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Editorial

The reason why psychiatrists should oppose war

Bernardo Carpiniello

Department of Medical Sciences and Public Health, University of Cagliari & Psychiatric Unit, University Hospital Agency, Cagliari, Italy; Past President SIP

Società Italiana di Psichiatria

Bernardo Carpiniello

The dramatic invasion of Ukraine has forced us to rethink the position of psychiatry and psychiatrists with regard to war and its tragic consequences. Literature reports highlight how approximately 2 billion people worldwide currently live in areas involved in armed conflicts resulting in violence, displacement, infrastructural damage and disruption of public health services, thus producing a negative effect on their health and wellbeing [1]. Death is sadly the most the most dramatic consequence of war. During the 20th century, armed conflicts were responsible for approximately 191 million deaths [2]. Available data underline how the majority of war victims are civilians. Indeed, the rate of 1 in 7 deaths among civilians during World War 1 rose to two thirds of deaths during World War 2, with a further increase to 90% of deaths during conflicts occurring at the end of the 20th century [3,4]. In addition to deaths and other physical injuries, war directly endangers the mental health of those involved. However, exposure to traumatic events (e.g. military attacks) is not the only stressor present in wartime, with mental disorders potentially stemming from a series of other consequences of armed conflicts such as displacement, loss of livelihoods, food and water shortages, exposure to traumatic incidents and forms of violence other than military aggression, loss of protective factors (e.g. family and financial stability) and other forms of migration-related distress, including lowering of socio-economic status [5]. War-related mental disorders comprise not only posttraumatic stress disorder (PTSD) but also other forms of stress-related conditions, such as insomnia, anxiety and depression. Moreover, during wars, individuals suffering from mental health issues are potentially more prone to exploitation and face other health- and wellbeing-related risks [5]. The most recent WHO systematic review and meta-analysis [6] reported a prevalence of mental disorders in populations involved in armed conflicts, assessed at any point in time, of approximately 22·1%; the mean comorbidity-adjusted and age-standardised point prevalence of depression, anxiety, and post-traumatic stress disorder was 13·0% for mild forms and 4·0% for moderate forms; the mean comorbidity-adjusted, age-standardised point prevalence for severe disorders (schizophrenia, bipolar disorder, severe depression, severe anxiety, and severe post-traumatic stress disorder) was 5·1%; all these figures were considerably higher than those obtained for general populations not involved in armed conflicts. Exposure to war-related distress may also produce long-lasting consequences on mental health, as demonstrated in a study of Vietnamese subjects who had been exposed earlier in life to three types of war traumas (death and injury, stressful living conditions, and fearing death and/or injury); the higher level of exposure was associated with poorer health in later-life across a large number of outcomes, such as number of diagnosed health conditions, mental distress, somatic symptoms, physical functioning, post-traumatic stress symptoms and chronic pain [7]. The impact of war on the mental health of

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Correspondence:
Bernardo Carpiniello
bcarpini@iol.it

civilian populations is of particular relevance. Indeed, studies conducted in this field have shown a definite increase in both incidence and prevalence of mental disorders in these populations, with women, children, elderly and the disabled classified as the most vulnerable groups [8]. Civilian populations seeking refuge from conflicts, attempting to escape the direct danger of warfare, experience food insecurity and loss of livelihoods. It has been calculated that almost 40% of the 68.5 million people currently displaced by conflict have crossed international borders, while the remaining approx. 60% are internally displaced people [9]. No less than 4 million Ukrainian refugees are expected to be displaced by the current armed conflict. A review of studies on the long-term mental health of 16,010 war-affected refugees found prevalence rates of depression ranging from 2.3-80%, of PTSD from 4.4-86%, of anxiety disorder from 20.0 and 88% of depression, with average prevalence estimates being typically in the range of 20% and above. The significant heterogeneity of data is due to both methodological and other factors, such as the country of origin of refugees and their destination for resettlement; higher exposure to pre-migration traumatic experiences and post-migration stress were the most consistent factors associated with mental disorders, with a poor post-migration socio-economic status as a factor particularly associated with depression [10]. Data present in literature reveal how both war trauma and post-migration stressors exert a powerful influence on mental health, whilst the post-migration environment seems to play a fundamental role in either fostering or impeding recovery from war-related trauma and grief; moreover, other daily-life stressors related to the experience of displacement, such as social isolation, poverty, family violence, discrimination and uncertainty over asylum status have been acknowledged as relevant factors affecting mental health [11]. Lastly, it should be taken into account that refugees and asylum seekers may frequently have been exposed not only to the consequences of war in their country of origin, but also survived a dangerous journey, struggling with negative reception in transit and host countries [12]. Women, children and adolescents are among the most vulnerable populations during conflicts. Exposure to armed conflicts is associated with increased prevalence of anxiety disorders, such as post-traumatic stress disorder, and depression among children, adolescents, and women, both during and after conflicts. It has been estimated that the average prevalence of anxiety disorders and major depression among conflict-affected populations is two to four times as high as global prevalence estimates, with a large effect of conflict exposure on women's mental health, with several studies reporting a greater effect of conflicts on women than men, often related to gender-based violence [13]. Armed conflict is a negative social determinant of child health, with a certain number of studies documenting how adversity during childhood can alter the architecture of the brain and neuroendocrine function, leading to alterations in learning, behaviour, and physiology, in turn predisposing the developing child to maladaptive behaviours and ill health throughout their life course [14]. Literature indicates regressive, behavioral and cognitive symptoms emerging as consequences of distress, including bedwetting, fear, sadness, aggression, hyperactivity and inattention during the conflict, together with clear-cut syndromes such as adjustment disorders, depression, anxiety and, to a greater extent, post-traumatic stress [15]. Finally, several studies seem to indicate the possibility of a transgenerational transmission of the consequences of war on mental health. Indeed, a study of 1966 adult subjects whose fathers had served in the Australian army during the Vietnam War demonstrated that almost 40 years after the war, the adult offspring of deployed veterans were more likely to be diagnosed with anxiety and depression, featuring suicide ideation, suicidal plans and self-harm behaviours more frequently than the progeny of comparable, non-deployed army veterans [16].

In conclusion, war is one of the most powerful threats to mental health, particularly for innocent victims of conflicts such as civilians. The duty of psychiatry and the psychiatrist is to safeguard the mental health of the population. For this reason, the recourse to war as a means by which to resolve conflicts should be unfailingly and universally rejected - both now and forever.

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Società Italiana di Psichiatria

Review

Evidenze cliniche e forensi condivise in tema di perizia psichiatrica, suicidio e comportamento violento sulla persona

Èvidences cliniques et médico-légal partagées au sujet du expertise psychiatrique, suicide et comportement violent sur la personne

Clinical and forensic evidence shared on the subject of psychiatric expertise, suicide and Interpersonal physical violence

Evidencias clínicas y forenses compartidas sobre el tema de pericia psiquiátrica, suicidio y comportamiento violento contra la persona


Enrico Zanalda


Massimo di Giannantonio


Giancarlo Nivoli

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Correspondence:
Enrico Zanalda
enrico.zanalda@yahoo.it

Massimo di Giannantonio
digiannantonio@unich.it

Giancarlo Nivoli
giancarlonivoli@gmail.com

Sono riportate a scopo di aggiornamento e di discussione critica, a livello internazionale, tradotte in italiano, francese, inglese e spagnolo, alcune evidenze cliniche e forensi in tema di perizia psichiatrica, suicidio e comportamento violento sulla persona.

Certaines èvidences cliniques et médico-légales sur l'expertise psychiatrique, le suicide et les comportements violents sur la personne, traduites en italien, français, anglais et espagnol, sont rapportées à des fins de mise à jour et de discussion critique, au niveau international.

Some clinical and forensic evidence on psychiatric expertise, suicide and violent behavior on the person are reported, translated into Italian, French, English and Spanish, for the purpose of updating and critical discussion, at international level.

Algunas evidencias clínicas y forenses sobre pericia psiquiátrica, suicidio y comportamiento violento contra la persona se reportan, traducidas al italiano, francés, inglés y español, con el propósito de actualización y discusión crítica, a nivel internacional.

Presidenza della Società Italiana di Psichiatria
Enrico Zanalda
Massimo di Giannantonio

Presidenza della Società Italiana di Psichiatria Forense
Giancarlo Nivoli

Pisa,30,ottobre,2021

La perizia psichiatrica: dal controllo sociale all'indicazione di cura

Questo scritto è un aggiornamento scientifico psichiatrico, clinico e forense, in tema di perizia e consulenza psichiatrica. Si tratta di dieci osservazioni psichiatrico forensi condivise e accettate dalla Società Italiana di Psichiatria (SIP) e dalla Società Italiana di Psichiatria Forense (SIPF) che, secondo la legge italiana (n. 43/2017) hanno valore giuridico in tema di buone pratiche cliniche assistenziali e peritali e valutazione della responsabilità professionale dello psichiatra (1, 2).

Il contributo della psichiatria alla valutazione giuridica della pericolosità

Il concetto di pericolosità è un concetto giuridico in tema di difesa sociale e di controllo sociale ed è di pertinenza e competenza, per legge, esclusivamente del magistrato. Non è compito della psichiatria e della psichiatria forense la difesa sociale, il controllo sociale, stabilire la premeditazione, dichiarare le aggravanti o le attenuanti, ecc. La psichiatria in tema di diagnosi e terapia, di sua pertinenza e competenza, illustrerà in ambito peritale al magistrato la gravità clinica del disturbo psichico e il grado di intensità delle cure da praticare (sul territorio, in comunità, in strutture ad alta intensità di cure come le REMS, ecc.) contestualizzate e fattibili in relazione al caso specifico. Il magistrato potrà utilizzare queste informazioni psichiatriche sulla base del suo potere discrezionale e sulla base di quanto la legge prevede in tema di criteri giuridici per la valutazione della pericolosità.

La condivisione tra chi scrive la perizia e chi riceve in cura il periziando

Le indicazioni di cura, quando è il caso, contenute in una perizia psichiatrica (dove e da chi il periziando deve essere curato) debbono essere condivise tra chi scrive la perizia e chi accoglierà in cura il periziando. Questa condivisione evita conflitti di competenze tra i protagonisti dell'accertamento giudiziario, disfunzioni nell'amministrazione della Giustizia e della Sanità ed è una variabile medico psichiatrica che contribuisce a validare i percorsi di cura e di riabilitazione. Questa condivisione di informazioni psichiatriche è offerta alla valutazione del magistrato.

La perizia come documento medico-psichiatrico

La perizia psichiatrica non contiene solo la risposta ai quesiti specifici del magistrato, ma nelle informazioni utili ai fini di giustizia fornisce una documentazione medico-psichiatrica utile ai percorsi di cura e di riabilitazione, previsti per legge, nei confronti del periziando. Si tratta di una documentazione medico-psichiatrica che dovrà seguire il periziando nei suoi percorsi terapeutici con facile reperibilità da parte del personale trattante per documentare e validare le scelte trattamentali.

La differenza tra la Psichiatria Forense e altre discipline del sapere

La Psichiatria Forense presenta finalità e metodologie diverse dalle finalità e metodologie di altre discipline del sapere come la Psichiatria clinica, le Psicoterapie, la Psicologia, la Psicoanalisi, la Genetica, la Farmacoterapia, l'esame con reattivi mentali, la diagnosi attraverso l'immagine, gli accertamenti diagnostici di laboratorio, ecc. Confondere le finalità e la metodologia della Psichiatria Forense con le finalità e le metodologie di altre discipline può essere motivo di confusione ed errori che riducono la validità scientifica e forense della perizia.

I criteri per la validità forense di una perizia

Una perizia per essere dichiarata valida a livello forense deve rispettare una precisa criteriologia. La Società Italiana di Psichiatria ha messo in luce una serie di variabili che debbono essere rispettate in una perizia: il tipo d'incarico, il diario delle operazioni peritali, la descrizione dei fatti per cui si procede, l'anamnesi medico psichiatrica ed eventualmente criminale, l'esame psichiatrico diretto, la valutazione clinica e il nesso causale, le osservazioni psichiatrico-forensi, la risposta ai quesiti. Il magistrato in qualità di "custode del metodo scientifico" ha il diritto-dovere, di valutare la metodologia con cui la perizia viene redatta e se lo ritiene dichiararla incompleta o addirittura "non ammissibile" al processo.

I criteri per l'appropriatezza della perizia

La perizia psichiatrica, come tutta la documentazione medica, deve rispondere ai criteri di appropriatezza clinica. Deve anche rispettare l'appropriatezza giuridica e forense di sintesi e di chiarezza e contenere tutte le informazioni necessarie e non tutte le informazioni possibili. L'appropriatezza di una perizia si basa anche sull'accurata valutazione clinica e psichiatrico forense del caso contestualizzandola correttamente alla situazione per cui è stata richiesta.

La qualificazione dei periti e consulenti

L'esecuzione della perizia e della consulenza psichiatrica richiedono una qualificazione come prevista da norme di legge, codici deontologici e buone pratiche cliniche assistenziali. La legge in particolare richiede una competenza reale sullo specifico compito da svolgere. La Società Italiana di Psichiatria ha definito i criteri per la qualificazione del perito psichiatra: medico chirurgo, specialista in Psichiatria con un'esperienza clinica psichiatrica assistenziale in struttura pubblica di almeno otto anni oltre gli anni di specializzazione e un adeguato curriculum in relazione alla valutazione del caso in oggetto. Questa qualificazione garantisce il magistrato della competenza specifica del perito e di avere delle risposte ai quesiti congrue all'organizzazione del Sistema Sanitario Nazionale che sovente deve essere coinvolto nel percorso di cura del soggetto.

La ricusazione e denuncia del perito e consulente

La legge prevede la ricusazione del perito e consulente quando non è qualificato o affidabile. Esistono criteri di legge per stabilire la qualificazione. Esiste anche una giurisprudenza specifica nazionale e una ampia letteratura internazionale che stabilisce i criteri di affidabilità del perito. La domanda di ricusazione, adeguatamente motivata, deve essere inoltrata al magistrato di competenza. Il perito e il consulente possono rispondere professionalmente della correttezza del loro operare per eventuali imperizia, negligenza e imprudenza.

La ricerca di uniformità, l'esecuzione da remoto, la risposta immediata

Tra le attuali tendenze di evoluzione della perizia e consulenza psichiatrica, già presenti in alcune nazioni europee, sono da segnalare la ricerca di uniformità (impiego della stessa metodologia forense evitando disparità di metodologie); l'esecuzione da remoto (sempre maggior utilizzo dei mezzi telematici nelle varie fasi della elaborazione per una maggior funzionalità esecutiva); la risposta immediata, standardizzata e concisa (visita del periziando soprattutto in occasione di decisioni urgenti, e immediata risposta a quesiti specifici in elaborato scritto standardizzato di due, tre pagine).

La formazione e aggiornamento scientifico in Psichiatria Forense

La legge prevede per l'ottenimento del titolo di specialista in Psichiatria la formazione in ambito peritale e in tema di valutazione della responsabilità professionale. Si tratta di due argomenti specifici della psichiatria forense con importanti conseguenze nella gestione quotidiana della assistenza psichiatrica. L'aggiornamento scientifico dei periti e dei consulenti è un criterio della loro qualificazione e affidabilità.

Conclusioni

Le dieci osservazioni psichiatrico forensi sopra elencate costituiscono la premessa indispensabile alla corretta esecuzione di una perizia psichiatrica. Il Magistrato, nei casi previsti per legge, può ricorrere alla costituzione di un collegio di periti. Sia la Società Italiana di Psichiatria che la Società Italiana di Psichiatria Forense ritengono tale modalità corretta qualora il collegio nell'insieme rispetti la qualificazione richiesta.

L'expertise psychiatrique pénale: du contrôle social à l'indication des soins

Cet article est une mise à jour scientifique psychiatrique, clinique et médico-légale sur le sujet de l'expertise psychiatrique pénale. Il s'agit de dix observations psychiatriques médico-légales partagées et acceptées par la Società Italiana di Psichiatria (SIP) e Società Italiana di Psichiatria Forense (SIPF) qui, conformément à la loi italienne (n. 43/2017), ont une valeur juridique en termes de bonne assistance clinique, de pratiques d'experts et d'évaluation de la responsabilité professionnelle du psychiatre (1, 2).

La contribution de la psychiatrie à l'appréciation juridique de la dangerosité

Le concept de dangerosité est un concept juridique en termes de défense sociale et de contrôle social et est de pertinence et de compétence, par la loi, exclusivement pour le magistrat. La défense sociale, le contrôle social, l'établissement de la préméditation, la déclaration de circonstances aggravantes ou atténuantes, etc. ne relèvent pas de la psychiatrie et de la psychiatrie légale. La psychiatrie en termes de diagnostic et de thérapie, de sa pertinence et de sa compétence, illustrera au magistrat la sévérité clinique du trouble psychique et le degré d'intensité des traitements à pratiquer (sur le territoire, dans la communauté, dans des structures à forte intensité tyherapeutique de tels que REMS, etc.) contextualisés et réalisables par rapport au cas spécifique. Le magistrat pourra utiliser ces informations psychiatriques sur la base de sa discrétion et sur la base de ce que la loi prévoit en termes de critères juridiques d'appréciation de la dangerosité.

Le partage entre qui rédige l'expertise et qui soigne l'expetrisé

Les indications de traitement, quand il y a indications, contenues dans un rapport psychiatrique (où et par qui l'éxpertisé doit être traitée) doivent être partagées entre la personne qui rédige l'expertise et qui recevra en traitment l'expertisé. Ce partage évite les conflits de compétence entre les protagonistes de l'évaluation judiciaire, les dysfonctionnements dans l'administration de la justice et de la santé et est une variable médicale psychiatrique qui permet de documenter et valorisér les parcours de traitement et de rééducation. Ce partage d'informations psychiatriques est proposé à l'évaluation du magistrat.

L'expertise psychiatrique en tant que document médico-psychiatrique

L'expertise psychiatrique contient non seulement la réponse aux questions spécifiques du magistrat mais dans les informations utiles aux fins de la justice, il fournit une documentation médico-psychiatrique utile pour les parcours de traitement et de rééducation de l'expertisé, prévus par la loi. Il s'agit d'une documentation médico-psychiatrique que devra suivre l'expertisé dans ses parcours

thérapeutiques avec une disponibilité aisée par le personnel soignant pour documenter et valider les choix de traitement.

La différence entre la psychiatrie légale et les autres disciplines de la connaissance scientifique

La psychiatrie légale a des objectifs et des méthodologies différents des objectifs et des méthodologies d'autres disciplines de la connaissance telles que la psychiatrie clinique, les psychothérapies, la psychologie, la psychanalyse, la génétique, la pharmacothérapie, l'examen avec des réactifs mentaux, le diagnostic par images , tests de diagnostic de laboratoire, etc. Confondre les objectifs et la méthodologie de la psychiatrie légale avec les objectifs et les méthodologies d'autres disciplines peut être une source de confusion et d'erreurs qui réduisent la validité scientifique et médico-légale de l'expertise psichiatrique.

Les critères de validité médico-légale d'une expertise psychiatrique

Pour être déclarée valide au niveau médico-légal, une expertise doit respecter des critère précis. La Società Italiana di Psichiatria ont mis en évidence une série de variables qui doivent être respectées dans une appréciation: le type de mission, le journal des opérations d'experts, la description des faits pour lesquels on procède, la histoire psychiatrique et médicale et éventuellement les antécédents criminels, l'examen psychiatrique direct, l'évaluation clinique et le lien de causalité, les observations psychiatriques médico-légales, la réponse aux questions. Le magistrat en tant que «gardien de la méthode scientifique» a le droit et le devoir d'évaluer la méthodologie avec laquelle l'expertise est rédigé. Le magistrat peut juger l'expertise incomplète ou même «non recevable» au procès a cause de "non validité "selon la methode scinetifique et médico-légal.

Les critères de pertinence du rapport

Le rapport psychiatrique, comme toute documentation médicale, doit répondre aux critères de pertinence clinique. Il doit également respecter la pertinence médico-légale et contenir toutes les informations nécessaires et non toutes les informations possibles. La pertinence d'une évaluation est basée sur une évaluation médico-légale clinique et psychiatrique précise du cas, en le contextualisant correctement à la situation pour laquelle il a été demandé.

La qualification des experts et consultants

L'exécution de l'éxpertise psychiatrique nécessite une qualification requise par la loi, les codes d'éthique et les bonnes pratiques de soins cliniques. La loi en particulier exige une réelle compétence sur la tâche spécifique à accomplir. La Società Italiana di Psichiatria ont défini les critères de qualification de l'expert psichiatre: medecin, spécialiste en psychiatrie avec une expérience d'assistance psychiatrique clinique dans une structure publique d'au moins 8 ans, sans compter les années de spécialisation, un curriculum professionel adéquat par rapport à l'évaluation du cas d'espèce. Cette qualification garantit au magistrat la compétence spécifique de l'expert et d'avoir des réponses aux questions propres à l'organisation du système national de santé qui doit souvent être impliqué dans le parcours de soins du patient.

La recusation de l'expert et du consultant

La loi prévoit la récusation de l'expert et du consultant lorsqu'il n'est pas qualifié ou fiable. Il existe des critères juridiques pour établir la qualification. Il existe également une jurisprudence nationale spécifique et une large littérature internationale qui établit les critères de fiabilité de l'expert. La demande de récusation, dûment motivée, doit être transmise au magistrat compétent. L'expert et le consultant peuvent répondre professionnellement de l'exactitude de leur travail et de toute inexpérience, négligence et imprudence.

La recherche de l'uniformité, l'exécution à distance, la réponse immédiate

Parmi les tendances actuelles de l'évolution de l'expertise et du conseil en psychiatrie, déjà présentes dans certains pays européens, il faut noter la recherche d'uniformité (utilisation d'une même méthodologie médico-légale évitant les disparités de méthodologies); exécution à distance (utilisation croissante des moyens télématiques dans les différentes étapes de traitement pour une plus grande fonctionnalité exécutive); la réponse immédiate, standardisée et concise (visite de l'expert et réponse immédiate à des questions précises dans un rapport écrit standardisé de deux ou trois pages).

Formation et mise à jour scientifique en psychiatrie légale

La loi prévoit une formation dans le domaine de l'expertise et dans le domaine de l'évaluation de la responsabilité professionnelle pour l'obtention du titre de spécialiste en psychiatrie. Ce sont deux thèmes spécifiques de la psychiatrie légale avec des conséquences importantes dans la gestion quotidienne des soins psychiatriques. La mise à jour scientifique des experts et consultants est un critère de leur qualification et de leur fiabilité.

Conclusions

Les dix observations psychiatriques médico-légales énumérées ci-dessus constituent la prémisse indispensable pour la bonne exécution d'une épertise psychiatrique. Le magistrat, dans les cas prévus par la loi, peut recourir à la création d'un collège d'experts. Tant la Società Italiana di Psichiatria e Società Italiana di Psichiatria Forense considèrent que cette méthode est correcte si le collège dans son ensemble satisfait à la qualification requise.

Psychiatric expertise: from social control to indication of treatment

This paper is a psychiatric, clinical and forensic scientific update on psychiatric expertise. It consists of ten forensic psychiatric observations shared and accepted by the Società Italiana di Psichiatria (SIP) and the Società Italiana di Psichiatria Forense (SIPF), which, according to italian law (n 43/2017) have legal value on the subject of good clinical practices and evaluation of the psychiatrist's professional responsibility (1, 2).

The contribution of psychiatry to the legal assessment of dangerousness

The concept of dangerousness is a juridical concept on the subject of social defence and social control and is the exclusive competence of the magistrate. It is not the task of psychiatry and forensic psychiatry to assess social defence, social control, establish premeditation, declare aggravating or mitigating circumstances, etc. Psychiatry, in terms of diagnosis and therapy, which is its pertinence and competence, will illustrate to the magistrate the clinical seriousness of the mental disorder and the degree of intensity of the treatment to be applied (on the territory, in the community, in high intensity care facilities such as REMS, etc.), contextualised and feasible in relation to the specific case. The magistrate may use this psychiatric information on the basis of his discretionary power and on the basis of what the law provides for in terms of legal criteria for the assessment of dangerousness.

Sharing between the expert and the case manager

The treatment indications, when appropriate, contained in a psychiatric report (where and by whom the patient must be treated) must be shared between the writer of the report (expert) and the person who will treat the patient (case manager). This sharing avoids conflicts of competences between the protagonists of the judicial assessment, dysfunctions in the administration of Justice and Health and is a medical-psychiatric variable that contributes to validate the treatment and rehabilitation paths. This sharing of psychiatric information is offered to the magistrate's assessment.

The report as a medical-psychiatric document

The psychiatric report does not only contain the answer to the magistrate's specific questions, but in the information useful for the purposes of justice, it provides a medical-psychiatric documentation useful for the treatment and rehabilitation paths, foreseen by the law, for the patient. This is a medical-psychiatric documentation that will have to follow the patient in his or her therapeutic pathways, which can be easily retrieved by the treating personnel in order to document and validate the treatment choices.

The difference between Forensic Psychiatry and other neuroscientific disciplines

Forensic psychiatry has different aims and methodologies from the aims and methodologies of other disciplines of knowledge such as clinical psychiatry, psychotherapy, psychology, psychoanalysis, genetics, pharmacotherapy, examination with mental reagents, diagnosis by means of imaging, diagnostic laboratory tests, etc. Confusing the aims and methodology of forensic psychiatry with the aims and methodologies of other disciplines can lead to confusion and errors that reduce the scientific and forensic validity of the report.

Criteria for the forensic validity of an expert report

In order to be declared forensically valid, an expert report must respect a precise criteria. The Società Italiana di Psichiatria has highlighted a series of variables that must be respected in an expert report: the type of assignment, the diary of the expert operations, the description of the facts for which proceedings are being taken, the medical-psychiatric and possibly criminal anamnesis, the direct psychiatric examination, the clinical evaluation and the causal link, the psychiatric-forensic observations, the answer to the questions. The magistrate, in his capacity as "guardian of the scientific method", has the right and duty to evaluate the methodology with which the report is drawn up and, if he considers it necessary, to declare it incomplete or even "inadmissible" at trial.

Appropriateness Criteria of expertise

The psychiatric report, like all medical documentation, must meet the criteria of clinical appropriateness. It must also respect forensic appropriateness and contain all necessary information and not all possible information. The appropriateness of an expert report is based on an accurate clinical and forensic psychiatric assessment of the case, correctly contextualising it to the situation for which it was requested.

The qualification of experts

The performance of psychiatric expertise and counselling requires qualification as required by law, codes of ethics and good clinical care practices. The law in particular requires real expertise on the specific task to be performed. The Società Italiana di Psichiatria has defined the criteria for the qualification of the psychiatric expert: physician, specialist in psychiatry with at least eight years of clinical psychiatric care experience in public facilities in addition to the years of specialisation and an adequate curriculum in relation to the assessment of the case in question. This qualification guarantees the magistrate of the expert's specific competence and answers to questions in line with the organisation of the National Health System, which often has to be involved in the subject's treatment pathway.

Recusal and denunciation of expert

The law provides for the objection of experts and advisers when they are not qualified or reliable. There are legal criteria for establishing qualification. There is also specific national case law and a large body of international literature establishing criteria for the reliability of the expert. The request for objection, with adequate reasons, must be submitted to the competent magistrate. The expert and the consultant can be professionally liable for the correctness of their work for any guilty inexperience, negligence and imprudence.

The search for uniformity, remote execution, immediate response

Among the current trends in the evolution of psychiatric expertise and counselling, already present in some European countries, are to be reported the search for uniformity (use of the same forensic methodology avoiding disparities of methodologies); remote execution (increasing use of telemedia in the various stages of processing for greater executive functionality); the immediate, standardized and concise response (visit of the expertise and immediate response to specific questions in a standardized two- or three-page written report).

Training and scientific updating in forensic psychiatry

In order to obtain the title of specialist in psychiatry, the law provides for training in forensic psychiatry and in the assessment of professional responsibility. These are two specific topics of forensic psychiatry with important consequences in the daily management of psychiatric care. The scientific updating of experts and consultants is a criterion of their qualification and reliability.

Conclusions

The ten forensic psychiatric observations listed above constitute the indispensable premise for the correct execution of a psychiatric expertise. The Magistrate, in the cases provided for by law, may resort to the constitution of a panel of experts. Both the Società Italiana di Psichitria and the Società Italiana di Psichiatria Forense consider this modality to be correct if the panel as a whole meets the required qualifications.

La pericia psiquiátrica: desde el control social a la indicación del tratamiento psiquiàtrico

Este artículo es una actualización científica psiquiátrica, clínica y forense sobre el tema de la pericia y de la evaluaciòn juridica psiquiátrica. Se trata de diez observaciones psiquiátricas forenses compartidas y aceptadas por la Società Italiana di psichiatria (SIP) y por la Società Italiana di Psichiatria Forense (SIPF) que, según la ley italiana (n. 43/2017), tienen valor legal en términos de buenas prácticas clínicas asistenciales y peritales i evaluación de la responsabilidad profesional del psiquiatra (1, 2).

Contribución de la psiquiatría a la evaluación jurídica de la peligrosidad social

El concepto de peligrosidad social es un concepto jurídico en materia de defensa social y control social y es de relevancia y competencia, jurídicamente, exclusivamente del magistrado. La defensa social, el control social, establecer la premeditación, declarar agravantes o atenuantes, no son tareas especificas que pertenecen a la psiquiatría clinica y forense. La psiquiatría, en términos de diagnóstico y terapia, por su relevancia y competencia, será de ayuda al magistrado con respecto a la gravedad clínica del trastorno mental y a el grado de intensidad de los tratamientos a practicar (en el territorio, en la comunidad, en estructuras de alta intensidad de la atención como REMS, etc.) contextualizados y factibles en relación al caso específico. El magistrado podrá utilizar esta información psiquiátrica en función de su discreción y en función de lo que disponga la ley en términos de criterios legales para evaluar la peligrosidad social.

La compartición entre la persona que redacta la pericia y la persona responsable del tratamiento psiquiàtrico

Las indicaciones de tratamiento, en su caso, contenidas en una pericia psiquiátrica deben ser compartidas entre la persona que redacta la pericia y la persona responsable del tratamiento psiquiàtrico. Este compartir evita conflictos de competencia entre los protagonistas de la verificación judicial, disfunciones en la administración de Justicia y Salud y es una variable médico psiquiátrica que ayuda a validar las trayectorias de tratamiento y rehabilitación. Este intercambio de información psiquiátrica se ofrece a la evaluación del magistrado.

La pericia como documento médico-psiquiátrico

La pericia psiquiátrica no solo contiene la respuesta a las preguntas específicas del magistrado sino que tambièn proporciona la información útil para los fines de la justicia, asegura documentación médico-psiquiátrica útil para las trayectorias de tratamiento y rehabilitación, establecidas por la ley. Se trata de una documentación médico-psiquiátrica que deberá seguir el paciente en sus trayectorias terapéuticas con fácil disponibilidad por parte del personal tratante para documentar y validar las opciones de tratamiento.

La diferencia entre Psiquiatría Forense y otras disciplinas cientificas

La Psiquiatría Forense tiene objetivos y metodologías diferentes respecto a otras disciplinas cientificas como Psiquiatría Clínica, Psicoterapias, Psicología, Psicoanálisis, Genética, Farmacoterapia, examen con reactivos mentales, diagnóstico por imagen, pruebas diagnósticas de laboratorio, etc. Confundir los objetivos y la metodología de la Psiquiatría Forense con los objetivos y metodologías de otras disciplinas cientificas puede provocar confusiones y errores que reduzcan la validez científica y forense de la pericia psiquiàtrica.

Los criterios para la validez forense de una pericia

Para ser declarada válida a nivel forense, una pericia debe respetar unos criterios específicos. La Società Italiana di Psichiatria ha destacado una serie de variables que deben respetarse en una pericia: el tipo de mandato, el diario de las operaciones peritales, la descripción de los hechos por los que se procede, los antecedentes médicos, psiquiátricos y posiblemente penales, los examenes psiquiátrico, la evaluación clínica y el nexo causal, las observaciones psiquiátricas-forenses, las respuestas a las preguntas. El magistrado como “garante del método científico” tiene el derecho y el deber de evaluar la metodología con la que se elabora la pericia y puede declarar la pericia psiquiàtrica “no admisible” para el juicio.

Los criterios de idoneidad de la pericia

La pericia psiquiátrica, como toda la documentación médica, debe cumplir con los criterios de idoneidad clínica. También debe respetar la idoneidad forense y contener toda la información necesaria y no toda la información posible. La pertinencia de una pericia se fundamenta sobre una minuciosa evaluación clínica y psiquiátrica forense del caso, contextualizándolo correctamente a la situación para la que ha sido solicitada.

La calificación de los peritos y de los expertos

La ejecución de la pericia psiquiàtrica requiere una calificación como lo exigen la ley, los códigos éticos y las buenas prácticas clínicas. La ley, en particular, exige una competencia real en la tarea específica a realizar. La Società Italiana di Psichiatria ha definido los criterios para la calificación del psiquiatra: mèdico, especialista en psiquiatría con experiencia en asistencia clínica psiquiátrica en una estructura pública desde por lo menos ocho años (sin contar los años de residencia) y un plan de estudios adecuado en relación a la evaluación del caso en cuestión. Esta calificación garantiza al magistrado la competencia específica del perito y respuestas adecuadas a las preguntas que se ajusten a la organización del Sistema Nacional de Salud que a menudo debe participar en el proceso de tratamiento psiquiàtrico de la persona.

La recusación y denuncia del perito

La ley prevé la recusación del perito i expertocuando no esté calificado o no sea fiable. Existen criterios legales para establecer la calificación. También existe una jurisprudencia nacional específica y una amplia literatura internacional que establece los criterios de fiabilidad del perito. La solicitud de recusación, debidamente motivada, deberá ser remitida al magistrado competente. El perito i el expertodeben responder profesionalmente de la veracidad y precisión de su trabajo por cualquier inexperiencia, negligencia e imprudencia.

La búsqueda de uniformidad, ejecución remota, respuesta inmediata

Entre las tendencias actuales en la evolución de la pericia psiquiàtrica, ya presente en algunos países europeos, cabe destacar la búsqueda de la uniformidad (uso de la misma metodología forense evitando disparidades de metodologías); ejecución remota (uso creciente de medios telemáticos en las distintas etapas de procedimiento para una mayor funcionalidad ejecutiva); la respuesta inmediata, estandarizada y concisa (visita del experto y respuesta inmediata a preguntas específicas en un escrito estandarizado de dos o tres páginas).

Formación y actualización científica en Psiquiatría Forense

La ley prevé para obtener el título de especialista en psiquiatría la formación en ámbito perital y en materia de evaluación de la responsabilidad profesional. Se trata de dos temas específicos de la psiquiatría forense con importantes consecuencias en la gestión diaria del tratamiento psiquiátrico. La formaciòn y la actualización científica de los expertos es un criterio de calificación y confiabilidad.

Conclusiones

Las diez observaciones psiquiátricas forenses enumeradas anteriormente constituyen la premisa indispensable para la correcta ejecución de una pericia psiquiatrica. El Magistrado, en los casos previstos por la ley, podrá recurrir al establecimiento de un colegio de expertos. Tanto la Società Italiana di Psichiatria como la Società Italiana di Psichiatria Forense consideran que este método es correcto si el colegio en su conjunto cumple con la calificación requerida.

Suicidio del paziente, responsabilità professionale dello psichiatra, cartella clinica come documento forense

Il suicidio del paziente è uno tra gli eventi più drammatici che possono accadere nella pratica psichiatrica. È anche una tra le cause più frequenti della incriminazione penale e civile dello psichiatra. Allo scopo generale di migliorare la buona pratica clinica assistenziale dello psichiatra in tema di trattamento e prevenzione del suicidio possono essere consultate, con i loro vantaggi e criticità, numerose linee guida (1). Oggetto del presente scritto è di riportare, alcune evidenze cliniche e forensi condivise in tema di suicidio approvate dalla Società Italiana di Psichiatria (SIP) e Società Italiana di Psichiatria Forense (SIPF) (1, 2).

Il suicidio è un evento a eziologia multideterminata, diagnosi multiassiale e trattamento multistrategico

Aspetti clinici

Il suicidio è un evento:

1. **a eziologia multideterminata (*Recognition of multicausality*)** (1) e cioè a una eziologia clinica legata a numerose variabili biologiche, psicologiche, psichiatriche, culturali, sociali, contestuali, ecc che interagiscono nel singolo individuo;
2. **a diagnosi multi assiale (*Multiaxial diagnosis*)** (1) e cioè la formulazione di una diagnosi che valuti la complessa eziologia bio-psico-sociale e l'unicità e irripetibilità delle circostanze psico-socio-culturali di tempo, luoghi e persone del singolo caso clinico;
3. **a intervento preventivo e trattamentale multistrategico (*Multicomponent interventions, Multisectorial approach*)** (1) e cioè provvedimenti terapeutici e preventivi, in relazione al caso clinico, nel campo medico, psicologico, psichiatrico, sociale, culturale, assistenziale, economico, legislativo, politico, ecc.

Responsabilità professionale

L'affermazione semplicista *si è ucciso perché era depresso* non è condivisibile sotto l'aspetto clinico e forense. La depressione non è causa clinica e forense unica e diretta del suicidio: non tutti i depressi si uccidono e non tutti quelli che si uccidono sono depressi. Inoltre il disturbo psichico è un *fattore clinico di rischio*, tra i numerosi fattori clinici di rischio e non, a priori, una *causa forense*. La psichiatria clinica ha fini sociali e metodologie di valutazione diverse dalla psichiatria forense. L'affermazione corretta, rispettosa della complessità scientifica clinica e forense del suicidio, che non è legato a una causa unica, potrebbe essere: allo *stato attuale delle conoscenze è difficile capire perché quel soggetto si* è *ucciso … era depresso, narcisista, impulsivo, aggressivo e in particolare era molto turbato e disperato perché aveva perso il lavoro ed era stato abbandonato dalla moglie che amava profondamente...*

Cartella clinica

In cartella clinica e nelle informazioni cliniche e forensi a livello scientifico e nelle comunicazioni di massa deve risultare con chiarezza: l'eziologia multideterminata, la diagnosi multiassiale e gli interventi multistrategici di prevenzione del suicidio. Soprattutto devono essere segnalati in cartella clinica i fattori di rischio clinico che non sono di pertinenza e competenza dello psichiatra (crollo finanziario, divorzio, problemi lavorativi, malattie organiche, ecc.) (*No single factor is sufficient to explain why a person died by suicide:* WHO).

L'interazione tra fattori protettivi clinici e fattori di rischio clinico nel suicidio. La differenza tra psichiatria clinica e psichiatria forense

Aspetti clinici

In tema di suicidio è possibile affermare a livello clinico (1):

1. nella psichiatria clinica il suicidio è il risultato clinico della interazione, nel singolo caso, tra fattori protettivi clinici e fattori di rischio clinico;
2. i fattori protettivi clinici e di fattori di rischio clinico non sono fattori di causa forense;
3. i fattori di rischio clinico possono essere presenti e il soggetto non si suicida, i fattori protettivi clinici possono essere presenti e il soggetto si suicida;
4. i fattori protettivi clinici e di rischio clinico sono numerosi in clinica e possono, a seconda delle linee guida essere oltre il centinaio (1). La loro singola valutazione scientifica è complessa sotto l'aspetto qualitativo, quantitativo e inter-relazionale, e sono variabili in rapporto alle differenti e numerose linee guida nazionali e internazionali (1).

Responsabilità professionale

La valutazione psichiatrica del rischio di suicidio limitata ad alcuni fattori di rischio clinico (pregressi tentativi suicidari, autolesionismi, ecc.) nel singolo caso clinico, non è accettabile sotto il profilo scientifico e clinico. Inoltre si presta a *interpretazioni semplificatorie* non scientifiche: lo *psichiatra ha dimenticato … ha sottovalutato … questo fattore di rischio … quindi è responsabile del suicidio.* La valutazione della *suicidalità clinica* di un paziente deve essere fatta attraverso l'*eziologia clinica* con *l'esame dei fattori di rischio clinico e dei fattori protettivi clinici presenti*, allo *stato attuale* e *concretamente*, nel soggetto al momento specifico dei fatti. La valutazione forense della responsabilità dello psichiatra in tema di suicidio deve essere formulata attraverso la *causalità forense* che è differente dall'*eziologia clinica*. L'eziologia clinica non contiene concetti giuridici che sono presenti nella causalità forense.

Cartella clinica

In cartella clinica e nella informazione psichiatrica, deve essere presente un elenco significativo e una valutazione dei fattori di rischio clinico e un elenco significativo dei fattori protettivi clinici nel singolo caso. Questo elenco, per avere valore forense, deve avere carattere di *concretezza*

(non fattori teorici) e *attualità* (al momento dei fatti e non nel corso della vita). Deve sempre essere utilizzato in cartella clinica e nelle comunicazioni informative il termine *clinico* (fattore di rischio clinico, fattore di protezione clinica, ecc.) per chiarire la differenza tra valutazione clinica e valutazione forense.

Il suicidio è un evento imprevedibile e inevitabile

Aspetti clinici

Negli aspetti clinici sono da considerare due differenti eventualità:

- **prevenzione del suicidio:** non sono in discussione la validità scientifica, l'utilità clinica e il valore umano di tutte le modalità di prevenzione del suicidio a livello clinico e statistico, nelle sue varie fasi, inteso come un grave problema di sanità pubblica da affrontare con provvedimenti non solo sulla base di un modello medico-psichiatrico ma anche e soprattutto un modello sociale, modello psico-sociale e modello ecologico estesi a leggi nazionali, a interventi comunitari, a ruoli di istituzioni pubbliche, alla riduzione dello stigma, alle facilitazioni della ricerca di aiuto, a educazione dei mezzi di comunicazioni di massa, ecc. (approccio multisettoriale) (1);
- **prevedibilità ed evitabilità del suicidio nel singolo caso.** In questo senso:
  1. non esiste un metodo di valutazione scientifica *clinico, attuariale o misto* che permetta, nel singolo caso clinico di stabilire con obiettività di dati che: *un soggetto si ucciderà e un altro soggetto non si ucciderà* (**imprevedibilità**);
  2. non esistono misure terapeutiche (ricovero, contenzione, osservazione visiva continua, farmacoterapia, ecc.) in grado di evitare, soprattutto a media e lunga scadenza, che: *un soggetto che ha deciso di uccidersi o prima o dopo lo metta in atto* **(inevitabilità**);
  3. quanto precede è giustificato dalla esistenza nella valutazione suicidaria di numerose criticità diagnostiche: *i fattori di rischio clinico e di protezione clinica possono variare rapidamente nel tempo come qualità, quantità e interazione reciproca; presenza di simulazioni e dissimilazioni dell'intento suicidario non manifeste e non rilevabili clinicamente; ambivalenza altalenante, non necessariamente consapevole, tra desiderio di vivere e di morire; impulsività situazionale anche egodistonica allo stile di vita, ecc.* (**difficoltà sino a impossibilità prognostica**) (1).

Responsabilità professionale

Non è accettabile sotto il profilo clinico e forense il *disfattismo psicologico e operativo* (non c'è niente da fare); *l'onnipotenza reattiva e millantatoria* (il suicidio è sempre, o quasi sempre, prevedibile ed evitabile); *l'ignoranza colpevole* (cioè non sapere che la *psichiatria clinica* e la *psichiatria forense* non sono la stessa disciplina, che la *eziologia clinica* non deve essere confusa con la *causalità forense*, che in diritto non esiste il concetto di *imprevedibilità*, *inevitabilità* e *difficoltà o impossibilità a evitare un evento*: *ad impossibilia nemo tenetur,* che in medicina e in particolare in psichiatria esiste il *rischio consentito, ecc*); *l'emarginazione dei familiari* (non sono qualificati a interventi terapeutici, intralciano la terapia, ecc). È auspicabile un atteggiamento consapevole del terapeuta (*pur consapevole della imprevedibilità e inevitabilità qualcosa* ***posso e debbo*** *fare per prevenire il suicidio)* e dei familiari nella prevenzione del suicidio del loro congiunto *(debbono essere informati, psico-educati e responsabilizzati ai fini terapeutici in modo mirato alle loro capacità, disponibilità e autodeterminazione e dopo il suicidio del congiunto seguiti, quando è il caso, con la postvention).*

Cartella clinica

In cartella clinica deve essere documentata:

1. la *coerenza* tra valutazione integrata dei fattori di rischio clinico e protettivi clinici e le misure cautelative adottate per la *cura* e *protezione* del soggetto;
2. la documentazione sulla *informazione e aderenza al trattamento del soggetto suicidario* concernente i familiari nei loro diritti di assistenza al congiunto e doveri di cittadini;
3. la cura e la protezione del soggetto debbono essere rispettose dei *diritti e doveri, previsti per legge, dei cittadini sottoposti a cure mediche* (diritto alla comunicazione, privacy, consenso, rifiuto delle cure, ecc.).

Criticità della farmacoterapia nella prevenzione del suicidio

Aspetti clinici

Nella farmacoterapia sono da considerare due differenti eventualità:

1. **farmacoterapia e disturbo psichico**. Non sono in discussione i miglioramenti dei sintomi psichiatrici e della qualità di vita che la farmacoterapia ha portato e sta portando alla terapia dei disturbi psichici;
2. **farmacoterapia e suicidio**. La farmacoterapia per la prevenzione del suicidio presenta numerose criticità (1): il suicidio (come l'omicidio) è un evento multi determinato e non esistono farmaci che guariscono gli eventi multi determinati; il disturbo psichico è solo uno tra i moltissimi fattori clinici di rischio clinico del suicidio e i fattori di rischio clinico non sono fattori causali forensi del suicidio; il farmaco può agire, nel caso più favorevole, su di un sintomo e non sulla totalità di un disturbo psichiatrico; il farmaco non agisce su tutti i componenti della suicidalità del paziente che sono estranei al sintomo e al disturbo psichiatrico; ecc. (1).

Responsabilità professionale

Non è accettabile sotto il profilo clinico e forense affermare dopo il suicidio del paziente (ex post), senza *motivare* e *approfondire in modo adeguato (1): lo psichiatra non ha somministrato il farmaco che avrebbe salvato dal suicidio … ha*

sbagliato a prescrivere il farmaco giusto … ha sbagliato a diminuire, aumentare, sospendere il farmaco... quindi è responsabile del suicidio del paziente … È doveroso che ogni valutazione forense della terapia farmacologica in tema di suicidio sia effettuata con criteri rispettosi del metodo scientifico e quindi "*contempli la valutazione dei suoi rischi e dei suoi benefici; la differenza tra efficienza ed efficacia; la sua reale efficacia su obiettivi specifici; i fenomeni di resistenza totale o parziale; le percentuali di successo nelle varie strategie alternative per vincere la resistenza; l'intolleranza; effetti collaterali; effetti paradossi; sindromi da assuefazione; sindromi da astinenza; sindromi da rimbalzo; effetto nocebo; interazioni farmacologiche; variazioni farmacocinetiche o farmacodinamiche prevedibili e non prevedibili; le ricadute, remissioni, ricorrenze e la storia evolutiva naturale del disturbo psichico dipendenti e indipendenti dal farmaco; l'esistenza di errori non rilevanti ai fini del nesso di causalità; la autodeterminazione, aderenza alla cura e tipologia del rapporto terapeutico in rapporto alle aspettative terapeutiche del farmaco; le peculiarità bio-psico-sociali del singolo caso in esame in rapporto alla funzionalità della specifica farmacoterapia; ecc."* (1).
La valutazione clinica e forense della farmacoterapia, nei casi di accusa, in tema di suicidio dovrebbe, per inderogabile rigore di completezza scientifica, illustrare sulla base di evidenze cliniche condivise, non solo:

1. "perché è ipotizzato che una terapia errata ha causato il *suicidio*";
2. ma anche, nei dettagli scientifici e operativi concreti: "quale *sarebbe stata la terapia giusta, illustrata e motivata nei dettagli, che avrebbe evitato il suicidio".*

Cartella clinica

Nella cartella clinica deve sempre essere documentata la *coerenza* tra sintomi psichiatrici e terapia farmacologica e la *giustificazione del razionale* alla base di ogni modifica della terapia farmacologica.

Osservazioni conclusive

Quanto precede è necessario sia approfondito con il testo originale (1) (circa 560 pagine; 402 riferimenti bibliografici) e con una abbreviata Guida Psichiatrico Forense (2) (85 pagine) che contengono anche i principi alla base della responsabilità in equipe, della continuità e interruzione delle cure, dei pregiudizi e delle emozioni sul suicidio e della qualificazione e affidabilità dei periti e consulenti che debbono valutare la responsabilità dello psichiatra. Inoltre quanto precede deve essere adattato a specifici contesti legislativi e giurisprudenziali nazionali di applicazione, in ambito penale e civile, al singolo caso clinico, alle specificità del sistema nazionale di assistenza psichiatrica e all'indispensabile aggiornamento legato al progredire del sapere scientifico e dell'evoluzione del diritto.

Suicide du patient, responsabilité professionnelle du psychiatre, dossier médical comme preuve documentaire devant le tribunal

Le suicide du patient est un des événements les plus dramatiques pouvant survenir dans la pratique psychiatrique. C'est aussi l'une des causes les plus fréquentes de mise en accusation pénale et civile du psychiatre. Dans le but général d'améliorer les bonnes pratiques cliniques du psychiatre en matière de traitement et de prévention du suicide, de nombreuses lignes directrices peuvent être consultées, avec leurs avantages et leurs criticité (1). L'objet de cet article est de rapporter les informations cliniques et médico-légales partagées sur le suicide approuvées par la Società Italiana di Psichiatria (SIP) et la Società Italiana di Psichiatria Forense (SIPF) (1, 2).

Le suicide est un événement avec une étiologie multidéterminée, un diagnostic multiaxial et un traitement multistratégique

Aspects cliniques

Le suicide est un événement:

1. à une étiologie multidéterminée (***Recognition of multicausality***) (1), c'est-à-dire à une étiologie clinique liée à de nombreuses variables biologiques, psychologiques, psychiatriques, culturelles, sociales, contextuelles, etc. qui interagissent chez le même individu;
2. un **diagnostic multi-axial** (***Multiaxial diagnosis***) (1), c'est-à-dire la formulation d'un diagnostic qui évalue l'étiologie bio-psycho-sociale complexe et le caractère unique et non reproductible des circonstances psycho-socio-culturelles du temps, des lieux et des personnes du cas individuel Clinique;
3. à **l'intervention préventive et thérapeutique multistratégique** (***Multicomponent interventions, Multisectorial approach***) (1), c'est-à-dire mesures thérapeutiques et préventives, en relation avec le cas clinique, dans les domaines médical, psychologique, psychiatrique, social, culturel, social, économique, législatif, politique, etc.

Responsabilité professionnelle

La déclaration simpliste "*s'est suicidé parce qu'il était déprimé*" n'est pas acceptable sous l'aspect clinique et médico-légal. La dépression n'est pas la seule cause clinique et médico-légale directe du suicide: ce ne sont pas toutes les personnes déprimées qui se suicident et toutes les personnes qui se tuent ne sont pas déprimées. De plus, le trouble mental est un *facteur de risque clinique*, parmi les nombreux facteurs de risque cliniques et non "a priori" une *cause médico-légale*. La psychiatrie clinique a des finalités sociales et des méthodologies d'évaluation différentes de la psychiatrie légale. L'énoncé correct, res-

pectueux de la complexité scientifique clinique et médico-légale du suicide, qui n'est pas lié à une seule cause, pourrait être: "*dans l'état actuel des connaissances, il est difficile de comprendre pourquoi ce sujet s'est suicidé... il était déprimé, narcissique, impulsif, agressif et en particulier il était très bouleversé et désespéré parce qu'il avait perdu son emploi et avait été abandonné par la femme qu'il aimait profondément ...*".

Dossier clinique

Dans les dossiers médicaux et dans les informations cliniques et médico-légales au niveau scientifique et dans les communications de masse, les éléments suivants doivent être clairement indiqués: l'étiologie multidéterminée, le diagnostic multiaxial et les interventions de prévention du suicide multistratégiques. Surtout, les facteurs de risque cliniques qui ne sont pas de la pertinence et de la compétence du psychiatre (effondrement financier, divorce, problèmes de travail, maladies organiques, etc.) doivent être rapportés dans le dossier médical (*No single factor is sufficient to explain why a person died by suicide*: WHO).

L'interaction entre les facteurs de protection cliniques et les facteurs de risque cliniques du suicide. La différence entre la psychiatrie clinique et la psychiatrie légale

Aspects cliniques

Au sujet du suicide, il est possible d'affirmer au niveau clinique (1):

1. en psychiatrie clinique, le suicide est le résultat clinique de l'interaction, dans le cas individuel, entre les facteurs de protection clinique et les facteurs de risque cliniques;
2. les facteurs de protection clinique et les facteurs de risque cliniques ne sont pas des facteurs de cause médico-légale;
3. des facteurs de risque cliniques peuvent être présents et le sujet ne se suicide pas, des facteurs cliniques de protection peuvent être présents et le sujet se suicide;
4. les facteurs cliniques de protection et de risque sont nombreux en clinique et peuvent, selon les recommandations, dépasser la centaine (1). Leur évaluation scientifique est complexe sous les aspects qualitatifs, quantitatifs et interrelationnels, et est variable par rapport aux différentes et nombreuses directives nationales et internationales (1).

Responsabilité professionnelle

L'évaluation psychiatrique du risque de suicide limité à certains facteurs de risque cliniques (tentatives de suicide antérieures, auto-agression, etc.) dans le seul cas clinique, n'est pas acceptable d'un point de vue scientifique et clinique. Elle se prête aussi à des *interprétations de simplification* non scientifiques: *le psychiatre a oublié … il a sous-estimé … ce facteur de risque … donc il est responsable du suicide*. L'évaluation de la *suicidalité clinique* d'un patient doit se faire à travers *l'étiologie clinique* avec un *examen des facteurs de risque cliniques et des facteurs de protection clinique présents, à l'état actuel et concrètement*, chez le sujet au moment précis des faits. L'évaluation médico-légale de la responsabilité du psychiatre dans le suicide doit être formulée à travers une *causalité médico-légale* qui est différente de l'étiologie clinique. L'étiologie clinique ne contient pas de concepts juridiques présents dans la causalité médico-légale.

Dossiers médicaux

Dans le dossier médical et dans les informations psychiatriques, il doit y avoir une liste significative et une évaluation des facteurs de risque cliniques et une liste significative des facteurs cliniques de protection (1) dans le cas individuel. Cette liste, pour avoir une valeur médico-légale, doit être de nature *concrète* (non théorique) et *d'actualité* (au moment des faits et non au cours de la vie). Le terme *clinique* (facteur de risque clinique, facteur de protection clinique, etc.) doit toujours être utilisé dans le dossier médical et dans les communications d'information pour clarifier la différence entre l'évaluation clinique et l'évaluation médico-légale.

Le suicide est un événement imprévisible et inévitable

Aspects cliniques

Dans les aspects cliniques, deux éventualités différentes doivent être envisagées:

- **prévention general du suicide:** validité scientifique, utilité clinique et valeur humaine de toutes les modalités de prévention du suicide au niveau clinique et statistique, dans ses différentes phases, du suicide comme un grave problème de santé publique à traiter par des mesures non seulement sur la base d'un modèle médico-psychiatrique mais aussi et surtout d'un modèle social, psycho-social et écologique , modèle sociologique, psychosocial, écologique) étendu aux lois nationales, aux interventions communautaires, aux rôles des institutions publiques, de la réduction de la stigmatisation, de la facilitation de la recherche d'aide, de l'éducation a la prevention de suicide par des moyens de communication de masse, etc. (approche multisectorielle) (1);
- **prévisibilité et évitement du suicide dans le cas individuel**. Dans ce sens:
  1. il n'existe pas de méthode d'évaluation scientifique *clinique, actuarielle ou mixte* permettant, dans le cas clinique specific, d'établir objectivement des données que: *un sujet se tuera et un autre ne se tuera pas* (**imprévisibilité**);
  2. il n'y a pas de mesures thérapeutiques (hospitalisation, contention, observation visuelle continue, pharmacothérapie, etc.) susceptibles d'éviter, surtout à moyen et long terme, que: *une personne qui a d*écidé de se suicider avant ou après la met en place (**inévitabilité**);
  3. ce qui précède est justifié par l'existence dans l'évaluation suicidaire de nombreuses difficultées diagnostiques: *les facteurs de risque cliniques et*

les facteurs de protection clinique peuvent varier rapidement dans le temps tels que la qualité, la quantité et l'interaction réciproque; présence de simulations et de dissimilations d'intention suicidaire non manifestes et non cliniquement détectables; ambivalence fluctuante, pas nécessairement consciente, entre le désir de vivre et de mourir; impulsivité situationnelle, y compris style de vie ego-dystonique, etc. (**difficulté jusqu'à l'impossibilité pronostique**) (1).

Responsabilité professionnelle

Le défaitisme psychologique et opérationnel n'est pas acceptable d'un point de vue clinique et médico-légal (il n'y a rien à faire); *omnipotence réactive et vantardise* (le suicide est toujours, ou presque toujours, prévisible et évitable); *l'ignorance coupable* (c.-à-d. ne pas savoir que la *psychiatrie clinique* et la *psychiatrie légale* ne sont pas la même discipline, que *l'étiologie clinique* ne doit pas être confondue avec la *causalité médico-légale*, qu'en droit il n'y a pas de concept *d'imprévisibilité, d'inévitabilité et de difficulté ou d'impossibilité pour éviter un événement: ad impossibilia nemo tenetur*, qu'en médecine et en particulier en psychiatrie il y a le *risque permis*, etc.); la *marginalisation des membres de la famille* (ils ne sont pas qualifiés pour les interventions thérapeutiques, entravent la thérapie, etc.). Une attitude consciente du thérapeute (*bien que conscient de l'imprévisibilité et de l'inévitabilité du suicide, **je peux et dois** faire quelque chose pour prévenir le suicide*) et des membres de la famille dans la prévention du suicide de leur proche (*ils doivent être informés, psycho-éduqués et rendus responsables à des fins thérapeutiques dans un visant leurs capacités, leur disponibilité et leur autodétermination et après le suicide du parent suivi, le cas échéant, de la postvention*).

Dossiers médicaux

Dans le dossier médical doit être documenté:

1. la *cohérence* entre l'évaluation intégrée des facteurs de risque cliniques et des facteurs de protection clinique et les mesures de précaution adoptées pour les *soins et la protection* du sujet;
2. la documentation sur *l'information et l'adhésion au traitement du sujet suicidaire* concernant les membres de la famille dans leurs droits d'assistance aux parents et devoirs des citoyens;
3. La prise en charge et la protection du sujet doivent être respectueuses des *droits et devoirs, prévus par la loi, des citoyens subissant un traitement médical* (droit à la communication, à la vie privée, au consentement, au refus de traitement, etc.).

Criticité de la pharmacothérapie dans la prévention du suicide

Aspects cliniques

En pharmacothérapie, deux possibilités différentes sont à considérer:

1. **pharmacothérapie et trouble psychique**. Les améliorations des symptômes psychiatriques et de la qualité de vie que la pharmacothérapie a apporté et conduit à la thérapie des troubles mentaux ne sont pas en cause;
2. **pharmacothérapie et suicide**. La pharmacothérapie pour la prévention du suicide présente de nombreux problèmes critiques (1): le suicide (comme l'homicide) est un événement multidéterminé et il n'existe aucun médicament qui guérit des événements multidéterminés; le trouble mental n'est qu'un des nombreux facteurs de risque cliniques du suicide et les facteurs de risque cliniques ne sont pas des facteurs médico-légaux du suicide; le médicament peut agir, dans le cas le plus favorable, sur un symptôme et non sur la totalité d'un trouble psychiatrique; le médicament n'agit pas sur toutes les composantes de la suicidalité du patient qui ne sont pas liées au symptôme et au trouble psychiatrique; etc. (1).

Responsabilité professionnelle

Il n'est pas acceptable d'un point de vue clinique et médico-légal d'affirmer après le suicide du patient (ex post), sans *motiver et enquêter adéquatement* (1): "*le psychiatre n'a pas administré le médicament qui aurait sauvé du suicide... il a eu tort de diminuer, d'augmenter, de suspendre le médicament... donc il est responsable du suicide du patient...*". Il est impératif que toute évaluation médico-légale de la pharmacothérapie en termes de suicide soit réalisée avec des critères qui respectent la méthode scientifique et donc: *"l'évaluation de ses risques et avantages; la différence entre efficience et efficacité; sa réelle efficacité sur des objectifs spécifiques; les phénomènes de résistance totale ou partielle; les taux de réussite des différentes stratégies alternatives pour surmonter la résistance; intolérance; effets secondaires; effets paradoxaux; syndromes addictifs; syndromes de sevrage; les syndromes de rebond; effet noyer; interactions médicamenteuses; changements pharmacocinétiques ou pharmacodynamiques prévisibles et imprévisibles; les rechutes, les rémissions, les récidives et l'histoire évolutive naturelle du trouble psychique dépendant et indépendant du médicament; l'existence d'erreurs non pertinentes aux fins du lien de causalité; l'autodétermination, l'adhésion au traitement et le type de relation thérapeutique par rapport aux attentes thérapeutiques du médicament; les particularités bio-psycho-sociales du cas individuel en question par rapport à la fonctionnalité de la pharmacothérapie spécifique; etc."* (1).

L'évaluation clinique et médico-légale de la pharmacothérapie, en cas d'accusation, au sujet du suicide doit, pour la rigueur absolue de l'exhaustivité scientifique et de la metodologie médico légale, illustrer sur la base de preuves cliniques partagées:

1. "*parce qu'on suppose qu'une thérapie incorrecte a causé le suicide*";
2. mais aussi, dans les détails scientifiques et opération-

nels concrets: "*quelle aurait été la bonne thérapie, illustrée et motivée en détail, qui aurait évité le suicide*".

Dossiers médicaux

La *cohérence* entre les symptômes psychiatriques et la pharmacothérapie et la *justification* de la justification de toute modification de la pharmacothérapie doivent toujours être documentées dans le dossier médical.

Remarques finales

Ce qui précède doit être approfondi avec le texte original (1) (environ 560 pages; 402 références bibliographiques) et avec un guide médico-psychiatrique abrégé (2) (85 pages) qui contient également les principes sous-tendant la responsabilité dans l'équipe, de la continuité et interruption des traitements, préjugés et émotions sur le suicide et de la qualification et fiabilité des experts et consultants qui doivent évaluer la responsabilité du psychiatre. En outre, ce qui précède doit être adapté aux contextes nationaux d'application législative et jurisprudentielle spécifiques, dans le domaine pénal et civil, au cas clinique individuel, aux spécificités du système national d'assistance psychiatrique et à l'indispensable mise à jour liée au progrès des connaissances scientifiques et à l'évolution de la loi.

Patient's suicide, Psychiatrist's professional responsibility, medical record as a forensic document

The patient's suicide is one of the most dramatic events that can happen in psychiatric practice. It is also one of the most frequent causes of the psychiatrist's criminal and civil indictment. Numerous guidelines can be consulted, with their advantages and criticalities, in order to improving the psychiatrist's good clinical practice in terms of suicide treatment and prevention (1). The objective of this paper is to report clinical and forensic evidence shared on the subject of suicide approved by the Società Italiana di Psichiatria (SIP) and the Società Italiana di Psichiatria Forense (SIPF) (1, 2).

Suicide is an event with a multidetermined etiology, multiaxial diagnosis and multistrategic treatment

Clinical aspects

Suicide is an event with:

1. a **multidetermined etiology** (***Recognition of multicausality***) (1). The clinical etiology is linked to numerous biological, psychological, psychiatric, cultural, social, contextual variables, etc. that interact in the single individual;
2. a **multi-axial diagnosis** (***Multiaxial diagnosis***) (1), i.e. the formulation of a diagnosis that evaluates the complex bio-psycho-social etiology and the uniqueness and unrepeatability of the psycho-socio-cultural circumstances of time, places and people of the individual case clinical;
3. a **preventive and multistrategic treatment intervention** (***Multicomponent interventions, Multisectorial approach***) (1), i.e. therapeutic and preventive measures, in relation to the clinical case, in the medical, psychological, psychiatric, social, cultural, welfare, economic, legislative, political fields, etc.

Professional responsibility

The simplistic statement "he *killed himself because he was depressed"* is not acceptable from a clinical and forensic point of view. Depression is not the only direct clinical and forensic cause of suicide: not all depressed people kill themselves and not all who kill themselves present with a depression. Furthermore, the mental disorder is a clinical risk factor, among a number of clinical risk factors and not, a priori, a forensic cause. Clinical psychiatry has social purposes and evaluation methodologies different from forensic psychiatry. The correct statement, respectful of the clinical and forensic scientific complexity of suicide, which is not linked to a single cause, could be: "*in the current state of knowledge it is difficult to understand why that subject killed himself...he was depressed, narcissistic, impulsive, aggressive and in particular he was very upset and desperate because he had lost his job and had been abandoned by the wife he loved deeply...".*

Clinical record

In clinical records and in clinical and forensic information at a scientific level and in mass communications, the following must be clearly stated: the multidetermined etiology, the multiaxial diagnosis and the multistrategic suicide prevention interventions. Above all, the clinical risk factors that are not of the psychiatrist's relevance and competence (financial collapse, divorce, work problems, organic diseases, etc.) must be reported in the medical record (*No single factor is sufficient to explain why a person died by suicide*: WHO).

The interaction between clinical protective factors and clinical risk factors in suicide. The difference between clinical psychiatry and forensic psychiatry

Clinical aspects

Regarding suicide it is possible to state, by a clinical point of view (1):

1. in clinical psychiatry, suicide is the clinical result of the interaction, in the individual case, between clinical protective factors and clinical risk factors;
2. clinical protective factors and clinical risk factors are not forensic cause factors;
3. clinical risk factors may be present and the subject does not commit suicide, clinical protective factors may be present and the subject commits suicide;

4. clinical protective and risk factors are numerous and may, depending on the guidelines, be over a hundred (1). Their single scientific evaluation is complex from a qualitative, quantitative and inter-relational aspects, and vay depending on the different and numerous national and international guidelines (1).

Professional responsibility

Psychiatric assessment of suicide risk limited to some clinical risk factors (previous suicide attempts, self-harm, etc) in the specific clinical case, is not acceptable from a scientific and clinical point of view. It also lends itself to *simplifying non-scientific interpretations*: "*the psychiatrist has forgotten … he has underestimated … this risk factor … therefore he is responsible for suicide"*. The assessment of a patient's *clinical suicidality* must be done through the *clinical etiology with the examination of the clinical risk factors and clinical protective factors present, at the current state and concretely*, in the subject at the specific moment of the facts. The forensic assessment of the psychiatrist's responsibility for suicide must be formulated through *forensic causality* which is different from *clinical etiology*. Clinical etiology does not contain legal concepts that are present in forensic causation.

Clinical record

In the medical record and in the psychiatric information, there must be a meaningful list and an evaluation of the clinical risk factors and a meaningful list of the clinical protective factors (1) in the individual case. This list, to have a forensic value, must be of a *concrete* nature (not theoretical factors) and *topicality* (at the time of the facts and not in the course of life). The *clinical* term (clinical risk factor, clinical protection factor, etc.) must always be used in the medical record and in information communications to clarify the difference between clinical evaluation and forensic evaluation.

Suicide is an unpredictable and inevitable event

Clinical aspects

In the clinical aspects, two different eventualities have to be considered:

- **prevention of suicide**: the scientific validity, clinical usefulness and human value of all the modalities of prevention of suicide at a clinical and statistical level, in its different phases understood as a serious public health problem to be addressed with measures not only on the basis of a medical-psychiatric model but also and above all a social model, psycho-social model and ecological model extended to national laws, to community interventions, to roles of public institutions, to the reduction of stigma, to the facilitation of the search for help, to the education of mass communication media, etc (multisectorial approach) (1);
- **predictability and avoidability of suicide in the individual case**. In this sense:

1. there is no *clinical, actuarial or mixed* scientific evaluation method that allows, in the single clinical case, to objectively establish that: *one subject will kill himself and another subject will not kill himself* (**unpredictability**);
2. there are no therapeutic measures (hospitalization, restraint, continuous visual observation, pharmacotherapy, etc.) capable of avoiding, especially in the medium and long term, that: *a person who has decided to kill himself or herself before or after puts it in place* (**inevitability**);
3. the foregoing is justified by the existence in the suicidal assessment of numerous diagnostic critical issues: *the clinical risk factors and clinical protection factors can vary rapidly over time such as quality, quantity and reciprocal interaction; presence of simulations and dissimilations of suicidal intent that are not manifest and not clinically detectable; fluctuating ambivalence, not necessarily conscious, between the desire to live and to die; situational impulsiveness including ego-dystonic to lifestyle, etc*. (**difficulty up to prognostic impossibility**) (1).

Professional responsibility

Psychological and operational defeatism is not acceptable from a clinical and forensic point of view ("there is nothing to be done"); *reactive and boastful omnipotence* (suicide is always, or almost always, predictable and avoidable); *guilty ignorance* (i.e. not knowing that *clinical psychiatry* and *forensic psychiatry* are not the same discipline, that *clinical etiology* must not be confused with *forensic causality*, that in law there is no concept of *unpredictability, inevitability and difficulty or impossibility to avoid an event: ad impossibilia nemo tenetur*, that in medicine and in particular in psychiatry there is the *permitted risk*, etc); *the marginalization of family members* (they are not qualified for therapeutic interventions, hinder therapy, etc). A conscious attitude of the therapist (*although aware of the unpredictability and inevitability something* ***I can and must do*** *to prevent suicide*) and of the family members in the prevention of suicide of their relative is desirable (*they must be informed, psycho-educated and made responsible for therapeutic purposes in a aimed at their abilities, availability and self-determination and after the suicide of the relative followed, when appropriate, with postvention*).

Medical records

In the medical record must be documented:

1. the *consistency* between the integrated assessment of clinical risk factors and clinical protective factors and the precautionary measures adopted for the *care and protection* of the subject;
2. the documentation on the *information and adherence to the treatment of the suicidal subject* concerning the family members in their rights of assistance to the relative and the duties of citizen;
3. the care and protection of the subject must be respectful of the rights *and duties, provided for by law, of citi-*

zens undergoing medical treatment (right to communication, privacy, consent, refusal of treatment, etc.).

Critical issues of pharmacotherapy in the prevention of suicide

Clinical aspects

In pharmacotherapy of suicide two different possibilities are to be considered:

1. **pharmacotherapy and psychic disorder**. The improvements in psychiatric symptoms and quality of life that pharmacotherapy has brought and is leading to the therapy of mental disorders are not in question;
2. **pharmacotherapy and suicide**. Pharmacotherapy for suicide prevention has numerous critical issues (1): suicide (like homicide) is a multi-determined event and there are no drugs that cure multi-determined events; the mental disorder is only one among the many clinical risk factors of suicide and the clinical risk factors are not forensic causative factors of suicide; the drug can act, in the most favorable case, on a symptom and not on the totality of a psychiatric disorder; the drug does not act on all components of the patient's suicidality that are unrelated to the symptom and psychiatric disorder; etc. (1).

Professional responsibility

It is not acceptable from a clinical and forensic point of view to affirm after the patient's suicide (ex post), without *adequately motivating and investigating* (1): "*the psychiatrist did not administer the drug that would have saved him from suicide...he was wrong to prescribe the right drug... it was wrong to decrease, increase, suspend the drug... therefore it is responsible for the patient's suicide*...". It is imperative that any forensic evaluation of medical therapy in terms of suicide is carried out with criteria that respect the scientific method and therefore:
"Contemplate the assessment of its risks and benefits; the difference between efficiency and effectiveness; its real effectiveness on specific objectives; the phenomena of total or partial resistance; the success rates in the various alternative strategies to overcome the resistance; intolerance; side effects; paradoxical effects; addiction syndromes; withdrawal syndromes; rebound syndromes; walnut effect; drug interactions; predictable and unpredictable pharmacokinetic or pharmacodynamic changes; relapses, remissions, recurrences and the natural evolutionary history of the psychic disorder dependent and independent of the drug; the existence of errors not relevant for the purposes of the causal link; self-determination, adherence to treatment and type of therapeutic relationship in relation to the therapeutic expectations of the drug; the bio-psycho-social peculiarities of the individual case in question in relation to the functionality of the specific pharmacotherapy; etc." (1).
The clinical and forensic evaluation of pharmacotherapy, in cases of accusation, on the subject of suicide should, for the essential rigor of scientific completeness, illustrate on the basis of shared clinical evidence, not only:

1. "*because it is assumed that incorrect therapy caused the suicide*";
2. but also, in the concrete scientific and operational details: "*what would have been the right therapy, illustrated and motivated in detail, which would have avoided suicide*".

Medical records

The *consistency* between psychiatric symptoms and drug therapy and the *justification of the rationale* behind any modification of drug therapy must always be documented in the medical record.

Concluding remarks

The foregoing needs to be deepened with the original text (1) (about 560 pages; 402 bibliographical references) and with an abbreviated Forensic Psychiatric Guide (2) (85 pages) which also contain the principles underlying the responsibility in the team, of the continuity and interruption of treatments, prejudices and emotions on suicide and of the qualification and reliability of the experts and consultants who must evaluate the responsibility of the psychiatrist. Furthermore, the foregoing must be adapted to specific national legislative and jurisprudential contexts of application, in the criminal and civil field, to the individual clinical case, to the specificities of the national psychiatric assistance system and to the indispensable update linked to the progress of scientific knowledge and evolution. of law.

El suicidio del paciente, la responsabilidad profesional del psiquiatra, los registros medicos como documentación forense

El suicidio del paciente es uno de los eventos más dramáticos que pueden ocurrir en la práctica psiquiátrica. También es una de las causas más frecuentes de acusación penal y civil del psiquiatra. Con el propósito general de mejorar la buena práctica clínica del psiquiatra acerca del tratamiento y prevención del suicidio, se pueden consultar numerosas guías, con sus ventajas y criticidades (1). El objeto de este artículo es reportar algunas evidencias clínicas y forenses compartidas sobre el tema del suicidio, aprobadas por la Società Italiana di Psichiatria (SIP) y la Società Italiana di Psichiatria Forense (SIPF) (1, 2).

El suicidio es un evento con etiología multideterminada, diagnóstico multiaxial y tratamiento multiestratégico

Aspectos clínicos

El suicidio es un evento:

1. con **etiología multideterminada** (***Recognition of multicausality***) (1), es decir, a una etiología clínica relacionada con numerosas variables biológicas, psicológicas, psiquiátricas, culturales, sociales, contextuales, etc. que interactúan en el mismo individuo;
- un **diagnóstico multiaxial** (***Multiaxial diagnosis***) (1), es decir, la formulación de un diagnóstico que evalúe la compleja etiología bio-psicosocial y la singularidad e irrepetibilidad de las circunstancias psico-socio-culturales de tiempo, lugares y personas respecto al caso clínico individual;
- con **intervención preventivas y multiestratégicas** (***Multicomponent interventions, Multisectorial approach***) (1), es decir, intervenciones terapéuticas y preventivas, en relación con el caso clínico, en el ámbito médico, psicológico, psiquiátrico, social, cultural, asistencial, económico, legislativo, político, etc.

Responsabilidad profesional

La siguente declaración simplista *"se suicidó porque estaba deprimido"* no es aceptable desde un punto de vista clínico y forense. La depresión no es la única causa clínica y forense directa de suicidio: no todas las personas que padecen de depresiòn se suicidan y no todos los que se suicidan están deprimidos. Además, el trastorno mental es un *factor de riesgo clínico*, entre los numerosos factores de riesgo clínicos y no es, a priori, una causa forense. La psiquiatría clínica tiene finalidades sociales y metodologías de evaluación diferentes de la psiquiatría forense. La afirmación correcta, respetuosa de la complejidad científica clínica y forense en un caso de suicidio, que no está relacionada a una sola causa, podría ser: "*en el estado actual de conocimiento es difícil entender por qué ese sujeto se suicidó...estaba deprimido, narcisista, impulsivo, agresivo y en particular estaba muy molesto y desesperado porque había perdido su trabajo y había sido abandonado por la esposa que amaba profundamente ...".*

Registros médicos

En las historias clínicas y en la información clínica y forense a nivel científico y en las comunicaciones masivas, se debe precisar claramente cuanto sigue: la etiología multideterminada, el diagnóstico multiaxial y las intervenciones multiestratégicas de prevención del suicidio. Sobre todo, los factores de riesgo clínico que no son de relevancia y competencia del psiquiatra (colapso económico, divorcio, problemas laborales, enfermedades orgánicas, etc.), todos deben ser reportados en la historia clínica (*No single factor is sufficient to explain why a person died by suicide*: WHO).

La interacción entre los factores de protección clínicos y los factores de riesgo clínicos en el suicidio. La diferencia entre psiquiatría clínica y psiquiatría forense

Aspectos clinicos

Sobre el tema del suicidio es posible afirmar, a nivel clínico (1):

1. en psiquiatría clínica, el suicidio es el resultado clínico de la interacción, en el caso individual, entre factores clínicos protectores y de riesgo;
2. los factores de protección clínica y los factores de riesgo clínicos no son factores de causa forense;
3. pueden ser presentes factores de riesgo clínicos y el sujeto no se suicida, pueden ser presentes factores de protección clínicos y el sujeto se suicida;
4. los factores clínicos de protección y de riesgo clínico son numerosos en la clínica y pueden, según las guias clinicas, superar los cien (1). Su valoración científica es compleja desde el punto de vista cualitativo, cuantitativo e interrelacional, y es variable en relación a las diferentes y numerosas directrices nacionales e internacionales (1).

Responsabilidad profesional

La evaluación psiquiátrica del riesgo de suicidio que se limita a algunos factores de riesgo clínicos (intentos previos de suicidio, autolesiones, etc.) en el caso clínico especifico, no es aceptable desde el punto de vista científico y clínico. También se presta a *interpretaciones de simplificación* no científicas como: "*el psiquiatra ha olvidado... ha subestimado...este factor de riesgo...por lo tanto, es responsable del suicidio"*. La valoración de la suicidalidad clínica de un paciente debe realizarse *a través de la etiología clínica con el examen de los factores clínicos de riesgo y los factores clínicos protectores presentes, en el estado actual y concretamente*, en el sujeto en el momento específico de los hechos. La evaluación forense de la responsabilidad del psiquiatra en el suicidio debe formularse a través de una *causalidad forense* que es diferente de la *etiología clínica*. La etiología clínica no contiene conceptos legales que estén presentes en la causalidad forense.

Registros médicos

En la historia clínica y en la información psiquiátrica, debe ser presente un listado significativo y una evaluación de los factores de riesgo clínicos y un listado significativo de los factores de protección clínica (1) en el caso especifico. Este listado, para tener valor forense, debe ser de carácter *concreto* (no se trata pues de factores teóricos) y de *actualidad* (en el momento de los hechos y no en el transcurso de la vida). El término *clínico* (factor de riesgo clínico, factor de protección clínica, etc.) debe utilizarse siempre en la historia clínica y en las comunicaciones de información para aclarar la diferencia entre evaluación clínica y evaluación forense.

El suicidio es un evento impredecible e inevitable

Aspectos clinicos

En los aspectos clínicos, hay que considerar dos eventualidades diferentes:

- **prevención del suicidio**: no están en juicio la validez científica, la utilidad clínica i el valor humano de todas las modalidades de prevención del suicidio a nivel clí-

nico y estadístico, en sus distintas fases, entendida como un grave problema de salud pública que debe abordarse con medidas no solo sobre la base de un modelo médico-psiquiátrico sino también y sobre todo un modelo social, psicosocial y ecológico extendidos a las leyes nacionales, las intervenciones comunitarias, los roles de las instituciones públicas, la reducción del estigma, la facilitación de la búsqueda de ayuda, la educación de los medios de comunicación de masas, etc. (enfoque multisectorial) (1);

- **previsibilidad y evitabilidad del suicidio en el caso especifico**. En este sentido:

1. no existe un método de evaluación científico *clínico, actuarial o mixto* que permita, en un caso clínico, establecer objetivamente que: *un sujeto se suicidará y otro sujeto no se suicidará* (**Impredecibilidad**);
2. no existen medidas terapéuticas (hospitalización, inmovilización, observación visual continua, farmacoterapia, etc.) capaces de evitar, especialmente a medio y largo plazo, que: *una persona que haya decidido suicidarse antes o después de la puesta en acción* (**inevitabilidad**);
3. lo que precede se justifica por la existencia en la evaluación del suicidio de numerosas criticidades diagnósticas: *los factores de riesgo clínico y los factores de protección pueden variar rápidamente en el tiempo en calidad, cantidad e interacción recíproca; presencia de simulaciones y disimilaciones de intención suicida no manifiesta y no detectable clínicamente; ambivalencia fluctuante, no necesariamente consciente, entre el deseo de vivir y el de morir; impulsividad situacional también ego-distónica respecto al estilo de vida, etc.* (**dificultad hasta imposibilidad pronóstica**) (1).

Responsabilidad profesional

El *derrotismo psicológico y operacional* no es aceptable desde el punto de vista clínico y forense (no hay nada que hacer); *omnipotencia reactiva y jactanciosa* (el suicidio es siempre, o casi siempre, predecible y evitable); *ignorancia culpable* (es decir, no saber que la *psiquiatría clínica y la psiquiatría forense* no son la misma disciplina, que la etiología clínica no debe confundirse con la *causalidad forense*, que en derecho no existe el concepto de *imprevisibilidad, inevitabilidad y dificultad o imposibilidad de evitar un evento: ad impossibilia nemo tenetur*, que en medicina y en particular en psiquiatría existe el *riesgo permitido*, etc); la *marginación de los miembros de la familia* (no están calificados para intervenciones terapéuticas, dificultan la terapia, etc.). Es deseable una actitud consciente del terapeuta (*aunque consciente de la imprevisibilidad e inevitabilidad de algo que **puedo y debo** hacer para prevenir el suicidio*) y de los miembros de la familia en la prevención del suicidio de su familiar (*deben estar informados, psicoeducados y responsable con fines terapéuticos en forma orientada a sus capacidades, disponibilidad y autodeterminación y tras el suicidio del familiar seguido, en su caso, con posvención*).

Registros médicos

En la historia clínica debe ser documentado:

1. la *coherencia* entre la evaluación integrada de los factores clínicos de riesgo y los factores clínicos de protección y las medidas cautelares adoptadas para el *cuidado y protección* del sujeto;
2. la documentación sobre la *información y adherencia al tratamiento del sujeto suicida* de los familiares en sus derechos de asistencia al familiar y los deberes de los ciudadanos;
3. el cuidado y protección del sujeto debe ser respetuoso de los *derechos y deberes, previstos por la ley, de los ciudadanos en tratamiento médico* (derecho a la comunicación, intimidad, consentimiento, negativa de tratamiento, etc.).

Criticidad de la farmacoterapia en la prevención del suicidio

Aspectos clinicos

Con respecto a la farmacoterapia se deben considerar dos posibilidades diferentes:

1. **farmacoterapia y trastorno psíquico**. Las mejorías en los síntomas psiquiátricos y la calidad de vida que la farmacoterapia ha traído y está conduciendo a la terapia de los trastornos psíquicos no están en duda;
2. **farmacoterapia y suicidio**. La farmacoterapia para la prevención del suicidio tiene numerosos aspectos críticos (1): el suicidio (como el homicidio) es un evento múlti- determinado y no existen medicamentos que curen los eventos múlti-determinados; el trastorno mental es sólo uno de los muchos factores de riesgo clínico de suicidio y los factores de riesgo clínico no son factores forenses causales de suicidio; el medicamento puede actuar, en el caso más favorable, sobre un síntoma y no sobre la totalidad de un trastorno psiquiátrico; el fármaco no actúa sobre todos los componentes de la tendencia suicida del paciente, que no están relacionados con el síntoma y el trastorno psiquiátrico; etc. (1).

Responsabilidad profesional

No es aceptable desde el punto de vista clínico y forense afirmar, después del suicidio del paciente (ex post), sin *motivar e investigar adecuadamente, cuanto sigue* (1): *"el psiquiatra no le administró el fármaco que lo habría salvado del suicidio...se equivocó al prescribir el medicamento correcto...estuvo mal disminuir, aumentar, suspender el medicamento...por lo tanto, es responsable del suicidio del paciente..."*. Es imperativo que cualquier evaluación forense de la terapia con medicamentos en términos de suicidio se lleva a cabo con criterios que respetan el método científico y por lo tanto: *"contemplar la evaluación de sus riesgos y beneficios; la diferencia entre eficiencia y efectividad; su efectividad real en objetivos específicos; los fenómenos de resistencia total o parcial; las tasas de éxito en las distintas estrategias alternativas para*

superar la resistencia; intolerancia; efectos secundarios; efectos paradójicos; síndromes de adicción; síndromes de abstinencia; síndromes de rebote; efecto nuez; interacciones con la drogas; cambios farmacocinéticos o farmacodinámicos predecibles e impredecibles; recaídas, remisiones, recurrencias y la historia evolutiva natural del trastorno psíquico dependiente e independiente de la droga; la existencia de errores no relevantes a los efectos del vínculo causal; autodeterminación, adherencia al tratamiento y tipo de relación terapéutica en relación a las expectativas terapéuticas del fármaco; las peculiaridades biopsicosociales del caso individual en cuestión en relación con la funcionalidad de la farmacoterapia específica; etc." (1).

La evaluación clínica y forense de la farmacoterapia, en casos de acusación legal, sobre el tema del suicidio, debe, para el rigor esencial de la exhaustividad científica, ilustrar sobre la base de la evidencia clínica compartida, no solo:

1. "porque se supone que una terapia incorrecta provocó el suicidio".

Sino también, en los detalles científicos y operativos concretos:

2. "cuál hubiera sido la terapia adecuada, ilustrada y motivada en detalle, que hubiera evitado el suicidio".

Registros médicos

La *coherencia* entre los síntomas psiquiátricos y la terapia con medicamentos y la *justificación de la razón* de ser de cualquier modificación de la terapia con medicamentos siempre deben documentarse en el registro médico.

Observaciones finales

Es necesario profundizar en lo anterior con el texto original (1) (alrededor de 560 páginas; 402 referencias bibliográficas) y con una Guía Psiquiátrica Forense abreviada (2) (85 páginas) que también contengan los principios que subyacen a la responsabilidad en el equipo, de la continuidad e interrupción de tratamientos, prejuicios y emociones sobre el suicidio y de la calificación y confiabilidad de los expertos y peritos que deben evaluar la responsabilidad del psiquiatra. Además, lo anterior debe adecuarse a los contextos legislativos y jurisprudenciales nacionales específicos de aplicación, en el ámbito penal y civil, al caso clínico individual, a las especificidades del sistema nacional de atención psiquiátrica y a la indispensable actualización vinculada al avance de la ciencia, el conocimiento y evolución del derecho.

Comportamento violento sulla persona, responsabilità professionale dello psichiatra, cartella clinica come documento forense

Il comportamento violento sulla persona (CVP: percosse, lesioni personali, omicidio attuato e tentato) (*violent behavior on person*: VBP; *comportement violent sur la personne:* CVP) messo in atto da un paziente psichiatrico nei confronti di terzi è uno degli eventi più drammatici e dolorosi sul piano umano e più frequenti per incriminazione penale e responsabilità civile dello psichiatra. A scopo generale di migliorare la buona pratica clinica assistenziale dello psichiatra in tema di trattamento e prevenzione del CVP possono essere consultate, con i loro vantaggi e criticità numerose linee guida (1). Oggetto del presente scritto è di mettere in luce alcune evidenze cliniche e forensi condivise in tema di CVP approvate dalla Società Italiana di Psichiatria (SIP) e dalla Società Italiana di Psichiatria Forense (SIPF) (1, 2).

Il CVP è un evento a eziologia multi determinata, diagnosi multi assiale e trattamento multi strategico

Aspetti clinici

Il CVP è un evento (1):

1. a **eziologia multideterminata (*Recognition of multicausality*)** (1) e cioè a una eziologia clinica legata a numerose variabili biologiche, psicologiche, psichiatriche, culturali, sociali, contestuali, ecc. che interagiscono nel singolo individuo;
2. a **diagnosi multi assiale (*Multiaxial diagnosis*)** (1) e cioè la formulazione di una diagnosi che valuti la complessa eziologia bio-psico-sociale e la unicità e irripetibilità delle circostanze psico-socio-culturali di tempo, luoghi e persone del singolo caso clinico;
3. a **intervento preventivo e trattamentale multistrategico (*Multicomponent interventions, Multisectorial approach*)** (1) e cioè provvedimenti terapeutici e preventivi, in relazione al caso clinico, nel campo medico, psicologico, psichiatrico, sociale, culturale, assistenziale, economico, legislativo, politico, ecc.

Responsabilità professionale

Non è corretto sotto l'aspetto clinico e forense affermare: *quel paziente ha ucciso la moglie perché schizofrenico con delirio persecutorio*. Non tutti i soggetti con questo disturbo psichico uccidono la moglie, per uccidere la moglie non c'è bisogno di un disturbo psichico, una persona può presentare una diagnosi di schizofrenia con deliri persecutori e uccidere la moglie per gelosia o per molti altri motivi, non esiste un legame diretto tra delirio di persecuzione e CVP ma debbono essere valutate nel singolo caso le *variabili intermedie* come psicopatie, antisocialità, emozioni, passioni, ecc., l'offerta del contenuto apparentemente delirante può essere un'*auto legittimazione* e non la vera *motivazione*, nel delirio esistono vari *livelli di comprensione* della realtà, ecc. (1). L'affermazione corretta, rispettosa delle evidenze cliniche e forensi potrebbe essere: *allo stato delle conoscenze è difficile capire perché quella persona ha ucciso la moglie … quella persona aveva già*

usato violenze fisiche con altre donne, era molto possessiva e talvolta sadica con la moglie, era impulsiva, era in cura per schizofrenia, presentava contenuti rivendicatori e persecutori, ultimamente era molto frustrata e aggressiva perché la moglie non si concedeva sessualmente …

Cartella clinica

In cartella clinica, nelle informazioni cliniche e forensi a livello scientifico, nelle comunicazioni di massa deve risultare con chiarezza l'eziologia multi determinata, la diagnosi multi assiale e gli interventi terapeutici multistrategici in tema di CVP. La cartella clinica deve riportare la diagnosi e la terapia psichiatrica. *La cartella clinica non è una perizia o una consulenza forense* e non deve riportare impropri, inadeguati e non giustificati *nessi di causalità* tra disturbo psichico e CVP (… *ha ucciso perché era schizofrenico … ha ucciso perché era delirante …).*

L'apprendimento psicologico e sociale del CVP senza disturbo psichico

Aspetti clinici

Come una persona apprende, senza partecipazione di psicopatologie di interesse psichiatrico, il comportamento sociale rispettoso della integrità fisica altrui, così può apprendere, sempre senza invocare un disturbo psichico, un CVP e cioè un comportamento non rispettoso della integrità fisica altrui. Questo dato clinico si basa su di una ricchissima bibliografia criminogenetica e criminodinamica (1) attraverso le *teorie sociologiche* (teoria delle aree criminali, della disorganizzazione sociale, della devianza,etc); le *teorie psicologiche* (dei contenitori,dell'identità personale, dei ruoli ecc.); le *teorie psicoanalitiche* (proiezioni di mondi interni sul mondo esterno, identificazioni proiettive, ecc.); le *strategie del disimpegno morale* del determinismo triadico reciproco (diffusione o dislocazione della responsabilità, attribuzione proiettiva della colpa, disumanizzazione della vittima, ecc.); le *teorie della violentizzazione* del comportamento (invece di apprendere la socializzazione si apprende la violentizzazione); le varie *sottoculture della violenza* (valorizzazione a buona visibilità sociale del CVP per gestire i rapporti interpersonali); l'importanza motivazionale delle *emozioni e passioni* (rabbia, vendetta, gelosia, invidia, orgoglio, ecc.). Esiste poi una semeiotica specifica, senza disturbo psichico, che concerne il CVP: *i guadagni secondari, i cicli di violenza, gli schemi ripetitivi, i percorsi strutturati, i viraggi improvvisi, gli aloni progressivi, la riattuazione, la multifattorialità limitata e specifica, i segni premonitori, la comunicazione simbolica, le minacce, ecc.* (1).

Responsabilità professionale

Non è accettabile sotto il profilo clinico e forense che uno psichiatra valuti e gestisca il CVP ignorando tutta l'eziologia e le dinamiche della violenza interpersonale senza il disturbo psichico e interpreti il CVP esclusivamente *alla luce della psicopatologia descritta nei trattati di psichiatria o nei manuali statistici e diagnostici classificatori categoriali del disturbo psichico.* Questi trattati e manuali non sono idonei alla valutazione forense. Concretamente non è accettabile, sotto il profilo clinico e forense, che in presenza di un CVP sulla persona e presenza di un disturbo psichico *sia sempre, in via pregiudiziale, senza esame del nesso di causalità, responsabilità dello psichiatra se il soggetto compie un agito di violenza.*

Cartella clinica

In cartella clinica quindi deve essere presente: *diagnosi e terapia psichiatrica* documentata e giustificata, e *assenza di valutazioni di nessi causali* tra disturbo psichico e CVP.

L'interazione tra fattori di rischio clinico e fattori protettivi clinici del CVP

Aspetti clinici

In tema di CVP è possibile affermare a livello clinico (1):

1. nella psichiatria clinica il CVP è il risultato clinico dell'interazione, nel singolo caso, tra fattori protettivi clinici e fattori di rischio clinico;
2. i fattori protettivi clinici e i fattori di rischio clinico non sono fattori di causa forense;
3. i fattori di rischio clinico possono essere presenti e il soggetto non commette un CVP, i fattori protettivi clinici possono essere presenti e il soggetto commette un CVP;
4. i fattori protettivi clinici e di rischio clinico sono numerosi in clinica e possono, a seconda delle linee guida, essere oltre il centinaio (1). La loro singola valutazione scientifica è complessa sotto l'aspetto qualitativo, quantitativo e inter-relazionale, e sono variabili in rapporto alle differenti e numerose linee guida nazionali e internazionali (1).

Responsabilità professionale

La valutazione isolata e limitata ad alcuni fattori di rischio clinico (precedenti CVP, carriera criminale, etc.) nel singolo caso non è accettabile sotto il profilo clinico e forense: *lo psichiatra ha dimenticato di considerare questo fattore di rischio … ha sottovalutato questo fattore di rischio … quindi è responsabile del CVP del paziente* … La valutazione clinica e corretta del CVP del soggetto deve essere fatta con *l'esame integrato dei fattori di rischio clinico e dei fattori protettivi clinici presenti, allo stato attuale e concretamente, nel singolo caso al momento dei fatti in esame e in riferimento al fatto specifico.* La valutazione forense del CVP deve essere fatta sulla base della *causalità forense* (di pertinenza e competenza della disciplina forense) e non sulla base della *eziologia clinica* (di pertinenza e competenza delle discipline mediche) La psichiatria clinica ha fini sociali e metodologie di valutazione diverse dalla psichiatria forense.

Cartella clinica

In cartella clinica e nella informazione scientifica psichiatrica deve essere presente:

1. *un elenco significativo dei fattori di rischio clinico e un elenco significativo dei fattori protettivi clinici del singolo soggetto*. Questo elenco, per avere valore forense, deve avere carattere di *concretezza* (non teorico) e *attualità* (al momento dell'esame e non nel corso di tutta la vita). Deve sempre essere utilizzato il termine *clinico* (fattore di rischio clinico, di protezione clinica, ecc.) per chiarire la differenza tra valutazione clinica e valutazione forense e **non confondere, in particolare, un fattore generico di *rischio clinico* con un fattore specifico di *causalità forense*.** Quanto precede è indice di *diligenza, perizia e prudenza* (buona pratica clinica assistenziale) di chi ha svolto la complessa e difficile valutazione ed evita la contestazione forense: "non scritto in cartella: non fatto".

Il CVP è un evento imprevedibile e inevitabile

Aspetti clinici

Nell'ambito della prevedibilità e della inevitabilità sono da considerare due fatti differenti:

A. prevenzione del CVP. Non sono in discussione l'utilità clinica e umana di tutte le misure di *prevenzione generale* del CVP nel ridurre i fattori di rischio clinico e nel potenziare i fattori di protezione clinica: attenzione selezionata ai fattori socio demografici (basso livello economico, isolament6,356,35 sociale), ai fattori psicologici individuali (famiglie maltrattanti, situazioni di crisi,) ai fattori psico-sociali (legati alla criminalità, all'abuso di sostanze voluttuarie, al disturbo psichico, sottocultura della violenza, situazioni di anomia, opportunità sociali differenziali, ecc) ecc. Non sono in discussione le utili modalità di *prevenzione clinica in particolari situazioni di crisi* (soggetti confusi e spaventati non in grado di comunicare, in stato di grave agitazione psicomotoria, allucinati e minacciosi, ecc.) ecc. o tutti i provvedimenti che mirano a una *promozione della salute mentale* e a un *miglioramento della qualità di vita* (attenzione alla salute psichica nel suo aspetto più ampio come contemplato dalla Organizzazione Mondiale della Sanità: OMS);

B. prevedibilità ed evitabilità del CVP nel singolo caso clinico:

1. non esiste un metodo di valutazione scientifica *clinico, attuariale misto* che permetta, nel singolo caso clinico di stabilire con obiettività di dati che: *un soggetto metterà in atto un CVP e un altro soggetto non metterà in atto un CVP* (**imprevedibilità**);
2. non esistono misure terapeutiche (ricovero, contenzione, osservazione visiva continua, farmacoterapia, ecc.) in grado di evitare, soprattutto a media e lunga scadenza, che: *un soggetto che ha deciso di mettere in atto un CVP o prima o dopo lo metta in atto* **(inevitabilità**);
3. quanto precede è giustificato dalla esistenza nella valutazione del CVP di numerose criticità diagnostiche: *i fattori di rischio clinico e di protezione clinica, pur non rivestendo valore di causalità forense, possono variare rapidamente nel tempo come qualità, quantità e interazione reciproca; presenza di simulazioni e dissimulazioni dell'intento di CVP non manifeste e non rilevabili clinicamente; impulsività situazionale anche ego-distonica allo stile di vita, etc.* (**difficoltà sino a impossibilità prognostica**) (1).

Responsabilità professionale

Non è accettabile sotto il profilo clinico e forense il *disfattismo psicologico* (non c'è niente da fare per prevenire ed evitare il CVP); *l'onnipotenza reattiva e millantatoria* (il CVP è sempre prevedibile ed evitabile, se non sempre nella maggior parte dei casi); *l'ignoranza colpevole* (cioè non sapere che la *psichiatria clinica* e la *psichiatria forense* non sono la stessa disciplina, che in diritto non esiste il concetto di *imprevedibilità*, *inevitabilità* e *difficoltà od impossibilità a evitare un evento*: *ad impossibilia nemo tenetur,* che in medicina e in particolare in psichiatria esiste il *rischio consentito, etc*); *l'emarginazione pregiudiziale* dei familiari (non sono capaci, non hanno il diritto o dovere,). È auspicabile un atteggiamento di tipo consapevole di chi deve valutare e gestire il CVP (*pur consapevole della imprevedibilità e inevitabilità qualcosa **posso e debbo** fare per prevenire il CVP del soggetto e, nei termini di legge, quando esiste una concretezza e attualità di obiettivi specifici della violenza etero diretta, prevenire, nei limiti del fattibile e consentito da norme, danni a terze persone).* Si deve provvedere, quando è il caso ed è possibile, a una *implicazione dei familiari* nel trattamento (debbono essere informati, psicoeducati, responsabilizzati in modo mirato alle loro capacità, autodeterminazione e aderenza alla loro psico-educazione).

Cartella clinica

In cartella clinica deve essere documentata:

1. la *coerenza* tra valutazione integrata dei fattori di rischio clinico e protettivi clinici e le misure cautelative adottate per la *cura* e *protezione* del soggetto;
2. la documentazione sulla *informazione e aderenza al trattamento del soggetto suicidario* concernente i familiari nei loro diritti di assistenza al congiunto e doveri di cittadini;
3. la cura e la protezione del soggetto debbono essere rispettose dei *diritti e doveri, previsti per legge, dei cittadini sottoposti a cure mediche* (diritto alla comunicazione, privacy, consenso, rifiuto delle cure, ecc.).

La farmacoterapia nella prevenzione del CVP

Aspetti clinici

Nell'ambito degli aspetti clinici della farmacoterapia sono da considerare due differenti eventualità:

1. farmacoterapia e disturbo psichico. A livello clinico non sono in discussione i miglioramenti dei sintomi psichiatrici e della qualità di vita che la farmacoterapia ha portato e sta portando alla terapia dei disturbi psichici;

2. **farmacoterapia e CVP**. La farmacoterapia per la prevenzione del CVP presenta numerose criticità (1): il CVP è un evento multi determinato e non esistono farmaci che guariscono gli eventi multideterminati; il CVP non è un sintomo di una specifica entità psichiatrica nosografica; il farmaco può agire sulla irritabilità, agitazione , ansia, insonnia, ecc. ma questi sintomi (additional risk factors) sono presenti in tutta la popolazione generale, oltre non avere valore causale forense, non sono necessariamente in nesso causale giuridico con il complesso agire bio-psico-sociale del CVP; il farmaco cura il disturbo psichico e il disturbo psichico è solo uno tra i moltissimi fattori di rischio clinico del CVP e i fattori di rischio clinico non sono fattori di causalità forense del CVP; il farmaco può agire, nel caso più favorevole, su di un sintomo e non sulla totalità di un disturbo psichiatrico e non su tutti i componenti del CVP del soggetto che sono estranei al sintomo e al disturbo psichiatrico e sono rappresentati dalla motivazioni alla violenza di natura psicologica, sociale, culturale, economica, sessuale, circostanziale, ecc. (1).

Responsabilità professionale

Non è accettabile sotto l'aspetto scientifico e forense che: *sarebbe sufficiente somministrare a tutti gli agitati, irritabili, ansiosi un calmante, a tutti gli psicotici un adeguato antipsicotico, a tutti i disturbi dell'umore e gli impulsivi uno stabilizzante dell'umore, ecc. … per evitare il CVP.* Non è accettabile sotto il profilo forense una valutazione dell'effetto del farmaco che si limiti ad affermare, dopo il CVP del paziente (ex post), senza *motivare* e *approfondire in modo adeguato* (1)*: … lo psichiatra non ha somministrato il farmaco che avrebbe evitato il CVP … ha sbagliato a prescrivere il farmaco giusto … ha sbagliato a diminuire, aumentare, sospendere il farmaco... quindi è responsabile del CVP del paziente …* È doveroso che ogni valutazione clinica e forense della terapia farmacologica in tema di CVP sia effettuata con criteri rispettosi del metodo scientifico e quindi *"contempli la valutazione dei suoi rischi e dei suoi benefici; la differenza tra efficienza ed efficacia; la sua reale efficacia su obiettivi specifici; i fenomeni di resistenza totale o parziale; le percentuali di successo nelle varie strategie alternative per vincere la resistenza; l'intolleranza; effetti collaterali; effetti paradossi; sindromi da assuefazione; sindromi da astinenza; sindromi da rimbalzo; effetto nocebo; interazioni farmacologiche; variazioni farmacocinetiche o farmacodinamiche prevedibili e non prevedibili; le ricadute, remissioni, ricorrenze e la storia evolutiva naturale del disturbo psichico dipendenti e indipendenti dal farmaco; l'esistenza di errori non rilevanti ai fini del nesso di causalità; la autodeterminazione, aderenza alla cura e tipologia del rapporto terapeutico in rapporto alle aspettative terapeutiche del farmaco; le peculiarità bio-psico-sociali del singolo caso in esame in rapporto alla funzionalità della specifica farmacoterapia; ecc."* (1).

La valutazione clinica e forense della farmacoterapia, nei casi di accusa, in tema di CVP dovrebbe, per inderogabile rigore di completezza scientifica, illustrare sulla base di evidenze cliniche condivise, non solo:

1. "perché è ipotizzato che una terapia errata ha causato il *CVP*";
2. ma anche, nei dettagli scientifici e operativi concreti: "*quale sarebbe stata la terapia giusta, illustrata e motivata nei dettagli, che avrebbe evitato il CVP".*

Cartella clinica

Nella cartella clinica deve sempre essere documentata la *coerenza* tra sintomi psichiatrici e terapia farmacologica e la *giustificazione del razionale* alla base di ogni modifica della terapia farmacologica.

Osservazioni conclusive

Quanto precede è necessario sia approfondito con il testo originale (1) (circa 560 pagine; 402 riferimenti bibliografici) e con una abbreviata Guida Psichiatrico Forense (2) (85 pagine) che contengono anche i principi alla base della responsabilità in équipe, della continuità e interruzione delle cure, dei pregiudizi e delle emozioni sul CVP, della importanza della vittimologia nella valutazione del CVP e della qualificazione e affidabilità dei periti e consulenti che debbono valutare la responsabilità dello psichiatra. Inoltre quanto precede deve essere adattato a specifici contesti legislativi e giurisprudenziali nazionali di applicazione, in ambito penale e civile, al singolo caso clinico, alle specificità del sistema nazionale di assistenza psichiatrica e all'indispensabile aggiornamento legato al progredire del sapere scientifico e dell'evoluzione del diritto.

Comportement violent sur la personne, responsabilité professionnelle du psychiatre, dossier médical comme preuve documentaire devant le tribunal

Le comportement violent sur la personne (CVP) réalisé par un patient psychiatrique envers des tiers est l'un des événements les plus dramatiques et douloureux sur le plan humain et plus fréquents de la mise en accusation pénale et de la responsabilité civile du psychiatre. Dans le but général d'améliorer les bonnes pratiques cliniques du psychiatre en termes de traitement et de prévention des CVP, de nombreuses recommandations peuvent être consultées, avec leurs avantages et leurs criticité (1). L'objet de cet article est de mettre en évidence certaines informations cliniques et médico-légales partagées au sujet du CVP approuvées par la Società Italiana di Psichiatria (SIP) et la Società Italiana di Psichiatria Forense (SIPF) (1, 2).

Le CVP est un événement avec une étiologie multi-déterminée, un diagnostic multi-axial et un traitement multi-stratégique

Aspects cliniques

Le CVP est un événement (1):

1. à une étiologie multidéterminée (***Recognition of multicausality***) (1), c'est-à-dire à une étiologie clinique liée à de nombreuses variables biologiques, psychologiques, psychiatriques, culturelles, sociales, contextuelles, etc. qui interagissent chez le même individu;
2. un **diagnostic multi-axial (*Multiaxial diagnosis*)** (1), c'est-à-dire la formulation d'un diagnostic qui évalue l'étiologie bio-psycho-sociale complexe et le caractère unique et non reproductible des circonstances psycho-socio-culturelles du temps, des lieux et des personnes du cas individuel clinique;
3. à **l'intervention préventive et thérapeutique multistratégique (*Multicomponent interventions, Multisectorial approach*)** (1), c'est-à-dire mesures thérapeutiques et préventives, en relation avec le cas clinique, dans les domaines médical, psychologique, psychiatrique, social, culturel, social, économique, législatif, politique, etc.

Responsabilité professionnelle

Ce n'est pas correct d'un point de vue clinique et médico-légal affirmer: "*ce patient a tué sa femme parce qu'il était schizophrène avec un délire de persécution*." Tous les sujets atteints de ce trouble mental ne tuent pas leur femme, pour tuer la femme il n'y a pas besoin de trouble psychique, une personne peut présenter un diagnostic de schizophrénie avec des délires de persécution et tuer sa femme par jalousie ou pour de nombreuses autres raisons, n'existe pas un lien direct entre délire de persécution et CVP mais des *variables intermédiaires* telles que psychopathies, antisocialité, émotions, passions, etc. qui doivent être évaluées dans le cas individuel, l'offre du contenu apparemment délirant peut être une *auto-légitimation* et non la véritable *motivation*, dans le délire il existe différents niveaux de compréhension de la réalité, etc. (1). La déclaration correcte, respectueuse des evidences cliniques et médico-légales pourrait être: *"à l'état des connaissances, il est difficile de comprendre pourquoi cette personne a tué sa femme... cette personne avait déjà utilisé la violence physique avec d'autres femmes, était très possessif et parfois sadique avec sa femme,* était *impulsif,* était *traité pour la schizophrénie, présenté des revendicationes et de persécuteurs, était dernièrement très frustrée et agressive parce que sa femme ne se donnait pas sexuellement ...".*

Dossiers médicaux

Dans le dossier clinique, dans l'information clinique et médico-légale au niveau scientifique, dans la communication de masse, l'étiologie multi-déterminée, le diagnostic multi-axial et les interventions thérapeutiques multi-stratégies dans le domaine du CVP doivent être clairement indiqués. Le dossier médical doit rapporter le diagnostic et la thérapie psychiatrique. *Le dossier médical n'est pas une expertise ou un conseil médico-légal* et ne doit pas faire état de *liens de causalité* inappropriés, inadéquats et injustifiés entre le trouble psychique et le CVP (*… il a tué parce qu'il était schizophrène …).*

L'apprentissage psychologique et social du CVP sans trouble psychique

Aspects cliniques

Comme une personne apprend, sans la participation de psychopathologies d'intérêt psychiatrique, le comportement social qui respecte l'intégrité physique des autres, toujours sans invoquer un trouble psychique, la personne peut apprendre un CVP qui ne respecte pas l'intégrité physique des autres. Ces données cliniques s'appuient sur une bibliographie criminogénétique et criminodynamique très riche (1) à travers des *théories sociologiques* (théorie des zones criminelles, désorganisation sociale, déviance, etc.); *théories psychologiques* (des contenants, de l'identité personnelle, des rôles, etc.); *théories psychanalytiques* (projections de mondes internes sur le monde extérieur, identifications projectives, etc.); les *stratégies de désengagement moral* du déterminisme triadique mutuel (diffusion ou dislocation de responsabilité, attribution projective de blâme, déshumanisation de la victime, etc.); les *théories de la violence* comportementale (au lieu d'apprendre la socialisation, on apprend la violence); les différentes *sous-cultures de la violence* (valorisation du CVP avec une bonne visibilité sociale pour gérer les relations interpersonnelles); l'importance motivationnelle des émotions et des passions (colère, vengeance, jalousie, envie, fierté, etc.). Il existe également une sémiotique spécifique, sans perturbation psychique, qui concerne le CVP: *gains secondaires, cycles de violence, motifs répétitifs, chemins structurés, changements brusques, halos progressifs, réactivation, multifactorialité limitée et spécifique, panneaux d'avertissement, communication symbolique, menaces, etc*. (1).

Responsabilité professionnelle

Il n'est pas cliniquement et légalement acceptable pour un psychiatre d'évaluer et de gérer la CVP en ignorant toute l'étiologie et la dynamique de la violence interpersonnelle sans le trouble psychique et d'interpréter la CVP *exclusivement à la lumière de la psychopathologie décrite dans les traités de psychiatrie ou les manuels statistiques et classificateurs catégoriels du trouble psychique*. Ces traités et manuels ne conviennent pas à une évaluation médico-légale. Concrètement, il n'est pas acceptable, d'un point de vue clinique et médico-légal, qu'en présence d'un CPV sur la personne et en présence d'un trouble psychique il *soit toujours, à titre préjudiciel, sans examen du lien de causalité, la responsabilité du psychiatre si le sujet accomplit un acte de la violence*.

Dossiers médicaux

Le dossier médical doit donc inclure: un *diagnostic et une thérapie psychiatriques* documentés et justifiés, et *l'absence d'évaluation des liens de causalité* entre le trouble psychique et la CVP.

L'interaction entre les facteurs de risque cliniques et les facteurs de protection clinique de la CVP

Aspects cliniques

Au sujet de la CVP, il est possible d'affirmer au niveau clinique (1):

1. en psychiatrie clinique, la CVP est le résultat clinique de l'interaction, dans le cas individuel, entre les facteurs de protection clinique et les facteurs de risque cliniques;
2. les facteurs de protection clinique et les facteurs de risque cliniques ne sont pas des facteurs de cause médico-légale;
3. des facteurs de risque cliniques peuvent être présents et le sujet ne commet pas de CVP, des facteurs cliniques de protection peuvent être présents et le sujet commet un CVP;
4. les facteurs de risque cliniques de protection et de risque cliniques sont nombreux en clinique et peuvent, selon les recommandations, dépasser la centaine (1). Leur évaluation scientifique est complexe sous les aspects qualitatifs, quantitatifs et interrelationnels, et est variable par rapport aux différentes et nombreuses directives nationales et internationales (1).

Responsabilité professionnelle

L'évaluation isolée et limitée à certains facteurs de risque cliniques (CVP antérieure, carrière criminelle, etc.) dans le cas individuel n'est pas acceptable d'un point de vue clinique et médico- légal: "*le psychiatre a oublié de considérer ce facteur de risque ... a sous-estimé ce facteur de risque ... donc il est responsable du CVP du patient ...*". L'évaluation clinique et correcte du CVP du sujet doit être faite avec *l'examen intégré des facteurs de risque cliniques et des facteurs de protection clinique présents, à l'état actuel et concrètement, dans le cas individuel au moment des faits considérés et en référence au fait spécifique*. L'évaluation médico-légale du CVP doit être faite sur la base de la *causalité médico-légale* (de la pertinence et de la compétence de la discipline médico-légale) et non sur la base de l'étiologie clinique (de la pertinence et de la compétence des disciplines médicales). La Psychiatrie clinique a des finalités sociales et des méthodologies d'évaluation différentes de la psychiatrie légale .

Dossiers médicaux

Les éléments suivants doivent être présents dans le dossier médical et dans les informations scientifiques psychiatriques:

1. *une liste significative de facteurs de risque cliniques et une liste significative des facteurs de protection clinique du sujet individuel*. Cette liste, pour avoir une valeur médico-légale, doit être *concrète* (non théorique) et d'*actualité* (au moment de l'examen et non tout au long de la vie). Le terme *clinique* (facteur de risque clinique, facteur de protection clinique, etc.) doit toujours être utilisé pour clarifier la différence entre évaluation clinique et évaluation médico-légale et **ne pas confondre, en particulier, un facteur de risque clinique générique avec un facteur de causalité médico-légale spécifique**. Ce qui précède est une indication de la *diligence, de l'expertise et de la prudence* (bonnes pratiques de soins cliniques) de ceux qui ont effectué l'évaluation complexe et difficile et évite le préjudice: "non inscrit dans le dossier: pas fait".

Le CVP est un événement imprévisible et inévitable

Aspects cliniques

Dans le contexte de la prévisibilité et de l'inévitabilité, deux faits différents doivent être considérés:

1. **prévention general de CVP**. L'utilité clinique et humaine de toutes les *mesures générales de prévention* du CVP dans la réduction des facteurs de risque cliniques et l'amélioration des facteurs de protection clinique n'est pas remise en cause: attention particulière aux facteurs sociodémographiques (faible niveau économique, isolement social), aux facteurs psychologiques individuels (familles abusives, situations de crise,) aux facteurs psychosociaux (liés à la criminalité, à l'abus de substances voluptueuses, aux troubles psychiques, à la sous-culture de la violence, aux situations d'anomie, aux opportunités sociales différentielles, etc.), etc. Les méthodes utiles de prévention clinique dans des *situations de crise particulières* sont object d'attention (sujets confus et effrayés, incapables de communiquer, en état d'agitation psychomotrice sévère, hallucinés et menaçants, etc.) etc. E'galement important sont les mesures visant à *promouvoir la santé mentale* et à *améliorer la qualité de vie* (attention à la santé mentale dans son aspect le plus large tel qu'envisagé par l'Organisation mondiale de la santé: OMS);

2. **prévisibilité et évitabilité de la CVP dans le cas clinique specifique**:
   A. il n'y a pas de méthode d'évaluation scientifique *clinique, actuarielle ou mixte* qui permette, dans le cas clinique specifique, d'établir objectivement des données que: *un sujet mettra en œuvre un CVP et un autre ne mettra pas en œuvre un CVP* (**imprévisibilité**);
   B. il n'y a pas de mesures thérapeutiques (hospitalisation, contention, observation visuelle continue, pharmacothérapie, etc.) capables d'éviter, notamment à moyen et long terme, que: un sujet qui a décidé de mettre en œuvre un CVP avant ou après mettre en place (**inévitabilité**);
   C. ce qui précède est justifié par l'existence dans l'évaluation du CVP de nombreuses difficultées diagnostique: les facteurs de risque cliniques et la protection clinique, bien que n'ayant pas la valeur de causalité médico-légale, peuvent varier rapidement dans le temps quant à la qualité, la quantité et l'interaction mutuelle; présence de simulations et de dissimilations de l'intention de CVP qui ne sont pas manifestes et non détectables cliniquement; impulsivité situationnelle, y compris style de vie egodystonique, etc. (**difficulté jusqu'à l'impossibilité pronostique**) (1).

Responsabilité professionnelle

Le *défaitisme psychologique* n'est pas acceptable d'un point de vue clinique et médico-légal ("il n'y a rien à faire pour prévenir et éviter la CVP"); *omnipotence réactive et vantardise* (le CVP est toujours prévisible et évitable, sinon toujours dans la plupart des cas); *ignorance coupable* (c'est-à- dire ne pas savoir que la *psychiatrie clinique et la psychiatrie légale* ne sont pas la même discipline, qu'en droit, il n'y a pas de concept *d'imprévisibilité, d'inévitabilité et de difficulté ou d'impossibilité d'éviter un événement: "ad impossibilia nemo tenetur"*, qui en médecine et en particulier en psychiatrie il y a le *risque permis*, etc.); la *marginalisation préjudiciable* des membres de la famille (ils ne sont pas capables, ils n'ont ni droit ni devoir). Une attitude consciente de ceux qui doivent évaluer et gérer le CVP est souhaitable (*tout en étant conscient de l'imprévisibilité et de l'inévitabilité, "je peux et je dois faire quelques chose pour éviter le CVP du sujet" et, en termes de droit, lorsqu'il y a un caractère concret de violence directe, pour éviter, dans les limites du faisable et autorisé par la loi, les dommages aux tiers*). Lorsque cela est approprié et possible, *les membres de la famille doivent être impliqués* dans le traitement (ils doivent être informés, psychoéduqués, rendus responsables de leurs capacités, de leur autodétermination et du respect de leur psychoéducation).

Dossiers médicaux

Le dossier médical doit être documenté:
1. la *cohérence* entre l'évaluation intégrée des facteurs de risque cliniques et des facteurs de protection clinique et les mesures de précaution adoptées pour les *soins et la protection* du sujet;
2. la documentation sur *l'information et l'adhésion au traitement du sujet suicidaire* concernant les membres de la famille dans leurs droits d'assistance aux parents et devoirs des citoyens;
3. la prise en charge et la protection du sujet doivent être respectueuses des *droits et devoirs, prévus par la loi, des citoyens subissant un traitement médical* (droit à la communication, à la vie privée, au consentement, au refus de traitement, etc.).

Pharmacothérapie dans la prévention de la CVP

Aspects cliniques

Dans les aspects cliniques de la pharmacothérapie, deux éventualités différentes doivent être envisagées:
1. **pharmacothérapie et trouble psychique**. Au niveau clinique, les améliorations des symptômes psychiatriques et de la qualité de vie que la pharmacothérapie a apporté à la thérapie des troubles mentaux ne sont pas en cause;
2. **pharmacothérapie et CVP**. La pharmacothérapie pour la prévention du CVP présente de nombreuses difficultées (1): la CVP est un événement multi-déterminé et il n'existe aucun médicament qui guérit des événements multi-déterminés; CVP n'est pas un symptôme d'une entité psychiatrique nosographique spécifique; le médicament peut agir sur l'irritabilité, l'agitation, l'anxiété, l'insomnie, etc. mais ces symptômes (additional risk factors) sont présents dans l'ensemble de la population générale, en plus de n'avoir aucune valeur causale médico-légale, ils ne sont pas nécessairement en lien de causalité juridique avec l'action biopsychosociale complexe du CVP; le médicament traite le trouble psychique et le trouble psychique n'est que l'un des nombreux facteurs de risque cliniques de CVP et les facteurs de risque cliniques ne sont pas des facteurs de causalité médico-légale de CVP; le médicament peut agir, dans le cas le plus favorable, sur un symptôme et non sur la totalité d'un trouble psychiatrique et non sur toutes les composantes du CVP du sujet qui ne sont pas liées au symptôme et au trouble psychiatrique et sont représentées par les raisons de violence de la nature psychologique, social, culturel, économique, sexuel, circonstanciel, etc. (1).

Responsabilité professionnelle

Il n'est pas acceptable du point de vue scientifique et médico-légal que: "*il suffirait d'administrer un sédatif à toutes les personnes agitées, irritables, anxieuses, un antipsychotique adéquat à tous les psychotiques, un équilibreur de l'humeur pour tous les troubles de l'humeur et les impulsifs, etc … pour éviter le CVP.*" Il n'est pas acceptable d'un point de vue médico-légal une évaluation de l'effet du médicament qui se limite à affirmer, après le CVP du patient (ex post), *sans motiver et enquêter de*

manière adéquate (1): "... le psychiatre n'a pas administré le médicament qui il aurait évité le CVP ... il a eu tort de prescrire le bon médicament, ... il a eu tort de diminuer, d'augmenter, de suspendre le médicament ... donc il est responsable du CVP du patient ..." Il est impératif que toute évaluation clinique et médico-légale de la pharmacothérapie en termes du CVP est réalisé avec des critères qui respectent la méthode scientifique et donc: *"envisager l'évaluation de ses risques et avantages; la différence entre efficience et efficacité; sa réelle efficacité sur des objectifs spécifiques; les phénomènes de résistance totale ou partielle; les taux de réussite des différentes stratégies alternatives pour surmonter la résistance; intolérance; effets secondaires; effets paradoxaux; syndromes addictifs; syndromes de sevrage; les syndromes de rebond; effet noyer; interactions médicamenteuses; changements pharmacocinétiques ou pharmacodynamiques prévisibles et imprévisibles; les rechutes, les rémissions, les récidives et l'histoire évolutive naturelle du trouble psychique dépendant et indépendant du médicament; l'existence d'erreurs non pertinentes aux fins du lien de causalité; l'autodétermination, l'adhésion au traitement et le type de relation thérapeutique par rapport aux attentes thérapeutiques du médicament; les particularités bio-psycho-sociales du cas individuel en question par rapport à la fonctionnalité de la pharmacothérapie spécifique; etc." (1).*

L'évaluation clinique et médico-légale de la pharmacothérapie, en cas d'accusation, en termes de CVP doit, pour la rigueur essentielle de l'exhaustivité scientifique et de la metodologie médico- légale, illustrer sur la base de preuves cliniques partagées, non seulement:

1. "*parce qu'on suppose qu'une thérapie incorrecte a causé le CVP*";
2. mais aussi, dans les détails scientifiques et opérationnels concrets: "*quelle aurait été la bonne thérapie, illustrée et motivée en* détail, qui aurait évité le *CVP*".

Dossiers médicaux

La *cohérence* entre les symptômes psychiatriques et la pharmacothérapie et la *justification* de toute modification de la pharmacothérapie doivent toujours être documentées dans le dossier médical.

Remarques finales

Ce qui précède doit être approfondi avec le texte original (1) (environ 560 pages; 402 références bibliographiques) et avec un guide de psychiatrie légale abrégé (2) (85 pages) qui contient également les principes sous-tendant la responsabilité dans l'équipe, de la continuité et interruption des traitements, préjugés et émotions sur le CVP, l'importance de la victimologie dans l'évaluation du CVP et la qualification et la fiabilité des experts et consultants qui doivent évaluer la responsabilité du psychiatre. En outre, ce qui précède doit être adapté aux contextes nationaux d'application législative et jurisprudentielle spécifiques, dans le domaine pénal et civil, au cas clinique individuel, aux spécificités du système national d'assistance psychiatrique et à l'indispensable mise à jour liée au progrès des connaissances scientifiques et à l'évolution. de la loi.

Interpersonal physical violence, Psychiatrist's professional responsibility, medical record as a forensic document

Interpersonal physical violence (IPV: beatings, personal injury, homicide and attempted homicide) committed by psychiatric patients is one of the most dramatic and painful event at the human level, and frequently leads to psychiatrist's criminal prosecution and civil cases. A number of clinical guidelines can be consulted in order to improve clinical practice in terms of treatment and prevention of IPV, with their advantages and criticalities (1). The object of this paper is to highlight clinical and forensic evidence about IPV which have been approved by the Società Italiana di Psichiatria (SIP) and Società Italiana di Psichiatria Forense (SIPF) (1,2).

IPV is an event characterized by a multi-determined etiology, a multi- axial diagnosis and a multi-strategic treatment

Clinical aspects

The IPV is an event distinguished by (1):

1. **a multi-determined etiology (*Recognition of multi-causality*)**. The clinical etiology is linked to a number of biological, psychological, psychiatric, cultural, social and contextual variables, that may interact in the single individual;
2. **a multi-axial diagnosis (*Multiaxial diagnosis*)**. The diagnosis evaluates the complex bio- psycho-social etiology and the uniqueness and unrepeatability of the psycho-socio-cultural circumstances of time, places and people of the individual clinical case;
3. **a multistrategic preventive and treatment intervention (*Multicomponent interventions, Multisectorial approach*)**. Therapeutic and preventive measures are taken in relation to the clinical case, considering the medical, psychological, psychiatric, social, cultural, welfare, economic, legislative, political aspects.

Professional responsibility

From the forensic and clinical point of view, the following statement is not appropriate: *"The patient killed his wife because he was schizophrenic with a persecutory delirium"*. In fact, not all subjects with a psychic disorder kill their wife; to kill the wife there is no need for a psychic disorder; a person diagnosed with schizophrenia with persecutory delusions may kill his wife for other reasons,

such as jealousy; it does not exist a direct link between persecutory delusion and IPV but there are a number of *intermediate variables* such as psychopathies, antisociality, emotions, passions, etc; The delusional symptoms must be evaluated in the individual case, and can be identified as a *self-legitimation* instead of the real *motivation*; the delusion present with various *levels of understanding* of reality. The correct statement, respectful of clinical and forensic evidence could be the following: "*at the state of current knowledge, it is difficult to understand the reason why that person killed his wife ... that person had already abused physically other women, had already been very possessive and sometimes sadistic with his wife, had already expressed impulsivity. Furthermore he had been treated for schizophrenia, presenting with claimants persecutors delusions and, over the period before the homicide, he was very frustrated and aggressive because his wife did not indulge herself sexually...".*

Medical records

The multi-axial diagnosis and the multi-strategy therapeutic interventions and the multi-determined etiology in the field of IPV must be clearly shown in the medical record, in the clinical and forensic information at a scientific level, in mass communication. The medical record must report the diagnosis and psychiatric therapy. *The medical record is not a forensic expertise* and must not report improper, inadequate and unjustified *causal links* between a psychiatric disorder and IPV (*… he killed because he was schizophrenic … he killed because he was delusional …).*

The psychological and social learning and intergenerational transmission of the IPV without psychic disorder

Clinical aspects

Every person learns during lifetime a social behavior respectful of the physical integrity of others. Similarly an individual may learn, without the participation of psychopathologies, the IPV and a behavior that does not respect the physical integrity of others. These clinical data are based on a very rich criminogenetic and criminodynamic bibliography (1) through *sociological theories* (theory of criminal areas, social disorganization, deviance, etc); *psychological theories* (theory of containers, personal identity, roles, etc.); *psychoanalytic theories* (projections of internal worlds onto the external world, projective identifications, etc); *the strategies of moral disengagement* of mutual triadic determinism (diffusion or dislocation of responsibility, projective attribution of blame, dehumanization of the victim, etc); the *theories of the violentization* of behavior (instead of learning about socialization a personal learns violence); the various *subcultures of violence* (enhancement of the IPV with good social visibility to manage interpersonal relationships); the motivational importance of *emotions and passions* (anger, revenge, jealousy, envy, pride, etc). There is also a specific semiotics, without psychic disturbance, which concerns the IPV: *secondary gains, cycles of violence, repetitive patterns, structured paths, sudden changes, progressive halos, reactivation, limited and specific multifactoriality, warning signs, symbolic communication, threats, etc.* (1).

Professional responsibility

It is not clinically and forensically acceptable for a psychiatrist to evaluate and manage IPV ignoring the aetiology and dynamics of interpersonal violence without the psychic disorder and to interpret IPV *solely in light of the psychopathology described in psychiatry manual or statistical diagnostic manuals and categorical classifiers of psychic disorder*. These manuals are not suitable for forensic evaluation. In concrete terms, it is not acceptable, from a clinical and forensic point of view, to assign the responsibility to the psychiatry when IPV is committed by an individual with a mental disorder, *without examination of the causal link*.

Medical records

The medical record must include: a documented and justified *psychiatric diagnosis and therapy*, and the *absence of evaluations of causal links* between psychic disorder and IPV.

The interaction between clinical risk factors and clinical protective factors of IPV

Clinical aspects

About IPV it is possible to state, at a clinical level, the following (1):

1. in clinical psychiatry, IPV is the clinical result of the interaction, between clinical protective factors and clinical risk factors in each specific case;
2. clinical protective factors and clinical risk factors are not forensic causal factors;
3. clinical risk factors may be present and the subject does not implement IPV; clinical protective factors may be present and the subject commits IPV;
4. clinical protective and clinical risk factors are numerous in the clinic and can, depending on the guidelines, be over a hundred (1). Their single scientific evaluation is complex from a qualitative, quantitative and inter-relational aspect, and they vary in relation to the different and numerous national and international guidelines (1).

Professional responsibility

The evaluation isolated and limited to some clinical risk factors (previous IPV, criminal career, etc.) in the individual case is not acceptable from a clinical and forensic point of view: "*the psychiatrist has forgotten to consider this risk factor ... he has underestimated this factor of risk ... therefore it is responsible for the patient's* IPV *...".* The clinical and correct evaluation of the subject's IPV must be performed with the *integrated examination of the clinical risk factors and the clinical protective fac-*

tors, concretely present in the specific case at the moment of the facts under consideration and with reference to the specific fact. The forensic evaluation of the IPV must be led on the basis of *forensic causality* (relevance and competence of the forensic discipline) and not on the basis of *clinical etiology* (relevance and competence of medical disciplines). Clinical psychiatry has social purposes and evaluation methodologies different from forensic psychiatry.

Medical records

The following information must be present in the medical record and in the psychiatric scientific information:

1. a *significant list of clinical risk factors and a significant list of the individual clinical protective factors*. In order to have a forensic value, this list must be of a *concrete* nature (not theoretical) and *topical* (at the time of the examination and not throughout life). The term *clinical* (clinical risk factor, clinical protection factor) must always be used to clarify the difference between clinical evaluation and forensic evaluation and **not to confuse, in particular, a generic *clinical risk* factor with a specific *forensic causation* factor**. The foregoing is an indication of *diligence, expertise and prudence* (good clinical practice) of those who have carried out the complex and difficult assessment and avoids the forensic dispute: "*not written in the record: not done*".

The IPV is an unpredictable and inevitable event

Clinical aspects

In the context of predictability and inevitability, two different facts are to be considered:

1. prevention of IPV. The clinical and human utility of IPV *general prevention* measures in reducing clinical risk factors and enhancing clinical protective factors are not questioned: selected attention to socio-demographic factors (low economic level, social isolation), to individual psychological factors (abusive families, crisis situations) to psycho-social factors (linked to crime, abuse of voluptuous substances, psychic disturbance, subculture of violence, situations of anomie, differential social opportunities, etc). The useful methods of *clinical prevention in particular crisis situations* are being discussed (confused and frightened subjects unable to communicate, in a state of severe psychomotor agitation, hallucinated and threatening, etc.). and all measures aimed at *promoting mental health and improving the quality of life* (attention to mental health in its broadest aspect as contemplated by the World Health Organization, WHO);

2. predictability and avoidability of IPV in the specific clinical case:

A. there is no *clinical, actuarial or mixed* scientific evaluation method that allows, in the specific clinical case, to objectively establish that: *one subject will implement* IPV *and another subject will not implement a* IPV (**unpredictability**);

B. there are no therapeutic measures (hospitalization, restraint, continuo*us visual observation, pharmacotherapy, etc.) capable of avoiding, especially in the medium and long term, that: a subject who has decided to implement IPV either before or after the put in place (***inevitability***);*

C. the *foregoing is justified by the existence in the evaluation of IPV of numer*ous diagnostic critical issues: *the clinical risk and clinical protection factors, while not having forensic causality value, can vary rapidly over time in terms of quality, quantity and reciprocal interaction; presence of simulations and dissimilations of the intent of* IPV *that are not manifest and not clinically detectable; situational impulsiveness including ego-dystonic lifestyle, etc.*(**difficulty up to prognostic impossibility**) (1).

Professional responsibility

Psychological defeatism is not acceptable from a clinical and forensic point of view ("there is nothing to be done to prevent and avoid IPV*"*); *reactive and boastful omnipotence* ("IPV is always predictable and avoidable, if not always in many cases"); *guilty ignorance* (i.e. not knowing that *clinical psychiatry and forensic psychiatry* are not the same discipline, that in law there is no concept of *unpredictability, inevitability and difficulty or impossibility to avoid an event*: *ad impossibilia nemo tenetur*, which in medicine and in particular in psychiatry there is the *permitted risk*, etc); the *prejudicial marginalization* of family members ("they are not capable, they do not have the right or duty"). A conscious attitude of those who must evaluate and manage the IPV is desirable (*although aware of the unpredictability and inevitability, something* ***I can and I must do*** *to prevent the* IPV *and, according to law, when there is a concreteness and relevance of specific objectives of direct hetero violence, to prevent, within the limits of what is feasible and permitted by law, damage to third parties*). When appropriate and possible, *family members must be involved* in the treatment (they must be informed, psychoeducated, made responsible for their abilities, self- determination and adherence to their psycho-education).

Medical records

The medical record must include:

1. the *consistency* between the integrated assessment of clinical risk factors and clinical protective factors and the precautionary measures adopted for the care and protection of the subject;
2. the documentation on *information and adherence to the treatment of the suicidal subject;*
3. concerning family members in their rights of assistance to the relative and duties of citizens;
4. the care and protection of the subject must be respectful of *rights and duties, provided for by law, of citizens undergoing medical treatment* (right to communication, privacy, consent, refusal of treatment).

Pharmacotherapy in the prevention of IPV

Clinical aspects

In the context of the clinical aspects of pharmacotherapy, two different eventualities must be considered:

1. **pharmacotherapy and psychic disorder**. From a clinical point of view, the improvements in psychiatric symptoms and the quality of life that pharmacotherapy has brought and is leading to the therapy of mental disorders are not in question;
2. **pharmacotherapy and IPV**. Pharmacotherapy for the prevention of IPV presents numerous criticalities (1): IPV is a multi-determined event and there are no medications that cure multi-determined events; IPV is not a symptom of a specific nosographic psychiatric entity; the drug can act on irritability, agitation, anxiety, insomnia, but these symptoms (additional risk factors) may be present in the whole general population, besides not having forensic causal value, and they are not necessarily in a juridical causal link with the complex biopsychosocial nature of IPV; the drug treats the mental disorder and the mental disorder is only one among the many clinical risk factors of IPV. Clinical risk factors are not forensic causation factors of IPV. The drug can be effective, in the most favorable case, for symptoms but not for the complex psychiatric disorder or for all aspects of IPV, unrelated to symptoms and psychiatric disorder, and are represented by the reasons for violence of nature psychological, social, cultural, economic, sexual, circumstantial (1).

Professional responsibility

It is not acceptable from the scientific and forensic point of view the following statement: "*it would be sufficient to prescribe all agitated, irritable, anxious people with a sedative, all psychotic patients with an adequate antipsychotic, all patients with a mood disorders and impulsivity with a mood balancer, etc … to avoid* IPV". It is not acceptable from a forensic point of view an evaluation of the effect of the drug, that is limited to affirming after the patient's IPV (ex post), without adequately *motivating and investigating* (1): "*... the psychiatrist has not administered the drug that would have avoided the* IPV *... he was wrong to prescribe the drug, ... he was wrong to decrease, increase, suspend the drug ... therefore he is responsible for the patient's* IPV". It is imperative that any clinical and forensic evaluation of drug therapy in terms of IPV is carried out with criteria that respect the scientific method and therefore: "C*ontemplate the assessment of its risks and benefits; the difference between efficiency and effectiveness; its real effectiveness on specific objectives; the phenomena of total or partial resistance; the success rates in the various alternative strategies to overcome the resistance; intolerance; side effects; paradoxical effects; addiction syndromes; withdrawal syndromes; rebound syndromes; walnut effect; drug interactions; predictable and unpredictable pharmacokinetic or pharmacodynamic changes; relapses, remissions, recurrences and the natural evolutionary history of the psychic disorder dependent and independent of the drug; the existence of errors not relevant for the purposes of the causal link; self-determination, adherence to treatment and type of therapeutic relationship in relation to the therapeutic expectations of the drug; the bio- psycho-social peculiarities of the individual case in question in relation to the functionality of the specific pharmacotherapy"* (1).

The clinical and forensic evaluation of pharmacotherapy in cases of IPV, in cases of legal charge, should illustrate, for the essential rigor of scientific completeness, on the basis of shared clinical evidence, not only:

1. "because *it is assumed that incorrect therapy caused the IPV*";
2. but also, in the concrete scientific and operational details: "*what would have been the right therapy, illustrated and motivated in detail, which would have avoided IPV*".

Medical records

The *consistency* between psychiatric symptoms and drug therapy and the *justification of the rationale* behind any modification of drug therapy must always be documented in the medical record.

Concluding remarks

The foregoing needs to be deepened with the original text (1) (about 560 pages; 402 bibliographic references) and with an abbreviated Forensic Psychiatric Guide (2) (85 pages) which also contain the principles underlying the responsibility in the team, of the continuity and interruption of treatments, prejudices and emotions about IPV, the importance of victimology in the evaluation of the IPV and the qualification and reliability of the experts and consultants who must evaluate the psychiatrist's responsibility. Furthermore, the foregoing must be adapted to specific national legislative and jurisprudential contexts of application, in the criminal and civil field, to the specific clinical case, to the specificities of the national psychiatric assistance systems and to the indispensable update linked to the progress of scientific knowledge and evolution of law.

El comportamiento violento contra la persona, la responsabilidad profesional del psiquiatra, los registros medicos como documento forense

El comportamiento violento contra la persona (CVP: palizas, lesiones personales, homicidio perpetrado e intentado) (VBP Violent Behavior on Person; CVP comportement violet sur la personne) realizado por un paciente psiquiátrico es uno de los hechos más dramáticos y dolorosos a nivel humano y más frecuente, que conducen a la persecución penal y responsabilidad civil del psiquiatra. Con el propósito general de mejorar la buena práctica clínica del psiquiatra en cuanto al tratamiento y prevención del CVP, se pueden consultar numerosas guías con sus ventajas y criticidades (1). El objeto de este artículo es destacar algunas pruebas clínicas y forenses compartidas sobre el tema del CVP, aprobadas por la Società Italiana di Psichiatria (SIP) y la Società Italiana di Psichiatria Forense (SIPF) (1, 2).

El CVP es un evento con etiología multi-determinada, diagnóstico multi-axial y tratamiento multi-estratégico

Aspectos clinicos

El CVP es un evento caracterizado por (1):

1. una **etiología multideterminada** (***Recognition of multicausality***) (1), o sea una etiología clínica con numerosas variables biológicas, psicológicas, psiquiátricas, culturales, sociales y contextuales, que interactúan en el mismo individuo;
2. un **diagnóstico multiaxial** (***Multiaxial diagnosis***) (1) que evalúe la compleja etiología bio- psicosocial y la unicidad e irrepetibilidad de las circunstancias psico-socioculturales del tiempo, lugares y personas de cada caso clínico;
3. una **intervención preventiva y terapéutica multiestratégica** (***Multicomponent interventions, Multisectorial approach***) (1), o sea medidas terapéuticas y preventivas, en relación con el caso clínico en el ámbito médico, psicológico, psiquiátrico, social, cultural, asistencial, económico, legislativo, político campos.

Responsabilidad profesional

Desde el punto de vista clínico y forense la siguente afirmaciòn es incorrecta: *ese paciente mató a su mujer porque era esquizofrénico con delirio persecutorio*. No todos los sujetos con este trastorno mental matan a su esposa. De hecho para matar a la esposa no hay necesidad de un trastorno psíquico: una persona puede padecer una esquizofrenia con delirios persecutorios y matar a su esposa por celos o por muchas otras razones. No existe un vínculo directo entre el delirio de persecución y el CVP, sino existen *variables intermedias* como psicopatía, antisocialidad, emociones, pasiones, etc. que deben ser evaluadas en el caso individual. La oferta del contenido aparentemente delirante puede ser una *auto-legitimación* y no la *motivación* real porque en el delirio hay varios *niveles de comprensión* de la realidad (1). La afirmación correcta, respetuosa de la evidencia clínica y forense podría ser: *con los conocimientos que tenemos es difícil entender por qué esa persona mató a su esposa: seguramente esa persona ya había usado violencia física con otras mujeres o era muy posesivo y sádico con su esposa, tambien impulsivo; puede ser que estaba siendo tratado por esquizofrenia, que habia presentado contenido reivindicativo y perseguidor, o que últimamente estaba muy frustrado y agresivo porque su esposa no le complacía sexualmente.*

Registros médicos

En el registro medico, en la divulgacion clínica y forense, se debe mostrar con claridad la etiología multideterminada, el diagnóstico multiaxial y las intervenciones terapéuticas multiestrategias en el campo del CVP. La historia clínica debe indicar el diagnóstico y la terapia psiquiátrica. *El registro médico no es una pericia legal o analisis forense* y no debe poner inapropiados vínculos de causalidad, inadecuados e injustificados entre el trastorno psíquico y el CVP *(...mató porque era esquizofrénico, mató porque estaba delirante...*).

El aprendizaje psicológico y social del CVP sin trastorno mental

Aspectos clínicos

En la misma manera de que una persona sin psicopatologías de interés psiquiátrico aprende un comportamiento social que respete la integridad física de los demás, asì puede aprender un CVP, o sea un comportamiento que en cambio no lo respeta. Estos datos clínicos se basan sobre una bibliografía criminogenética y criminodinámica muy rica (1) a través de *teorías sociológicas* (teoría de áreas criminales, desorganización social, desviación, etc), *psicológicas* (de contenedores, identidad personal, roles, etc.), *psicoanalíticas* (proyecciones de mundos internos sobre el mundo externo, identificaciones proyectivas, etc.), tambien *estrategias de desvinculación moral* del determinismo triádico mutuo (difusión o dislocación de la responsabilidad, atribución proyectiva de la culpa, deshumanizaciónacción de la víctima, etc), *teorías de la violentaización* del comportamiento (en lugar de aprender sobre socialización, se aprende sobre violencia), distintas *subculturas de la violencia* (potenciación del CVP con buena visibilidad social para gestionar las relaciones interpersonales) y la importancia motivacional de las *emociones y pasiones* (ira, venganza, celos, envidia, orgullo, etc.). En este fenomeno existe también una semiótica específica para quien non tiene perturbación psíquica: *ganancias secundarias, ciclos de violencia, patrones repetitivos, caminos estructurados, cambios bruscos, halos progresivos, reactivación, multifactorialidad limitada y específica, señales de alerta, comunicación simbólica, amenazas, etc*. (1).

Responsabilidad profesional

No es aceptable en el ambito clínico y forense que un psiquiatra evalúe y maneje el CVP ignorando toda la etiología y la dinámica de la violencia interpersonal sin el trastorno psíquico, ni siquiera que interprete el CVP únicamente mirando a la psicopatología descrita en los tratados de psiquiatría o en los manuales estadísticos y clasificadores *de las categorias de trastorno psíquico*. Estos tratados y manuales no son adecuados para la evaluación forense. Concretamente no es admisible, desde el punto de vista clínico y forense, que *si el sujeto realiza ese acto de violencia* (CVP) contra una persona y tiene un trastorno mental, *sea siempre, con carácter prejudicial y sin examen de la relación de causalida juridica, responsabilidad del psiquiatra*.

Registros médicos

Por lo tanto, la historia clínica debe incluir: *diagnóstico y terapia psiquiátricos* documentados y justificados sin *evaluaciones de vínculos causales* entre el trastorno psíquico y el CVP.

La interacción entre los factores clínicos de riesgo y los factores clínicos protectivos del CVP

Aspectos clinicos

Sobre el tema del CVP se puede afirmar a nivel clínico (1):

1. en psiquiatría clínica, el CVP es el resultado clínico de la interacción, en el individuo, entre factores clínicos protectores y factores clínicos de riesgo;
2. los factores de protección clínica y los factores de riesgo clínicos no son factores de causa forense;
3. pueden estar presentes factores de riesgo clínicos y el sujeto no comete un CVP, pueden estar presentes factores de protección clínicos y el sujeto comete un CVP;
4. los factores clínicos de protección y de riesgo clínicos son numerosos en la clínica y pueden, según las pautas, superar los cien (1). Su valoración científica única es compleja desde el punto de vista cualitativo, cuantitativo e interrelacional, y es variable en relación con las diferentes y numerosas directrices nacionales e internacionales (1).

Responsabilidad profesional

La valoración limitada a determinados factores de riesgo clínico (CVP precedentes, carrera delictiva, etc.) en el caso individual no es aceptable desde el punto de vista clínico y forense: si hace eso, *el psiquiatra se olvida de considerar este factor de riesgo. lo subestima, por lo tanto es responsable del CVP del paciente...* La evaluación clínica y correcta del CVP del sujeto debe realizarse con *el examen integrado de los factores clínicos de riesgo y los factores clínicos protectivos presentes realmente en la actualidad, en el caso individual y en el momento de los hechos examinados, con referencia al hecho concreto*. La evaluación forense del CVP debe basarse en la causalidad forense (de relevancia y competencia de la disciplina forense) y no en la etiología clínica (de relevancia y competencia de las disciplinas médicas). La psiquiatría clínica tiene finalidades sociales y metodologías de evaluación diferentes respeto a la psiquiatría forense.

Registros médicos

Debe estar presente en el registro clínico y en la divulgacion científica psiquiátrica:

1. *un elenco significativo de factores clínicos de riesgo y de los factores clínicos protectivos individuales*. Este elenco, para tener valor juridico debe ser *practico* (no teórico) y *actual* (en el momento del examen y no durante toda la vida). El término *clínico* (factor de riesgo clínico, factor de protección clínico, etc.) se debe utilizar siempre para aclarar la diferencia entre evaluación clínica y forense **y no se debe confundir, en particular, un factor de *riesgo clínico* genérico con un factor de *causalidad forense* específico**. Lo anterior es una muestra de *diligencia, pericia y prudencia* (buena práctica clínica) de quien ha llevado a cabo la compleja y difícil evaluación y evita la impugnación forense: “no escrito en el registro: no hecho”.

El CVP es un evento impredecible e inevitable.

Aspectos clinicos

En el contexto de la previsibilidad y la inevitabilidad, se deben considerar dos hechos diferentes:

1. **prevención del CVP.** No se cuestiona la utilidad clínica y humana de todas las medidas de *prevención general* del CVP para reducir los factores de riesgo clínicos y mejorar los factores de protección clínicos: poner atención a los factores sociodemográficos (bajo nivel económico, aislamiento social), a los factores psicológicos individuales (familias abusivas, crisis situaciones,) a factores psicosociales (vinculados a la delincuencia, abuso de sustancias voluptuosas, perturbación psíquica, subcultura de la violencia, situaciones de anomia, oportunidades sociales diferenciales, etc.), etc. Los métodos útiles de *prevención clínica en situaciones de crisis particulares* no están en duda (sujetos confundidos y asustados incapaces de comunicar, en estado de agitación psicomotora severa, amenazadores y con alucinaciones etc.), ni siquiera todas las medidas encaminadas a *promover la salud mental y mejorar la calidad de vida* (atención a la salud mental en su aspecto más amplio contemplado por la Organización Mundial de la Salud: OMS);
2. **previsibilidad y evitabilidad del CVP en el caso clínico único**:

A. no existe un método de evaluación científica *clínico, actuarial o mixto* que permita, en un solo caso clínico, de establecer objetivamente que *un sujeto implementará un CVP y otro sujeto no implementará un CVP* (**impredecibilidad**);
B. no existen medidas terapéuticas (hospitalización, inmovilización, observación visual continua, farmacote-

rapia, etc.) capaces de evitar, especialmente a medio y largo plazo, que *un sujeto que haya decidido implantarse un CVP en el futuro lo implementarà* (**inevitabilidad**);

C. lo anterior se justifica por la existencia en la evaluación del CVP de numerosas criticidades diagnósticas: *los factores de riesgo clínico y la protección clínica, aunque no tienen el valor de causalidad forense, pueden variar rápidamente en el tiempo en t*érminos de calidad, cantidad y reciprocidad, presencia de simulaciones y disimilaciones de la intención *del CVP que no son manifiestas y no detectables clínicamente, tambien impulsividad situacional ego-distónica al estilo de vida, etc. (***dificultad hasta imposibilidad pronóstica**) (1).

Responsabilidad profesional

Clinicamente y juridicamente el *derrotismo psicológico* no es aceptable (no hay nada que hacer para prevenir y evitar el CVP), ni la *omnipotencia reactiva y jactanciosa* (el CVP es siempre predecible y evitable, si no siempre en la mayoría de los casos), la *ignorancia culpable* (no saber que la *psiquiatría clínica y la psiquiatría forense* no son la misma disciplina, que en derecho no existe el concepto de *imprevisibilidad, inevitabilidad y dificultad o imposibilidad de evitar un evento*: *ad impossibilia nemo tenetur*, que en medicina y en particular en psiquiatría existe el *riesgo permitido*, etc), la *marginación perjudicial* de los miembros de la familia (no son capaces, no tienen el derecho ni el deber). Es deseable una actitud consciente de quienes deben evaluar y gestionar el CVP (*aunque consciente de la imprevisibilidad y la inevitabilidad, **puedo y debo** hacer algo para prevenir el CVP del sujeto y para prevenir, en términos de derecho, cuando hay una concreción y relevancia de hetero violencia, dentro de los límites de lo factible y permitido por la ley, daños a terceros*). Cuando es posible, hay que incluir a los miembros de la familia en el tratamiento (deben ser informados, psicoeducados, responsabilizados por sus habilidades, autodeterminación y adherencia a su psicoeducación).

Registros médicos

En el registro médico debe estar documentado:

1. la *coherencia* entre la evaluación integrada de los factores clínicos de riesgo y los factores clínicos de protección y las medidas cautelares adoptadas para el *cuidado y protección* del sujeto;
2. la documentación sobre *información y adherencia al tratamiento del sujeto suicida* de los familiares en sus derechos de asistencia al familiar y deberes de los ciudadanos;
3. el cuidado y la protección del sujeto debe ser respetuosos de los *derechos y deberes, previstos por la ley, de los ciudadanos en tratamiento médico* (derecho a la comunicación, privacy, consentimiento, rechazo de tratamiento, etc.).

Farmacoterapia en la prevención del CVP

Aspectos clinicos

En el contexto de los aspectos clínicos de la farmacoterapia, se deben considerar dos eventualidades diferentes:

1. **farmacoterapia y trastorno psíquico**. Clinicamente no se dudan las mejoras de los síntomas psiquiátricos y de la calidad de la vida que la farmacoterapia ha traído y está conduciendo a la terapia de los trastornos mentales;
2. **farmacoterapia y CVP**. La farmacoterapia para la prevención del CVP presenta numerosos aspectos críticos (1): el CVP es un evento de múltideterminados y no existen fármacos que curen los eventos multideterminados; el CVP no es un síntoma de una entidad psiquiátrica nosográfica específica; el farmaco puede afectar a la irritabilidad, agitación, ansiedad, insomnio, etc. pero estos síntomas (additional risk factors) que están presentes en toda la población general, no solo no tienen valor causal forense, sino tambien no necesariamente tienen un vínculo causal jurídico con la compleja acción biopsicosocial del CVP; el fármaco trata el trastorno mental y el trastorno mental es solo uno de los muchos factores de riesgo clínicos del CVP y los factores de riesgo clínicos no son factores forenses que causen el CVP; el fármaco puede actuar, sobre un síntoma y no sobre la totalidad de un trastorno psiquiátrico, ni sobre todos los componentes del CVP del sujeto que no están relacionados con el síntoma y el trastorno psiquiátrico y están representados por las razones por violencia de naturaleza psicológica, social, cultural, económica, sexual, circunstancial, etc. (1).

Responsabilidad profesional

No es aceptable desde el punto de vista científico y forense que: *sería suficiente administrar un sedante a todas las personas agitadas, irritables, ansiosas, un antipsicótico adecuado a todos los psicóticos, un equilibrador del estado de ánimo para todos los trastornos del estado de ánimo e impulsivos, etc... para evitar el CVP*. No es aceptable desde el punto de vista forense una evaluación del efecto del fármaco que se limite a afirmar, después del CVP del paciente (ex post), sin *motivar e investigar adecuadamente* (1), que *el psiquiatra no ha administrado el fármaco que habría evitado el CVP , que se equivocó al prescribir el fármaco correcto, que se equivocó al disminuir, aumentar, suspender el fármaco, por lo tanto es responsable del CVP del paciente ...* Es imperativo que cualquiera evaluación clínica y forense de la farmacoterapia en términos del CVP se lleve a cabo con criterios que respeten el método científico y por lo tanto: "*contemplar la evaluación de sus riesgos y beneficios; la diferencia entre eficiencia y efectividad; su efectividad real en objetivos específicos; los fenómenos de resistencia total o parcial; el porcentaje de éxito en las distintas estrategias alternativas para superar la resistencia; intolerancia;*

efectos secundarios; efectos paradójicos; síndromes de adicción; síndromes de abstinencia; síndromes de rebote; efecto nocebo; interacciones con la drogas; cambios farmacocinéticos o farmacodinámicos predecibles e impredecibles; recaídas, remisiones, recurrencias y la historia evolutiva natural del trastorno psíquico dependiente e independiente de la droga; la existencia de errores no relevantes a los efectos del vínculo causal; autodeterminación, adherencia al tratamiento y tipo de relación terapéutica en relación a las expectativas terapéuticas del fármaco; las peculiaridades biopsicosociales del caso individual en relación con la funcionalidad de la farmacoterapia específica; etc." (1).

La evaluación clínica y forense de la farmacoterapia, en casos *de* acusación, en términos de CVP, debe, para el rigor esencial de la integridad científica, ilustrar sobre la base de la evidencia clínica compartida, no solo

1. "*porque se supone que una terapia incorrecta provocó el CVP*";
2. sino tambien en los detalles científicos y operativos concretos: "*cuál hubiera sido la terapia adecuada, ilustrada y motivada en detalle, que hubiera evitado el CVP*".

Registros médicos

La *coherencia* entre los síntomas psiquiátricos y la terapia con medicamentos y la *justificación de la razón* de ser de cualquier cambio de la terapia con medicamentos siempre deben documentarse en el registro clínico.

Observaciones finales

Es necesario profundizar en lo anterior con el texto original (1) (alrededor de 560 páginas; 402 referencias bibliográficas) y con una Guía Psiquiátrica Forense abreviada (2) (85 páginas) que también contienen los principios que subyacen a la responsabilidad en el equipo, a la continuidad e interrupción de tratamientos, a prejuicios y emociones sobre el CVP, a la importancia de la victimología en la evaluación del CVP y a la calificación y confiabilidad de los expertos y consultores que deben evaluar la responsabilidad del psiquiatra. Además, lo anterior debe adecuarse a los contextos legislativos y jurisprudenciales nacionales específicos de aplicación, en el ámbito penal y civil, al caso clínico individual, a las especificidades del sistema nacional de atención psiquiátrica y a la indispensable actualización vinculada al avance de la ciencia a el conocimiento y a la evolución del derecho.

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Giacomo d'Andrea

Original article

Esketamine in treatment resistant depression: a study protocol for a retrospective, real-life, multicentric study

Giacomo d'Andrea[1], Mauro Pettorruso[1], Chiara Di Natale[1],Stefano Barlati[3], Giuseppe Maina[4], Andrea Fagiolini[5], Bernardo dell'Osso[6], Giorgio Di Lorenzo[7], Marco Di Nicola[8], Alessandro Bertolino[9], Antonio Vita[3], Giovanni Martinotti[1,2], Massimo di Giannantonio[1], the Esketamine Study Group*

[1] Department of Neuroscience, Imaging and Clinical Sciences, "G. d'Annunzio" University, Chieti, Italy; [2] Department of Pharmacy, Pharmacology, Clinical Science, University of Hertfordshire, Herts, UK; [3] Department of Clinical and Experimental Sciences, University of Brescia; Brescia, Italy; Department of Mental Health and Addiction Services, ASST Spedali Civili of Brescia, Brescia, Italy; [4] Rita Levi Montalcini Department of Neuroscience, University of Turin, Turin, Italy; [5] Department of Molecular and Developmental Medicine, Department of Psychiatry, University of Siena, Siena, Italy; [6] Department of Biomedical and Clinical Sciences L. Sacco, Department of Mental Health, University of Milan, ASST Fatebenefratelli-Sacco, Milano, Italy; [7] Psychiatry and Clinical Psychology Unit, Fondazione Policlinico Tor Vergata, Rome, Italy; [8] Department of Psychiatry, Fondazione Policlinico Universitario Agostino Gemelli IRCCS, Rome, Italy; [9] Department of Basic Medical Science, Neuroscience and Sense Organs, University of Bari Aldo Moro, Bari, Italy

Summary

Background. Major Depressive Disorder represents a global burden disease with highly heterogenous clinical features. Approximately 30-50% of patients do not respond to first-line therapies, experimenting treatment-resistant depression (TRD). Recently Esketamine, an innovative and rapidly-acting agent, has been approved for the management of TRD. Esketamine efficacy has been widely investigated in several trials, but real-world studies are needed to validate RCT results in clinical practice. Besides, there is an urgent need to investigate potential markers able to predict treatment response to Esketamine. **Methods.** We design a protocol for a multicentric, retrospective, observational and real-world study to evaluate efficacy, safety and tolerability of Esketamine nasal spray treatment in a clinical and non-experimental sample of TRD patient, speculating on possible TRD subphenotypes with high response rates to Esketamine treatment. Anamnestic data and Psychometric assessment (MADRS, HAMD, BPRS, BDI) related to three different stages will be considered: baseline (T0), 1 month (T1) and three months (T2) from the treatment beginning. **Discussion.** This study will provide a real-world experience of Esketamine use in a clinical sample of TRD patients from several Italian Mental Health Services. Clinical settings will give a real-world sample, possibly characterized by several differences from the experimental sample of esketamine RCT (with probably higher rates of co-occurrent disorders, substance abuse, longer illness duration and more heterogenous therapies administered). Furthermore, we

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Correspondence:
Giacomo d'Andrea
giacomo.dandrea1993@gmail.com

Conflict of interest
The Authors declare no conflict of interest.

* Esketamine Study Group:
Giuseppe Nicolò, Mauro Percudani, Roberto Delle Chiaie, Antonello Bellomo, Pasquale De Fazio, Alessandro Cuomo, Matteo Marcatili, Gianluca Rosso, Miriam Olivola, Stefania Di Mauro, Ileana Andriola, Vassilis Martiadis, Domenica Nucifora, Sergio De Filippis, Sandro Belletti, Andreas Conca, Chiara Mattei, Antonio Ventriglio, Alessandro Valchera, Maria Pepe, Francesco di Carlo, Rebecca Collevecchio, Alessio Mosca, Rosalba Carullo, Teresa Di Crosta.

will couple psychometric assessments, anamnestic data and clinical response to Esketamine to identify possible clinical markers predictor of response. Identify TRD subphenotypes with high response rates to treatment may represent a relevant scientific development, considering the urgent need of "tailored" therapies to overcome resistance in TRD.

Key words: Esketamine, Major Depressive Disorder, TRD, glutamatergic agents, real-world study

Background

Major Depressive Disorder (MDD) is a common psychiatric disorder that impairs psychosocial functioning and limits the quality of life of those affected. Currently, mood disorders determine significant costs, amounting to 113.4 billion euros in Europe, with 37% of direct costs related to psychiatric treatments and 63% related to indirect social costs [1]. Furthermore, WHO ranked MDD as the third largest cause of global health expenditure on disease and predicted that it will be the first by 2030 [2].

MDD is a highly heterogeneous diagnostic entity that includes various and recurrent symptoms with clinical manifestations that could be supported by different pathophysiological mechanisms. Over the years, the clinical heterogeneity of depression has led to different attempts to define clinical subtypes of MDD to improve the diagnosis and treatment of this disorder. To date, however, we are still far from a correct categorization of the depressive universe in all its different clinical manifestations and from a correct subtyping that takes into account the different neurobiological mechanisms underlying MDD. Due to the clinical heterogeneity of depression, approximately 30-50% of patients do not respond to first-line therapies, experimenting treatment-resistant depression (TRD) [3], defined as the absence of a clinical response to two antidepressants of appropriate dose and duration (≥ 4-6 weeks) [4].

An open question concerns the substrates underlying this clinical heterogeneity and high rates of TRD. Conventional antidepressant treatments target the monoaminergic systems, which are thought to be the neurobiological substrates of depression. According to this hypothesis, depressive symptoms are associated with dysfunction of the dopamine, norepinephrine, and serotonin systems [5]. However, the absence of a clinical response to conventional antidepressant in a consistent part of MDD subjects suggests that a non-monoaminergic etiology may underlie TRD [6].

In light of this, several studies have focused on the role of glutamatergic neurotransmission in depressive disorders as a potential therapeutic target in TRD [7,8]. Glutamate plays a crucial role in synaptic transmission and neuronal plasticity, being involved in brain areas implicated in mood and affectivity [7]. Several neuroimaging studies have shown significant reductions in glutamate levels in unipolar depression in the anterior cingulate cortex and parietal white matter [9-11]. Furthermore, glutamatergic activity is reduced in the dorsolateral prefrontal cortical area (DLPFC) and in the dorsomedial and ventromedial anterolateral prefrontal areas in patients with TRD [12].

Besides, some studies have found normal or increased glutamate levels in patients who were in remission after electroconvulsive therapy [13,14], suggesting that glutamate levels can be rebalanced by treatments with proven antidepressant efficacy [15,16].

The relevance of glutamatergic activity in TRD is also supported by the antidepressant action of molecules with glutamatergic activity such as ketamine, an NMDA receptor antagonist [17], widely investigated by several studies [18,19]. Ketamine, despite its efficacy, remains a complex treatment due to the challenging management of the intravenous formulation and the significant risk of side effects [20].

Given the evidence supporting the glutamatergic hypothesis, a new therapeutic option for the treatment of TRD has recently been approved by the Italian Medicines Agency (AIFA): Esketamine nasal spray.

Esketamine (the S-enantiomer) shows a NMDA antagonism stronger than ketamine itself [21] with lower side effects rates [22]. The antidepressant efficacy of esketamine has been demonstrated in several studies [23-25], with data indicating a remission rate greater than 50% in TRD [26]. A randomized clinical trial (RCT) showed significant improvement in depressive symptoms in patients treated with esketamine along with an oral antidepressant, lasting up to 52 weeks [26].

Esketamine also showed a favorable safety profile with few serious adverse events (less than 5%) in pivotal studies [22]. The most common adverse effects include dissociative symptoms (affecting between 11.1 and 31.4% of subjects in pivotal trials) [22], such as changes in body perception, depersonalization, and derealization [21].

Although previous findings show the good efficacy and tolerability of esketamine in TRD, real-world studies are needed to validate the results observed in RCTs in patients' samples from the general practice.

Furthermore, given the extreme clinical heterogeneity of both TRD and MDD, studies investigating clinical phenotypes, based on psychopathological and anamnestic data, more likely to respond to Esketamine are necessary. Finding valuable clinical markers of response to Esketamine would have a significant impact in clinical practice, reducing healthcare costs and limiting failed antidepressant trials.

Aims of the study

Considering previous evidences, the main aim of this study is:

- to evaluate efficacy of Esketamine nasal spray treatment in a clinical and non-experimental sample of TRD patients, estimating the reduction of depressive

symptoms at one month (T1) and at three months (T2), highlighting its safety and tolerability.

Secondary aims of the study are:

- to investigate clinical TRD subphenotypes more responsive to Esketamine through anamnestic data and psychometric scales, used in the clinical practice of TRD management, aiming to identify clinical markers predictive of response to Esketamine;
- to evaluate differences in remission rates (MADRS score < 10) in different clinical profiles of patients with TRD.

Materials and methods

This will be an observational, retrospective and multicentric study conducted on a sample of patients with TRD treated with Esketamine nasal spray on the recommendation of a psychiatrist and in compliance with the indications provided by AIFA and the common clinical practice of TRD management.

Several centers will be involved in this study: the coordinating centers will be the "G. d'Annunzio" University of Chieti and the University of Brescia.

Other centers involved will be: Cattolica del Sacro Cuore "A. Gemelli" University Hospital of Rome, "A. Moro" University of Bari, Tor Vergata University of Rome, "Milano Statale" University, "Milano Bicocca" University, University of Siena, "Magna Graecia" University of Catanzaro, University of Pavia, University of Torino, "Villa Maria Pia" Clinic of Rome, "Von Siebenthal" Clinic of Rome, ASL Frosinone, ASL Napoli 1, ASL Sud Tirolo, ASL Messina, ASL Umbria 2.

In this retrospective study, psychometric scales and clinical information will be analyzed in patients with TRD who already performed treatment with Esketamine Nasal Spray.

Clinical and psychopathological parameters related to three different stages will be considered: baseline (T0), 1 month (T1) and three months (T2) from the treatment beginning.

Inclusion Criteria

- Patients over 18 years of age.
- Patients with a Major Depressive Episode, undergoing at least two conventional antidepressant treatments in the absence of an adequate clinical response (TRD).
- Patients in treatment with an SSRI or SNRI.
- Patients for whom Esketamine nasal spray treatment has been considered appropriate, according to AIFA indications and common clinical practice of TRD management, regardless of the study.

Exclusion Criteria

Comorbid organic pathologies (untreated arterial hypertension, previous cerebro-vascular disorders) which represent an absolute contraindication to Esketamine according to AIFA.

Anamnestic data

Anamnestic data will be considered concerning aspects related to affective temperament, any previous manic or hypomanic episodes, family history for mood disorders, concomitant use or substance abuse, number of previous depressive episodes, duration of the current depressive episode.

Psychometric scales

The scales considered at times T0, T1 and T2 will be as follows:

- **Montgomery Asberg Depression Rating Scale** (MADRS-10 items): to assess the severity of mood disorders, concentration, physical condition, sleep disorders found in depressive states [27];
- **Brief Psychiatric Rating Scale** (BPRS-24 items): for an assessment of the global psychopathological condiction [28];
- **Hamilton Depression Scale** (HAM-D-21 items): to assess the severity and pervasiveness of depression;
- **Beck Depression Inventory** (BDI-21 items): self-administered scale consisting of 21 items to evaluate the subjective perception of depresive symptoms;
- **Hamilton Anxiety Scale** (HAM-A-21 items): to assess the severity of the anxious symptoms.

Sample size calculation and Statistical Analysis

Sample size was calculated using the G*Power software and the ANOVA: repeated measures, within factors test.

The sample size calculation will be based on an expected response to Esketamine of 40%, in line with previous findings, considering a significance level of 0.05% and a power of 95%, and with the hypothesis of a premature dropout or a non-initiation of the treatment of 20% of the patients, considering the non-experimental sample. Thus, the estimated sample size will be n = 100.

Statistical analyses will be performed using SPSS 20.0 software (SPSS Inc., Chicago, IL, USA). All tests will be two-tailed, with a statistical significance level set at $p < 0.05$.

Pearson's t-tests for continuous variables and $\chi 2$ tests for categorical variables will be performed. The comparison of psychometric data in the different stages (T0, T1 and T2) will be performed with a t-test for paired samples.

For the identification of predictors of efficacy, change in clinical rating scale scores (response/remission) between the different stages (T0, T1 and T2) will be considered as a dependent variable. Potential predictors (clinical and demographic characteristics, baseline scores and change in clinical measures) will then be included in a multiple regression analysis. Based on clinical and anamnestic data, possible stratification of the sample into different groups will be evaluated, and differences in response and remission between these groups will be assessed through t-test analysis for independent samples.

Ethical considerations

The study will be conducted in accordance with the ethical principles stated in the Helsinki Declaration (2013) [29]. The local ethics committee will examine all documentation to safeguard the rights and confidentiality of the subjects. The protocol and the documentation relating to this study and any revisions of these documents will be used only with the authorization of the local ethics committee.

Discussion

In recent years, new trends in psychiatry have focused on finding innovative and rapidly-acting tools to counteract TRD, considering the global economic and health burden of this disease, with large direct and indirect costs for those affected and their caregivers [30,31].

The rapid onset and the easy way of administration of Esketamine, together with a good safety profile, has determined its recent approval by FDA, EMA and AIFA as therapeutic tool for TRD. Several RCT have shown its antidepressant efficacy when administered together with an oral SSRI/SNRI [23-25], showing a symptoms' remission rate higher than 50% in TRD patients [26].

However, despite the availability of different experimental trial about Esketamine efficacy on TRD, there is a lack of studies conducted in a clinical and non-experimental setting. In this observational, retrospective and multicentric study, we aim to evaluate the efficacy, safety, and tolerability of Esketamine in a clinical sample of TRD patients from different Italian Mental Health Services. Our goal is to provide a *real-world* experience of Esketamine to better understand its efficacy and safety profile, investigating both mild and serious adverse effects' rates. We will focus on possible risk of manic/hypomanic switches, intensity of dissociative symptoms, evaluating the drop-out rates in a clinical and non-experimental settings. Clinical setting will provide a *real-world* sample, possibly characterized by several differences from the experimental sample of esketamine RCT (with probably higher rates of co-occurrent disorders, substance abuse, longer illness duration and more heterogenous therapies administered).

The secondary aims of our study are in line with the urgent need of "tailored" therapies in the psychiatric field. Clinical markers predictor of response represents an important matter, in particular for TRD, a widespread disease with high economic and social burdens. Considering this, we will investigate any relationship between anamnestic data (e.g. time from disorder onset, episode duration, years of disease, number of episodes, affective temperaments, co-occurrent substance use, comorbidity with other psychiatric disorders) and clinical effectiveness of Esketamine. Besides, possible relationship between type of antidepressant molecules and add-on therapies (SSRI, SNRI, other antidepressants, mood stabilizers, antipsychotics) and clinical efficacy of Esketamine will be assessed.

Predicting esketamine efficacy and create data-driven TRD subtypes based on clinical features would have a significant impact in clinical practice, reducing costs in terms of healthcare expenditure and the average risk of failed trials.

Conclusions

This study will provide a real-world experience of esketamine use in the context of Italian mental health services, highlighting the external validity and clinical practice utility of this novel, rapidly acting tool for TRD. Investigating the use of esketamine in a real-world sample of patients may help to better clarify its clinical efficacy and safety profile, and help clinicians identify patient populations that are more likely to experience positive outcomes following esketamine administration, with significant implications for reducing costs and improving TRD treatments.

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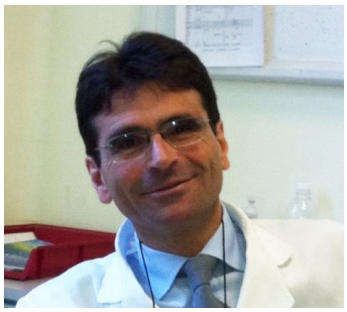
Gender dysphoria and psychiatric comorbidity: a ten-years descriptive study

Anna Gualerzi[1], Flavia Capirone[1], Claudia Schettini[1], Fabrizio Bert[2], Vincenzo Villari[1], on Behalf CIDIGEM

[1] Psychiatric Unit-CIDIGEM, Department of Neuroscience and Mental Health;
[2] Department of Public Health and Pediatric Sciences, AOU City of Health and Science of Turin, Italy



Vincenzo Villari

Summary

Objectives. Despite being recognized as an unfavourable prognostic factor for Gender Affirming Therapy (GAT) and for long-term psychosocial adjustment in gender dysphoria (GD), coexisting psychiatric disorders has rarely been assessed with standardized diagnostic instruments. This study aims to investigate sociodemographic features and to assess current and lifetime psychiatric coexisting disorders in subjects diagnosed with GD.

Methods. Our sample was composed by subjects attending CIDIGEM – a Public Health Service for GD people in Turin, Italy – in order to enter the programme for gender affirming therapy, from January 2005 to October 2015. All subjects fulfilled the criteria for GD according to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR/DSM-5). All subjects underwent an accurate diagnosis about their gender disorder, in order to investigate the coexisting mental health concerns and to distinguish these from gender dysphoria for ascertain eligibility and readiness for hormone and/or surgical gender affirming therapy. All patients have been comprehensively evaluated independently by two mental health professionals, competent to work with GD adults, via psychological and psychiatric interviews and particularly with Semi-Structured Clinical Interview (SCID I and SCID II) and Global Assessment Functioning (GAF). Statistical analysis was conducted using SAS ver 9.3 Istitute Inc., Cary, NC, USA. Between-group comparisons of categorical variables were performed using chi-square analysis. The significance level was set at $p < 0.05$.

Results. In 10 years of clinical activity, a consecutive series of 462 patients referred to CIDIGEM in Turin (Italy) from January 2005 to October 2015 in order to enter the program for gender affirming therapy. Two hundred and ninety-eight subjects fulfilled the criteria for Gender Dysphoria and were enrolled in the study with their written informed consent. Among the 298 subjects enrolled in the study, 201 (67.45%) and 97 (32.55%) met the criteria for MtF and FtM GD, respectively. The MtF:FtM sex ratio was 2.07:1. The mean age at the first access to our clinic was 32.27 ± 10.78 years.

We have found differences among the socio-demographic features analyzed in the two subgroups (MtFs, FtMs), such as sex ratio, but in age, family relationships, sexual orientation, history of prostitution and sexual abuse they were statistically significant ($p < 0,05$). A positive correlation was found between higher rate of prostitution, older age and lower level of education. A positive history of psychiatric comorbidity diagnosis according to DSM (N = 298) was found in 55.03% (N = 164) of subjects. In the current anamnesis, instead, we found that 49.66% (N = 148) of the sample was referable to axis I disorders and 18.79% (N = 56) to axis II, above all cluster B disorders. A comparison of the distribution between past and current Axis I anamnesis showed that anxiety, mood disorders and adjustment disorders were the most represented. We used the Global Assessment of Functioning (GAF), a numeric scale, to evaluate the social functioning and the majority of subjects (N = 203/297, 68.35%) were functioning above 61 or had some weak symptoms. No statistically difference has been found between MtFs and FtMs. In our sample the current presence of psychiatric diagnosis was a contraindication to Gender Affirming Surgery (GAS) only in 0.50% of MtFs, while in 16.10% of MtFs and in 13.19% of FtMs it was necessary to use caution and strengthen the mental health monitoring of these subjects.

Conclusions. According to our data GD is an indipendent clinical condition and according to some authors we regard GD as a nosological entity and assume psychiatric

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Correspondence:
Vincenzo Villari
vvillari@cittadellasalute.to.it

Conflict of interest
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comorbidity as a consequence of the persistent gender dysphoria. We found a higher levels of Axis I and II psychiatric coexisting disorders in patients with a GD diagnosis than the general population. Psychiatric coexisting disorders are often connected to minority stress related to gender dysphoria as a psychological reaction to GD condition, and they are almost never a controindication for gender affirming therapy, if the patient is under good psychopathological control. Several hypotheses could explain this result. Mental health professionals working in gender unit like CIDIGEM are formed to investigate and take care of coexisting psychiatric disorders, given their prognostic impact. This could be explained by our assessment methods which were conducted with standardized diagnostic instruments and also by the sensitivity of the professionals: they were able to identify and eventually treat subthreshold disorders in order to improve them. Our sample does not represent all trans people and ours results have to be interpreted prudently. Finally, our data are in accord with WPATH International Standards of Care that state: "When mental health concerns are present, it must be well controlled before hormone and surgery therapy".

Key words: gender dysphoria, gender identity disorder, psychiatric disorders

Introduction

Sexual identity is a multidimensional construct that encompasses four elements: biological sex, gender identity, gender role and sexual orientation. Biological sex is the sex assigned at birth, refers to one's biological status as either male, female or intersex, while gender identity refers to a person's internal sense of being male, female or some category other than male or female. When one's gender identity and biological sex are not congruent, the individual may identify along the transgender spectrum [1,2]. In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders - DSM-5 [3], Gender Dysphoria (GD) is defined as a condition characterized by a marked incongruence between one's experienced/expressed gender and the assigned one, and is associated with clinically significant distress. Previous term for GD was Gender Identity Disorder in DSM-IV-TR [4]. A person whose assigned sex at birth is female but has a male gender identity is a transman (also known as female-to-male or FtM), conversely a transwoman is a person whose assigned sex at birth is male but has a female gender identity (also known as male-to-female or MtF).

In adults with GD, the discrepancy between experienced/expressed gender and sex assigned at birth is often accompanied by a desire to be rid of one's primary and/or secondary sex characteristics and/or a strong desire to replace one's primary and/or secondary physical sex characteristics with those of the other gender. According to the literature, GD is a very complex clinical condition that can not be explained by one single cause [5-8]. Following the biopsychosocial model, GD results of complex interaction between several features like genetic, hormonal and psychological factors [9-12]. The nature of these interactions is not completely understood.

Since these studies have relied on clients seen by gender identity specialists or clinics, it has been argued that the true prevalence of GD (transsexualism) could be underestimated because it is difficult to get an accurate estimate of GD prevalence due to several bias: social tolerance of GD depend on country and studies largely consider hospitaliers cohorts but not all affected individuals might seek out care at specialized centers [13]. In a recent meta-analysis regarding prevalence studies for gender dysphoria, the overall prevalence was reported as 1:14705 for MtFs and 1:38461 for FtMs [14]. According to many authors, the number of individuals with gender dysphoria (GD) has increased over the years in western countries [14-16]. As example, K.J. Zucker [17] highlights an increase in the prevalence of gender dysphoria in adulthood. In the past, sex-ratio was in favour of transwomen but in the last few years, many authors observe a rise of transmen asking for affirming care [18-22]. In recent years, indeed, an increase in FtMs has been observed, with two countries showing a clear inversion of the sex ratio with a prevalence of FtMs: Japan (2.2:1) and Poland (3.4:1) [3,18,23].

GD people that want to comply sex assigned at birth with the perceived gender identity and ask help to healthcare services undertake a transitioning pathway regulated by specific legislation. In Italy, since 1982, according to the Law n. 164/1982 and jurisprudential developments, trans people can undergo gender affirming surgery. In the past, surgical operation was necessary to get identity card change. Since 2015, thanks to the ruling Pronunciation n. 221/2015 of the Constitutional Court, trans people can get name change even without hormonal and/or surgical therapy. However, the Constitutional Court reiterates the importance of the seriousness and irreversibility of the path chosen by the individual and a local court must confirm through rigorous technical investigations the completion of the transitioning process. The high complexity of transitioning process requires not only a specific legislation but also a global and personalized clinical approach in specialistic centers. In Piedmont, Italy, the clinical center dedicated to transitioning pathways of GD subjects is named CIDIGEM (Centro Interdipartimentale Disturbi Identità di Genere Molinette), whose operating protocol is based on international guidelines among which the seventh version of the World Professional Association for Transgender Health (WPATH) Standards of Care [24] and national guidelines [25].

CIDIGEM is a multidisciplinary gender team, made up of psychologists, psychiatrists, endocrinologists, urologists, plastic surgeons, gynecologists and members of the ONIG (Osservatorio Nazionale sull'Identità di Genere), the National Observatory on Gender Identity. In particular, psychologists and psychiatrists are involved in providing and supporting GD people mental health care.

In the past, GD was considered by some authors to be part of an underlying psychiatric comorbidity, namely borderline personality or psychotic disorder [26,27]. Other authors considered GD as a nosological entity and assumed psychiatric comorbidity as a consequence of the persistent

gender dysphoria and the concomitant psychosocial distress [28-30]. People presenting with gender dysphoria may struggle with a range of mental health concerns [31-32]. A literature review published on 2016 show that the prevalence of psychiatric disorders in GD people is higher than general population [33].
The most frequent psychiatric disorders in GD people are anxiety and mood disorders. It is important to point out that suicide risk is significantly higher in trans people than in general population. While psychiatric coexisting disorders tend to decrease and to reach the general population level after gender affirming cares, suicide risk for transgender remains relevant [13,34,35].
There is a lack in the scientific literature about the co-existence of GD and mental health issues in Italian transgender population. This study aims then, thanks to CIDIGEM experience, to:

- investigate sociodemographic features of the GD sample assisted by CIDIGEM;
- assess current and lifetime prevalence of psychiatric comorbidity on Axes I and II in subjects diagnosed with Gender Dysphoria (GD).

Methods

A cross-sectional study was performed in order to recruit all the patients who referred to CIDIGEM from 2005 to 2015 and fulfilled the inclusion criteria. The first criterion of inclusion was meeting the GD requirements according to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR/DSM-5), while the second one was to have not yet undergone any genital surgery as gender affirming therapy.
According to national ONIG and international WPATH standards of care, all the patients underwent an accurate diagnosis about their gender disorder, in order to investigate the coexisting mental health concerns and to distinguish these from gender dysphoria for ascertain eligibility and readiness for hormone and/or surgical gender affirming therapy.
All patients have been comprehensively evaluated independently by two mental health professionals, qualified to work with adults with GD diagnosis, via psychological and psychiatric interviews, and all the data were collected as part of the clinical and psychodiagnostic routine procedure. Socio-demographic features have been assessed by analyzing patient medical records. We collected socio-anagraphic data, medical history, including patient's medical issues, past surgical history, family medical history, social history and medications, psychosexual development, sexual activity and habits. The presence of coexisting psychiatric disorders has been evaluated via Semi-Structured Clinical Interview for DSM-IV (SCID I and SCID II) [36,37] to assess axis I and axis II disorders.
Since this study enrolled patients from 2005 to 2015, we decided to keep this subdivision in order to compare our data with previous studies in literature where psychiatric comorbidity was still assessed as axis I and axis II disorders.
We used the Global Assessment of Functioning (GAF) [38] to evaluate the social functioning. GAF is a numeric scale used by mental health clinicians to rate subjectively the social, occupational, and psychological functioning of an individual. Scores range from 100 (extremely high functioning) to 1 (severely impaired).
This study has been approved by the Ethics Committee Intercompany AOU Città della Salute e della Scienza of Turin - AO Order Mauriziano - ASL "City of Turin" on 5 March 2018 (file no. CS2 / 579). Written informed consent was obtained from each participant.

Statistical analysis

Statistical analysis was conducted using SAS (vers. 9.3 Institute Inc., Cary, NC, USA). Frequencies are expressed using percentages for categorical variables and mean ± SD (standard deviation) or median (Interquartile range) for continuous variables. Between-group comparisons of categorical variables were performed using chi-square analysis. The significance level was set at $p < 0.05$.

Results

In 10 years of clinical activity, a consecutive series of 462 patients referred to CIDIGEM in Turin (Italy) from January 2005 to October 2015 in order to enter the program for gender affirming therapy. Two hundred and ninety-eight subjects fulfilled the criteria for Gender Dysphoria and were enrolled in the study with their written informed consent. Among the 298 subjects enrolled in the study, 201 (67.45%) and 97 (32.55%) met the criteria for MtF and FtM GD, respectively. The MtF:FtM sex ratio was 2.07:1. The mean age at the first access to our clinic was 32.27 ± 10.78 years. MtFs were significantly older than FtMs (mean age 33.61 ± 10.98 years *vs* 29.47 ± 9.85 years; $p = 0.002$). The average number of new cases per year was 42.
The 63,85% (N = 190) of the subjects underwent all the diagnostic-therapeutic process at CIDIGEM from diagnosis to hormone and/or surgical treatments, while 25% (N = 74) of GD patients were already diagnosed in other dedicated centers and referred to CIDIGEM only for the Gender-Affirming Therapy, finally 11.15% (N = 34) had a mixed process. Regarding country of birth, 8.05% (N = 24) were from non-EU countries, while 87.92% (N = 262) were Italian natives. The 61% (N = 184) live in Northern Italy. No significant differences were found between the two subgroups (MtFs vs FtMs; $p = 0.08$).
The main sociodemographic features of the sample are reported in Table I.
No statistically significant differences between MtFs and FtMs were observed with regard to average educational level, relationship and parenthood. In particular, average educational level was 11.34 ± 3,29 years, 70.61% (N = 209) of the subjects were employed and only 3.72%

Table I. Characteristics of the sample, n (%).

	Tot n = 298	MtF (n = 201)	FtM (n = 97)	p-value
Education level (years)	11.34 ± 3.30	11.24 ± 3.30	11.57 ± 3.27	0.422
Occupation, n (%)				0.040
Employed	209 (70.61)	133 (66.50)	76 (79.17)	
Unemployed	69 (23.31)	50 (25.00)	19 (19.79)	
Retired	7 (2.36)	7 (3.50)	0 (0.00)	
Sex Worker	11 (3.72)	10 (5.00)	1 (1.04)	
Adopted, n (%)	8 (2.71)	-	-	-
Civil Status n (%)				0.378
Single	197 (66.55)	127 (63.82)	70 (72.16)	
Stable Relationships cohabitation	77 (26.01)	54 (27.14)	23 (23.71)	
Married	18 (6.08)	15 (7.54)	3 (3.09)	
Separed-Divorced	4 (1.35)	3 (1.51)	1 (1.03)	
Parenting n (%)	11 (3.69)	-	-	-

(N = 11) were sex workers. The 66.67% (N = 198) of the patients were not in any type of relationship, while 3.69% (N = 11/298) had biological children; 2.71% (N = 8/295) of subjects were adopted.

Conversely we have found significant differences in the two subgroups (MtFs, FtMs) in sexual orientation ($p < 0.001$), absence of family relationships ($p = 0.023$), history of prostitution ($p < 0.001$) and sexual abuse ($p = 0.006$).

Regarding sexual orientation (N = 298), sexual attraction exclusively toward same genotypic sex is the most prevalent. Then heterosexuality, according to their gender identity, is the prevalent sexual orientation ($p < 0.001$). The 86.57% of MtFs (N = 174) are attracted to males and 4.98% (N = 10) to female, while FtMs are frequently attracted to women (86.60%, N = 84) with 6.19% (N = 6) presenting homosexual orientation ($p < 0.001$). Bisexuality is declared in 6.47% (N = 13) and 7.22% (N = 7) for MtFs and FtMs, respectively, while 1.99% (N = 4) MtFs and 0.00% (N = 0) FtMs are attracted to neither males nor females.

Regarding psychosocial history (N = 283), the comparison between MtFs and FtMs was statistically significant in both history of sexual abuse and prostitution. In particular, 12.11% (N = 23) MtFs *vs* 2.15% (N = 2) FtMs had a positive history of sexual abuse ($p = 0.003$); while 25.26% (N = 49) MtFs *vs* 1.08% (N = 1) FtMs had a positive history of prostitution ($p < 0.001$). A positive correlation was also found between prostitution and older age (OR 1.03; CI95% 1.01-1.06, $p = 0.036$) and lower level of education (OR 0.31; CI95% 0.19-0.51; $p < 0.001$), meaning a positive history of prostitution had a higher probability to be observed in older patients presenting low educational level.

Family relationships were divided in 3 categories: good relationships, conflicting relationships and no family connections. Good family relationships were the most represented and were comparable between subgroups (63.00%, N = 126 MtFs; and 63.83%, N = 60 FtMs). Conflicting relationships were higher in FtMs (30.85%, N = 29 vs 22.50%, N = 45), while no family connections were reported in 11.00% (N = 22) of MtFs and in 3.19% (N = 3) of FtMs.

A positive history for suicide thoughts/attempts has been found in 34/193 patients (17.62%), while a positive history of psychiatric hospitalization in 12 subjects (4.03%).

A positive history of psychiatric comorbidity diagnosis according to DSM (N = 298) was found in 55.03% (N = 164) of subjects. In the current anamnesis, instead, we found that 49.66% (N = 148) of the sample is referable to axis I disorders and 18.79% (N = 56) to axis II. A comparison of the distribution between past and current Axis I anamnesis showed that anxiety, mood disorders and adjustment disorders are the most represented (Fig. 1).

Among current Axis I disorders the distribution of specific disorders was:

- anxiety disorders in 70.47% (N = 105/149), in particular 16.19% (N = 17) is Generalized Anxiety Disorder (GAD), 23.81% (N = 25) is Panic Disorder and 4.76% (5) is anxiety caused by substances abuse;
- mood disorders in 52.70% (N = 78), in particular major depression in 26.92% (N = 21) and bipolar disorder in 5.13% (N = 4);
- adjustment disorders in 38.67% (N = 58);
- substances related disorders in 27.33% (N = 41), with 92.68% (N = 38) consuming occasionally cannabinoids

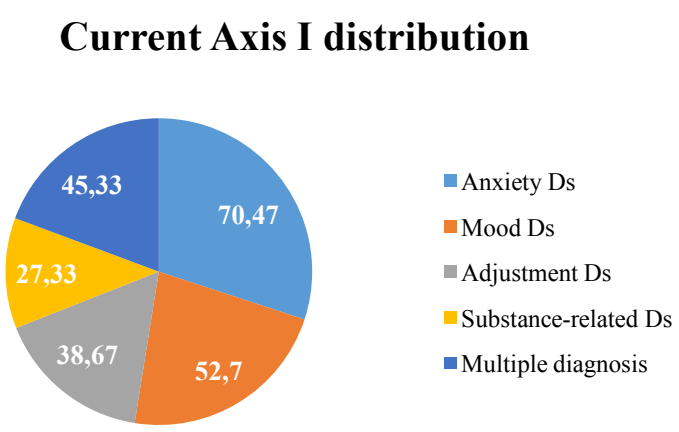

Figure 1. DSM Axis I diagnoses of GD subjects (n = 148).

or alcohol before to start the gender affirming therapy;
- more than one diagnosis in 45.33% (N = 68).

We also found that 4.67% (N = 7) of the subjects had eating disorders while schizophrenia and other psychotic disorders were found to be irrelevant (2.67%, N = 4).

Axis II psychiatric comorbidities are related to personality disorders (N = 64/297, 21.5% of the sample). The cluster A personality disorder was found in 5 patients (7.81%), a cluster B diagnosis in 35 patients (54.59%), a cluster C diagnosis in 11 patients (17.19%) and a personality disorder not otherwise specified in 13 patients (20.31%), as shown in Figure 2. Thus, 233 patients (78.45%) have no personality disorder comorbidity.

The global assessment of psychological, social and occupational functioning (GAF) found that the majority of subjects (N = 203/297, 68.35%) are functioning above 61 or have some weak symptoms.

In our sample the current presence of psychiatric diagnosis was a contraindication to Gender Affirming Surgery (GAS) only in 0.50% of MtFs, while in 16.10% of MtFs and in 13.19% of FtMs it was necessary to use caution and strengthen the mental health monitoring of these subjects.

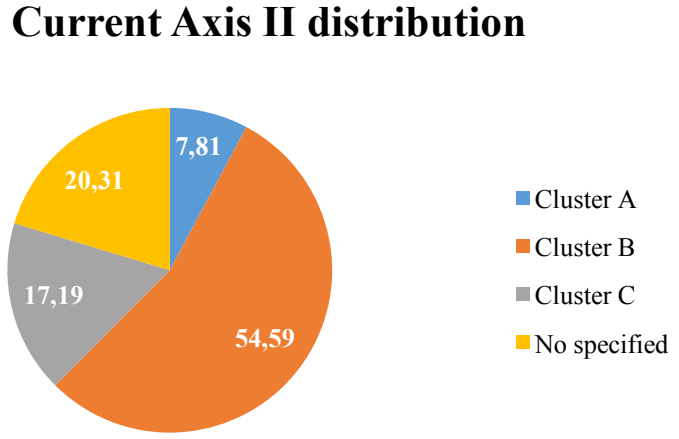

Figure 2. DSM Axis I diagnoses of GD subjects (n = 148).

Discussion and Conclusions

Our cross-sectional study aimed to investigate sociodemographic features of a Gender Dysphoria sample of patients assisted by the CIDIGEM center of Turin (Italy) and to assess in the same sample the current and lifetime prevalence of psychiatric comorbidities on Axes I and II.

Our sample cannot represent all trans persons, but only the GD subjects, seeking for professional treatment, according to standards of care.

We have found significant differences between the two subgroups (MtFs, FtMs) in terms of sociodemographic characteristics except psychiatric comorbidities and social functioning. Our data confirm those of the literature with respect to the ratio MtFs *vs* FtMs: literature ratio = 2.5:1 (CIDIGEM ratio = 2.07:1) [14]; also agreeing with a previous study involving 140 GD subjects enrolled from several Italian dedicated centers (sex ratio = 1,9:1) [39].

Further studies confirming the inversion of the sex ratio in favor of FtM subjects have emerged in the last year. A study conducted in Asturias analyzed a sample of 42 adolescents up to the age of 18 between 2016 and 2019, finding a sex ratio of 2:1 in favor of transmen, who also made up the majority (93%) of service seekers in the 2018, the year of greatest attendance to the Gender Identity Treatment Unit [40].

A study conducted in Germany, which collects clinical data from a sample of 350 patients in the period between 2009 and 2017, found a sex ratio of 1:1.89 in favor of FtM subjects for the first time compared to studies conducted previously, with a significant increase in transmen starting from 2013. In this study there is also a greater satisfaction in transmen to the results of hormonal therapy, with a 100% for transmen *vs* 96% for transwomen [41].

Positive social history of prostitution and sexual abuse was almost exclusively present in the transwomen subgroup. We found a significant relation among prostitution, age and level of education. Prostitution was higher in the older and less educated transwomen people. Transmen subgroup in our sample showed more frequently conflicts in their relationships with the family, while transwomen more often declared to have no contacts with the family. Probably, the social (and familiar) stigma is more evident for transwomen since their feminine characteristics and behaviours are less acceptable and often associated to prostitution and then source of shame for the family of these subjects. In some way, we can confirm a previous study of Fisher AD et al. who claimed that FtMs display better social functioning [39]. Social stigma and conflicts or no contacts with family can be acknowledged as potential source of minority stress in transgender people [42].

Our data on Current Axis I diagnoses are higher than those found in several (but not all) studies described in the international literature [28,39,43-47]. Few articles in literature reports levels of current psychiatric Axis I comorbidity similar to those reported by us [48,49].

Our data showed Axis I psychiatric comorbidities mainly

related with mood, anxiety disorders and adjustment disorders as confirmed in previous studies [28,43,50]. Subjects used drugs only occasionally and most of these were soft drugs and the subjects did not show any kind of dependence. It is very interesting to observe how these disorders are mild and not severe and they do not impede the subject from following the gender affirming process. A possible reason of that is our tendency to explore and eventually treat subthreshold anxiety and mood symptoms too, in order to achieve a better clinical outcome.

Our data show a lower percentage of psychiatric comorbidities on Axis II than that found in literature, but according to literature, they confirm the presence of personality disorders in the GD population. In particular Cluster B have been identified as the most frequently diagnosed among Axis II disorders [28,47,50-52].

According to our results and to some authors [28,29,44], we consider GD as a clinical condition that does not associate with severe psycopathology and it thus can be considered independent.

For us, the psychiatric comorbidity is often a psychological reaction to GD condition, and it almost never forbids Gender Affirming Surgery, if the patient is under good psychopathological control.

This follows the 2011 WPATH International Standards of Care that state: "When Mental Health concerns are present, it must be well controlled before hormone and surgery therapy". When gender dysphoria coexists with severe psychopathological conditions such as psychosis, these conditions must be compensated by using psychotropic medication and/or psychotherapy prior to gender affirming therapy. No surgery should be performed while a patient is actively psychotic [53].

This study assessed the psychiatric comorbidities in GD subjects, further studies are necessary, especially in order to evaluate – using standardized diagnostic instruments – if psychiatric comorbidity might influence the post GAT outcome. In this regard, another research of CIDIGEM, not yet published, have investigated the impact of psychiatric coexisting disorders on post-surgical outcome, considering their impact on different features like sexual satisfaction and quality of life after surgery.

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Original article

Preventive strategies in gambling disorder: a survey investigating the opinion of gamblers in the Lazio region

Giovanni Martinotti[1,2], Francesco Di Carlo[1], Antonio Tambelli[1], Ottavia Susini[1], Debora Luciani[1], Rolando Tucci[1], Giulia Stefanelli[1], Monica Santangelo[1], Daniele Di Battista[1], Virginia Faiola[3], Maria Luisa Carenti[4], Pietro Casella[4], Enrico Zanalda[5], Mauro Pettorruso[1], Massimo Di Giannantonio[1]

[1] Department of Neuroscience, Imaging and Clinical Sciences, "G. d'Annunzio" University, Chieti, Italy; [2] SRP Villa Maria Pia, Mental Health and Addiction Inpatient Unit, Rome, Italy; [3] Sportello Adolescenza "T'ascolto Bro", Fondi, Latina; [4] Department of Mental Health and Addiction Services, ASL RM1, Rome, Italy; [5] Department of Mental Health, Azianda Sanitaria Locale (ASL) TO3 & Azienda Ospedaliera Universitaria (AOU) San Luigi Gonzaga, Orbassano, Italy, SIP, Società Italiana di Psichiatria

Summary

Background. Gambling disorder is an increasing phenomenon around the world. In Italy, its prevalence is about 1.01%. To date, many international governments have adopted restrictive measures to contain and prevent the transition from social to problematic behaviours and psychopathological consequences, but further evaluation is needed. Because of the poor effectiveness of the gambling restrictions policies, the aim of this observational, cross-sectional study was to explore both gamblers' and mental health professionals' opinions about prevention strategies for gambling disorder.

Methods. A specific questionnaire was formulated by experts from the Italian Society of Psychiatry (SIP) and widely disseminated. The only inclusion criterion was to have gambled at least 5 times in the last year on sports betting, poker, online games, or slots. The questionnaire was disseminated online, in gambling halls, and in outpatient and inpatient units. Data from clinicians dealing with gambling disorder were collected through a different questionnaire formulated by SIP experts and disseminated through an online survey.

Results. A total of 250 people fulfilled the inclusion criterion and were included in the study. The evaluated sample included 75 pathological gamblers (PG), 58 problematic gamblers (PrG) and 117 non-pathological gamblers (NPG) according to the SOGS assessment tool. Opinions of the subjects were differentiated according to the answers given as rational, NPGs, PrGs, or PGs. Differences between the three groups with respect to opinions were not significant apart from a proposal regarding the possibility of inserting betting limits based on the time interval of a "game" (negative opinions: PG, 61.1%; PrG, 38.5%; NPG, 41.1%), limitations of opening hours for gambling halls (negative opinions: PG, 64.2%; PrG, 48.7%; NPG, 48.2%), and the establishment of minimum distances between gambling halls and meeting centres (negative opinions: PG, 62.2%; PrG, 50.0.5%; NPG, 43.2%). The opinions of professional workers (psychiatrists, psychologists, psychiatric rehabilitators) confirmed the relevance of exclusion registers.

Discussions. The most desired proposal was the creation of exclusion registers determined by the gamblers themselves (self-exclusion registers), by the patients' relatives, or even by the mental health operators. Other possible measures concerned revising the gambling parameters of devices in order to direct individuals at risk to the network of territorial care services and to improve

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Correspondence:
Giovanni Martinotti
giovanni.martinotti@gmail.com

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psychoeducation. Applying the results of neuroscience research dealing with addiction is necessary to assess the impact of the most diverse measures adopted, with the goal of establishing at an early stage the strategies aimed at effectively identifying vulnerable individuals at risk of addiction.

Key words: gambling disorder, prevention, treatment

Introduction

Gambling disorder is the only behavioural addiction included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) under the category "Substance-Related and Addictive Disorders" [1] The characteristic of gambling disorder is a maladaptive gambling behaviour, persistent and recurrent, that modifies the personal [2,3] and/or professional life of the patient [4]. The severity of the disorder can be mild, moderate or severe.

Many works have studied the prevalence of adult problem gambling in recent years. Extended gambling availability and participation have been connected with significant increases in the prevalence of gambling disorder, associated comorbidities and other gambling-related problems. Globally, prevalence ranges from 0.2% to 5.3% in adult populations. This number increases twice or three times when considering people experiencing subclinical problematic gambling [2]. The countries with the highest prevalence are the US (0.4-0.6%), UK (0.6-0.9%), Germany (0.2-0.6%), Australia (0.5-2.0%) and Hong Kong (1.8%) [5].

The Italian situation was surveyed by Barbaranelli et al. in 2013 with a sample of 1,979 people. The prevalence of gambling disorder was about 1.01%, as evaluated by the South Oaks Gambling Screen (SOGS) and the Problem Gambling Severity Index (PGSI) [3] Lotteries were the most played games, but the percentage of people involved in online gambling at least once was much more restricted. According to an approximate estimate, the money used for gambling ranged from 0.5 to 2,300 euros per year. People began to gamble at a mean age of 27, but there was a small percentage (8%) who started to gamble under the age of 18. A quarter of gamblers had a parent who gambled regularly, and about 6% had a problematic gambler as a parent. People who had other family members who gambled regularly made up 48% [3].

In recent years, problematic gambling has been increasingly considered a public health concern, and governments have tried to regulate it, promoting responsible gambling and providing assistance to problematic gamblers. Prevention strategies play a crucial role in reducing gambling-related harm, both for the general population and for at-risk or problematic gamblers. As demonstrated by recent reviews, the strategies of governments and the gambling industry have generally failed to reduce gambling damage. Although a number of measures seem to have some efficacy, they are not supported by sufficient evidence-based data, and the most commonly implemented interventions are often the least effective [2]. According to recent studies, demand reduction interventions, which are mainly focused on risk awareness, have been found to have limited effects. Conversely, one of the most effective strategies seems to be restrictions on smoking and alcohol inside game rooms [6].

To date, the European Parliament has not established specific regulations to intervene in gambling problems. However, between 2013 and 2014, interventions were legitimized in the member states in order to protect consumers, regulate online gaming and reduce the gambling phenomenon among minors. In Germany, self-exclusion lists are widespread in the territory and managed by Germany's State Treaty on Gambling. In Spain, a dedicated register lists everyone who voluntarily excludes themselves. In both countries, self-exclusion lists have emerged as an effective prevention strategy [7]. In the UK, the Gambling Commission is a non-departmental public executive body of the government that it is responsible for regulating gambling and supervising gaming law. The Gambling Commission also monitors the percentage of pathological and non-pathological gamblers. Their BeGambleAware project provides advice for responsible gambling, a smartphone app to supervise a personal budget, a social media interface that hides gambling advertising, and the Gambling Therapy app that provides cognitive-behavioural therapy (CBT) support. In addition, other free of charge services, including a national helpline, London Problem Gambling Clinic and Game Care, are available to support people with gambling-related problems [8,9].

Because gambling is legal under US federal law, each state is free to regulate or prohibit the practice within its borders. Online gambling has been more strictly regulated: The Unlawful Internet Gambling Enforcement Act of 2006 (UIGEA) outlaws financial transactions involving online gambling service providers [10] In Australia, since the introduction of new gambling services, including online gambling, the Commonwealth has taken a more active role, and the Australian gambling industry is also regulated by state and territory authorities [11]

In Italy, since 2012, many strategies have been implemented through Decreto Balduzzi [12] (Legge 189/2012), such as including gambling disorder in essential medical assistance levels (LEA), establishing a national gambling observatory, and prohibiting entry for minors in gambling areas. The "Distanziometro" is a restrictive measure to relocate gaming areas 300 or 500 meters away from sensitive places such as educational institutions of all levels, residential or semi-residential facilities in the health or socio-medical field, places of worship, accommodation facilities for protected categories, youth gathering places, sports facilities and oratories. Other restrictions have been introduced through the Decreto Dignità [13] (Legge 96/2018), such as obligatory health insurance cards and specific opening times to access gambling areas,

absolute prohibition of gambling advertisements, and removal of non-standard equipment.
However, there are still doubts about the effectiveness of these restrictions. The prohibitionist approach that many states have adopted does not seem to reduce the gambling phenomenon. PGs are less sensitive to externally imposed limitations, considering psychobiological dysregulation, and most gamblers can easily decide to choose another gambling area farther away. Moreover, the ban on gambling in urban areas could paradoxically favour pathological gambling (stigma), and online gambling could even be increased [14]. Furthermore, most of the intervention strategies to tackle gambling disorder have been proposed by experts or determined by political needs, without taking into consideration the opinions of the gamblers themselves and of the professionals who have direct contact with them.
To fill this gap, the primary aim of the present study was to directly ask gamblers, divided into different levels of gambling severity, what preventive measures they would consider to be useful for reducing the impacts of gambling disorder. The secondary aim was to ask professional workers (psychiatrists, psychologists, psychiatric rehabilitators) operating in the gambling area, which, according to their experience, are the strategies most likely to be effective and capable at preventing the development of gambling disorder.

Materials and Methods

Design

This was an observational, cross-sectional study.

Procedures

For the primary outcome of the study, a specific questionnaire consisting of 79 questions was developed by a board of experts from the Italian Society of Psychiatry (Società Italiana di Psichiatria, SIP). The questionnaire was self-administered, and the mean completion time was 25 minutes. The only inclusion criterion in the study was to have gambled (sports betting, poker, online games, slots) at least 5 times in the last year. This was decided to ensure inclusion in the sample of only those who actively gamble. In order to have a better chance of collecting a large sample, the questionnaire was disseminated both through an online survey and by physically going to betting rooms, bingo halls, casinos and tobacconists with slot machines. Eight gaming rooms that had previously expressed their availability to participate were involved in the project. They were all located in Rome and surrounding areas. A further part of the sample was selected from clinical centres for gambling disorder in the Lazio region (ASL-Roma 1, Roma, SRP Villa Maria Pia, Roma, Sportello Adolescenza, Fondi [LT]). Participation in the study was anonymous and in most cases free of compensation. Only individuals surveyed in betting rooms and clinical centres received a shopping voucher of 5.29 euros for their participation.
For the secondary outcome of the study, a specific questionnaire was developed to address clinicians dealing with gambling disorder, including psychiatrists, physicians and other professional workers (psychologists, psychiatric rehabilitators) working in addiction services (SERDs). The questionnaire was disseminated through an online survey throughout the Lazio region. Participation was anonymous and free of compensation.

Measures

The questionnaire addressing gamblers was divided into four sections. The first section collected socio-demographic data (sex, age, education, marital status, psychiatric diagnoses, use of psychotropic medications, substance use). The second section included the South Oaks Gambling Screen (SOGS) questionnaire and a series of questions about gambling habits and preferences. The third section (see Tab. I for details) included many questions investigating the opinions of gamblers regarding some of the most common gambling-reduction interventions provided by different European governments. Finally, the last section investigated the consequences of the Covid-19 pandemic for gambling habits. The questionnaire addressing physicians was divided into two sections. The first investigated physicians' opinions about which regulations adopted in Europe to counteract the phenomenon of gambling disorder have had the greatest influence on the gambling habits of their patients. The last section investigated the consequences of the COVID-19 pandemic on the gambling habits of their patients.
The SOGS is a widely used screening tool for evaluating pathological gambling. It was developed on the basis of DSM-III criteria for pathological gambling in clinical populations [15]. It is widely used in epidemiological and clinical studies [2] and investigates different aspects of gambling, such as the frequency of gambling activities, daily budget, difficulty in controlling gambling behaviours, and awareness of one's gambling problem. Accuracy of SOGS in the general population was verified by Stinchfield [16] on the basis of DSM-IV criteria [17] proclaiming a high hit rate (0.96), with high sensitivity (0.99), modest specificity (0.75), low false positive rates (0.04) and low false negative rates (0.11). The total score on the SOGS ranges from 0 to 20. Based on SOGS scores, the sample was divided into three subsamples: those with SOGS scores of 1 and 2 were classified as non-pathological gamblers (NPG), those with scores of 3 and 4 were classified as problem gamblers (PrG) and those with scores equal to or greater than 5 were identified as pathological gamblers (PG).

Results

A total of 933 people fulfilled the inclusion criterion and were included in the study. An additional 3,781 people

Table I. Questions about the preventive strategies of the questionnaire administered to the reference sample.

How useful do you consider the ban on creating an account with virtual gaming sites?
How useful do I think it is to protect people who have submitted an application, on a voluntary basis (or by family members), to be prohibited from participating in gambling?
How useful do you think it is to remove slot machines from bars and public places?
How useful do you think it is to ban advertising gambling?
How much do you think it is useful to adequately inform users about the risks related to gambling?
How useful do you think it is to define a maximum betting limit?
How useful do you think it is to limit the number of arcades or the number of gaming machines per inhabitant?
How useful do you think it is to limit the visibility and advertising of games on Internet?
How useful do you think it is to allow the game ONLY in dedicated spaces?
How useful do you think the obligation to use the health card to play is useful?
How useful do you think it is to ban gambling to minors?
How useful do you think it is to establish minimum distances (250 to 500 meters) between gaming halls and meeting centers (schools, sports centers, places of worship, residential structures, etc.)?
How useful do you think it is to limit the opening hours of the gambling halls (slots and video lottery)?
How useful do you think the ban on serving alcohol in gambling halls is?
How useful do you think it is to limit your bets based on the time frame of a "game" (for example: the maximum use of 20 cents is allowed in 5 seconds of euros and 2 euros of winnings; maximum hourly loss of 80 euros; maximum payout per hour of 500 euros)
How useful do you think it is to prohibit gambling for people clinically suffering from Pathological Gambling, placing them in protected lists?
How useful do you think it is to ban betting rolls transmitted duringlive events (ex. during a football match the wording appears on the site"bet now!" with the odds at that precise moment)?
How useful do you think it is to prevent "no deposit bonuses" or "free bets"?
How useful do you think it is to create a national database with the gaming profiles of all citizens by imposing a maximum monthly limit of money used in gaming calculated on the basis of declared income?
How useful do you think it is to ban the use of cash in all types of gambling?
How useful is it to prohibit the distribution of food in gambling establishments (slot rooms, bingo etc.)?

were surveyed but did not meet the inclusion criterion and so were excluded from the analysis. Ultimately, the evaluated sample included 289 PG, 259 PrG and 385 NPG, according to the SOGS assessment tool.

The socio-demographic characteristics of the sample are given in Table II, which shows a strong prevalence of males (M:F = 4:1). In the sub-sample of PGs, there is, in addition to the higher prevalence of males, an average

Table II. Sociodemographic and clinical data of the sample divided according to the score of SOGS.

	Gender	Age (average)	Educational qualification	Occupation	Marital status	Psychiatric diagnosis
SOGS 1, 2 (NPG)	M= 76,03%	32,68 years	middle school 9,92%	students 42,98%	married 22,31%	yes 4,96%
	F= 23,97%		high school diploma 62,81%	unemployed 13,22%	engaged 34,71%	no 95,4%
			master's degree 27,27%	employees 38,84%	single 42,98%	
				retired 4,96%		
	Gender	**Age (average)**	**Educational qualification**	**Occupation**	**Marital status**	**Psychiatric diagnosis**
SOGS 3,4 (PrG)	M= 85,96%	31,61 years	primary school diploma 1,75%	students 38,59%	married 15,78%	yes 3,5%
	F= 14,03%		middle school 15,78%	unemployed 12,28%	cohabiting 12,28%	no 96,5%
			high school diploma 61,40%	employees 38,59%	engaged 33,33%	
			three-year degree 10,52%	self employed 7,01%	single 38,59%	
			master's degree10,52%	entrepreneur 1,75%		
				retired 1,75%		
	Gender	**Age (average)**	**Educational qualification**	**Occupation**	**Marital status**	**Psychiatric diagnosis**
SOGS ≥5 (PG)	M 86,08 %	41 years	primary school diploma 1,26%	students 26,92%	married 21,79%	yes 8,86%
	F 13,92%		middle school 20,25%	unemployed 8,97%	cohabiting 12,82%	no 91,14%
			high school diploma 58,22%	employees 43,59%	engaged 28,20 %	
			three-year degree 10,13%	self employed 15,38%	single 37,18%	
			master's degree 8,86%	retired 3,85%		

age of 41, a marital status of single, and the presence of a psychiatric comorbidity in 8.86% of the sample. The subsample of pathological gamblers evidenced a preference for games such as slots and poker machines.

Table III shows the opinions of the subjects in relation to possible strategies useful for preventing pathological gambling. The opinions were differentiated according to the answers given by NPGs, PrGs and PGs. The possible strategies considered most effective, with minimal differences between groups, were: 1) restriction of entry into the rooms or spaces of those people who have submitted an application, on a voluntary basis (or by family members), with respect to participation in gambling (88.2% of PGs had a positive opinion about this proposal); 2) restriction of entry into rooms or spaces dedicated to gambling of patients diagnosed with pathological gambling disorder (78.1% of PGs had a positive opinion about this proposal); 3) increased preventive aspects useful for providing clear indications about damages due to pathological gambling (73% of PGs had a positive opinion about this proposal); and 4) the insertion of a maximum limit on the amounts gambled (67.8% of PGs had a positive opinion about this proposal). In addition to these opinions, there is a strong and univocal indication of the obligation to prohibit access to the rooms or gaming places for subjects under the age of 18.

The strategies considered less effective were reported as: 1) limiting distribution of food in gambling areas (76.2% of PGs had a negative opinion about this proposal); 2) limiting the global number of gaming rooms (60.1% of PGs had a negative opinion about this proposal); 3) limiting the opening hours for gambling halls (60% of PGs had a negative opinion about this proposal); 4) establishing minimum distances between gambling halls and meeting centres (59.3% of PGs had a negative opinion about this proposal); 5) inserting betting limits based on the time interval of a game (58.4% of PGs had a negative opinion about this proposal); and 5) limiting the use of cash (58.2% of PGs had a negative opinion about this proposal).

Differences between groups (PGs, PrGs, NPGs) with respect to the different opinions were not significant, apart from the proposal regarding inserting betting limits based on the time interval of a game (negative opinions: PG, 61.1%; PrG, 38.5%; NPG, 41.1%; $p < .05$), limiting the opening hours of gambling halls (negative opinions: PG, 60%; PrG, 48.7%; NPG, 48.2%; $p < .05$) establishing minimum distances between gambling halls and meeting centres (negative opinions: PG, 59.3%; PrG, 50.9%; NPG, 43.2%; $p < .05$).

Table IV provides the opinions of professional workers (psychiatrists, psychologists, psychiatric rehabilitators) operating in the field of gambling disorder in relation to possible useful strategies for preventing the development of pathological gambling.

Discussion

In this pilot study, conducted in the Lazio region, the opinions of subjects who presented a pathological level of gambling (PG) were evaluated in comparison to others who presented a problematic (PrG) or non-pathological type of gambling (NPG), in line with the criteria of the SOGS scale. This study is the first scientific contribution that has systematically evaluated the opinions of a large number of gamblers selected through online dissemination of a specific questionnaire and concretely intercepting significant levels of gamblers in specific contexts, such as gaming rooms in the territory of the Lazio region and in

Table III. Opinions of the subjects in relation to possible strategies useful for preventing pathological gambling. For each question it is implied "How useful do you think it is..". A possible answer, not indicated in the table, was "not applicable".

	SOGS [1,2]	SOGS [3,4]	SOGS [5]
…to remove slot machines from bars and public places?	Negative 26,9% Positive 70,08%	Negative 19,63 % Positive 80,35%	Negative 39,8% Positive 60%
…to ban advertising gambling?	Negative 37,59% Positive 58,11%	Negative 42,85 % Positive 57,13 %	Negative 47,8% Positive 47,9%
…to adequately inform users about the risks related to gambling?	Negative 18,79% Positive 78,63%	Negative 16,06 % Positive 82,13 %	Negative 24% Positive 73%
…to define a maximum betting limit?	Negative 4,77% Positive 71,79%	Negative 16,05 % Positive 82,13%	Negative 29,7% Positive 67,8%
…to limit the number of arcades or the number of gaming machines per inhabitant?	Negative 49,56% Positive 47%	Negative 41,06 % Positive 57,13%	Negative 60,1% Positive 33,3%
…to limit the visibility and advertising of games on Internet?	Negative 21,35% Positive 73,49%	Negative 33,91 % Positive 64,28 %	Negative 37,3% Positive 58,6%
…to allow the game ONLY in dedicated spaces?	Negative 26,49% Positive 70,93%	Negative 24,99 % Positive 69,64 %	Negative 29,3% Positive 66,3%
…to use the health card to play is useful?	Negative 51,27% Positive 44,43%	Negative 39,27 % Positive 60,7 %	Negative 50,6% Positive 45,3%
…to ban gambling to minors?	Negative 11,10% Positive 84,61%	Negative 8,92 % Positive 91,06 %	Negative 9,4% Positive 82,6%
...to establish minimum distances (250 to 500 meters) between gaming halls and meeting centers (schools, sports centers, places of worship, residential structures, etc.)?	Negative 43,5% Positive 53%	Negative 50,9 % Positive 48,21 %	Negative 59,3% Positive 38,4%
…to limit the opening hours of the gambling halls (slots and video lottery)?	Negative 48,2% Positive 47,86%	Negative 48,7 % Positive 49,99%	Negative 60% Positive 34,7%
…the ban on creating an account with virtual gaming sites?	Negative 39,27% Positive 57,14%	Negative 43,74 % Positive 53,07 %	Negative 32,2% Positive 55,8%
…the ban on serving alcohol in gambling halls?	Negative 36,74% Positive 58,11%	Negative 47,35 % Positive 45,6 %	Negative 48,1% Positive 50,6%
…to limit your bets based on the time frame of a "game" (for example: the maximum use of 20 cents is allowed in 5 seconds of euros and 2 euros of winnings; maximum hourly loss of 80 euros; maximum payout per hour of 500 euros)	Negative 41% Positive 50,42%	Negative 38,59 % Positive 54,38 %	Negative 58,4% Positive 29,3%
…to prohibit gambling for people clinically suffering from Pathological Gambling, placing them in protected lists?	Negative 17,93% Positive 76,91%	Negative 15,77 % Positive 78,94 %	Negative 19% Positive 78,1%
…to protect people who have submitted an application, on a voluntary basis (or by family members), to be prohibited from participating in gambling?	Negative 14,28% Positive 80,95 %	Negative 15,62 % Positive 84,37 %	Negative 10,8% Positive 88,2%
…to ban betting rolls transmitted during live events (ex. during a football match the wording appears on the site"bet now!" with the odds at that precise moment)?	Negative 41,87% Positive 53,84%	Negative 29,81 % Positive 66,66 %	Negative 41,3% Positive 54,6%
…to prevent "no deposit bonuses" or "free bets"?	Negative 51,27% Positive 44,43 %	Negative 50,87 % Positive 45,6 %	Negative 45,3% Positive 48%
…to create a national database with the gaming profiles of all citizens by imposing a maximum monthly limit of money used in gaming calculated on the basis of declared income?	Negative 38,46% Positive 44,42 %	Negative 47,35 % Positive 42,1 %	Negative 53,3% Positive 40%
…to ban the use of cash in all types of gambling?	Negative 52,98% Positive 35,88%	Negative 64,89 % Positive 28,06%	Negative 58,2% Positive 38,6%
…to prohibit the distribution of food in gambling establishments (slot rooms, bingo etc.)?	Negative 61,53% Positive 31,61 %	Negative 80,69 % Positive 17,53 %	Negative 76.2% Positive 16%

bars where there are slot machines and other types of games. Furthermore, in order to identify severe pathological gamblers, the evaluation concerned clinical reference centres where patients receive a specific treatment for gambling disorder.

The socio-demographic and clinical data identified through the SOGS scale are in line with recent epidemiological studies concerning the Italian population in relation

Table IV. Opinions of professional workers (psychiatrists, psychologists, psychiatric rehabilitators) operating in the field of gambling disorder in relation to possible useful strategies for preventing the development of pathological gambling. "Based on your clinical experience, how useful do you think it is…" is provided for each question.

QUESTIONS	NEGATIVE	POSITIVE	NOT APPLICABLE
1) Based on your clinical experience, how useful do you think it is to remove slot machines from bars and public places for GD patients?	16,4%	81,97%	1,64%
2) …forbidden to advertise gambling for GD patients?	24,6%	75,4%	0
3) …to adequately inform GD patients about gambling risks?	3,28%	96,72%	0
4) …to define a maximum limit in games for GD patients?	21,3%	75,4%	3,28%
5) …to limit the number of arcades or the number of gaming machines per inhabitant for GD patients?	21,32%	78,69%	0
6) …to limit the visibility and advertising of gaming on the internet for GD patients?	14,76%	85,25%	0
7) …to allow play ONLY in dedicated spaces for GD patients?	40,98%	59,02%	0
8) …the obligation to use the health card for GD patients?	32,78%	67,22%	0
9) …to ban gambling from minors GD patients?	13,12%	85,24%	1,64%
10) …to establish minimum distances (from 250 to 500 meters) between gaming rooms and aggregation centers (educational establishments, sports centers, places of worship, residential structures, etc.) for GD patients?	34,43%	65,58%	0
11) …to limit the opening hours of the gaming rooms (slots and video lotteries) for GD patients?	18,04%	81,96%	0
12) …to ban alcohol serving in gambling halls for GD patients?	21,3%	78,7%	0
13) …to limit the bets based on the time interval of a "game" (for example: maximum use of 20 euro cents and 2 euros of winnings is allowed in 5 seconds; maximum hourly loss of 80 euros; maximum hourly payout of 500 euros) for GD patients?	18,04%	81,96%	0
14) …to forbid gambling for people clinically affected by Pathological Gambling, placing them on protected lists?	29,51%	62,3%	8,2%
15) …to ban betting rolls transmitted during live events (eg during a football match the word bet now! Appears on the website with the odds at that precise moment) for the GD patients?	21,32%	77,05%	1,64%
16) …to prevent "no deposit bonuses" or "free bets" for GD patients?	22,96%	73,77%	3,28%
17) …to create a national database with the gaming profiles of all citizens by imposing a maximum monthly limit of money used in gaming calculated on the basis of declared income?	24,6%	57,37%	18,03%
18) …to ban the use of cash in all types of gambling for GD patients?	26,23%	67,21%	6,56%
19) …to forbid the distribution of food in gambling establishments (eg slot rooms, bingo) for GD patients?	39,34%	57,37%	3,28%
20) Based on your clinical experience, throughout the closing of the betting / bingo halls during the lock down for the Covid-19 pandemic, the frequency of gambling of GD patients, on average, is:	Decreased: 36,07%	Increased: 21,31%	Unchanged: 42,62%

to the gambling phenomenon (National Institute of Health, National Gaming Survey 2018) [18]. However, we need to emphasize that our sample does not represent a clear picture of the gambling situation in the region, but was specifically determined with the aim of recruiting a larger number of PrGs and PGs, whose opinions were a main target of the study. In our sample, the higher prevalence among gamblers of male subjects, who were over 30, single, and had unstable work situations was consistent with previous international and Italian studies [18].

The proposal that gained the most consent among all the typologies of gamblers concerned the possibility of creating dedicated registers listing those people who are prohibited in gambling sites. This proposal is of great interest with respect to gambling areas in which it is possible to play without limitation. The creation of these registers could be determined by the gamblers themselves (self-exclusion registers), by the patients' relatives, or even by the operators (psychiatrists, psychologists, psychiatric rehabilitation technicians, and so on) who treat affected patients. This type of model has been proposed in other countries with favourable and very promising long-term results, especially if guided and well-integrated with the territorial health network of addiction services, mental health centres (CSM) and the qualified Third Sector. The implementation of integrated early intervention and active

prevention tools should necessarily consider reporting by the player's family members.
It would also be very useful, as evidenced by the responses to the questionnaire of all types of interviewees, to clearly exclude individuals under 18 from accessing gambling venues. Minors are undoubtedly at risk due to a still partial neurodevelopment process. These aspects also apply to preventive strategies for substance use disorders and would find a parallel application area in gambling.
Another central area that emerges from the pilot study is that, regardless of the severity of the clinical situation, there is a need to increase prevention with more targeted psychoeducation strategies. This should be able to detail all the possible risks deriving from the game and also highlight all the cognitive biases reported by gamblers. These cognitive biases in fact represent false illusions in the imaginations of gamblers, which exacerbates the clinical picture by pushing gamblers to continue gambling while chasing cognitive tricks.
Regarding the opinions of specific strategies to be implemented to prevent and limit the development of pathological gambling, it is surprising to note how the strategies recently proposed in Italy received a low consensus among gamblers. However, knowing the neurobiological mechanism of craving, it is somehow understandable that the use of the metre distance may play a limited role. The gambler, particularly if pathological, is certainly not dissuaded from not having the ability to play at hand. The compulsive aspects of the pathological search for the source of pleasure go far beyond geographic limitations. The gambler is a subject who, without particular limitations, is ready to leave the neighbouring areas in order to satisfy his specific requests. This mechanism is typically observed in not just gambling, but also in the vast world of addictions when the addicted patient is ready to make enormous efforts to reach the place of sale to purchase the substance. The phenomenon of craving, in relation to both a substance and to gambling, is characterized by being compelling and not deferrable, despite any type of limitation. For this reason, it is not surprising that we found a higher prevalence of negative opinions about this preventive proposal among PGs with respect to PrGs and NPGs. PGs are well aware that such a typology of limitation can barely limit their craving for gambling. Recent data are consistent with our study and highlight how a portion of problem gamblers (on average 10%) often choose to go to rooms distant from their home, precisely to hide the discomfort that may arise. A recent Italian document [19] points out that most gamblers have no problem choosing a venue farther away: 69% of sports betting players, 65% of slots players and 61% of players would move to another point of sale. The practically absolute ban on gambling in urban areas could paradoxically favour those affected by gambling disease, thus determining the concentration of the venues in peripheral places, isolated from the gaze of others and the resulting stigma. Furthermore, relocating the gambling areas to outside major centres would end up creating a high concentration of gambling venues in marginal areas, further depressing peripheral areas that are already heavily penalized, with a probable negative influence on the social gamblers normally residing in the same areas.
The same considerations apply to the restrictions concerning gambling time. Although it may, in fact, seem reasonable to put limitations on the 24-hour availability of gambling, too-restrictive limitations could hardly be expected to lead to tangible results, as was also clearly reported by the interviewed gamblers. In agreement with our data, a recent study showed that the interruption of the game not accompanied by a specific intervention to be implemented during the break period, is not an effective tool for treating this behaviour [14].
These considerations are in line with what has been reported with prohibitionist drug policies, which did not lead to a contraction of the supply or a reduction of substance use. Clinic treating addiction, in particular substances, have confirmed this for decades: those who have an addiction are not sensitive to limitations imposed from the outside, as evidenced by almost a hundred years of prohibitionist strategies, the *Volstead Act* in the US (1927) and the recent *war on drugs* in the Philippines (2020). These experiences that tended to be unsuccessful seem to have induced more than anything else the maintenance of damage induced by the illicit use of substances and facilitated a progressive impoverishment of public resources that could have been dedicated to the addiction sector to activate appropriate preventive, rehabilitative and treatment strategies. It seems clear that these efforts should be redirected towards the development of different models of care, where treatment and rehabilitation capable of increasing early knowledge of risk factors have paramount importance [20,21].
Another element that emerges from the data is the answers provided by health professionals who work with problems related to gambling. The opinions are in line with what has been reported by gamblers, firmly confirming the greater relevance of some strategies, such as exclusion registers, than that of others.

Conclusion

What emerged from this pilot study carried out in the Lazio region is that preventive strategies for a phenomenon of such severe gravity should be based on logic derived from profound clinical reflections of psychiatrists and health professionals who work directly in the field of pathological gambling and who know, in depth, the reality of gamblers. The search for simplistic solutions, able to reduce the gambling sector present in our country, can only partially and temporarily stem the problem. Instead, it would be desirable to favour controlled and legal gambling venues along with appropriate monitoring systems, such as the exclusion lists. This operation would help avoid the development of illegal and clandestine gambling and temper the development of online gambling, which is more

difficult to control and manage. It would then be desirable that the income guaranteed by the gambling sector could then really contribute to favouring psychoeducational intervention strategies, as also reported by the opinions of the gamblers interviewed.
Other possible measures concern the revision of the gambling parameters of devices to make it possible to trace and measure access to gambling in terms of time spent and money spent, allowing the possible early identification of at-risk individuals. The development of systems of this type could hopefully allow for the identification of those in need of a specific intervention. These interventions should be implemented by practitioners specifically trained in counselling tools and psychological support and able to direct those who are vulnerable to the network of territorial care services (CSM, Third Sector) and should include those who have repeatedly exceeded the limits in the exclusion register, as acknowledged by the gamblers interviewed in our study. The management of the exclusion register could provide for temporary or definitive exclusions, or even differentiations regarding the type of game, limiting exclusive access to those games with rapid turnover, which more typically afflict and characterize those who are suffering from gambling disorder.
In this scenario, it is therefore desirable to have a greater influence of those who dedicate themselves to the treatment of addictions every day, as well as greater consideration of the results of neuroscience research dealing with addiction [22]. This approach would make it possible to promptly and objectively assess the impact of the most diverse measures adopted, with the goal of establishing strategies aimed at effectively identifying vulnerable individuals at risk of addiction at an early stage.

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Book Review

The Role of Dynamic Psychiatry and Psychotherapy in Psychiatric Rehabilitation

Giacomo Gatti

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When my friend and colleague Giacomo Gatti asked me to write a review of his latest work, I felt honored and delighted to be able to express my appreciation. This appreciation arose spontaneously as, prior to publication, I had the opportunity to read draft several excerpts of the text.
This volume will prove valuable, not only for students of the subject matter (as with all readers interested in the subject matter) but especially for young graduates and psychiatry specialists, psychologists, rehabilitation therapists, social workers and any other practitioners intending to work, in a conscious and constructive way, in the field of mental health.

This derives, first of all, from the fact that the author, given his philosophy of knowledge, along with the integration of biological, psychological and social models is something unavoidable and concretely recommended in the clinic, and not, as for many, a generic theoretical statement, a “flatus vocis”, which allows easy loopholes and refuge in one’s own particular vision. Therefore, do not be influenced by the fact that he has a solid and well-founded psychoanalytic training, which obviously gives body and consistency to the acute psychopathological descriptions of the various clinical conditions that are described in detail. It is certainly not a text aimed solely at psychodynamic psychiatry students (even if the latter will be able to find themselves at ease and appreciate the vastness of the points of view expressed). On the contrary, it aims to show the substantial inseparability of the various knowledge and practices that must unfold in the course of the treatment of serious pathologies. In this regard, it is significant that the author, in the last section of the volume, has the therapists of the “Passaggi” community exhibit a series of clinical cases in which the importance of integration of interventions: psychological ones, pharmacological ones, those of social insertion, those of a family context, etc. is presented. Only in this way can the “complexity” of these problems be approached.

This, moreover, is consistent with the fact that one of the presuppositions that informs the setting of the treatise is that of the indivisibility of the moment of treatment from that of rehabilitation, and that both moments cannot be conceived except in the “continuum” of an interdisciplinary and multi-contextual perspective. Some consequences derive from this: the first is that to treat and rehabilitate one must know the dynamics of the onset of the disease, the second is that, in this field, all practitioners must have a store of basic knowledge, both with respect to psychopathology, and with respect to the problems of the “therapeutic relationship”. In essence, it also means recognizing the ubiquitous nature of the phenomena of “transference” and “countertransference” at individual, group, personal and institutional levels.
This is why Gatti repeatedly insists, explicitly and implicitly, on the need for an

"emotional knowledge" of oneself, possibly on the part of all practitioners in the "treatment-rehabilitation" area.

It is well known that, strictly speaking, throughout the twentieth century, psychoanalysts believed that the only way to acquire this "peculiar" self-knowledge was to carry out a prolonged personal analysis. Gatti does not enter into the merits of the age-old question, but rather urges understanding that there may be myriad ways to address the issue of this "training" in introspection and the ability to "relate", in therapeutic dynamics and that, in any case, it is essential to question oneself about the issue. For example, one such path is that of group-analysis. It is not broadly known that for some years now in Great Britain, Germany and other Western countries, it has been compulsory to participate in "Groups Balint" organized by local institutions for a period of 1 to 2 years. As is well known, Michael Balint (psychoanalyst, pupil of Sandor Ferenczi) already in the 1950s had understood the importance of training in the "therapeutic relationship" of general practitioners. Later this type of training was also extended to non-medical health workers and finally to non-health sectors, in particular towards those professions that have the "helping relationship" as the central moment of their operation.

Without dwelling on this topic, however, I here point out that some acquisitions of psychoanalytic thought, beyond the divisions of "school", the rigidity of traditional psychoanalytic institutions and the infinite variety of psychotherapeutic practices (psychodynamic and not) now have universal recognition, in training programs, at many levels.

We are still in a phase in which, not only in Italy, the various schools, recognized by the ministries and authorized to "train" psychotherapists have little dialogue with each other. This must change. . Already now, for example, the more aware cognitivist-oriented schools are attentive to some elements of clear psychoanalytic extraction. Basically, in addition to the transference / countertransference phenomena, other aspects such as the presence of unconscious processes (clearly demonstrated, at an experimental level, as well as by neuroscience), the concept of intrapsychic conflict, drive dynamics and their importance in the genesis of psychic disorders, should be common cultural understanding for all those involved in therapy.

In this text Gatti, in addressing above all those who work in public services for the treatment and rehabilitation of seriously ill patients, exposes a series of elements of "clinical psychoanalysis" which constitute a "breviary" of real psychopathology dynamics in which the explanation of the mechanism of onset of symptoms is explained through the description of the conscious and unconscious processes that underlie them, along a tradition inaugurated by some analysts, particularly attentive to concrete clinical practice, which led them to write treatises with high-level didactic intentions such as Fenichel, Glover, Arieti, Kernberg, Gabbard. The authors to whom Gatti refers are many more, belonging to different psychoanalytic currents and, sometimes opposed, such as Klein, Mahler, Bion, Kohut, etc., but from all these he manages to draw a synthesis of great efficacy, given an over forty-year personal practice, which allows him, on the one hand to look critically at many commonplaces accumulated over time in private and institutional clinical practice and, on the other, to propose, in a way effective, and with an original and very lively style, a series of clinical cases followed by himself and, in the last part of the text, as already mentioned, other cases followed at the "Passaggi" therapeutic community, consistent with the criteria described above.

On the whole, it can certainly be said his orientation is adherent to the thought of Otto Kernberg, in particular with respect to his approach to personality disorders, but his work is also influenced by the teaching of Aries and is most evident in the treatment of the field of psychosis and mood disorders. But, I repeat, what matters most is the synthesis of many contributions of thought that he was able to offer and the contribution of a personal, wide-ranging and truly original clinical experience.

Mario Giordano