsychiatry may help to understand its autonomy, if not nosographycal at least psycopathological, assigned to it in the past and to ex-

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Correspondence:
Domenico De Berardis
domenico.deberardis@aslteramo.it;
dodebera@aliceposta.it

plain the decline. But not before I have found in the *etymological dictionary Italian* Carlo Battisti and John Alessio [2]. That the word **ecmnesìa** dates back to the XIX century and belongs to the conceptual sector of medicine (are reported the expression "delirium *ecmnèsico*" and the word of the latin *ecmnēsia scientific*), experiencing in the *dictionary of the Italian Language* "Treccani" [3] (which circumscribes the meaning in a "status abnormal psychic characterized by the loss of memories of life recently and the feeling of reliving a period of past life") the etymological base in the compound of Greek εκ "outside" and*mnesia* – of *amnesia*, word in turn derived from the Greek αμνησία (α – privative and μνησις – from the theme of μιμνήσκω "remember"), through the French *amnésie*.

Jean-Albert Pitres and the case of Albertine

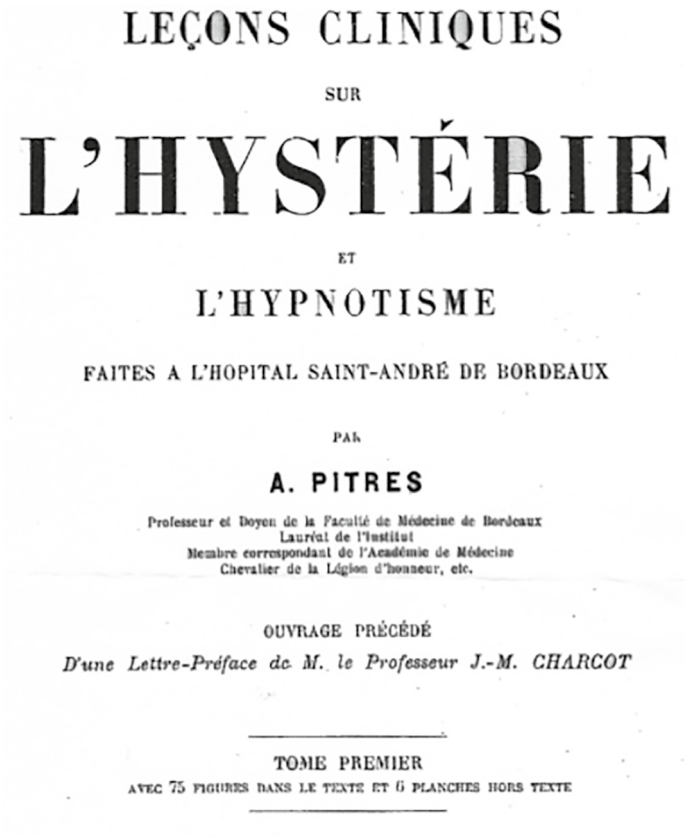
The reference to the French area takes us back to the *Lecons cliniques sur l'hystérie et l'hypnotisme* plots between 1884 and 1890 to "Hôpital Saint-André" of Bordeaux for the course of internal clinical from Jean-Albert Pitres (who lived between 1848 and 1927, then "Professeur et doyen" of the Faculty of Medicine of Bordeaux) and published in Paris in 1891 [4] (Tab. I). In this work, dedicated to his teacher "M. The Professeur J.-M. Charcot", which is acting as guarantor through a "lettre-préface" in which he reveals the "communion of scientific ideas" on the implant "neuropatologico" of the hysteria, Pitres – of which survive today, rather than sporadic references to the hysteria, eponimi of neurological order (the sections of P. The brain, the sign of the chalice of P. in the paralysis of the cubitale, the sign of P. In tabe dorsal, the aphasia amnestica FR or "nominum amnesia" etc.) –Informs you have given the name of "*ecmnésie* " to certain complex phenomena of "*amnésie partielle rétrograde avec reversion de la personnalité*" to the indications of "M. The professeur Espinas" (scholar known for the extremism of its allegations about the origin of the aesthetic sense from sexuality animal).

The first observations of Pitres on ecmnesia – concerning Albertine M., "one of the hysterical more interesting that has passed between our hands" – dating back to 1882. In the fifty-second lesson, dedicated to the "variations of personality in the Member hypnotics", after recalling the very clear distinction made by Charles Richet (physiologist forerunner of "sleepwalking caused") between "*moi*" and "*personnalité*" ("*The moi* est a phénomène de Sensibilité et d'driving innervation, *personnalité* est a phénomène de mémoire") and after having described the variations of personality from alienation ("phénomène de l'objectivation des types") and those from alternation ("phénomene de la double conscience avec amnésie périodique"), Pitres introduces those from reversion ("phénomene de l'ecmnésie") in which subjects in a state of sleepwalking spontaneous or provoked lose completely the remembrance of acquisitions of a long period of their lives, sometimes even of many years, and At the same time due to the effect of this "amnesia retrograde partial", lose the concept of their personalities present resuming the one that they had at the exact moment in which stops their memory. Observes in that regard that Albertine had attacks convulsive frequent which terminated normally with a frenzied phase prolonged: "The delirium, as is the rule in such cases, you relate almost always of salient episodes of the past life of sick". It was, "according to the expression very right of Briquet", a "delirium of reminiscent". Pitres noticed however a peculiarity that was until then escape both Briquet that other historians of the hysteria: i.e. that for the whole duration of the delirium the sick woman had lost in an absolute manner the memory of everything that had happened after the event that occupied his mind, while he remembered very well the facts prior to this event.

Pitres stated in 1886 that the ecmnesic delirium could be caused through three different methods: precise orders, imparted during the status of hypnotic sleep, wake up to an age well determined or perform acts related to it; the sudden action of the processes ipnogeni while attention was concentrated on any event of past life; excitement of certain points of the body functioning as "idéogènes zones", whose effects are illustrated by four photographs (Tab. II) of the infantile Albertine caught in theatrical attitudes, prey to delusions ecmnesici caused by the compression of the "zones ideo-ecmnésiques" represented respectively by the region under-maxillary (the sick is furious against a nearby who had killed a hen, Tab. II, Fig. 1), from the sternum-collarbone (desperate cries for the departure from a family at which he was employed as a maid, Tab. II, Fig. 2), by the spinous processes of the lumbar region (hears music and performs a dance learned from girl, Tab. II, Fig. 3) and from the base of the spinous mastoidee (sees a snake that flees among the shrubs: "This hallucination is not that the reminiscent of fright causatole a day by the sight of a snake in a stain", Tab. II, Fig. 4). He left to his pupil Henri Blanc-Fontenille to expose these facts in the doctoral thesis [5].

In the 57th lesson (on "attacks of delirium") the case of Albertine will offer Pitres the opportunity to include "attacks of ecmnesic delirium" between the three main forms of "delirium hysterical," after "attacks of mania hysterical" and "delirium allucinatorio". "L'*ecmnesia* – it reaffirms – is a form of partial amnesia in which the memory of events older than a certain period of life is integrally preserved while the memory of events subsequent to this period is totally abolished", and therefore this phenomenon must give rise to the psychic changes from which you can get an idea of the role that memory plays on the functioning of the intellectual faculties. The effect of this partial amnesia you will produce in the mental state of the subject a radical transformation, of which the clinical observation of Albertine gives test. A test "experimental": "The ipnotismo allows you to do, so to speak, the experimental study of madness", says Pitres, and ecmnesic delirium that Albertine manifested through procedures hypnotic "must be re-

Table I. The frontispiece of the "Lecons cliniques sur l'hystérie et l'hypnotisme" published in Paris in 1891.



LEÇONS CLINIQUES

SUR

L'HYSTÉRIE

ET

L'HYPNOTISME

FAITES A L'HOPITAL SAINT-ANDRÉ DE BORDEAUX

PAR

A. PITRES

Professeur et Doyen de la Faculté de Médecine de Bordeaux
Lauréat de l'Institut
Membre correspondant de l'Académie de Médecine
Chevalier de la Légion d'honneur, etc.

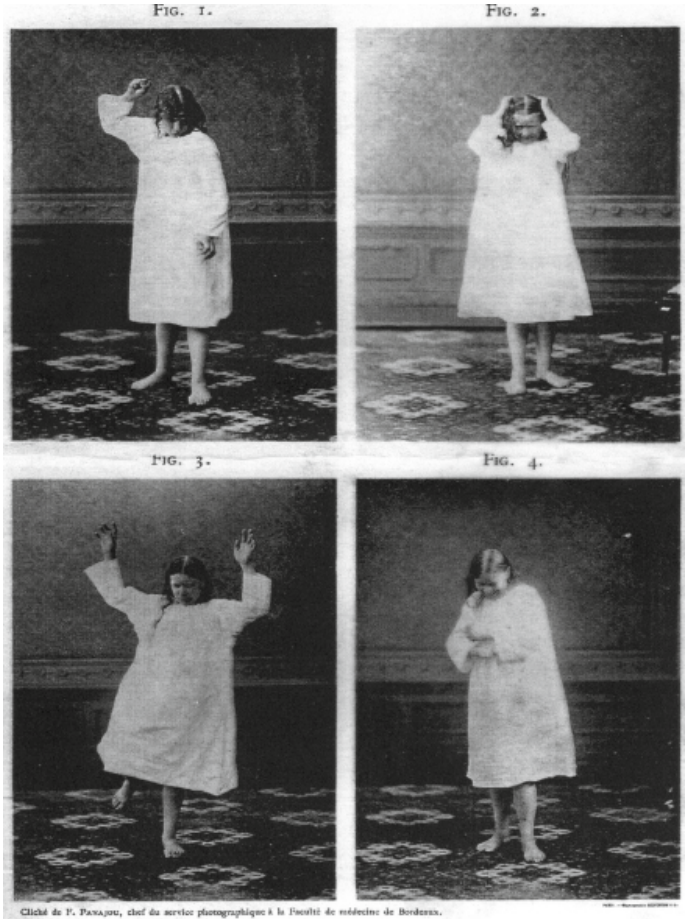
OUVRAGE PRÉCÉDÉ

D'une Lettre-Préface de M. le Professeur J.-M. CHARCOT

TOME PREMIER

AVEC 75 FIGURES DANS LE TEXTE ET 6 PLANCHES HORS TEXTE

Table II. The effects of the excitation of the zones ideo-ecmnesiche of Albertine M… (taken from: Pitres A. Lecons cliniques sur l'hystérie et l'hypnotisme. T. II. Paris: Doin 1891. Cliche of F. Panajou, head of the Photographic service at the Faculty of Medicine of Bordeaux).



garded as a variety of delusions monoideici caused", one reads in the 58th lesson on "Delusions ystery-hypnotics caused". We could talk about "experimental hallucinations" *ante litteram* (*v.a.*). Pitres, in conclusion, after catalogd the ecmnesic delirium as symptomatic expression of the hysteria, identifies in the alteration of the memory type ecmnesico a moment psicogenetico of Hysterical affections, so that the reversion of the personality of Albertine at a time earlier in the development of isterici episodes will disappear current symptoms (emianestesia) and isterogene areas. But at this point, abandon the case of Albertine (of evocative assonance proustiana) tralascer-emo and those liable to the same interpretation reported by Pitres (for which the ecmnesic delirium did not seem to be very rare), why not more essential to the theme in question.

Freud and Mrs Cäcilie

In 1895, four years after the *clinical lessons on the hysteria* of Pitres, are published in Vienna The *Studien über Hysterie* of Josef Breuer and Sigmund Freud [6]. In the last clinical case" content in the opera and signed by Freud, *Ms Elisabeth von R.* (of very special importance because for the first time there is systematically used the "rule fundamental psychoanalytic" of "free associations" to change the "cathartic method" of Breuer), in the conclusion of the epicrisi the author recalls the first case of hysteria observed together with Breuer: Lady Cäcilie M., "My case more serious and more instructive d hysteria".

After about a year from the hypnotic healing from a facial neuralgia, illness of Mrs Cäcilie – "person exceptionally equipped, in particular of artistic talent, whose spiccatissimo sense of form is manifested in the poems of accomplished beauty" – is characterized by the Member that, according to the sick, you were given in her even before in various moments in the course of its thirty-year disease: "In fact, is now produced a surprising amount of episodes isterici, that the patient was able to locate in the past to their proper point, and soon were recognizable even the connections of ideas very often involute which had determined the order of succession of these episodes. It was as a series of images with the comment. Pitres must have had in mind something similar when he described his "*délire ecmnésique*". The manner in which it was played one of these states isterici belonging to the past, it was

very strange. First manifested itself in the patient in perfect health a mood pathological colorful especially that the patient misconosceva regularly attributed it to some fact banal of last hours; then, in a state of increasing turbidity of conscience, followed isterici symptoms: hallucinations, pain, cramps, declamazioni long, and at the end there emerged the allucinatoria apparition of an experience of the past which could explain the mood initial and provide the determination of symptoms. With this last phase of the attack retook the clarity of conscience, disorders disappeared as if by magic and reigned again the welfare… until the next attack, half day after". Freud was usually called in the culminating moment of the phenomenon, and through hypnosis caused the reproduction of the traumatic event running "artificially" the end of the hitch.
The jump of the register with respect to the concept of Pitres occurs in the recognition of the use of the mechanisms of conversion and symbolization in the formation of isterici symptoms, but since these further developments outside the theme in speech, like Albertine we close here the nod to the clinical history of Madam Cäcilie.

The French School

With the exception of Freud, through cultural of his Parisian stay of 1885 at Charcot, concepts of Pitres will have a slight impact on psychiatric thought and psicopatologico of German language. There is of course the citation of the *ecmnesic delirium* in a German treaty of international renown in the early decades of the twentieth century known as the "Manual of Binswanger" [7] (Eight Binswanger uncle of Ludwig Binswanger who was his assistant in Jena): "The sick person is believed returned to his childhood or youth and ne relives a more or less long period", synthesizes Schultze, the author of the chapter on "hysteria" considered in the preface of Guicciardi to the italian edition "one of the gems of the manual". It is however in psychiatric School French heir to the lesson of Janet – especially for works of its three main representatives Baruch, Ey and Delay – that the ecmnesia will be transposed with the most clinical interest.
Henri Baruch already at the time of its *Thése de Paris* [8] 1926 had found the "curious" phenomenon of ecmnesia symptom as very important and frequent of mental confusion by intracranial hypertension in brain tumors [9] (such as those of the fourth ventricle) in its aspects of disorientation in time and onirismo, and this fact will bounce in the course of its production treatises – from *Psychiatrie médicale, physiologique et expérimentale* [10] '38 to *Précis de psychiatrie* [11] '50 until *Traité de psychiatrie* [12] '59 – with a constant criticism to the conviction of Pitres that ecmnesia ("This phenomenon of transfer of psichismo to an earlier period of existence") was patognomonica of hysteria: "It is curious to note that these facts of ecmnesia, that ancient authors attributed sometimes even to the suggestion or to magnetism, can be determined by a cause organic, such as brain tumors".
In 1950, in the ninth of its *Études psychiatriques* [13] (comprised in the second tomo – "semiologici aspects" – and focused on "memory disorders") Henri Ey defines "ecmnesie" (together with false recognitions, the illusion of the doppelganger and the feeling of "Jamais vu") in the "paramnesie or illusions of memory" characterized by "confusion of the past and the present" which distinguish them from localization errors in time or space. Ey brings to descrittivismo sindromico reificante of Pitres, to determinism of pathogenic reminiscences of Freud and the medical model-encefaloiatrico of Baruch a grading psicopatologico, indicating that these "tranches" of the past that in certain states parossistici occur to the conscience of the subject and acquire the value of the present, the memories are evoked with a vividness allucinatoria that causes them to lose their character of "remember". This is a veritable ipermnesia allucinatoria, "hallucinations de la mémoire" that sometimes occur in a form both fascinating and "pure" by apparentarsi to the revival of the past in the dream and in the onirismo referred does not constitute that one aspect.
In '54, in *Etude No. 24* (third tomo – "Structure of acute psychosis and destructuration of conscience" – entitled "confusion and delirium confused-dreamy") "déja vu", "Jamais vu", false recognitions, ecmnesie, illusions of the past and false memories are disorders grouped together as "paramnesie" that may appear typically "in confusing catastrophe, when conscience is thus deconstructed by one shall not be able to deploy its prospects temporo-spatial, that they can no longer operate the synthesis necessary for the constitution of the order of its relations existential and rational".
In the *Manuel de psychiatrie* signed by Ey with Paul Bernard and Charles Brisset [14], the semiology elusive of these disorders of memory will be riarticolata, mentioning "those strange allucinatorie recollections of the past to which we give the name of *ecmnesia* (current experience of a scene past) and found especially in epileptic destrutturazioni of conscience" in the lemma of ipermnesie ("that are present in the form of an irrepressible esaltamento the evocation of memories"), leaving in that of paramnesie ("falsifications of the act mnesico that combine in the perception the present and the past, the real and the imaginary") experiences such as the "illusion of the doppelganger" and "impression of ever seen".
Not tralasciava, Ey, in *Étude* of '50, the return of the thesis of Jean Delay (dating back to the early Forties) [15] on the ecmnesia as example of memory constituted exchanged with the memory constituent.
In the *Abrégé Psychologie de* extended from Delay with Pierre Pichot [16]. You will indicate with scientist spirit "some exaggerations" in the descriptions of the cases of ecmnesie, as the *panoramic vision* of life at the time of a danger of death or the revival of languages forget under the influence of anesthesia. For the two authors, in the ecmnesia (which is classified among the "*delusions of memory*") subjects often relive memories that are unable to evoke

in full consciousness, in a sort of freeing of memory impairments that occurs when the social schemes were dissolved from sleep, by disease or from a pharmacological intoxication, from *psychedelic drugs*, from the psychoanalytical method of free associations, by methods pharmacodynamic properties, with reference also to ecmnesie caused by electrical stimulations of the temporal lobe during surgical interventions for the treatment of epilepsy made from Penfield and by the same described since the '46 (as described by Ey in his *Traité des hallucinations* [17], where the "experimental hallucinations" of Penfield – the most important contribution by empirical Anglo-saxon matrix to the physiopathological understanding of the topic – rubricate are precisely as the "ecmnesie").

It is interesting to note that in France, in the middle of the century, also the academic neurology was careful not to neglect the specificity of the ecmnesia, so much so that in the *Pratique neurologique* Marcel Riser [18], teachers of Toulouse is detailed with a wealth semeiologica psicopatologica and who do not find ourselves in psychiatric treatises coeval. In the chapter on "memory disorders", it argues that the ecmnesia apparenta is to hyper and paramnesie since it is equally of a revival of the past strong, sometimes even brutal, but poorly located, mal criticized by the sick, which admits the transposition and adapts its behavior in the past that relives. There is an intermittent ecmnesia, which can lead to a genuine state of split personality and behavior in which the subject uses language, ways, attitudes of a child, the collegial, soldier who believes to be. In some cases underestimates the present or ignore, and even reaching out to deny it, in a singular confusion between the recognition of all the past – and not only of a tranche – and the identification of the present, with amputation of everything that does not belong to that past recognized ("this is the mental puerilism of Dupré"). Copy the reconnaissance nosodromica: "Member of ecmnesia meet especially in the course of senile dementias; not only these sick never stop always repeat their ancient memories, but they truly live and Li lie in the present time. The same thing occurs in the course of the accesses mental confusion, of certain tumors of the base, schizophrenia that it must very suspect; a large number of ecmnesie said simulated pitiatiche or fall in early dementia which will be fully manifested in later".

Paul Guiraud, in his *Psychiatrie clinique* [19]. The mid-fifties, returns to the "puerilismo mental Dupré" to emphasize how the ecmnesia of Pitres, although well described as Syndrome, both in his opinion imperfectly called, since this would not be of a "simple delirium of Memory" as it was said at the time of Charcot, but of the revival of a viable status of the global past, i.e. an authentic *ecbiose,* meaning "Member ecbiotici" *infantilism* and *puerilismo mental* Dupré.

In the mid-Sixties Henri Faure, medical training psychiatric both that literary, publish in the necklace of psychiatry directed by delay and Pichot the assay *Hallucinations et réalité perceptive* [20]. In the chapter on hallucinations and member a dreamy, after having criticized the structural analysis of Ey and in particular the theory of "destructuration of conscience" (with the jacksoniana phenomenology of its different levels) for the radicalism with which it speaks of "absence of worldliness" in delirium confused-dreamy or "annihilation of the objectivity" in the experience allucinatoria, distinguishes the "ipnici content and para-ipnici that are strictly autonomous with respect to the space outside objective" from those "who are clearly involved in the field surrounding space". The first group are those automatisms of awakening or sleep called "hypnagogies": lived that is the impose spontaneously on the "display" of our conscience, in the manner of a film of which we are the spectators, and that – as already described by Pitres (*v.i.*) and new studied by J.C. Benoit – can be "domesticated" by the therapist making appear themes and guiding them. Between the ipnagogici phenomena of a pathological nature, Faure lists the "hallucinations ecmnésiques" as intended by Sutter, Pélicier Debrie and in a report of 1954 [21]. Where were differentiated by "ecmnésie de Pitres". In the second group are including hand "paroxysmes ecmnésiques" ("efflorescence psycho-sensory" observed in sonnambulismi and in the "statuses seconds") and "hallucinations-réminiscences" ("ecmnésies"; "hallucinations du passé" or "délires de mémoire" of Delay): disorders psycho-acute sensory typical member post-emotional, often described as of hallucinations dream, in which the onirismo exerts its influence on the outside world: "The memory located in the environmental realities of significant stimuli capable of both unleash reminiscences, both serve as a concrete support to the deployment of this psychic lived", although it is not that "remémoration".

In *his Traité de psychopathologie* of Eugège Minkowski [22] (published in 1966), the ecmnesia is recovered in the paragraph on puerilismo of Dupré (between the problems connected with the alterations of affectivity) through the mediation didactic of the historical studies of Rene Charpentier and definitions of Antoine Porot.

Other latin countries

In Spain, we meet Antonio Vallejo Nágera (who had attended in Germany the lessons of Kraepelin, Gruhle and Schwalbe) that does not neglect in his *Tratado de psiquiatría* [23] (which dates back to the mid Forties) to insert punctually l'"ecmenesia" both in the framework of qualitative alterations of the "rememoracion", as in that of personality disorders, recognizing the nature hysterical or psicogenetica: "The subject completely lose the memory of the current synthesis and feels transported in earlier epochs of his life, mainly infantile, and thinks and acts accordingly."

The Son, Juan Antonio Vallejo-Nágera, accomplish a work of systemization within a more ambitious framework psicopatologica: in its *Introducción to the psiquiatría* [24]. Of the early Sixties, in chapter "autopsichico orientation and disorders of the awareness of the i. Autopercezione" describing between the *noise in the identification of the i* or of the

identity of the "i" the *alternating personality*, notes that "is more frequent the forgetfulness of the last stages of life, and therefore the patient (generally in senile dementia or organic) believed to be a young person or child and to live in the environment and with the people of that time. This disturbance has the name of *ecmnesia*".
In Italy, finally, stand out for lucidity and rigor of the systematic apparatus the monographs of Lucio Bini and Tullio Bazzi (the first of which, however, was formed neuropsichiatricamente in Vienna). In the monograph of 1949 *The psiconevrosi* [25], in the dissertation on the symptomatology of the "psiconevrosi hysterical" (where will not escape the mention of Pitres for "tremor hysterical" between the somatic symptoms) under the "psychic syndromes episodic" (crisis or pseudocrisi hysterical) placed member twilight delirious, which consist in terrifiche hallucinations or pleasant, associated with cues delirious: "Sometimes the delirium completely transforms the personality of the Sick which acts as if rivivesse a period of his childhood or Youth ("ecmnesic delirium")".
A lustre, later in the first volume of their *Treaty of psychiatry* ("Medical Psychology") [26] censureranno in no uncertain terms the Ey of *Etudes* for having made fall within the category of paramnesie (qualitative disorders of memory) "disorders (phenomenon of "seen" – jamais vu –; illusion of doubles, ecmnesie) that are not referable to the memory p.d. It is in fact symptoms closely linked to disturbances crepuscular of conscience and to the state of depersonalization".
The *Manual of psychiatry* of Franco Giberti and Romulus Rossi [27], mandate to prints at the beginning of the Seventies, will mark a turning point for terms and traditional definitions of psychiatric symptoms, as a reflection of the radical change of the Einstellung of psychiatrist. The ecmnesie, "although differently interpreted", still have a space between the "qualitative disorders" memory (paramnesie), but this is now a concept old fashioned, esangue, a sort of fossil fuels in a chapter of "Terminology and semeiotic psicopatologica" from the "meaning rich of resonances tired, born from the Psychiatry c.d. "descriptive" of the past decades stretched to encode the "symptoms" more than to understand the nature and the profoundly human behavior "pathological"".

Conclusions

That concludes our excursus on "ecmnesia of Pitres". Certainly not because the characteristics mnesiche alterations for which there has been returned from the pièce of Albertine do not exist anymore. Alludiamo to G.G., a woman quarantottenne that one of writing has had in care for several years in a structure psychiatric rehabilitation, whose Lebenswelt conforms to a condition psychosis of autism poor strutturatasi adolescence (diagnosis of dispatch was "syndrome disorganized schizophrenic", preceded by "hebephrenic schizophrenia") poorly responsive to interventions socioterapici pharmacological and (With antiepileptic/stabilizer – initially prescribed in prophylactic track following a doubt critical episode previous convulsivo insertion, with EEG devoid of specific elements – and typical antipsychotics – also depot – at the entrance, replaced with atypical immediately after) that almost on a daily basis is torn apart by bouffées the destructuring of the conscience of allucinatorio type-frenzied where I lived off you are suddenly moved and iridescent: in an attitude of Vision, animosamente dialogs with characters of his childhood, inscenando traumatic episodes (few, always the same) in a chaotic vortex of false recognitions (educators recognize an "old hog", the nurse etc.), cries, clastica fury, escapes... then everything calms down, without the memory of what happened, falling in the frozen shell of a clinofilia that pervades his whole day, also insensitive to community scan meals. It happens that the crepuscular episodes occur during the night in the form of nightmares sonnambulici, with terrifiche apparitions and infantile (Belfagor, a snake etc.). This form of existence in the sign of a radical communicative eclipses intercisa from fractures vertical dissociative personality with ecmnesiche productions that seem not to leave any traces in the atimormia on whose background is silhouetted, forced in reductive bed of Procuste of diagnostic manuals, it seems to us that good esemplifichi that what is missing is from a slope of psychiatry the taxonomic attitude that had given to the ecmnesia a statute of type scientific-naturalistic, on the other hand the sovraordinatore concept of hysteria inside which hovered and took sense experience psicopatologica of ecmnesico delirium. The diaspora of the hysteria in figures not more ordered by "organizers psychopathological", but satisfying "organizers nosografici" [28], has also dispersed the ecmnesia in a fenomenica of memory disorders where the study of the Erlebnis of disturbed person you replaced a neuropsychological systematic.
But if the ecmnesia as psicopatologica dimension no longer belongs to the clinical relevance, its function under metaphorical species is in our opinion still noticeable in the phenomenological analysis of temporality in music. Think about how in schumanniani *Davidsbündlertänze* the extraordinary effectiveness of formal cutting assembly is bases on the piercing reappearance of second dance inside the seventeenth part ("Wie aus der Ferne", as far) which surprises and moved to the listener as authentic return of the past, while schutzianamente lives and ages together to the executor in the same flow of the musical process [29]. It is not a question here of a formal feedback, a *cape* or a summary, but of a memory [30] which is configured as a "updating" ecmnesica [31], to the point that this return is connected to the way in which Schumann in the first edition signed each piece with the initial of Eusebius or Florestan or both the imaginary characters (modeled on brothers Walt Vult and of the novel by Jean Paul *Flegeljahre*) in which identified the two poles of his artistic personality, yes that the intimate character ("Innig") of the first – who signed the slow Ländler of second piece – interpenetrates with the complementary elazione second in the seventeenth song initialled together.

By reason of the aphorism pronounced by Alexis Weissenberg that "does not discover music: we can be discovered in the music", who knows that precisely from the musical aesthetics romantic and idiomatic from narrative structures to be put into psychiatry does not draw the reason to recover in new meanings and gnoseologiche prospects on the inside bring this obsolete but meaningful page of psychopathology.

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Società Italiana di Psichiatria

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Gianfranco Buffardi

Review

Integrated therapy: dedicated training and proposed patterns

Gianfranco Buffardi

Psychiatrist, psychologist, psychotherapist, degree in philosophy, Ph. D. in bioethics, Director of the Neo-Existential Psychotherapy School SPEs, President of the Istituto di Scienze Umane ed Esistenziali, ISUE (Human and Existential Sciences Institute), Naples

Summary

This study is a review of both the extensive literature on integrated mental health therapy and the author's clinical and training experience in this field.
The study wants to emphasize the need for training dedicated to the themes of therapeutic integration, the importance of some basic principles for making an integrative network and the mental attitude that professionals must acquire to correctly deal with the work involved in integrated therapy.
Those working in psychiatry, psychotherapy, and other mental health fields will be increasingly interested in integrated therapeutic processes in the future.

Key words: Integrated therapies; psychotherapies; existential therapy; personal training in mental health; help professions.

Introduction

Most mental health professionals today agree on the importance of the integrated therapies in psychiatric care, which has the merit, at least partially, of overcoming the stale contrast between classic medical treatments (pharmacological or nutritional), psychological treatments and rehabilitative treatments, as well as stimulating a specific new mental attitude for some new therapeutic choices.
Despite the large amount of attention that the scientific literature pays to this methodology, there is a lack of absolute clarity on what the meaning of therapeutic integration is and how it can be implemented.
This study would like to clarify the concept and propose some principles to realize a correct and profitable integrative methodology.

Integrated therapy (main text)

The therapeutic adjective means that it takes care of a disease

Before discussing the concept of integrated therapy, I believe that it is important to talk about the concept of disease.
There are many words and expressions related to "disease"; four of them appear most frequently and have complementary but subtly different meanings:
Disease: "*The term disease broadly refers to any condition that impairs the normal functioning of the body. For this reason, diseases are associated with dysfunctioning of the body's normal homeostatic processes* [1,2]. Objective disease, not necessarily accompanied by subjective experience.
Illness: The patient's experience of being ill: the sensation, the totally personal and subjective experience of the loss of health, also without a real disease.

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Correspondence:
Gianfranco Buffardi
gbuffardi@isue.it
g.buffardi@live.com

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Sickness: Social role of disease, status and negotiation between the sick person and society.
Disorder: *"A functional abnormality or disturbance. The term disorder is often considered more value-neutral and less stigmatizing than the terms disease or illness"* [2].
Using these different terms is needed because of the complexity of the concepts; this rising complexity of the concept of health has undergone change over time; currently, the WHO defines it in the following way: "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" [3].
An inclusive definition of disease could be the following: "*A disease is a particular abnormal condition that negatively affects the structure or function of part or all of an organism, and that is not due to any immediate external injury* [4]*. Diseases are often known to be medical conditions that are associated with specific symptoms and signs. A disease may be caused by external factors such as pathogens or by internal dysfunctions*" [5].
Furthermore, "*the definition of disease is fundamental the principle of transience: each pathology has a term that can be represented by the healing of the organism, by its adaptation to a different physiology (or to a different life condition) or by death*" [6].
People suffering from some kind of disease live with their set of symptoms, feelings, emotions every day; the existential "presence" of the disease affects the way in which those affected see the world:

- there are complex psychophysical anomalies that we call illness;
- there are sets of feelings, thoughts and lived emotions that people experience as a disease;
- there are observable events experienced by those who share existential space with those who have a disease that allow to recognize those people as individuals suffering from a disease;
- there is the possibility that these conditions cause physical, social, emotional damage to others.

Mental diseases clearly share all the aspects of physical diseases covered above in the following aspects:

- the symptomatic expressions of the disease;
- the relationship between illness and individuals;
- the relationship between a sick person and his or her environment;
- the progression of phases of time and states of well-being and illness;
- the relationship of other people with the sick person (at various levels, close family and friends, extended family, fellow citizens, society, etc.);
- the social and functional role of the individual as time progresses in stages;
- the consequences in all existential areas of the action of therapies and treatments or of their total or partial absence;
- social and existential outcomes of a mental illness in terms of stigma, self-stigma, stigma of healthcare professionals, etc.

An integrated approach should respond to all of these health needs.

Semantic clarification

"Integration is a process by which a system acquires and maintains a structural and functional unity, but it conserves the differentiation of the singular components; it is also the product of this process, because it preserves the internal balance of the system, social cooperation, and coordination between roles and institutions" [7].
In this definition, borrowed from the social science literature, we can already identify two important elements: structural and functional unity and the differentiation of the singular components; the need for "coordination" must be added to these elements: *"Integration means building common foundations. [...] Integration is not a simple sum of the components but the result of common management ..."* [8].
Integrated therapy could operate in very different ambits, given all of these elements, by intervening in the existential sphere of a single patient, a group, a disease, a population, a type of treatment, etc. In this sense, integrated therapy can be assimilated with the *"Collaborative Care Management (CoCM)"*, which is "… *a practice-based system of care designed to integrate treatment for common mental health disorders (e.g., depression, anxiety) into primary care settings using principles of chronic disease management* […] [9]. *This approach uses existing pharmacologic and psychotherapeutic treatments in a new way through a team-based approach* …" [10]. The A.I.M.S. (Advancing Integrated Mental Health Solutions) of the University of Washington suggests that evidence-based collaborative care includes five basic principles: "*patient-centred team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care*" [11]. In therapeutic integration, the "medical-centred" dimension of collaborative care is an integral, but not exclusive, part of therapeutic intervention.
Collaborative medicine takes care of all aspects of the disease and the disorder but fails to be equally effective in all aspects of the sickness, the most social sphere of disease, and in all aspects of the illness, the most intimate and existentially impactful area of the disease for the individual.
In synthesis, the following points are relevant:

- as a general concept, integration is a process in which different skills, knowledge, and cultures organize a common action aimed at one or more outcomes;
- integration in medicine is the choice to fight against disease by intervening with different strategies coordinated with each other, as in collaborative care, but also including non-medical skills, primary secondary tertiary prevention procedures, post-trauma rehabilitation, welfare;
- the specificity of integration in mental health care implies the management of different therapies and treat-

ments; today, the main perspective is one of consolidated work and study; this kind of care includes the existential aspects of the disease (and the existential aspects of the patient) and the effects of the disease in the social world and in relationships with other people.

Integrated therapies in psychiatry

the first period of studies on integrated therapies in psychiatry concerned the integration of different psychotherapeutic approaches: "*Integrative therapy is a progressive form of psychotherapy that combines different therapeutic tools and approaches to fit the needs of the individual client. With an understanding of normal human development, an integrative therapist modifies standard treatments to fill in development gaps that affect each client in different ways. By combining elements drawn from different schools of psychological theory and research, integrative therapy becomes a more flexible and inclusive approach to treatment than more traditional, singular forms of psychotherapy*" [12].

The limited outcomes of psychotherapy limited to a single approach or model stimulated this kind of research.

Clinical practice has welcomed unorthodox paths with eclectic methods of work and good results [13]. However, the combination of different psychological models has generated methodological and interpretative problems; this is an epistemological problem too often ignored or neglected by clinicians: *"The epistemological problem of integration is arising anew, where some methods based on deterministic models of psychological illness come face-to-face and interact among them"* [14].

The operational difficulty due to this epistemological impasse is evident despite the rarity of analytical studies about this topic.

Indeed, "*we are convinced that it is mainly the non-specific aspects of the treatment methods that achieve an effective result, and not the therapeutic procedures proper to the individual models*" [15].

Therefore, many studies have attributed therapeutic validity only to some aspects of psychotherapeutic practice: The *"Journal of Psychotherapy Integration primarily publishes original peer-reviewed papers consistent with five major pathways associated with psychotherapy integration:*

- *common factors (core elements to effective psychotherapy that transcend a specific orientation);*
- *technical eclecticism (application of the best treatment for a specific population and problem);*
- *theoretical integration (combining two or more theories and their associated techniques);*
- *assimilative integration (theoretical grounding in a single orientation with value added techniques drawn from other orientations);*
- *unification (meta-theoretical approaches that place theories, techniques, and principles into holistic frameworks)*" [16].

The integration of biological and psychological treatments appeared later in the scientific literature. It was preceded by some pioneering studies, often critical studies [17,18], or studies about specific psychotherapeutic approaches combined with pharmacotherapy [19,20], including between psychoanalysis and drugs: "*The association of psychopharmacotherapy and psychotherapy is a frequent clinical and often indispensable practice. […] From the psychodynamic perspective, there is the advantage of facilitating the understanding of transference*" [21].

Scientific research has dedicated much work to the study of synergy between drugs and psychotherapies.

Several hypotheses have been formulated, from the ability of both drugs and psychotherapy to modify the functional structure of the mind, conditioning the implicit memory [22], to psychotherapy as an epigenetic "drug" [23] and to a hyper-inclusive ratio that does not exclude social contingencies and the accessibility of the treatments to individuals [24].

Many studies have identified specific pathological conditions that have achieved good results through a combination of pharmacotherapy and psychotherapy treatments [25,26].

From a literature review, we can summarize the following: The integration of the mental health therapy that was applied before with singular psychotherapeutic approaches to tackle the gap of a treatment according a unique model has since been extended to all the possibilities of medical, psychological, social, existential, and rehabilitation intervention, to achieve the best care, prevention, prophylaxis, recovery and quality of life improvement of affected individuals.

In the context of psychotherapies, analysing whether it is better to integrate different reference models or only their different operating methods is a topical problem. Analytical work in this sense is unthinkable, but a different global reading, "lateral rather than vertical" [27], could focus attention on common operational and cultural factors [28].

Integrated care should also involve non-clinical areas (counselling, social assistance, mediation, etc.).

How to implement integration skills

Integrated therapy is an operational methodology that involves many different professions and knowledge.

However, in the international literature, we find very few suggestions about the procedural steps of integrated therapy.

Many authors have considered it sufficient to appeal to the professionalism of individual professionals to improve the integration of practices. This choice, at least in psychotherapy, has sometimes clashed with a number of insurmountable difficulties, including those involving the epistemological incompatibilities of the psychological models; some studies have addressed specific procedural, methodological or theoretical tools to overcome these difficulties, but they are very rare.

The integration among different health and non-health professions appears to lack simplicity: "*Integrated care is defined as health services that are managed and delivered such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector and, according to their needs, throughout the life course*" [29].

Individual professionals have to intervene in all steps of the integrative procedure: **sharing the income, focusing, building the integrated care in such a way that it can be followed, sharing information on the intermediate results, developing new focuses and new ways of information sharing, determining processes that will be repeated several times, managing a common outcome and follow-up procedures, conducting a common analysis of the outcome.**

It would be useful to develop codified patterns and be provided with fluid and continuous communication instruments among professionals. However, it should not be a static, pre-coded team but rather a multidisciplinary one, a sort of "virtual nursing home" in which the operators belong to a single firm offering all of the assistance. Real clinical practice presents us with very different situations, often impromptu, that include relationships among the different professions that must be built in that moment according to the needs of those being treated.

We believe that it is useful to share some operating and methodological principles:

1. Design of the integrative network:
   a. an integrative network is never a static building or a team prepared in advance that welcomes people with care needs. An integrative network is a network that is created extemporaneously, often motivated by the first clinical evaluation of an individual; each professional is predisposed to the possibility of referring their patient to experts from other professions who will potentially be integrated into the network to facilitate the temporary aggregation of skills;
   b. a network should identify a leader; we propose the psychiatrist as the leader because his or her attendance is a punctiform one, spaced out over time and based on a general clinical evaluation and verification of the results.
2. Improvement of integration skills:
   a. each professional needs clarity on the operations and methodologies of the other professionals who are participating in the integrated therapy;
   b. a basic "training" on the specific operating methods is useful for all who are preparing to help and/or become care professionals.
3. Organization of inter-professional communication:
   a. an integrated therapy programme should provide adequate and immediate information both for all professionals participating in the current phase of the supplementary programme and for those who may be involved in a subsequent phase;
   b. mental health professionals should be trained in effective communication in a clinical/therapeutic context beforehand, establishing the "golden rules" for mutual information exchanges.
4. Selection of a target:
   a. there are two ends on a continuum of choices:
      i. pre-organizing an integrated working group with targets in a specific condition (i.e., DCA groups or psychotic onset groups);
      ii. keeping a network of professionals ready to intervene in the integration with an individual patient whenever it is necessary.
5. Intermediate checks and possible new designs:
   a. it is necessary to create valid interdisciplinary verification tools;
   b. among these, development rating scales or rating scales on quality of life that have already been validated are preferred [30,31].
6. Out-come pattern:
   a. the problem of evaluating the outcome of integrated care often depends on the mental attitude of individual professionals. A "collaborative spirit" is preferred to a "competitive" one; unfortunately, I am obliged to use the conditional tense;
   b. an outcome procedure should be entrusted to an "ad hoc" packaged tool to avoid assessments that attribute different merits or responsibilities to the different professional approaches. This kind of instrument is not yet present in the scientific literature.

Which professionals should be selected for integrated care?

As we have already pointed out, professionals who participate in an integrated care project must have a background with some specific skills and attributes.

The first is the correct mental attitude, which means that the individual professional:

- does not consider his/her own competence to be more or less important or essential than that of others;
- accepts the possibility that his/her own reference model may dialogue with other reference models;
- was trained to suspend his/her judgement in favour of sharing views with other people (ἐποχή by Husserl) [32];
- will know to modify his/her work plan in compliance with the various supplementary projects.

We believe, on this basis, that it is not possible for a young professional who will participate in future integrative work can limit his/her knowledge to the competences of only his/her profession; he/she also has to know something about the fundamental aspects of the disciplines with which he/she has to integrate.

Some principles of psychopathology and psychiatric clinic must obviously be known by psychiatrists, psychologists

and psychotherapists but also to counsellors, educators, social workers, nurses, rehabilitators, sociologists, etc.
In addition, psychologists and psychotherapists, as well as other professionals, cannot ignore the effect of drug therapies on patients' symptoms, nor can clinicians ignore the fundamental terms of welfare, the administrative and legal procedures for granting indemnities or benefits, the legal instruments for forms of protection for people with mental problems, etc.
In this field, a common language or a communication system that allows the permeability of languages to acquire common skills is needed.
Communication practice between different professions and skills will facilitate the emergence of a language without cognitive barriers because professionals training will be designed for integration.
Many problems can arise among professionals who currently work with integrated therapy who have not received structured training for doing so; indeed, they may approach integrative processes starting from their own cultural positions, with communication mistakes possibly being made as a result.

Conclusions: professionals' training

Finally, this is the core goal of this study: to stimulate the reader to consider that integrated therapy in psychiatry (but, I believe, in every other branch that deals with therapies as well) requires professionals who have been trained to share a vast wealth of knowledge with other professionals in the care field.
Training dedicated to those who will work in integration will face many difficulties in achieving a common practice. Philosophical patterns, especially epistemological principles, are very important in creating a system of integration care that has received adequate procedures and communication methods.
A common practice also implies the need for lifelong continuous learning that expands to all of the professional fields involved. Imagine, therefore, a class of trainers who will dedicate part of their working space to a specific training programme for therapeutic mental health integration.
Finally, and importantly, I believe that constant self-reflection about one's own work and about the sense of belonging to a therapeutic project is necessary for each individual professional (even through working with a supervisor therapist, e.g. a Personal Existential Analysis) [33]. Professionals also need to conduct a self-reflection on their own existential space, as competent persons and persons in continuity with the world of others, with other things, and with him/herself.
All of the people who choose to become mental health care professionals need to participate in this kind of training: not only psychiatrists and psychologists but also professional nurses, educators and psychiatric rehabilitation technicians. Indeed, almost all conditions of psychological distress probably require integrated treatment.
In a nutshell, a training and operational plan for therapeutic integration professionals should include:

- the building of intermediate and outcome-verification tools to be made available to professionals;
- a basic training programme that includes:
  - principles of epistemology and methodology for operational and psychological models;
  - the basic principles of all professional areas possibly subject to integration; and
  - regulatory frameworks and social structures that can support supplementary programmes;
- a specific training programme for integration that includes:
- training about effective communication; and
- training about logical tools for creating a therapeutic integration network whenever necessary; and
- personal training that aims to implement one's own capability of suspending judgement [34] and self-reflection to reach the correct mental attitude.

The philosophical measure of one's own presence in the world and in the space of the care of the other people is a characteristic that each of us, as health professionals, should learn to exhibit.

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