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SUMMARY

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Treating not guilty by reason of insanity and socially dangerous subjects by community psychiatric services: an italian perspective

Il trattamento comunitario del malato di mente non imputabile socialmente pericoloso: la prospettiva italiana

Luca Castelletti • Franco Scarpa • Felice Carabellese

Abstract
Two years after the introduction of Italian forensic psychiatric reform, the new national residential network for subjects in security measures is now trying to develop and share common good practices of care, according to the contents of the new legislation. In this work, progressive steps of assessment and care of those admitted the new facilities named REMS will be illustrated, and the way new scenarios may impact on the role of the expert judgement in the Courts and their effects to forensic subjects' referral. Some critical points fostered by the new system, including criteria for admissions and clinical rationale for releases to lower levels of security, are discussed further in this work. It will be eventually described feasi ble solutions to overcome those issues, according to good evidence based practices.

Key words: REMS • risk assessment • risk managment • forensic psychiatric treatment

Riassunto
Il sistema trattamentale delle Residenze per l'esecuzione delle Misure di Sicurezza (REMS) pare avviarsi verso il superamento della difficile fase iniziale e prova ad interrogarsi sui suoi meccanismi di funzionamento interni ed esterni. In questa sede gli autori proveranno ad analizzare alcuni momenti del percorso di cura del malato di mente autore di reato socialmente pericoloso sottoposto a misura di sicurezza psichiatrica detentiva ed ad affrontare alcune criticità: dall'invio dell'Autorità Giudiziaria a seguito di accertamento peritale, sino alla sua dimissione a cura delle équipe dei Dipartimenti di Salute Mentale (DSM), facendo riferimento ai modelli teorici di assessment e trattamentali più accreditati e provando a fornire un loro contributo operativo efficace nel superare i diversi momenti problematici finora emersi.

Parole chiave: REMS • valutazione del rischio • gestione del rischio • trattamento psichiatrico-forense

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Treating not guilty by reason of insanity and socially dangerous subjects by community psychiatric services: an italian perspective

1. Introduction

The closure of forensic hospitals was first recommended by government in 2008, with Decreto della Presidenza del Consiglio, DPCM 01.04.2008, and it has been executed from 2014 onwards. Forensic hospitals, or Ospedali Psichiatrici Giudiziari, OPGs, have been substituted by an alternative network of residential care, SSN (Sistema Sanitario Nazionale, National Health System) based, care facilities called REMS - Residencies for the Application of Security Measures. The structural and functional characteristics of these facilities are defined by the Law and are aimed at assuring general security, individual care, rehabilitation programs in a community environment and small scale dimensions, as the maximum capacity is fixed at 20 beds each (Scarpa, Castelletti & Lega, 2017).

The basic principle for the closure of the OPGs wasn't only justified by the insufficiency of treatment provision of those structures. Five of the six OPGs were basically prison buildings, characterized by restrictive architecture and a shortage of medical staff (Scarpa 2005).

The novelty of the reform, introduced with Laws 9/2012 and 81/2014 is to give to the community mental health services the pivotal role of developing pathways of care for those found not guilty by reason of insanity and socially dangerous (NGRI) (Carabellese & Felthous, 2016). General psychiatric services, based on a network of community facilities, organized by the Departments of Mental Health, can provide treatment for patients not charged by Justice authority.

Their main tasks, established by the Italian reform of general mental health services contained in the Law 180/1978, are to give mentally ill users back their right to receive care on a voluntary basis with the only exceptions of severe, acute symptoms unrecognized by the subject and requiring urgent treatment (TSO Trattamento Sanitario Obbligatorio or Compulsory Medical Treatment) (Mandarelli et al, 2017).

For this reason, one contradiction of the forensic reform concerns how to match the principle of freedom to receive treatment with the obligation of restrictive measures, according to the Penal Code, ordered by a Judge when the person in charge is considered socially dangerous (Carabellese, Urbano, Mandarelli & Coluccia, 2018).

Law 09/2012, and the subsequent Law 81/2014, with the definitive closing of OPGs, state that new regional forensic facilities, the REMS, provide treatment for those in security measures with a high level of social dangerousness. Patients with a mild to weak degree of dangerousness should be treated within the network of community psychiatric services.

During the trial or at its end, Italian judicial system may apply two different measures.

The first is given for those deemed dangerous and consequently have to be referred to REMS In these cases, subjects found not guilty by reason of insanity, present a degree of "social dangerousness" that cannot be contained in a general community facility. A different measure is provided for those NGRI whose dangerousness level makes them eligible to be treated in a community facility or in private accomodation. In these cases, the Judge applies a different non custodial security measure called "libertà vigilata", sort of probation. According to the Individual Care Plan, patients can receive their treatment in a public or private facility at lower lever of security. They are asked in this way to respect Judge's prescriptions and to be supervised by public community officers. There are no specific criteria for the application of custodial or non-custodial measures, except for restrictive measure inside the REMS, defined by the Law 81/2014 as "the last resort". One of the main innovative aspects of the new legislation concerns the presence of exclusive criteria to refer a subject to the REMS. Custodial measures shouldn't be adopted in those cases community treatment isn't ready to match and control subject's dangerousness. Decision on the nature of security measure measures, and consequently level of security often depends on the capacity of the general mental health services to provide a therapeutic plan for the patients in charge.

2. Therapeutical aspects for the socially dangerous subjects: heredited and new challenges

Providing care programs in the new REMS reflects complex and multidimensional features of the target subjects admitted there.

The REMS network, developed in a short time and covering the whole Country from 2015, faces the hard challenge to develop efficient forensic therapeutical strategies ever experienced in Italy. Moreover experiences from other Countries seem unfit to be simply imported into Italian mental health system (Carabellese & Felthous, 2016). The new system has very little to share with previous forensic hospitals, during which scientific and clinical evidences has been very poor and physical, procedural and relational issues unproper.

At the end of 2014 there were 672 inmates in the 6 OPGs. Law 81/2014 prescribed no referrals to closing OPGs after 1st April 2015, even for those with a high level of dangerousness admitted in the REMS.

The number of patients inside the 6 OPGs fell progressively until their definitive closure. It took almost two years to complete the discharge of all the remaining patients and only on February 2017 the OPGs were finally closed. Currently, there are 35 new REMS with security measures that host up to 600 patients. REMS have a significant turnover

and, until now, have discharged around 300 patients (Corleone, 2017).

The request of admission of new patients to the REMS who are declared socially dangerous is steadily increasing, so as the list of subjects deemed dangerous waiting to be admitted out the new residencies. This may seem a contradictory remark to make, as most of them are waiting in their own houses, in ordinary facilities or, in some cases, in prison or in wards for acute psychiatric patients in general hospitals.

Legislator's will pointed on discontinuity with previous asylum-like system. The terms of the reform are rooted on the regional basis of care, single residential units with small numbers, maximum 20-bedded, included into the organization of NHS (SSN, Sistema Sanitario Nazionale) Departments of Mental Health. Nevertheless, estimated functional capacity of 600 national beds is now a matter of concern, as a "waiting list" of those referred to admission is in constant increase. Magistrates, clinical teams, ask for shared criteria to filter those subjects more suitable for a REMS-based treatment, at the moment unavailable. The lack of shared criteria enhances the dispute on the characteristics of the candidates benefiting for a forensic residential period or, otherwise said, to set the level of proper "social dangerousness" to be treated in the REMS.

In the shortage of a national database, it is currently unknown how many of those in "libertà vigilata" are in community facilities.

A recent study promoted by the National Institute of Health has described the clinical-demographic features of OPGs inmates just before their definite closing (Lega et al., 2014). Mean age of the 473 participants was 42,5 years, about 75% of those were singles with no children. The forensic in-patient prevalence rate (forensic in-patients per 100,000 population) was found to be 1.7, lower than that found in 2001.

In this respect Italy is similar to other Southern European Countries also showing low prevalence rates. Women accounted for 7.9% of the patients hospitalized in the OPGs, whereas female patients were found to represent 6.8% of the forensic inpatient population in 2001. The average age was 42.5 years. Around 73% of the participating patients were not married and had no children, 50% lived with their birth family prior to admission. There were statistically significant gender differences: women more often than men succeeded in forming a new family and more than 50% of female patients had children. A social disadvantage emerged in the patient group with low levels of education combined with unstable work and economic conditions. Over 30% of patients had a severe physical illness, about 24% were obese and 80% were smokers.

Compared with patients suffering for severe mental disorders receiving treatment at the Mental Health Centres, the OPG population was found to be more disadvantaged and to suffer from higher rates of comorbid physical illnesses. Over 50% of participants had a diagnosis of schizophrenia or other psychotic disorder. Personality disorders accounted for about 20% of diagnoses, more than observed in previous surveys. The administration of the SCID-I detected a high comorbidity with Axis I disorders, especially substance abuse or dependence and psychotic disorders. With regard to the severity of psychopathological symptoms and functioning by diagnostic groups, schizophrenic patients had more severe symptoms on the Brief Psychiatric Rating Scale (BPRS) and compromised functioning on the Global Assessment of Functioning (GAF). Rarely was the index crime the first manifestation of a psychiatric disorder: the mean duration of illness before admission was over 18 years, 75% of patients had been treated for a mental disorder in the past and over 60% had previous contact with the Department of Mental Health, often problematic contacts (30% of the sample had at least one forced hospitalization).

More recently, a small survey aimed to describe clinical and demograhic characteristics of has been done with the inmates in Nogara REMS, Veneto region. Patients' features indicate prevalent problems of adherence at therapeutical plans and behavioural misconducts (Castelletti et al., 2017). In most of the cases, these are subjects already in charge with public psychiatric services (Carabellese, Rocca, Candelli, Catanesi, 2014), with psychopathological multidimensional problems, including comorbidity with abuse of substances, personality disorder and cognitive impairment.

Criminological profile highlights a prevalence of crimes against persons (89%) of those about one quarter with lethal consequences. In half of cases victims are family members, and criminodynamics of the events recognize a psychotic mechanism of behavior. The descriptive analysis of these samples indicate areas of intervention for prevention policies for those at risk of aggressive behaviour (Carabellese, et al, 2015).

Different subsamples of inpatients are described in these early data. One is given by the combination of severe psychopatological characteristics and severity of crime, as homicides or attempted homicide, with prolonged period of staying due to long-lasting original security measure given by the Judicial Authority. A larger second group is composed by difficult patients, with a history of irregular caring relationships with community services, poor compliance, unstable familiar and affective environment, clinical, heterogeneous criminological profiles.

They share historical troubling relationship with community services, resulting in a large amount of unmet social and caring needs, frequently in causal relationship with the index crime. The clinical and criminological variables of the forensic population require a pattern of treatments that may be effective in such a complex environment (Scarpa F, Bonagura V, 2015).

3. REMS inmates and their specific therapeutical needs

Working with those referred to a forensic facility requires long periods of admission, longer than with general psychiatric clients. Particularly with subjects with a severe index crime and a severe diagnosis time of recovery may be prolonged, due to slow process of improving states of insight and self-confidence. For most of these subjects, it is a matter of "incorporating a crime into a non-criminal identity" (Drennan & Alred, 2012). The extent of the trauma to oneself that the offence has caused can itself be an obstacle to recovery.

Those with a milder index crime, frequently combined with a less severe mental impairment, are initially admitted with a temporary security measure: these forensic users require usually shorter periods for recovering from their relapses. They frequently present high rates of comorbidity, mainly with substance abuses and cognitive impairment, so enhancing the need to improve networking collaborations with target community services.

A reason of concern is due to the legislative frame of the subject admitted in security measure. Rocco's Penal Code (1930) has not been modified, so that the forensic clinical team has both therapeutical and custodial duties to the inmate, resulting in substantial management problems in those cases avoidant any therapeutical proposal (Catanesi, Carabellese, La Tegola, Alfarano, 2013).

Moreover, the Judicial Authority may apply undetermined periods of forensic hospitalization for those admitted through the application of temporary security measures, so contributing to give to forensic care plans a sense of instability and partial control.

The concept of Social dangerousness is in the Penal Code, Article 203, as the "general capacity for a subject to reoffend or committing new crimes". It is currently considered an insufficient criterion to establish appropriate referrals to forensic facilities for its vague, non specific notion (Rocca, Candelli, Rossetto & Carabellese, 2012). It is also a source of diffidence and stigma for most of professionals working in the mental health field who strongly reject any link with custodial practices. According with this background, in our clinical practice it may be useful to work critically on the judicial judgement of social dangerousness as starting point for creating clinical sense and promotion of self care for those admitted the REMS. That notion, cleared from any stigmatizing intent and declined for therapeutical interventions, may represent a starting point for gaining patients' insight. Their life failures are mostly caused by deviations, social exclusion, economic failures, social disadvanteges, health problems, personal progressive loss of hope and control over life., A cognitive reference to the provision at the base of REMS admission can ease users and their team with the work of gaining insight on goals of the forensic care pathway (Barker, 2015). Conversely, scotomization of the measure at the origin of the referral is at risk for mechanisms of denial and minimisation in the patient, althought clinical teams has the right to choose forms and timing to face and share analysis of internal and external factors at the base of the forensic measure (Scarpa, 2015).

4. Pathways of care in the REMS: what's specific

Concept of social dangerousness is elusive for the forensic teams trying to give clinical meaning to judicial terms. Avoiding any attempt to simply import concepts and practices developed in other cultural and social contexts into italian practice, the clinical practice of violence risk assessment in forensic settings can be a useful practice to dismantle the vague nature of social dangerousness and convert it into clinical concepts, terms, plans (Bonta, 2002; Heilburn et al., 2010; Castelletti et al, 2013, 2016; Lega at al., 2014; Carabellese, Mandarelli, 2017a).

A multidimensional approach unprovided by specific tools monitoring behavioral variables is at risk of unreliable therapeutical plans. In this way, forensic clinical staff is called to identify major dimensions involved in the forensic case, including anamnestic, current clinical characteristic, socioeconomic context, service provision.

A better definition on the rehabilitative goals to reach can be a helpful approach for the patient as well, who has more opportunities in this way to receive a comprehensive information of caring plan.

From a national perspective, the risk for a forensic patient to drop out from a rehabilitative program is at community level, during his admission in a residency or more frequently when released to a private accomodation (de Girolamo et al., 2016).

A lack of multidimensional approached including systematic assessment of risk factors for recidivism reduce the recognition and management of symptoms and their causal effects on behaviours. This may be even more important if assessment tools are applied to different settings. A lack of integrated and shared information and strategies across teams and with other institutional partners involved in the case may induce negative feelings in case of clinical and criminological relapses. This may induce teams involved in a forensic case to interrupt the community experience and refer eventually to forensic residency again. Otherwise, clinical teams trained for a multi dimensional assessment and management have more possibilities to prevent clinical and behavioural relapses and to focus on areas of interventions more sensitive for the subject's global outcome (Lindqvist & Skipworth, 2000; Monahan et al, 2001; Kennedy, 2002; Monahan et al, 2005; Moore & Drennan, 2013).

Historical information is of greatest importance in forensic psychiatry, to understand the current and future criminogenic potential of the subject, to make an assessment of potential future recidivism and moreover to identify those areas of interest and motivation not fully expressed in the past (Maden, 2007).

Clinical risk factors and future management risk factors provide key informations on development of pathways of care, inside the forensic facility and further at community level, so as to prevent relapses, readmissions or, worst case, reconvictions (Michel, 2013).

All processes regarding risk assessment and management should enhance active patient involvement, promoting transparency with the forensic client aimed at reducing frequent suspicious feelings of the patient to wards staff members. Moreover, it may facilitate patient's collaborative approach to care plans.

Law 81/2014 states the mandatory introduction of Individual Treatment Plan for community and forensic teams, as guarantee of early partnership in care. A patient's prompt participation into definition of areas to recover may facilitate a proper time of admissions into residencies. It also strengthens a dialect approach to the forensic patient, usually practised in the fields of needs assessment (Thomas et al., 2013) but also extended to the field of risk assessment.

Risk assessment tools may find application as mediators of individual or group psychotherapeutical settings, in a work of progressive disclosure of patients' denial areas or scarce insight. Shared use, operative intuition, dialectic approach, structured instrument for planning team's work to

include all community partners as early as possible: risk assessment structured judgment techniques are broading their fields of use and application (Hart & Logan, 2011; Robbè, de Vogel & Douglas, 2013).

The therapeutical setting for NGRI patients and those considered socially dangerous is done by an expert who decides of assessing the level of dangerousness from the Judge (Carabellese, 2017b). In many cases there is no agreement between the evaluation of the expert, and consequently the decision of the Judge, and the availability of a REMS bed. At the same time it is possible to have opinions which differ between the Court expert, normally a forensic psychiatrist, and the Mental Health Services' specialist regarding the adequacy of the facility, the clinical condition and the patient's needs. Court experts generally develop their assessments according to their expertise, at the expense of evidence based assessments. In a reformed forensic panorama, expert evaluation needs to link reason of insanity judgement with therapeutical recommendations. Instruments for violence risk assessment may be useful to cover this gap: they enhance the possibility to talk a common language ranging from capacity of the subject to the development of a pathway of care.

Structured assessment of forensic patients is a quite new practice in the Italian system: forensic experts, for example, use mainly diagnostic tools for the patients evaluation. They don't require specific tools for the assessment of the functional aspects of the mind, the capacity for standing on trial and the degree of dangerousness. Violence risk assessment doesn't receive specific attention and has only recently been introduced the REMS and the community services. The Historical Clinical and Risk Assessment of Violence (HCR20) is the most studied and adopted tool (Douglas et al., 2013).and the v3 version is currently under translation to be adopted in Italy.

In many Regions and/or Local Health Units of the National Health System special Forensic Units have been set up, flanking the role of the experts of the Courts. They report to the Judges whenever asked for information regarding the progress of the treatment, in terms of clinical status of the patients, they give advice to the psychiatrists and the healthcare workers looking after the patient. Most recent versions of structured judgment tools hit the mark of organizational and therapeutical aspects introduced with the new national legislation. Case formulation in forensic psychiatry is the result of two decades developing of risk assessment tools, and enables the clinician to put together the theorical and structured approach, or nomothemic moment, with the empirism of the clinical work for the individual patient (Haque & Webster, 2013). Formulation is developed as circular, coherent operational team activity aimed to produce clinical treatment acts to verify hypothesis with the clinical observation. It gathers systemic information and clinical team observations to plan projects, make clinical interpretations, and to practice on future patients' most likely scenarios. Clinical formulation assumes a narrative form, in which diverse and diachronic aspects of the patient are put together to be coherently assembled (Hart & Logan, 2011).

In forensic psychiatry, it's even more cogent than in general psychiatric to try to get meaning from patient's early past events, generally of traumatic nature, attachment styles and caregivers, and current treatment needs (Schimmenti, Carabellese & Caretti, in press).

5. The individual caring plan

Clinical teams operating in the REMS frequently deal with subjects with a history of severe life's failures regarding their internal resources and external ones, like the affective and familiar network. They live in a life signed by hopelessness, as their attempts are destined to be frustrated. This feeling is sometimes strengthened by social and institutional network, as personal stories of these subjects are rich of failures in the affective relationships, working activities, alliance with health services, and substances' addiction remedies. It enhances the clinical need to put together different information and points of view to create a coherent story. It includes heterogeneous contributions, reflecting the heterogeneity of the sample of people referred to the forensic facility. For most of them, an approach recovery-oriented as Good Lives Model can produce positive outcomes (Ward, 2002).

Most of REMS patients have problems in their vital research of "primary goods", that is "activities, experiences, or situations that are sought for their own sake and that benefit individuals and increase their sense of fulfilment and happiness" (Whitehead, Ward & Collie, 2007) and include things like autonomy, relatedness, knowledge, mastery, play and physical health.

For these Authors, problems derive from wrong strategies to obtain those goods, as: neglect of important primary goods, use of ineffective strategies to secure goods, conflict of strategies to secure goods, inability to implement strategies for securing goods. For those clients with a profile of personality disorder, and frequently comorbidity with substances abuse, the need principle derived by the RNR, Risk-Need-Responsivity approach (Andrews et al., 1990) may be useful, as offender assessment and management should focus on criminogenic needs, i.e. should target causal risk factors for antisocial behaviour.

According to the responsivity principle, services should be delivered in ways that maximize their effectiveness, meaning that the focus of management programs should be on skills acquisition, prosocial modeling and problem solving.

Design and management of programs delivered to offenders should match their individual learning style, motivation, abilities and strengths. Structured clinical judgement, especially if integrated with a structured assessment of protective factors (Robbè et al., 2013), has the potential to integrate apparently different approaches, and gives to the clinical team the possibility to integrate recovery oriented approaches and risk assessment and managememnt strategies according to individual features of the subject.

As in any psychiatric institution, clinical teams working in the REMS start working to the individual therapeutical project putting a diagnosis. When used in a broader way, including all DSM axis concerning functioning, social and working attitudes, diagnosing enables teams to produce their causal hypothesis on a sound basis (Foresti & Rossi Monti, 2002). It is a function of a thinking team, in which symptons aren't factors to check off the list, but expressions

of patient's background, in relation with his/her internal and external characteristics.

Dynamic diagnostic system, producing formulation and treatment programs in his circular proceeding, keeps open the possibility to monitor, test and re-assess strategies in an open model. This function allows the clinician to check the quality of formulations and possibly to adopt new informations gathered by clinical observations (Eels & Lombart, 2011). A REMS admission can be in this way a period for patient's life to recover from general pessimism around his life biography and personal identity and, eventually, to take responsibilities for his/her life choices. For the team and his community partners it is a setting to develop, in the general formulation model, explanatory hypothesis on what has occurred to the patient, with attention to be paid on precipitants events/factors, patient's resources and strengths, and on listing obstacles that may impair treatment outcome.

REMS' coherent mission and vision are protective for its internal and external functioning, for example towards court expert assessments, in terms that if the new REMS have the priority to guarantee "care and control", they can't be filled by subjects with low rates of unmet caring needs (Carabellese, 2017c; Felthous et al., in press).

It also limits service competences, creating a barrier against the neverendind mechanism of reproducing asylum-like situations, represented by methods of delegation and neglect, as Law 81 has correctly pointed out.

Individual Care Plan (*Piano Terapeutico Individuale*, PTI), is the main instrument REMS and community teams share to develop a common strategy for the patient pathway of care. It presents two risks: to become solely the REMS' PTI, contributing to the isolation of forensic system facilities with the general community services, or to be a bureaucratic paper no one really cares. To avoid worst scenarios, the PTI has to be open, inclusive, dialectical with institutional community partners. It may become a useful tool if it preserves potential to create valid and shared operational hypothesis, diagnostic and therapeutical formulations.

Its proper use may facilitate releases to lower levels of security, when decisions are linked to clear therapeutical goals to reach. It may also be a precious instrument to assess the "social dangerousness" of those in *libertà vigilata*, living in the community.

Actually, a defined shared individual care program is the main tool to help clinicians in the definition and assessment of steps of care, and conversely those aspects non-negotiable with the subject.

It may be a useful instrument even for subjects in *libertà vigilata* living at home or in community residencies, often lacking of specialist evaluation of their social dangerousness. The most common outcome in these cases is leaving situations as they are, so prolonging judicial measures like *libertà vigilata ad libitum*, without an ending, as shared criteria to assess the need of prolonging or stopping the measure are lacking.

The growing number of community forensic population represent a challenge to clinical teams, forensic experts and magistrates to cooperate in the development of shared assessment strategies to avoid neglect of those in probation. It is necessary in this way to abandon past hospital based model and, at patient's level, to enhance his active role towards the rehabilitative offer. In our opinion, it's prioritary to introduce in the daily practice instruments that may facilitate the dialectical interface between the team and user. Definition of areas of intervention should be shared with patients, promoting their active position into therapeutical processes.

At the Nogara REMS, we have started introducing the forensic version of the Camberwell Assessment of Needs, CANFOR, as a tool for dialectical interventions with the patient in the systematic analysis of social and caring needs (Thomas et al., 2003, Castelletti et al., 2015). Social and clinical characteristics of those referred to the REMS are suitable for a clinical approach sensitive to issues like hope for a better future and regain of identity.

REMS have the potential to become a precious experience for patient's recovery, for those of the familiar network, and for mental health services as well, frequently tired and hopeless towards forensic cases perceived as chronic and unrecoverable.

6. Towards a forensic psychiatry network

REMS system and community facilities has been running for two years, but the OPGs were not closed until January 2017. Till current times datahaven't recorded serious incidents inside the REMS, among the patients or against the staff, nor has there been noted an increase in adverse events among the patients admitted to community facilities. There, management difficulties can sometimes arise in the course of the patients' treatment due to the fact that those with legal restrictions live alongside those who are not charged of any crime.

One of the complaints made by the staff, and very often by the management itself is that personnel cannot be held responsible for the treatment of the patients and, at the same time, for their custody and supervision in order to be confident leaves and reconvictions related risks.

Recently, patients admitted to forensic residencial treatment show diverse problematic features, not only regarding their mental state: most of them are foreigners, without a residency permit, with personality disorders, sometimes having psychopathic traits, dual diagnoses, organic comorbidity or intellectual impairment. The case mix inside the REMS and the community facilities could become one of the critical factors leading the system to modify forensic network. Most of Italian regions have adopted a system of facilities at lower level of securitynspecifically developed to non custodial, measures like Puglia and Tuscany .

The Puglia region has established two REMS and a network of specialist residential facilities for those in non-custodial security measure, aimed to create different levels of care and supervision that may better suit different clinical characteristics of regional forensic psychiatric sample.

If the patient under non-custodial measure fails to respect the Judge's prescriptionshe could be referred to the REMS. However, time required to adopt these decisions is very lengthy and meanwhile patients are still in the facilities or sometimes in an acute ward or at their private accomodation, waiting to be admitted to a REMS. Different evaluations on how to set the actual level of security for a patient may sometimes become a field of controversy or debate between forensic, general mental health services and Court experts. Judge's requests to forensic and general men-

tal health services may be compelling: this to avoid that a person declared socially dangerous spends too much time a condition of lack of any supervision or control. For this reason, it is common for the Judge to ask the expert, and/or the psychiatric services, to develop a prompt and functional PTI, generally by referring the subject to a facility where restrictive prescriptions can be applied.

One more critical aspect regards the cost of the whole system: many facilities of the private, or non-profit sector, have been obliged to increase daily costs that often exceed 200 euro. The next years will be crucial for the adjustment of the system and the improvement of practices. The Italian reform of forensic sector may be a pilot experiment for other Countries towards the de-institutionalization of treatments for those who have committed crimes without resorting to hospital based care.

7. Conclusions

Two years after the radical reform interesting forensic sector in Italy, new REMS network has improved organization and internal functioning, derived from international experience on physical, procedural and relational security (Kennedy, 2002; Scarpa et al., 2017). It has also supported the pressure derived by the impact of Laws 09/12 and 81/14, inspiring the pivotal role of community teams for forensics.

Currently, data record highlight good functioning of the system in terms of releases and rates of readmissions and reconvictions (Corleone, 2017). Early positive outcomes require an implemented collaboration with judicial and prison system, general mental health services, public officers, stakeholders.

The spirit inspiring the closing of forensic hospitals has his roots in the reformist period that brought to definite ending of the civil asylums, forty years ago (Di Lorito et al., 2017). That model enhances the centrality of social psychiatry as necessary condition to operate recovery oriented treatment plans.

New Italian forensic practice has to deal with this view, in a way that may work efficiently with reformist issues. About risk issues, forensic and general psychiatric network may take benefit from an integration with recovery oriented models, looking at the risk taking paradigm and strength model (Slade, 2005). Concept of risk, in this manner, is viewed as life challenge for prosocial goals, real social integration, autonomy, advocacy and protection of the rights (Maone et al, 2015). Combination and integration of both concepts of risk, according to patient's features, his environment, service provision, quality of networks, may better suit the specific institutional and cultural italian ground for security measures.

Inclusion of different ways of conceiving risk may foster patient's active involvement into pathways of care and a more active participation of staff members to care programs as they *per natura* better identify themselves as mental health staff members despite custodial agents. Closing of OPGs has put the duty to adopt evidence based strategies of violence risk assessment functional at the development of risk management and caring strategies (Lindqvist & Skipworth, 2000; Monahan et al, 2001).

It is prioritary in this way the introduction in the daily practice of reliable instruments of violence risk assessment, bearing in mind that they have statistical limits and their use may present side-effects in terms of prolonged hospitalizations (Hillbrand &Young, 2008; Douglas et al., 2017)

In many regions and at national level, an agreement is requested to promote quality networking of the main actors and the interested stakeholders. The Juridical System (i.e Courts and Surveillance Judges), Community Psychiatric Services, lawyers, forensic experts and Social Services work together with the aim of developing shared practices to provide effective assessments and regulations.

We are confident that closure of forensic hospitals represents a valid opportunity for Italian psychiatry to plan and allocate proper resources to sustain the reform, including training and education for all professionals involved in processes of care.

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Forensic psychotherapy: a new discipline in italian psychotherapy and psychiatric tradition

La psicoterapia forense: una nuova disciplina nella tradizione psicoterapica e psichiatrica italiana

Francesco Spadaro

Abstract
Forensic Psychotherapy consists of the psychodynamic treatment of those who have perpetrated a crime or also have suffered from a crime. By extension, it also concerns other things that are related to this field: supervisions of forensic therapists, therapeutic groups with workers at various levels in the field (guards, social workers, nurses, etc) are within the spectrum and competence of Forensic Psychotherapy. Currently, it also considers the application of cognitive, behavioural or systems/family therapy interventions. The aim of this psychotherapy is not to condone the crime or excuse the criminal. On the contrary, treatment should achieve an assumption of responsibility of what has been done by the perpetrator, along with the clarification of the individual causes that gave origin to the crime, linked to the real – conscious and unconscious – emotions of the individual and their personal history. Benefits for society are mentioned, and they consist in a decrease in criminal behaviour, harmful behaviour, risky expositions, with a concomitant saving of public money. The essential aspects of the treatment (assessment, the setting, the therapeutic relationship, the evaluation protocols) are illustrated. Future perspectives are shown.

Key words: psychotherapy • crime • psychoanalysis • treatment • society

Riassunto
La Psicoterapia Forense è una psicoterapia psicodinamica rivolta a coloro che hanno perpetrato o subito un crimine. Nell'attualità clinica, nell'ambito della Psicoterapia Forense, vengono considerati anche altri indirizzi quali cognitivo, comportamentale, sistemico - familiare. Per estensione, riguarda tutto ciò che è correlato a questo settore: le supervisioni di terapeuti forensi, l'attività di counseling o di gruppi terapeutici con operatori impegnati a diverso livello nella area giuridica e dell'esecuzione penale (guardie carcerarie, operatori di comunità assistenti sociali, dipartimenti di salute mentale, ecc.), sono nello spettro e nella competenza della Psicoterapia Forense. Lo scopo della Psicoterapia Forense non è quello di condonare o giustificare il crimine commesso bensì la terapia mira ad ottenere un'assunzione di responsabilità da parte del paziente, via via che vengono alla luce le cause che hanno portato al reato e le emozioni ad esso correlate, consce ed inconsce, nonché la sua storia personale. In questa sede si affrontano i benefici sociali conseguenza di questa pratica clinica, quali la diminuzione della prevalenza e della reiterazione del comportamento criminale e dei comportamenti a rischio violenza ed il risparmio di denaro pubblico. Vengono illustrati gli aspetti essenziali del trattamento psicoterapico: l'assessment, il setting, la relazione terapeutica forense, il protocollo di valutazione, nonché le prospettive future.

Parole chiave: psicoterapia • crimine • psicoanalisi • trattamento • società

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Forensic psychotherapy: a new discipline in italian psychotherapy and psychiatric tradition

1. Foreword

Forensic psychotherapy is a discipline that was born and has developed approximately in the last 30 years. The aim of forensic therapy is the treatment of people who have dealt with and deal in violence. It means that, above all, it regards offenders and victims, that is people, men, women, minors who have acted with violence towards other human beings, objects, or society, or it regards those who have suffered themselves from violence. In a wider perspective, an aspect of forensic psychotherapy is also studying and working psychotherapeutically with people involved at different levels in the various fields and institutions that are crime-related: prisons, mental health organizations, community care, etc.).

Understanding what is behind an act of violence it is a quite recent interest in the history of mankind. In the far past, criminal acts were discussed and resolved without too many psychological considerations. Victims received even less consideration. Among the ancient Romans, the founders of the Law in the western world, criminal law occupied a very small space compared to the very detailed and wide-ranging civil law. Generally, people who had committed a crime were put on trial quite quickly and punished with cruel retaliatory punishments such as beatings and the stocks or were put to death through sadistic tortures, such as beheadings, eviscerations, lynchings, etc. (Kahr, 2011). We would say that there was either a form of unconscious identification with the aggressor (Kahr, ibidem) or a cathartic and symmetric expression of the aggressiveness and violence of the punisher.

Only in the last two centuries an interest in crime and violence has arisen, being observed from perspectives different from that of the strict trial and criminal procedure. The evolution of philosophy in Existentialism and Phenomenology, the birth of new disciplines like Sociology, Anthropology and mostly Criminology, founded by the Italian psychiatrist Cesare Lombroso, together with the systematization of psychological studies, and the birth of psychoanalysis are the reasons for such a rich proliferation of new studies in this field.

Therefore, people who have committed a crime have begun to be studied and classified. Their existences have been collected and phenomenologically described. In some cases, a personal rational meaning was investigated and found. A social etiology begun to be hypothesized. Philosophical reasons were proposed (Foucalt, Arendt). And of course psychiatrists who have been working in criminal mental hospitals of various levels of security, since their foundation, have studied and classified and treated their patients.

The birth and the development of psychoanalysis opened the area of treatment to what has been called "the talking cure", laying the foundation for all the psychotherapies. And its principal contribution remains the discovery of the unconscious, which means that all the acts of men and women have not only a conscious origin and explanation, but also an unconscious one.

Indeed, it has to be said that the founder of psychoanalysis, Sigmund Freud, after having recognized the role of the death drive as equal to the sexual drive in being the basic driving forces that direct the human behaviour, was quite reluctant in investigating the role of the death drive (in its psychological expressions: hate, destructiveness, aggressiveness) in manifestations other than mental disorders. On the other hand, many brilliant psychoanalysts and their pupils began to investigate this field, opening it to the attempt of a more profound comprehension of the human violence, and, after all, of the entire human behaviour: among the first generation, Ferenczi, Mrs Klein herself (who was also interested mainly in the role of hate in the inner world and there is no doubt that her contribution to this field is determinant), Alexander, Staub; and later, in the UK Winnicott, Fairbairn, Glover, Limentani, Friedlander, Pailthorpe, Welldon; while in the United States Menninger and more recently, Kohut, Kernberg, Gabbard among others; in Italy, already at the beginning of the nineteenth century Edoardo Weiss, (see Migliorino, 2016). Understanding the individual, conscious and unconscious, reason behind a crime has become therefore an area of increasing and increasingly enthusiastic research.

The passage from understanding the reasons – integrating classic psychopathology with psychoanalytic knowledge – to the treatment has been consequential and forensic psychotherapy has thus been born from the coupling of forensic psychiatry and psychoanalytic and psychodynamic psychotherapy (Cox, 1993; Welldon, 2011).

Here, I would also underline the fact that in medical sciences, clinical research and clinical therapy are two faces of the same coin. This means that the more forensic psychotherapy is applied, the more it reveals its potentialities in understanding the origin of violence in individuals with the ambitious aim of finding ways to prevent its acting out.

2. Forensic Psychotherapy

Forensic Psychotherapy consists of the psychodynamic treatment of those who have perpetrated a crime or also have suffered from a crime. By extension, it also concerns all things that are related to this field. Therefore, supervisions of forensic therapists, therapeutic groups with workers at various levels in the field (guards, social workers, nurses, etc) are within the spectrum and competence of Forensic Psychotherapy. In current clinical practice Forensic Psychotherapy also considers the application of cognitive, behavioural or systems/family therapy interventions (Riordan, 2017).

It has to be immediately clear that the aim of this psychotherapy is not to condone the crime or excuse the cri-

minal (Cox 1993; Welldon, 2011). On the contrary, treatment should achieve an assumption of responsibility by the perpetrator of what she/he has done. This assumption of responsibility comes out of the psychotherapeutic process along with the clarification of the individual causes that gave origin to the crime, linked to the real – conscious and unconscious – emotions of the individual and their personal history.

A further peculiarity of this discipline is that while psychotherapy is generally a dual situation (therapist/patient, therapist/group) and any other presence has to be avoided, otherwise the relationship can be put at risk, Forensic Psychotherapy is always a triangular situation: therapist/ patient (or group) and reality. Where reality is represented from time to time by the Court, the Prison, the family, the probation rules, the social workers that have a duty to monitor, the surveillance system, and so on. The most evident consequence of this is that the inner world and the outer world are always forced into a symmetric position. This means that the inner world fantasies aim to have a role in the outer world, the real one, (as happened in the crime). And, vice versa, the real world in some cases, as it may happen in psychotic individuals, or individuals with psychotic personality features, may be considered as a phantasmatic world.

It has been widely accepted that one of the characteristics of psychoanalytic and psychodynamic therapies is self-reference. Especially in the past, the more orthodox therapists would not accept any other parallel treatment for their patients. It is not important if things have changed in technical psychoanalytical guidelines, but it must be clear that Forensic Psychotherapy is only one of the treatments and rehabilitation investments, or projects, that the patient, it does not matter if it is an offender or a victim, has undertaken. This is an important point and it is linked to what has just been expressed above on the triadic (therapy, patient and society) experience of Forensic Psychotherapy. The therapist has always to discriminate what belongs to the inner world and what belongs to the real world. And he has to do this first with himself, then with the patient and also with society, represented by other psy-workers, workers in the field of law (judges, policemen, lawyers), social workers and so on. The more the forensic psychotherapist is integrated and collaborative with the other people and agencies involved in the world of the patient, of course without abandoning his deontology, the more he is orientated in the therapy. Feeling him- or herself to be omnipotent, being the only one that knows the truth about the patient, can be fatal in this field (Cordess & Cox, 1993).

Being part of a complex treatment and rehabilitation system and not being alone also allows the therapist to avoid being overwhelmed by responsibility and thus allows them to be able to read through the primitive unconscious defence mechanisms that forensic patients prefer and are accustomed to use (Bateman, 1996), and therefore avoiding the inclination towards acting, avoiding also the trap of collusion.

It has also been stressed that forensic psychotherapeutic treatment can evoke reactions in the other operators, or in the staff of agencies and institutions involved. These reactions may come from the unconscious mobilization of the patient's projections or from the internal mechanisms of defense of the operators themselves and of the agencies. They are elicited in order to reduce increasing anxiety (Mc Gauley & Humphrey, 2003) or simply to avoid the change, which is, even if expected, always disturbing.

This has to be always considered with the highest attention by the therapist in order to immediately take action to prevent or treat destabilizations in the other operators and agencies that eventually may attack and jeopardize the forensic psychotherapy.

3. The Aim of Treatment

The aim of Forensic Psychotherapy in its specificity is to develop a better awareness of the patient's mind and of the other's mind, to experience a better awareness of who they are, what they have done, and how the crime inflicted (offenders) or suffered (victims) has impacted on their mind and life and what damage it has created, to be able to experience powerful emotions and to be able to contain them. Things that eventually can involve a better sense of identity and a way to avoid psychotic and paranoid solutions (Mc Gauley & Humphrey, 2003).

A more ambitious aim could be to try to relate what life was before and after the crime. And try to compare the patient's inner world to the outer world in relationship with the crime, particularly with regard to the passage of time and relating the emotions to the time they actually belong (Spadaro, 2016).

Benefits for society must be mentioned, and they consist in a decrease in criminal behaviour, harmful behaviour, risky expositions, with a concomitant saving of public money.

In the treatment, we recognize many aspects. I describe the ones that in my opinion must be analyzed: the assessment, the settings, the therapeutic relationship, the evaluation protocols.

A) *The Assessment*

The assessment of a patient is a necessary procedure. It can be required by the Court, lawyers or other agencies, or it can be included in the multi-team working program. However, it is a fundamental step that precedes the eventual treatment (Carabellese, 2017). Indeed, we must have a perception of his/her psychopathology that is as clear as we can manage to have, to know his/her capacity to work and evolve, and to be able to sincerely participate to the therapeutic project. Very helpful are the Welldon's (2011) suggestions regarding the behaviour that the therapist has to maintain: clarity for the patient regarding the purpose of the meetings that must be three (in her model); to keep with the exact time frame of the meetings; "keep a straightforward approach, no too cold not too friendly", providing clear information so as to then have a correct evaluation, listening to the patient but being able to ask direct questions.

There is a general agreement on the efficacy of a clinical interview (Mc Gauley & Humphrey, 2003; Yakeley, 2010, Welldon, 2011). In this case, the capacity of a patient to undertake an introspective work will be investigated and the assessment does not differ from the clinical interviews performed in other settings different from the forensic ones. It is important

though that in forensic settings some precautions must be taken. For example, giving more space to the life history of the patient. A detailed report of the offending behaviour, with an attempt of classification of the type of violence acted out by the patient, relating all of it to the associated conscious and unconscious fantasies, has been suggested (Yakeley, 2010).

We must always remember that in most cases the forensic psychotherapist is working along with other figures and he/she is involved in a multi-team program. Thus, the interview report has to be legible also for people who are not psychologically and psychodynamically orientated.

The assessment should give us the idea of what *type of forensic patient* we have in front of us and whether he/she can begin forensic psychotherapy, individual or group therapy, or not.

The *type of forensic patient* is a very generic expression. However, it proves appropriate because this generality gives us the possibility of classically categorizing our patients following the current or preferred psychopathology of forensic psychiatry, or classifying the patient in accordance with psychodynamic theories (and the one to which we are closest), and also eventually adding a more practical classification such as the one proposed by Welldon (2011), evaluating the offence perpetrated: the offence as an equivalent of a neurotic symptom in which there is no financial gain, the "careerist" offence in which there is a financial gain and there are the patient's efforts not to be detected, the offence as a manic defence against a deep and underlying depression, a crime perpetrated to cover a sexual perversion, or, vice versa, sexual behaviour that stands for hidden violence.

In the assessment, it is also important to validate our clinical interview with all the elements coming from reality: such as the work of forensic psychiatrists, the court and the police reports, the reports of the family's interviews, prison reports, hospital clinical diaries.

The function of the assessment is to decide: whether work can be performed with the forensic patient (and what type of work); to contribute to the multidisciplinary management of the case (Mc Gauley & Humphrey, 2003); to investigate and identify the defence mechanisms of the patient's ego and have a vision, if possible of his/her main inner-world fantasies and how they are related to the violence perpetrated or suffered.

B) *The Settings*

The settings in which the forensic psychotherapy is performed varies widely, depending on many factors. First of all if it is important establish whether he/she is an in-patient or an out-patient. In the first case, he/she can be hosted in a high-, a medium-, or a low-security hospital. They can be patients of non-secure in-patient units. Or they can be out-patients of non-secure units, residential therapeutic communities or patients managed by forensic units and teams.

The Italian situation is very peculiar since there are no longer any long-term psychiatric hospitals and all the secure hospitals have been recently closed (Carabellese & Felthous, 2016). Forensic patients are either out-patients followed by day hospitals and national mental health units (Sacco, Losito, Carabellese, Buzzerio, 1991).

Or in-patients of residential therapeutic communities or for the more severe cases of offenders they are in-patients of special therapeutic communities called REMS (Residenze per la Esecuzione di Misure di Sicurezza). These last ones are under the control of the Department of Health and not the Department of Justice. It has to be underlined also that there is a very long tradition in the Italian Prisons of the presence of psychiatrists and psychologists working at different levels, also psychotherapeutically, with prisoners. This is due to a rehabilitation-orientated value of the sentencing in line with Italian Law (Catanesi, Carabellese & Rinaldi, 1998). Obviously the setting can be very different in these different types of units in which restraint is the most important element of reality and it is very different when the patients are out-patients.

In the first in-patient cases, violence is evidently considered an evident feature. The attention here not only regards the significance of violence for the patient, and what it stands for, but also what is left in the personality of the patient that can be useful for him/her in entering a less primitive level of mental functioning. It is always important to stress that the therapist, in order to be able to work, must have a feeling of being secure in his or her setting (Kernberg, 1992). For those in-inpatients who suffer from severe disorders and who belong to high- and medium-security units, speaking of a classical psychodynamic psychotherapeutic setting has no sense (Minne, 2008). Instead, what is important is creating a relationship that may provide the conditions necessary to get along, to work basically together, and eventually to feel together, and finally (who knows when it may happen) to think together.

Very different is the situation with out-patients, in which violence is not evident but has been acted out in the past and can be replicated. Generally speaking, the patients present less severe disorders or less severe symptoms. The forensic psychotherapy here has better potentialities and a better prognosis. However, the therapist may feel herself/himself to be in an uncomfortable situation if she/he is alone in dealing with the patient. He/she may feel that his/her main role is the control of violence, feeling responsible for this, more than understanding the inner and outer world of the patient. Another factor to be aware of is that with out-patients, the therapists often risk underevaluating the disorder of their patients. With patients that are subject to probation, trust and confidentiality, both in the therapist and in the patient, may not be totally sincere, challenging the effectiveness of the psychotherapy. Again, it is necessary that forensic psychotherapy must be considered separately from the evaluation of the patient in terms of his or her route in coming back to (or beginning, or finding) a fruitful role in his or her life and in society. This allows the pair, or the group in cases of group therapy, to be more open in feelings and emotions. It allows the therapists to attune with the unconscious and conscious psychic manifestations of the patient, pushing themselves to negotiate with him/her on how to approach their inner world. During this negotiation in this context it is important to avoid the therapists and/or their patients both being overwhelmed with paranoid, depressive, unbearable and destructive emotions (Minne, 2003).

C) *The Relationship*

Establishing a positive treatment alliance is a necessary condition, even if not sufficient in itself, in performing a good psychotherapy also in the forensic setting. It is evident that this not an easy task. Indeed, a positive treatment alliance means that the therapist and the patient work together to let the patient improve in his/her relationships, in his/her external world, in his/her relationship with the internal objects. A forensic patient has experienced violence and destructiveness in his/her history of relationships. If the transference is authentic (meaning that it is not perverted or collusive) the therapist will be object of quite the same types of feelings and emotions, in the range of violence, rage, destructiveness, despair. The therapist's countertranference can be similarly full of dread, rage, violence, despair, anguish, paranoid sensations.

Faced with these overwhelming emotions, unconscious defences such as idealization or denial can be elicited by both the parts. The devotion to containment by the therapist can lead to a depletion of his/her energies. An eventual abandoning of the therapy by the exhausted therapist may lead to catastrophic reactions by the patient, and may jeopardise the trust of the multi-disciplinary team regarding the effectiveness of the therapy.

Some authors differ among themselves in suggestions to avoid the above described disturbing and potentially psychic lethal elements. Perelberg (1999) considers the importance in the capacity of the analyst to perform maternal and paternal functions. In her theory, being the violence of the patient a defence towards a maternal fusion with a terrifying object, she considers the importance of the interpretations, as an activation of a healthy paternal function, which introduces separation and differentiation. Cartright (2002) considers as essential the therapist's empathic mirroring of the patient to establish and reinforce the therapeutic alliance, warning of precocious interpretations and interventions that can challenge the idealized self of the patient, thus leading to negative consequences in the treatment. Some authors (Bateman, 1999; Davies, 1999; Cartright, 2002) recommend the use of analyst-centred interpretations with violent patients, a technique through which the analyst attempts to clarify with the patient what he or she feels is going on in the mind of the analyst.

It is essential to be aware of the feelings or the emotions in the relationship, and in the transference-countertransference relationship. I personally consider useful and less dangerous to explicit to the patient those particular feelings or emotions, related to the unconscious fantasy in the *here and now* situation, and simultaneously timing it to the personal history of the patient's existence.

Yakeley (2010) highlights a very interesting point: while the forensic therapist is accustomed to experience negative feelings and thoughts, positive feelings and thoughts are often neglected or ignored. She considers the positive emotions (warmth, hope, enthusiasm) not only as a reflection of a good therapeutic alliance and progress, but in her view they can also be the fruit of a dangerous idealization. This observation is important and brilliant. However, I think that positive feelings and thoughts are not always necessarily something to beware of. Without hope and warmth there is no improving route. Also, the relationship with a forensic patient has some important landmarks that we have to bear in mind and that condition specifically this type of therapy.

The first one is the psychopathology of the patient (it is not really important whether the patient is an offender or a victim). Much more than in neurotic patients, or patients whose violence has been contained in fantasy or transformed into neurotic symptoms, or even sublimized, the crime, and the type of violent feature manifested or suffered by the forensic patient, is the tone that conditions for many years the therapy. Thus, paranoid patients will use paranoid mental function mechanisms. Sadistic patients will try to transform the therapy in a sadomasochistic relationship. The perverted patients will try always to pervert the therapeutic relationship and the meaning of the therapy. The masochistic patient will always demonstrate a masochistic solution. Psychotic patients will try to make the therapist mad. A patient in depressive despair will flood the setting with his or her anguish. And so on. This is a trend, a monotone trend, that the forensic patient can maintain for a long, long time, before the psychotherapist will be able to enlighten other tones in his/her soul. Another landmark in the forensic therapy is the crime itself, which, in the offender and in the victim, has functioned as T0. We can divide, with a benchmark similar to that of the birth of Christ, the life of our forensic patient as Before the Crime (bc) and After the Crime (ac). It is important to compare in the therapy, and with the patient, the two external lives – bc and ac – and his or her phantasmatic atemporal life in his or her internal world. The timing of the events and the emotions is a fundamental tool that it is necessary for the containment of violence (Spadaro, 2016) and of its trend to expand infinitely (Matte Blanco,1975).

6. Evaluation protocols

Here, there is not too much to report and and very much to do. Many reasons for this. First of all Forensic Psychotherapy is a fairly new discipline, and above all, it has been developed and performed in clinical settings and by clinicians more than academics. There is also a traditional reluctance of the psychotherapists in accepting any type of evaluation protocol. It is something that is considered to be against one of the foundations of the value and efficacy of psychotherapy: it being a unique and intimate experience. Nevertheless, Forensic Psychotherapy needs to develop evaluation protocols. It needs this because dealing with the forensic field and reality, in terms of society, Forensic Psychotherapy has to give proof of the efficacy of its methods. Let us also clearly say that public opinion, while it is apparently caring of victims, does not accept, or accepts with quite strong resistance, the treatment of the offenders.

Another obvious reason is that the evidenced based effectiveness of psychotherapeutic treatments for such difficult disorders has to be plainly indicated in such a difficult field, which engages so many professionals and social and economic resources, in order to avoid pseudo-scientific beliefs and therapeutic practices validated by habit. One example above all is the difficult psychotherapeutic treatment of personality disorders, which is one of the most controversial despite the fact that, in the end, its effectiveness has never been really evaluated (Bateman & Fonagy, 2000).

4. Conclusions

In the last 30 years a great deal has been written about the treatment of people who have experienced violence as offenders and/or as victims. Forensic Psychotherapy was born and has grown as a discipline. Many scientific associations that gathered clinicians working in this very special field have been created around the world: among these, the Italian Society of Forensic Psychotherapy (SIPFo; www.sipfo.it), as well as an International Society (the International Society for Forensic Psychotherapy). However, there is still a lot to do. The clinical field of Forensic Psychotherapy has enlarged its area of intervention: not only strongly suggesting the importance of clinical supervisions of forensic psychotherapists, but also promoting clinical work with social workers, police people and other workers in this field, implementing supervisions and counselling work for agencies and institutions. All this work has to be structured, evaluated and promoted. Moreover, the shortage of evaluation protocols has to be filled to make this discipline more widely recognized and essential as it clinically appears to be. Also, interdisciplinary relations with other areas, Criminology, Forensic Psychiatry, Law, have to be improved. Finally, a reorganization of all these 30 years of specific knowledge has to be performed.

However, it must be proudly stated that already Forensic Psychotherapists are giving humankind the possibility to bring light into the *Heart of Darkness* of men and women.

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The pharmacotherapy of clinical aggression in criminal offenders

La farmacoterapia delle condotte aggressive di interesse clinico negli autori di reato

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Abstract
Pharmacotherapy of clinical aggression begins with assessment of the individual regarding the nature of the aggression and diagnosis. In general psychiatry, but especially in the treatment of criminal offenders, addressing aggressive behavior as well as the mental disorder is essential for safe and effective treatment. Assessment and pharmacotherapy of impulsive aggression is informed by diagnosis, identification of evidence-based anti-impulsive aggressive agents (AIAAs), AIAAs risks and side effects, severity of aggression, prescription parsimony, pharmacotherapy history, and affordability and availability. Pharmacotherapy of aggression that is secondary to a mental disorder must address both the aggressive behavior and the disorder. Illustrative examples discussed here are the pharmacotherapy of aggression secondary to bipolar disorder, schizophrenia and psychotic disorders, and traumatic brain injury respectively.

Key words: aggressive behavior • criminal offenders • mental disorder • assessment • pharmacotherapy

Riassunto
La farmacoterapia dell'aggressività di interesse clinico inizia con la valutazione della sua natura e la diagnosi del disturbo che ne è eventualmente all'origine. E ciò nell'interesse dell'efficacia del trattamento e della sicurezza, specie in abito psichiatrico-forense.
La corretta valutazione e la farmacoterapia dell'aggressività impulsiva, sono infatti sostenute da un corretto processo diagnostico e dalla conoscenza, evidence-based, dei farmaci da utilizzare: la loro efficacia, gli eventuali effetti collaterali, il dosaggio minimo da usare, la loro affidabilità e disponibilità, eventuali trattamenti pregressi, oltre che dall'apprezzamento della severità della condotta aggressiva.
La farmacoterapia delle condotte aggressive secondarie ad un disturbo mentale, deve necessariamente indirizzarsi al trattamento della condotta e del disturbo che ne è alla base. Qui saranno affrontati tipici esempi di condotte aggressive secondarie a disturbo bipolare, a disturbo schizofrenico ed altri dusturbi psicotici, e secondarie a traumi cranici.

Parole chiave: condotta aggressiva • autore di reato • disturbo mentale • valutazione clinica • farmacoterapia

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Introduction

Not all aggression is clinical and not all clinical aggression is best treated with pharmacotherapy. Nonetheless in the treatment of criminal offenders, aggressive behavior should be assessed as well as their mental disorder(s), for safe and effective treatment. Most clinically relevant aggression is impulsive and may be amenable to pharmacotherapy or secondary to a mental disorder. Therefore treatment must begin with an assessment of the nature of the aggressive behavior as well as other primary psychopathology.

1. Assessment of Clinical Aggression

The aggression of the criminal offender must first be evaluated before developing a pharmacotherapeutic strategy (Felthous, 2013). Of the four basic approaches to the assessment of clinical aggression – diagnostic, behavioral, actuarial and phenomenological – (Felthous, 2010), the two most useful approaches for pharmacotherapy are diagnostic and phenomenological. The diagnostic approach to assessing clinical aggression is criticized as being less accurately predictive of future violence in comparison with the actuarial approach, yet it is the most used and most useful approach in psychiatric practice (Felthous, 2014). For example where violent behavior is secondary to mania, once bipolar disorder is diagnosed treatment with a mood stabilizer quells the manic symptoms including the risk of aggressive behavior (El-Mallakh, Roberts, & El-Mallakh, 2008; Felthous, 2010; Moeller & Swann, 2007; Tardiff, 2007).

The second most useful, but probably underused, approach to the assessment of clinical aggression is phenomenological, i.e. assessment of the nature of the aggression regardless of diagnosis. In theory ontogenetic, in practice this approach is descriptive and therefore termed phenomenological (Felthous, 2010). Phenomenological assessment addresses the dichotomous distinction between impulsive and premeditated aggression.

Assessment can be assisted with the structured interview developed by Stanford and Barratt, 1992, or by a version modified by Felthous and colleagues (2009), that relies on written records when the subject is an unreliable informant of his or her violent episodes. The phenomenon of impulsive aggression, well researched and described in the scientific literature, corresponds with intermittent explosive disorder whose criteria has been expanded in DSM-5.

2. Pharmacotherapy of Primary Impulsive Aggression

The aggression of criminal offenders is often primary impulsive aggression. Effective treatment and prevention of this behavior can go a long way towards improving the offender's adaptation to society and within prison systems, reducing physical harm that would otherwise be inflicted upon others and themselves. Nonpharmacotherapeutic measures, such as cognitive-behavioral therapy, have been shown to be effective and are indicated (Deffenbacher, 2003; McClosky, Nobeltt, Deffenbacher, Gollan, & Coccaro, 2008). Nonetheless optimal treatment often requires the use of an anti-impulsive aggressive agent (AIAA, Felthous, 2013).

The diagnostic approach, i.e., the medical model, informs efficacious treatment of manifestations of the disorder including abnormal aggression (Felthous, 2010). With the diagnostic approach, the clinician first assesses the patient's mental condition and diagnosis any presenting mental disorder, using standardized nomenclature such as that of the DSM-5 (American Psychiatric Association, 2015). Next an attempt is made, following the phenomenological approach, to assess the nature of the aggressive behavior, and the presence, severity and frequency of rage episodes of impulsive aggression in particular.

Impulsive aggression is defined as "a 'hair-trigger' response to a stimulus which results in a sudden agitated state that lasts from a few minutes to several hours (Elliot, 1990); the agitation builds to a crescendo and culminates in an aggressive act. During this state, interpersonal communication appears inefficient, and recall of the related events may be poor" (Felthous & Barratt, 2003, p. 130).

3. The Pharmacotherapy of Primary Impulsive Aggression

No anti-impulsive aggressive agent (AIAA) has been approved by the United States Food and Drug Administration for the treatment of impulsive aggression or intermittent explosive disorder. Therefore the treating clinician may decide to first attempt psychotherapy or environmental manipulation (Felthous, 2013). Particularly where the aggression is severe or nonpharmacotherapeutic measures have failed, an AIAA trial is indicated.

The first step in the treatment of primary impulsive aggression is accurate diagnosis of the condition. Assessment includes a description of the nature, severity and frequency of aggressive episodes as well as ideally a diagnosis of co-occurring personality disorder (Felthous, 2013). Next the clinician should obtain a medical history and look for prior use of psychotropic or anti-impulsive aggressive agents, with attention to their favorable effect or impulsive aggression as well as any side effects. If an AIAA has been tried before

with improvement in impulsive aggression, this agent may be selected as the treatment of choice.

Circumspection is warranted because none of the AIAAs are FDA approved for impulsive aggression. One must be especially vigilant against side effects either from the patient's history or during the course of treatment. Monitoring the patient's condition for reduction in aggressive episodes is important and more easily accomplished where the patient is imprisoned or an inpatient of a forensic hospital (Felthous, 2013). If the patient is treated as an outpatient, engagement of a co-inhabiting collateral source such as a spouse who can provide ongoing objective reports is recommended.

Felthous and Stanford (2015) proposed an algorithm for selecting an AIAA for the treatment of primary impulsive aggression in individual patients. The critical factors in this algorithm are: clearly define and characterize the aggressive behavior, identify those drugs with demonstrated efficacy in treating primary impulsive aggression through drug trials of sufficient quality, consider the risks, side effects, and contraindication for each AIAA with regard to the patient, assess the severity of the patient's aggressive outburst, and identify any co-occurring mental or medical condition that might also benefit from one of the AIAAs (Felthous & Stanford, 2015).

4. Diagnosis of Primary Impulsive Aggression

The first step, discussed above, is diagnosing primary impulsive aggression or its closest DSM condition, Intermittent Explosive Disorder (American Psychiatric Association, 2013). Its opposite, premeditated aggression, that is not impulsive is not expected to respond to an AIAA (Barratt et al., 1997a, 1997b). (For further information on the diagnosis of PIA, the reader is referred to Barratt et al. 1997a, 1997b; Stanford & Barratt, 1992; Felthous & Barratt, 2003; the DSM-5 criteria for IED (2013) or a reasonable modification of the IED criteria such as those used by Coccaro (Coccaro & Kavoussi, 1997; Coccaro, Kavoussi & Berman et al., 1998; Coccaro, Lee, & Kavoussi, 2009; Coccaro, 2011).

4.1 *The Anti-Impulsive Aggressive Agents (AIAA)*

Once impulsive aggression is diagnosed the next question is which agents are efficacious in treating it. No agent has been subjected to every phase of research that is necessary to gain approval by the U.S. Food and Drug Administration (FDA) for this indication. Nonetheless efficacy of five drugs has been demonstrated by at least two double-blind control studies. Felthous and colleagues reviewed the literature and identified 55 peer-reviewed studies on the pharmacotherapy of aggression. Each study was assessed using specific quality measures. Levetiracetam had negative results, so not all anticonvulsants are anti-impulsive aggressive agents. Those agents that were shown to be efficacious in at least two higher quality studies were: fluoxetine, phenytoin, carbamazepine/oxcarbazepine, valproate/divalproate, and lithium (Felthous, Lake, Rundle, & Stanford, 2013). Thus the selection of the best AIAA for a patient's primary impulsive aggression would come from these drugs.

4.2 *Risks and Side Effects*

Fluoxetine

The steps that follow need not be in any particular order. A critical consideration is the risks, side effects and contraindications of each of the AIAAs. Of all the AIAAs, fluoxetine has the most favorable side effect profile and is most conveniently administered because serum levels and other laboratory tests are not necessary.

As a rule AIAAs, including selective serotonin reuptake inhibitors (SSRIs) (Goldstein, Carbin, & Sundell, 1997) should be avoided in pregnant females for the treatment of PIA because of the risk of fetal abnormalities. Fluoxetine poses risk so if drug-drug interaction through the P450 system. If the patient must take another SSRI AIAA drug with a risk of drug-drug interaction with fluoxetine the clinician might well consider sertraline for which there is some, but less evidence of efficacy and which shows less, yet some drug-drug interaction via the P450 system. Or the physician may select another AIAA that does not interact with the other drug.

Valproate/Divalproex

Compared with lithium and the other anticonvulsant AIAAs, valproate/divalproex has a favorable side effect profile and would be commonly used for PIA. Because of the risk of neural tube defects it should not be used to treat impulsively aggressive women in the first trimester of their pregnancy (Bowden, 2004; Dreifus, Langer, Moline, & Maxwell, 1989). (Polycystic ovary syndrome is an increase risk for women treated with valoproate/divalproex.) It is not recommended for epileptic women with intellectually development disorder because of their increased risk of pancreatitis, and it should be used only with caution in offenders with intellectual disability (Buzan, Firestone, Thomas, & Dubovsky, 1995). Administration together with other antiepileptics is associated with an increased risk of hepatic failure. It should be avoided in patients with impaired liver functioning (Dreifus et al., 1989; Buzan et al., 1995). Women should be tested for pregnancy prior to the administration of valproate/divalproex (Felthous, 2013).

Carbamazepine

As with AIAAs generally carbamazepine should be avoided in pregnant women due to its heightened risk for low birth weight and teratogenic effects such as craniofacial deformities, digital hypoplasia and spina bifida (Jones, Lacro, Johnson & Adams, 1989; Ketter, Wang, & Post, 2004; Rosa, 1991). As for valproate/divalproate, women should be tested for pregnancy before prescribing (American Psychiatric Association, 2002a). Nursing mothers should be advised not to breastfeed their baby when carbamazepine is prescribed because it transfers into breast milk at half the concentration as that in maternal blood (Froescher, Eichelbaum, Niesen, Dietrich, & Rausch, 1984; Kuhnz et al., 1983). Because of the risk of carbamazepine-associated hyponatremia, carbamazepine and resulting confusion, carbamazepine should be used with caution, if at all, in elderly patients (Ketter et al., 2004).

Although not contraindication, some risks require special vigil and when prescribing carbamazepine: Stephen-Johnson syndrome, agranulocytosis aplastic anemia ("Carbatrol", 2003;

"Tegretaol", 2003), hepatitis, and impaired cardiac condition (Ketter et al., 2004), although the latter is less of a risk than for lithium (Connell, Rappeport, Gordon, & Brodie, 1984; Joffe, Post, Ballenger, Rebar, & Gold, 1986). Any patient with a cardiac history should have an EKG before carbamazepine/oxcarbazepine is prescribed (American Psychiatric Association, 2002a). Because patients of Asian ancestry have an elevated risk of epidermal necrosis and Stephen-Johnson syndrome (Winner, 2013), an alternative AIAA would be preferred for this population.

Phenytoin

Phenytoin's side effects are dose related (Trescher & Lesser, 2008). Because it is prescribed for PIA at a lower dose and serum level than what is needed for seizure control, the side effects should be less likely (Felthous, 2013). A side effect to consider when selecting an AIAA is its impairment of vitamin D absorption (Trescher & Lesser, 2008) leading to complications of hypocalcemia such as osteoporosis. For this reasons phenytoin is not the best AIAA for elderly, nonambulatory, or postmenopausal offenders. Phenytoin should not be prescribed for pregnant female offenders because of the risk to fetal development because of impaired folate metabolism caused by phenytoin. Phenytoin should not be coadministered with a contraceptive agent because it can render contraception ineffective (Trescher & Lesser, 2008), a concern that is especially applicable to offenders who are living in the community. Other side effects to monitor for include gingival hyperplasia, hirsutism, hypersensitive skin reaction, coarsening facial features, neurotoxicity and megaloblastic anemia (Trescher & Lesser, 2008).

Lithium

Although good evidence supports the use of lithium in the control of PIA (Campbell et al., 1984, 1995; Malone et al., 1998; Jones, Arlidge, Gilham, Reagu, van den Bree, & Taylor, 2011; Sheard, Marini, Bridges, & Wagner, 1976). Lithium should be avoided in the following populations: elderly persons who may be prone to lithium toxicity (Himmelhock, Neil, May, Fuchs, & Licata, 1980), women (Kirov, 1998), and patients with a history of thyroid disease (Kusalic & Engelsmann, 1999). Lithium should be avoided in patients with renal disease or renal insufficiency because of lithium's increased risk for renal tubular damage (Gitlin, 1999), diabetes insipidis (Bendz & Aurel, 1999) and renal insufficiency and failure (Fenves, Emmett, & White, 1984). Kidney function can be checked and monitored with periodic serum creatinine levels (American Psychiatric Association, 2002a).

Lithium is FDA-approved for certain mental disorders even when the patient has cardiovascular disease. It should however be avoided for the non-FDA approved indication of PIA (Felthous, 2013) because of its association with atrioventricular block (Martin & Piascik, 1985), sinus bradycardia (Stecker, 1994), T-wave changes and ventricular irritability (Mitchell & MacKenzie, 1982). Lithium should be avoided where there is the possibility of drug-drug interaction with adverse results. Neurotoxicity is associated with co-administration of lithium and calcium channel blockers such as diltiazem and verapamil (Dubovsky, Franks & Allen, 1987; Finely, Warren & Peabody, 1995; Helmuth, Ljaljevic, Ramirez, & Meltzer, 1989; Wright & Jarrett, 1991). When prescribed together with angiotensin-converting enzyme inhibitors (i.e., antihypertensive agents such as captopril and lisinopril (DasGupta, Jefferson, Kobak, & Greist, 1992; Finley, O'brien, & Coleman, 1996), thiazide diuretics (Finley, Warren & Peabody, 1995), and onsteroidal anti-inflammatory agents such as ibuprofen and naproxen (Johnson, Seidman, & Day, 1993). If the patient must be prescribed a medicine from one of these categories, then lithium would not be the AIAA of choice (Felthous, 2013). In correctional settings but also in the community psychiatric and medical treatment can be compartmentalized. Therefore, it behooves all prescribers to know what other medication the patient is taking. Lithium can rise to toxic levels.

4.3 *Severity of Aggression*

Although more research is needed on the pharmacotherapy of subtypes of primary impulsive aggression, there is some evidence that Type 1 intermittent explosive disorder responds to fluoxetine whereas Type 2 may best be treated with an anticonvulsant AIAA or lithium. Type 1 IED is manifested by frequent but not physically destructive or injurious aggressive outbursts, a subtype of IED introduced in DSM-5 (American Psychiatric Association, 2013). Although also including Type 2 IED, Type 1 IED was the inclusion threshold for Coccaro's studies showing efficacy in the treatment of primary impulsive aggression (Coccaro, Lee, Kavoussi, 2009; Coccaro & Kavoussi, 1997). Compared with the other AIAAs, fluoxetine has the most favorable side effect profile and is most convenient to administer (Felthous & Standord, 2015), because unlike lithium and anticonvulsant AIAAs, regular blood draws for serum levels are not necessary (Felthous, 2013; Coccaro & Kavoussi, 1997).

If the aggressive episodes are serious, involving destruction of property and physical injury to other persons, it may be more prudent to turn directly toward lithium or an anticonvulsant AIAA (Felthous, 2015). The studies by Barratt and colleagues showed efficacy of phenytoin in treating PIA with consequentially severe rage outbursts (Barratt et al., 1997a, 1997). If one AIAA results in no improvement after adequate trial, the other may be worth a trial. Although not tested empirically fluoxetine and an anticonvulsant AIAA may be more effective than either alone, fluoxetine affecting serotonin availability in the frontal lobes (Coccaro et al., 2009), whereas the anticonvulsant AIAAs adjust the glutamate/GABA balance in the amygdalae (Stahl & Morrisette, 2014).

4.4 *Parsimony*

Efficiency is a virtue in prescribing any medication. Especially when prescribing an AIAA for PIA, an indication not approved by the FDA, the justification can be increased if there is a co-occurring disorder in need of treatment for which an AIAA is approved. An example of a disorder that commonly co-occurs with mental disorders including PIA is seizure disorder. This co-occurrence would disfavor the selection of lithium which is not an anticonvulsant. This principle of parsimony also applies to the selection of an anticonvulsant for treatment of a seizure disorder that is co-occurring with PIA. Levetiracetam would be a disfavored anticonvulsant because it has no beneficial effect on PIA

(Mattes, 2008). For co-occurring PIA and seizure disorder, the selection of an AIAA that offers this "two-for-one" advantage is limited to phenytoin, carbamazepine/oxcarbazepine, and valproate/divalproex (Felthous, 2015).

This principle of parsimony may justify treating a pregnant woman's PIA with an anticonvulsant, if the anticonvulsant is an AIAA, and the type and frequency of seizures do not permit withdrawal of the anticonvulsant before conception (Felthous, 2015). This is because the risk of harm to mother and fetus is greater than the teratogenic risk of the anticonvulsant AIAA (Lowenstein, 2013). In this case precautions can be taken to reduce the teratogenic risk to the fetus: mono-anticonvulsant therapy, lowest effective dose in the first trimester, prescription of folate and oral vitamin K during the last two weeks of pregnancy and injecting the infant with vitamin K intramuscularly at birth (Beghi & DiMascio, 1986).

All AIAAs except phenytoin have been FDA approved for treatment of a mental disorder. The presence of such a disorder affords an opportunity for prescribing one agent for two mental conditions, impulsive aggression and the disorder for which the agent is an FDA approved treatment: Fluoxetine for depression, obsessive-compulsive disorder, and bulimia nervosa (Physician's Desk Reference, 2012), valproate for mania (Physician's Desk Reference, 2012). Valproate/divalproex, carbamazepine and lithium are mood stabilizers that are also effective agents for bipolar I and II disorders, and so are ideal for the treatment of co-occurring impulsive aggression (Felthous, 2013).

Other conditions for which an AIAA may also be effective are: panic disorder (Michelson et al., 2001), posttraumatic stress disorder (van der Kolk et al., 1994), premenstrual dysphoric disorder (Menkes, Taghavi, Mason, & Howard, 1993; Perlstein et al., 1997; Steiner et al., 1995; Su et al., 1993; Su et al., 1997; Wood, Mortola, Chan, Moossazadeh, & Yen, 1992), premature ejaculation (Graziottin, Montorsi, & Graziottin, 1996) and pain associated with diabetic neuropathy (Max et al, 1992), fibromyalgia (Arnold et al., 2002; Goldenberg, Mayskiy, Mossey, Ruthazer, & Schmid, 1996) and possibly nightmare disorder (Felthous, 2013), for fluoxetine, epilepsy and migraine headaches for valproate/divalproex (Physician's Desk Reference, 2012); trigeminal neuralgia (Boes et al., 2008), partial and generalized tonic-clonic seizures (Trescher & Lesser, 2008), and neuropathic pain (Harati & Bosch, 2008) for carbamazepine; painful dysesthesias of Fabry's disease (angiokeratoma corpus diffusum) (Islam and Roach, 2008) and pain of glossopharyngeal neuralgia (Boes et al., 2008) by carbamazepine as well as by phenytoin; partial and generalized tonic-clonic seizures (Brodie & Dichter, 1966) and trigeminal neuralgia (Boes et al., 2008), for phenytoin; prophylactic treatment of cluster headaches (Boes et al., 2008, for lithium. In addition to its mood stabilizing effect, lithium also has a specific anti-suicide effect (Ahrens & Müller-Oerhinghauseir, 2001).

4.5 *Pharmacotherapy History*

Important in selecting any psychotropic agent for any mental disorder, but especially important is selecting an AIAA for primary impulsive aggression, a non-FDA approved condition, is obtaining a careful medication history. The purpose is to find if a particular AIAA has been used before and was associated with reduction in the impulsive aggression and with few to no side effects (Felthous & Stanford, 2015). The treating psychiatrist should bear in mind the possibility that an AIAA was previously prescribed for another indication such as bipolar disorder or seizure disorder. If from careful questioning it was shown to have resulted in reduced impulsive aggression, this would favor the agents selection.

4.6 *Affordability and Availability*

An important consideration is the selection of any medication for any condition is whether the patient can afford it and whether it will be available to the patient. These conditions must be addressed before selecting an AIAA. If an agent is not available once the patient is transferred back to a jail or a prison, it may not be administered. A medication that is not affordable or available to the patient after discharge from the hospital into the community, he will not be expected to continue to take it (Felthous, 2013).

5. Aggression Secondary to a Mental Disorder

Aggressive behavior that is symptomatic of a specific mental disorder may phenomenologically be primarily impulsive, primarily premeditated but with an illness-derived motivation (e.g., delusion), mixed or both. At any rate the first approach is to prescribe in order to treat the primary disorder, as secondary aggression typically improves along with other symptoms of the disorder (Felthous, 2015). Where the aggression does not improve, another strategy can be considered such as adding an AIAA, especially if the aggression, though secondary, is primarily impulsive. In some cases the co-occurrence of aggressive behavior can inform the selection of the agent for treatment of the primary mental disorder.

5.1 *Bipolar Disorder*

Manic episodes can be attended by exceptionally aggressive behaviors, including impulsive aggression that is secondary to mania (Felthous, 2013). In a study by Quanbeck and colleagues, most of those with bipolar disorders who were arrested were manic (74.2%) and/or psychotic (59%) at the time of their arrest (Quanbeck, Stone, Scott, McDermott, Altshuler & Frye, 2004). The risk of aggression can be increased with psychosis or substance use (Asnis, Kaplan, Hundorfean, & Saeed, 1997). Although serious violence with mania is rare, manic patients are often assaultive or threatening (Krakowski, Volavka, & Brizer, 1986). Especially when restrained or when limits are placed on their behavior, patients with mania commonly react with aggression (Tardiff & Sweillam, 1980). In Fazel's study of over 3,700 individuals diagnosed with bipolar disorder in comparison with controls and unaffected siblings, those with bipolar disorder had an increased rate of violent crime, but excessively violent crime we associated with substance us co-

morbidity (Fazel, Lichtenstein, Grann, Goodwin, and & Langstrom, 2010).

Some of the efficacious mood stabilizers are also efficacious AIAAs. The risk of assaultiveness subsides *pari passo* as the mania is brought under control. Hyperactivity and impulsivity of mania are reduced by both valproate and lithium (Swann, Bowden, Calabrese, Dilsaver, & Morris, 2002). Hostility appears to be attenuated more effectively with valproate (Bowden, 2004; Swan et al., 2002). If either is effective the clinician can change the mood stabilizer to carbamazepine or topiramate (Moeller & Swann, 2007). In contrast to the anticonvulsants divalproex/valproate and carbamazepine, lithium although an effective AIAA for primary impulsive aggression (Barratt et al., 1997a, 1997b), phenytoin is not approved as an anti-mania agent. If aggression is not improved by the mood stabilizer alone risperidone may be added (Moeller & Swann, 2007). The American Psychiatric Association guidelines recommend the combination of an antipsychotic and a mood stabilizer such as lithium or carbamazepine as more effective in the treatment of severe aggression than either such agent alone (APA, 2002).

5.2 *Schizophrenia and Psychotic Disorders*

Antipsychotic agents are generally effective in the treatment of psychosis and schizophrenia, with quelling of any accompanying aggressive behavior. Aggressive behavior is most likely to occur with schizophrenia when the patient is actively psychotic (Keck, Strakowski, & McElroy, 2000). Although aggressive behavior can result from the psychotic symptoms themselves such as delusions (Taylor, 1985; Taylor et al., 1994), much of the aggressive behavior in schizophrenia can be described as impulsive (Felthous, 2008; Felthous et al., 2009). Atypical antipsychotics have been shown to reduce the aggressive behavior of psychotic disorders (Keck et al., 200; Nasralla & Tandon, 2002), more so even than typical antipsychotics (Chengappa, Goldstein, Greenwald, John & Levine, 2003; Citrome et al., 2001; Lieberman, 2004).

Several of the studies demonstrating superiority of an atypical antipsychotic in reducing hostility and aggression found favorable results with quetiapine (Chengappa et al., 2003; Lieberman, 2004; Nasrallah & Tandon, 2002). Before selecting quetiapine however, the clinician must also consider its singular reputation for abuse with an appreciation of the widespread substance abuse among offender populations (Eder, 2008; Pina, 2007).

An agent with demonstrated efficacy in reducing hostility in schizophrenic patients is olanzapine, significantly superior to haloperidol, amisulpride and quetiapine (Volavka, Czobor, & Derks, et al., 2011) and to perphenazine and quetiapine in another study (Volavka, Czobor, Citrome, & Van Dorn, 2014). The multicenter CATIE study showed olanzapine to be significantly more efficacious than perphenazine, quetiapine, risperidone, and ziprasidone in reducing hostility as assessed by the PANSS Hostility items (Volavka, Czobor, Citrome, and Van Dorn, 2016). The PANSS Hostility item, which may include overt aggression, is used as a proxy measure of aggression (Volovka, 2002): A meta-analysis of risk factors in persons with psychosis estimated that higher hostility scores and hostility during the study period were significantly associated with increased risk of violence (Witt, van Dorn, & Fazel, 2013).

Prior to recent research favoring olanzapine, risperidone was emerging as an especially effective antipsychotic agent in controlling aggression in patients with schizophrenia (Aleman & Kahn, 2001; Chengappa et al., 2000; Moeller & Swann, 2007). Like other atypical antipsychotics, risperidone was thought to reduce aggression by improving executive functioning, thought processing as well as controlling psychotic thoughts and perceptions that result in behavioral dyscontrol. If an atypical is ineffective, a typical antipsychotic can be tried (Felthous, 2013). For schizophrenia associated with violent behavior that is resistant to treatment, Morrisette and Stahl (2016) and Meyer (2016) recommend high-dose monotherapy of the selected antipsychotic using plasma levels rather than dosages for titration. Risperidone's D_2 occupancy, for example, can be estimated based on risperidone's serum concentration (Uchida, Takeuchi, & Graff-Guerrero et al., 2011). The usual dose range is 10-20 mg/day (Morrissette & Stahl, 2016), and the recommended plasma level is within the range 20-60 mg (Kiemke, Baumann, & Bergeman et al., 2011). The FDA approves up to 80 mg/day and very high doses are usually not tolerated (Morrisette & Stahl, 2016). For olanzapine the minimum threshold for response is 23.2 mg/ml (Perry, Lund, Sanger and Beasley, 2001). An estimated 70 mg ng/ml is needed for 80% D_2 occupancy (Uchida et al., 2011). The usual dose range is 10-20 mg./day, and recommended plasma levels are 20-80 ng/ml (Hiemke et al., 2011). In some forensic settings the dose administered is as high as 90 mg/day (Morrisette & Stahl, 2016). A treatment-compliance advantage for both risperidone and olanzapine is that they can be administered via a long acting depot formulations which can be supplemented with the oral formulation (Morrisette & Stahl, 2016). Clozapine is not the first choice because of its adverse side effect profile including the risk of potentially lethal agranulocytosis as well as the need for patient cooperation with multiple blood draws. However, where other agents have failed clozapine can often reduce psychotic symptoms as well as the schizophrenic patient's impulsively aggressive behavior (Buckley, Bartell, Donenwirth, Lee, Torigoe, & Schulz, 1995; Fava, 1997; Glazer & Dickson, 1998; Krakowski, Czobor, Citrome, Bark & Cooper, 2006; Moeller & Swann, 2007; Rabinowitz, Avnon, & Rosenberg, 1996). Even after controlling for sedation, clozapine directly reduces long-term violence in patients with schizophrenia (Chiles, Davidson, & McBride, 1994; Citrome et al., 2001). In some cases optimal effects are achieved by combining clozapine with one or more other antipsychotic agents (Hotham et al., 2016; Meyer, 2016).

No doubt mood stabilizers are often used in combinations with antipsychotic agents to control mood swings in schizoaffective disorder, but also to control aggressive behavior associated with schizophrenia. One study showed one third of schizophrenic patients were prescribed both an antipsychotic and a mood stabilizer (Citrome, Levine, & Allingham, 2000). A mood stabilizer that is commonly co-prescribed with an antipsychotic in the treatment of schizophrenia is valproate (Bowden, 2004), and studies show this can result in improved global functioning (Bogan, Brown, & Suppes, 2000; Casey et al., 2003; Wassef et al., 2000). Even

if aggressive behavior is not directly tested, one might reasonably assume that increased global functioning includes diminished aggressive behavior (Felthous, 2013). Some reports indicate that valproate is associated with reduced plasma levels of clozapine (Longo & Salzman, 1995) and olanzapine (Haslemo, Olsen, Lunde & Moldar, 2012). This raises the possibility of subtherapeutic levels of an antipsychotic agent when valproate is co-administered, unless the dose of the antipsychotic is increased. Dose and colleagues found that valproate combined with haloperidol reduced "hostile belligerence" in the treatment of schizophrenic psychosis (Dose, Hellweg, Yassouridis, Theison, & Einrich, 1998).

Carbamazepine has been used to treat psychotic and behavioral disorders (De Vogelaer, 1981), and it has been found to diminish aggressive behavior when combined with antipsychotic medication (Okuma et al., 1989). Carbamazepine may be an even more potent inducer of antipsychotic metabolism, requiring a higher dose of the antipsychotic and plasma antipsychotic levels (Meyer, 2016).

A third mood stabilizer which is also an AIAA has been shown to reduce aggressive behavior in schizophrenia, when prescribed in combination with an antipsychotic, in particular with clozapine (Bender et al., 2004). Of the three lithium is least likely to induce antipsychotic metabolism (Meyer, 2016). However its efficacy with other antipsychotics is not strongly (?) supported by the literature (Collins et al., 1991; Wilson, 1993).

6. Traumatic Brain Injury

Several studies have indicated an association between traumatic brain injury and criminal or violent conduct (Grafman et al., 1996; Sarapata et al., 1998; Freedman & Hemenway, 2000), the classic example being Phineas Gage (Harlow, 1848). In one study 33.7% of patients with TBI showed chronic aggressive behavior (Tateno, Jorge & Robinson, 2003).

The aggression associated with traumatic brain injury has been treated with beta adrenergic blockers (Greendyke & Kanter, 1986; Greendyke, Kanter, Shuster, Verstreate, & Wootton, 1986, 1989), the evidence provided by Greendyke and colleagues consisting of double-blind, placebo-controlled studies (Newman & Tardiff, 2017). In 1977 Elliot first described a favorable response to the treatment of TBI patients with rage outbursts who were prescribed propranolol. Especially, because propranolol and other beta-blockers are not FDA approved for treating TBI associated aggression, "two-for-one" indications may be considered (Felthous, 2013). Co-occurring conditions that may respond to propranolol providing further justification for its use in TBI include migraine headaches (Boes et al., 2008; Silberstein, 2000), tremor from multiple sclerosis (Blublin & Miller, 2008), neuroleptic-induced akathisia (Kulik & Wilbur, 1983; Lipinski, Zubenko, Barriera, & Cohen, 1983), restless leg syndrome (Ekbom, 1965), and familial essential tremor (Jankovic & Shannon, 2008). Cardiovascular conditions for which beta-blockers are FDA approved are ventricular tachycardia, supraventricular arrhythmias, angina from coronary arteriosclerosis, and hypertension (Jankovic & Shannon, 2008).

As with other agents not approved by the FDA for treatment of clinical aggression, the prescribing physician must be especially aware of the risks associated with beta-blockers (Felthous, 2013). Asthma, congestive heart failure, diabetes and third-degree atrioventricular block are contraindications. Common side effects are bradycardia, depression, diarrhea, fatigue, impotence, nausea and rash (Jankovic & Shannon, 2008). Neuropsychiatric side effects include ataxia, behavioral changes, confusion, and respiratory depression (Lublin, & Miller, 2003). Other side effects that can warrant discontinuation are hypotension, insomnia and nightmares (Boes et al., 2008).

Side effects such as bradycardia and hypotension were causes for discontinuations in early studies wherein doses of propranolol were higher than those commonly used to treat hypertension (Greendyke, Berkner, Webster, & Gulya, 1989). A recent study provided evidence for anti-aggressive efficacy with a lower dose; pindolal was prescribed at 3 mg. three times a day (Caspi et al., 2001).

The generic form of pindolal lends itself to easy titration. At higher doses pindolol shows partial agonism of intrinsic sympathomimetic activity (ISA) resulting in less bradiocardia and hypotension than occurs with propranolol (Newman & Tardiff, 2017).

Certain mood stabilizers which have demonstrated efficacy in the treatment of primary impulsive aggression, have also been shown to reduce aggression of TBI. Several studies support the use of carbamazepine (Azouvi, Jokic, Attal, Denys, Markabi, & Bussel, 1999; Geracioti, 1994; Horne & Lindley, 1995; Wroblewski, Joseph, Kupfer, & Kalliel, 1997). Lithium has been used where the aggression did not subside with haloperidol or propranolol (Haas & Cope, 1985), but lower doses of lithium are recommended for TBI associated aggression because of the increased sensitivity of TBI patients to lithium's side effects (Hornstein & Seliger, 1989). Because TBI associated aggression is phenomenologically impulsive, the question arises as to whether other AIAA would be as efficacious, but have not yet been subjected to drug trials in this population.

Conclusions

An important aspect of providing mental health services to offenders is the safe and effective pharmacotherapy of clinical aggression. Aggressive behavior that can subside with pharmacotherapy is primary impulsive aggression and aggression that is secondary to certain other mental disorders. Because no medication is FDA approved to treat impulsive aggression, the clinicians must give special attention to principles of selecting the most beneficial and effective AIAA with the least risk for the individual patient. Of the various mental disorders with the possibility of secondary aggression, three of the most common and serious disorders are addressed here – schizophrenia, bipolar disorder and traumatic brain injury — with emphasis on treating the disorder as well as the disorder's symptomatic aggression.

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Informed consent in forensic treatment. Lights, shadows, assumptions, perspectives

Il consenso informato al trattamento psichiatrico-forense. Luci, ombre, presupposti, prospettive

Felice Carabellese • Mariateresa Urbano • Anna Coluccia • Gabriele Mandarelli

Abstract
The progressive process leading to deinstitutionalization of socially dangerous insanity acquittees in Italy seems to have come to its conclusion. Forty years after the closure of psychiatric hospitals, the latest custodial models regarding forensic psychiatric patients also gave way to approaches to care and rehabilitation. In our opinion, however, the treatment of the forensic psychiatric deserves specific profiles in relation to treatments, methods, motivations, objectives, setting.
In this paper, the authors will address the topic informed consent to forensic psychiatric treatment, its relationship with the security measure and implications for treatment in the judicial context.

Key words: informed consent • sex offenders • juvenile offenders • psychiatric social dangerousness • psychiatric security measure

Riassunto
Il progressivo processo di deistituzionalizzazione dei malati di mente autori di reato socialmente pericolosi, sembra essere giunto infine alla sua conclusione. A quaranta anni circa dalla chiusura degli ospedali psichiatrici anche il modello custodialistico per i pazienti forensi lascia il passo a favore di un modello orientato alla cura ed alla riabilitazione. A nostro parere tuttavia il contesto forense possiede un suo profilo di specificità che riguarda metodi, trattamento, motivazioni, obiettivi, setting di cura.
Nell'articolo gli autori affrontano la tematica del consenso al trattamento psichiatrico-forense in corso di misure di sicurezza ed in differenti contesti giudiziari.

Parole chiave: consenso informato • sex offenders • minori autori di reato • sociale pericolosità • misure di sicurezza

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Informed consent in forensic treatment. Lights, shadows, assumptions, perspectives

Introduction

The progressive process leading to deinstitutionalization of socially dangerous insanity acquittees in Italy seems to have come to its conclusion. In 1980, psychiatric hospitals were closed in Italy, but forensic psychiatric hospitals (*Ospedali Psichiatrici Giudiziari*, OPGs) remained open and continued to admit patients. In 2008 the Italian Government issued a decree establishing the progressive closure of the 6 forensic psychiatric hospitals. In 2012 Law 9/2012 established that new small-scale residential facilities (*Residenze per l'Esecuzione della Misura di Sicurezza*, REMS) should be developed to admit insanity acquittees showing danger to public safety, consequently needing a custodial security measure. Finally, in 2014 Law 81 set deadlines, operational procedures and requested individualized discharge programs for such patients (Carabellese & Felthous, 2016).

The REMS are part of the Departments of Mental Health (DSM) of the Italian National Health Service (INHS), are under the responsibility of the Local Health and Social Associations (ASSL)[1]. This nature implies that the function of REMS is purely healthcare[2]. On the other hand, the Italian penal code still determines that the security measure involves detention of the patients. We therefore believe that this provision implies the existence of a custodial profile also within the REMS[3].

The same intentions of change seem to be seen, however, regarding the treatment of specific types of forensic patients. Among them, particularly sex offenders, a clinically heterogeneous group of subjects (Carabellese et al, 2012), for whom specific treatment projects are entrusted also to the IHNS.

There is also the varied world of the underage patients who commit crimes, which was already founded and addressed on rehabilitation and treatment approaches rather than punishment. (Aebi & Linde, 2012; Caldwell, 2011). This population often present with mental disorders (Green, 2014) whose treatment has been increasingly involving public psychiatric services.

This is not the place to face the difficulties associated with the transition period that coincides with the closure of the OPGs (Carabellese, 2017), nor the heterogeneity of the approaches and treatment models pertaining to minor offenders and/or sex offenders. The focus of this work is rather on the question of the right of the individuals to voluntarily consent or dissent to treatment in the context of forensic care, given the coercive nature of the placement in the REMS. In this respect, the Italian legislator appears, at least in part, to move in the direction of what is foreseen by the United Nations Convention on the Rights of Persons with Disabilities (CRPD[4]), ratified by Italy in February 2009.

We must point out that the Constitutional underpinnings of informed consent, which implies a competent, free, and informed choice preceded by a complete disclosure of clinically relevant information, also apply within a coercive measure. This includes the inviolable right to refuse treatment and care.

There are, however, obvious management and medicolegal issues that may arise if a REMS internist refused to adhere to the treatments provided by the Individual Rehabilitative Therapeutic Rehabilitation Project (PTRI). Considering the natural course of severe mental illness, refusal of treatment of adherence problems can emerge at different times and with different intensity over time. Different types of approaches may be required in response to such refusal (Carabellese, et al 2015): acute refusal in the face of a psychotic disruption with agitation presents intrinsically different profiles and implications than a chronic refusal to adhere to a cure provided by a safety measure.

The purposes of control and social defense are a specific mandate in forensic treatment, that inevitably affects the medical / patient relationship, making it different from others, forcing public health care providers to consider specific aspects of the forensic contexts (Felthous, 2010), which they would not otherwise consider, also having a privileged and to some extent challenging interlocutor to the Judicial Authority (AG).

1. Informed consent to treatment in the REMS

Why informed consent to treatment in the REMS has great ethical, clinical, and deontological implications? A possible answer underlines two questions: on the one hand we should consider the coercive nature of the psychiatric security measure, which entails the concept of medical care as necessary for the patients' rehabilitation and recovery, as well as for containment of the risk of recurrence and criminal behavior. In other respects, there we should consider the right to self-determination of the patient under the psy-

1 Il DL n. 211 del 22.12.2011, convertito in seguito con alcune modifiche nella Legge n. 9 del 2012, all'art 3-ter, co. 3 sancisce l'esclusiva gestione sanitaria delle REMS.

2 Il DM del 1 ottobre 2012, all'Allegato A stabilisce che le REMS hanno "*funzioni terapeutico/riabilitative e socio/riabilitative*", che la "*gestione interna è di esclusiva competenza sanitaria*" e che "*la responsabilità della gestione all'interno della struttura è assunta da un medico dirigente psichiatra*".

3 L. 26.07.1975 n. 354 (Norme sull'ordinamento penitenziario e sulla esecuzione delle misure privative e limitative della libertà).

4 United Nations General Assembly (2007). Convention on the Rights of Persons with Disabilities and Optional Protocol.

chiatric security measure, a right that could conflict with the purposes of the security measure itself, as well as with the principle of benefit.

The problem therefore lies in how much the right to self-determination, and possibly refusing to adhere to the therapeutic measure, may extend and with what limits in subjects subjected to psychiatric security measures. In trying to deal with this problem it is useful to recall the address of the Constitutional Court[5], which has determined that informed consent to care is a "fundamental principle of health protection", "the true right of the person, founding in the principles expressed by articles 2, 13, and 32 of the Constitutional Chart". Following this view, informed consent could be considered an expression and synthesis of two fundamental rights of the person, "that of self-determination and that of health"[6]. It is "an expression of conscious adherence to medical treatment proposed by the physician", a source of "legitimacy and foundation" of the medical act. Consequently, in those situations where there is lack of consent, the medical act "is certainly illicit, even when it is in the patient's interest". This approach explains why, in Italy, the validity of consent lies on the assumption of natural capacity and not of legal capacity. The natural capacity of the patient should be assessed on a case-by-case basis, and in Italy, differently from other European countries, the physician completely covers it.

Patients affected by severe mental illness, including those under a coercive psychiatric security measure, are not an exception to the rule that informed consent is necessary for any treatment and that treatment can be refused in case of patients' dissent. Considering that a valid consent requires patients' mental capacity to decide, we need to look at the real levels of forensic patients' capacity to accept or refuse treatment. Nonetheless, an assessment of decision-making capacity of forensic patients does not appear to be required by the law (Carabellese, et al, 2017; Mandarelli, et al, 2017a; Mandarelli, et al, 2017b).

In fact, even in the case of patients coercively admitted to the REMS informed consent to treatment is a prerequisite or legitimizing treatment his/her therapeutic-rehabilitative process which should be calibrated on the specific needs of care (Catanesi, Carabellese, La Tegola & Alfarano, 2013), and inevitably custody that the Health Department provides through the security measure issued by the judge.

The Italian Law includes only a few exceptions: a) involuntary commitment (TSO) b) involuntary assessment (AS) c) state of necessity. Nonetheless, Law 81 of 2014 did not foresee anything specific for psychiatric patients under a security measure[7]. The judge must moreover preliminarily try to consider and adopt any alternative measure to detention in REMS, making the latter the extreme choice after finding the inadequacy of any other alternative solution.

No change from the outlined scenario is derived from Law n. 103 of 23 June 2017, aimed at reforming the dual Italian criminal "dual track system". Law 103/2017 redefines the "second track" constituted by security measures, which are greatly diminished in favor of rehabilitative and therapeutic measures with the slightest possible limitation of personal freedom, to be implemented within the care and control (collective protection) framework[8].

A verdict of the Tutelary Judge of Reggio Emilia underlines the complexity of the problem[9], it established that involuntary civil commitment should not be invoked in case of a patient detained in the REMS due to the nature of the security measure. We are not aware of other similar judgments that have reiterated the same decision. We deem, however, that the clinical conditions that motivated such judgment are particularly frequent in forensic psychiatric

5 Corte Costituzionale, Sent. N. 438 del 15.12.2008

6 Corte Costi., Sent. N. 438 del 15.12.2008: "*…quello all'autodeterminazione e quello alla salute, in quanto, se è vero che ogni individuo ha il diritto di essere curato, egli ha, altresì, il diritto di ricevere le opportune informazioni in ordine alla natura e ai possibili sviluppi del percorso terapeutico cui può essere sottoposto, nonché delle eventuali terapie alternative; informazioni che devono essere le più esaurienti possibili, proprio per garantire la libera e consapevole scelta da parte del paziente e, quindi, la sua stessa libertà personale, conformemente all'art. 32, secondo comma, della Costituzione. Discende da ciò che il consenso informato deve essere considerato un principio fondamentale in materia di tutela della salute, la cui conformazione è rimessa alla legislazione statale*".

7 L.81/2014 co. 1, let. B: "*Il giudice dispone nei confronti dell'infermo di mente e del seminfermo di mente l'applicazione di una misura di sicurezza, anche in via provvisoria, diversa dal ricovero in un ospedale psichiatrico giudiziario o in una casa di cura e custodia, salvo quando sono acquisiti elementi dai quali risulta che ogni misura diversa non è idonea ad assicurare cure adeguate e a fare fronte alla sua pericolosità sociale…*"; "*Allo stesso modo provvede il magistrato di sorveglianza…*". Ed ancora: "*…il programma documenta in modo puntuale le ragioni che sostengono l'eccezionalità e la transitorietà del prosieguo del ricovero*" (L.81/2014 co. 8, 1-ter).

8 La Legge differenzia l'applicazione delle misure di sicurezza a seconda che i soggetti siano imputabili, semi-imputabili e non imputabili (art. 1, comma 16, lett. c.): Per i soggetti imputabili il regime del doppio binario è limitato ai soli gravi delitti ex art. 407, comma 2, lett. a) c.p.p.; Per i soggetti semi-imputabili il doppio binario cede il passo all'introduzione di un trattamento sanzionatorio finalizzato al superamento delle condizioni che hanno diminuito la capacità dell'agente, anche mediante il ricorso a trattamenti terapeutici o riabilitativi e l'accesso a misure alternative, fatte salve le esigenze di prevenzione a tutela della collettività; Per i soggetti non imputabili rimangono applicabili esclusivamente misure terapeutiche e di controllo, determinate nel massimo e da applicare tenendo conto della necessità della cura, e prevedendo l'accertamento periodico della persistenza della pericolosità sociale e della necessità della cura e la revoca delle misure quando la necessità della cura o la pericolosità sociale siano venute meno. Le REMS sono destinate inoltre ad accogliere (art.1, comma 16, lett. d) anche tutti coloro per i quali occorra accertare le relative condizioni psichiche, qualora le sezioni degli istituti penitenziari alle quali sono destinati non siano idonee, di fatto, a garantire i trattamenti terapeutico-riabilitativi, con riferimento alle peculiari esigenze di trattamento dei soggetti e nel pieno rispetto dell'art. 32 della Costituzione. (non so se questa parte forse si potrebbe mettere nel corpo del testo)

9 Sent. N. 602/2012 N.C.: "…non sussiste intrinsecamente alcuna esigenza di disporre un trattamento sanitario mediante ricovero in condizioni di degenza ospedaliere forzose di un soggetto che è già ristretto in struttura con duplice natura detentiva e curativa in forza di provvedimento dell'Autorità Giudiziaria…".

patients who are detained in the REMS (Carabellese, Rocca, Candelli, Catanesi, 2014).

The legislator's attitude is based on the indication of the "*favor libertatis*", i.e. giving subjectivity and dignity also to the mentally ill and socially dangerous, subjected to a security measure, and to provide fullness of intent to exercise the right to self-determination.

There are those who see potential difficulties in equally respecting fundamental rights that may become conflicting (Carabellese &Mandarelli, 2017), particularly the patients' right to self-determination, including refusal of treatment, and protection of the community, if such denial poses the consequent risk of aggressive and violent behavior (Simon & Gold, 2010). In other countries, treatment is compulsory as well as the security measure in its purely custodial aspect.

In other Countries[10] specific rules on forensic care have been provided, to protect the rights and dignity of offenders subjected to coercive treatment, as well as to guide and legitimate the healthcare professionals.

2. Informed consent to treatment in other forensic settings

2.1 *Informed consent to treatment of sex offenders*

We are now considering informed consent to the treatment of sex offenders, believing that this population is particularly explanatory of consent issues in forensic patients. Treating sex offenders in a forensic setting could imply responding to opposing needs, which must necessarily be met, and might therefore require caution by the health care staff involved.

The informed consent to forensic treatment of sex offenders, independently of its nature (psychotherapeutic, pharmacological, hormonal, socio-rehabilitative) follows a process that is certainly related to the traditional medical/patient relationship, but includes expectations, objectives, information obligations, individual factors, family, social, cultural-related factors affecting that relationship, connotating it precipitously. It is understood that, in our view, health care professionals should know these additional levels of complexity in the relationship with the sex offender, and take them into account to achieve effectiveness of forensic treatments. It is well known that sexual offenders tend to recur in their conduct more frequently than other offenders (Prentky, Barbaree, & Janus, 2015), although these are data on which there is no unambiguous convergence (Harris et al. al, 2011). In Italy, in the decade following year 2000 (Istat, 2011), the percentage of formerly criminal convicted individuals for a new sexual offense was 3.3%. Those pedophiles with preference for male pre-teen victims, seem to have the highest recurrence rates, (up to 35% in 15-year follow-up period, Harris & Hanson, 2004), compared to other sex offenders, whose criminal career tends to be more heterogeneous (Harris, 2009; Lussier & Cale, 2013; Blockland & Lussier, 2015).

A treatment-specific aspect to consider is therefore the need to achieve adequate knowledge of the type of sex offender to be treated. This implies preliminary acquisition of accurate information, prior to rehabilitation or other treatments. Factors which be assessed include some editable ones (Henning & Holdford, 2006), which can be a specific target for the treatment project (Hanson & Yates, 2013), psychosocial and family-related factors, (Bond & Ahmad, 2014; Andrews & Bonta, 2010; Saleh et al., 2009;), the offender's personality structure, with specific interest for psychopathic personality traits (Hanson, Morton-Bourgon, 2009; Bonta & Wormith, 2007), sexual interests and sexual fantasies (Carabellese, Maniglio, Greco, Catanesi, 2011; Maniglio, Carabellese, Catanesi, Greco, 2011).

A distinct psychopathic component of personality, with the manipulative attitude that characterizes it (Hare, 1993), can be an impediment to accept a therapeutic relationship which could be perceived as a "down" position (Kilgus et al, 2016), as well as to make a real change. These psychological features might imply reduced treatability of the offender; thus, they must be specifically assessed and disclosure of possible treatment risks, possible benefits and limits should be disclosed when acquiring informed consent.

Many Authors (Parens, 1998; Bloch et al, 1999; Scott & Holmberg, 2003; Smith, 2005; Sjostrand & Helgesson, 2008; Grubin & Beech; 2010; Gooren, 2011; McMillan, 2012) have questioned the validity of consent to the treatment of sex offenders, believing that they might not be completely free in their choice. Adhesion to the treatments could be in fact motivated on the thrust of possible juridical benefits, a common problem when considering forensic patients.

In some European Countries and in several US States specific rules provide for the possibility of voluntary hormonal and / or surgical antiandrogenic treatments, which are not necessarily alternative to restrictive measures, based on specific evidence indicating efficacy in reducing paraphilic thoughts and behavior (Gijs & Gooren, 1996; Losel & Schmucker, 2005; Schmucker, 2008 Krueger et al, 2009; Jordan et al, 2011).

In Italy, sex offenders are generally treated with psychological and socio-rehabilitative approaches. Realizing that this type of approach can be an alternative to restrictive measures, the actual motivation of the patient should be carefully considered.

It is therefore necessary to consider how the process of acquiring consent to the treatment of sex offenders should also be based on the availability of information not strictly related to the treatment, but which may determine both the validity / invalidity of the consent and an element on which to focus the treatment itself.

2.2 *Informed consent to treatment in forensic child and adolescent mental health*

The context for the care and treatment of underage offenders, subject to security measures, is particularly complex and articulated. There are several factors that explain this complexity: age-related cerebral maturation, possible neurodevelopmental disorders, or other psychiatric disorders, possible physical and / or emotional distance or lack of attachment and support figures.

10 For example the UK "Mental Health Act" of 1983, part II e part III.

In Italy the parents, or others juridically exerting the parental authority, are the appointed decision-makers provided by the Law, as concerning informed consent to treatment of people under 18 years of age. In case of lack of consent or dissent, TSO and ASO (Articles 33, 34 and 35 L. 833 of 1978) are the only ways to medically intervene for diagnostic and/or therapeutic purposes, in which it is possible to overcome the patients' will. The normative framework, however, does not make explicit mention of the minors, but does not exclude them either.

At a regulatory level, consent to care is considered valid where expressed by a person aged more than 18 years, thus the ability of minors to give a valid consent is considered "imperfect and incomplete". However, if medical intervention significantly affects the child's personal integrity and quality of life, and if there is a conflict between parent / guardian and a "mature" child/adolescent, the parents' opinion may not prevail over the will of the minor.

The latest national and international standards[11] have tended to overcome the premise that parents, or those exercising the parental authority, are the only ones to be able to exercise the right to express consent to medical acts involving children. Recent regulatory changes lead to consent being a "unilateral legal act" and not a contractual act; therefore, to express a valid consent, the ability to act, which is subject to age, but the natural capacity which can be present even in the "mature" minor.

The physician must therefore verify with the means at his/her disposal the actual consent / dissent of the child and whether the young patient is able to assume his responsibilities as well as appreciating the consequences of his will with respect to the specific treatment offered to him/her.

In this case, the doctor must consider as much as possible the will of the child evaluating also the context and the conditions in which it is located. The coercive sanitary procedures for patients aged under 18 years, must be the *extrema ratio*, regardless of whether there is parents' consent. In the event of a conflict between the will of those exercising parental responsibility and the minor, and if this can result in serious injury, the physician is obliged to report it to the competent authority only after having completed all attempts to acquire consent. The Juvenile Court is specifically responsible for the protection of the child even when the injury is only hypothetical.

The physician has the duty to transmit without delay the information concerning potential injury to health of an underage patient to the Public Prosecutor's Office at the Juvenile Court. The Public Prosecutor Office, upon receiving the information, verifies the validity of any prejudices that may arise in relation to the minor and the actual need to activate specific protection. The presence of these two conditions implies the timely intervention of the Juvenile Court, which in turn works with a series of interventions aimed at protecting the child and sometimes, if necessary, also with measures aimed at the decay of parental responsibility or at the estrangement of the minor. In cases of urgency, it is also possible to send the report directly to the Juvenile Court.

In the case of a child considered "mature" by doctors, therefore capable of appropriate decision-making, the following five situations may arise:

1) The minor and both parents give their consent to diagnostic procedures and treatment; in this case you can proceed according to your agreement with your doctor without the need to involve the competent court;
2) The child expresses his / her assent, but one or two parents deny consent to diagnostic procedures / treatment; in this case, the health care provider directs the report to the Public Prosecutor's Office at the Juvenile Court before conducting any further clinical approach;
3) The underage patient, one or two parents refuse and urgently needed psychiatric treatment; in this case, the health care provider activates the TSO by reporting the case to the Public Prosecutor's Office at the Juvenile Court afterwards;
4) The underage patient dissent with the proposed care, but both parents give their valid consent; it may be useful, if there are any requirements, to proceed to a TSO to better guarantee the child; the case is reported to the Public Prosecutor's Office at the Juvenile Court;
5) The underage patient dissent to accept care, the parents give consent to treatment, but there may be likely prejudices to the child's health; there are no conditions of urgency; in this case, the health care professional reports to the Public Prosecutor's Office at the Juvenile Court, including clarifications on the situation, specifying the efforts made to obtain the consent of the child, what are the feared prejudices as well as any suggestions for both the resolution of the situation and the elimination / reduction of prejudices deemed imminent to the minor;
6) About the place of execution of the TSO against a minor, it should be done considering the age of the subject and the necessary safeguards, but the law does not provide any specifics. For these reasons, we think that it is inappropriate to use adult psychiatric wards for involuntarily committed underage psychiatric patients. Following the acute hospitalization phase, an outpatient project should be set up to ensure the continuation of care and protection in suitable spaces even of a residential type.

We also believe that the required certifications of proposals and confirmation of a TSO toward a minor should be performed by specialists in child and adolescent psychiatry. The Child and Adolescent Neuropsychiatry Service must always be involved in the diagnosis and treatment process during the child's stay in TSO. The natural reception center, if present, is just the infantile neuropsychiatry department as it is adequately equipped to meet the needs of the child as well as the presence of clinically specific staff.

Summarizing, children and adolescents should be involved in the decision-making process on care and in parallel with the verification of the actual mental and cognitive abilities. A cerebral structural immaturity has been associ-

11 Onu, New York 1989, Convenzione sui diritti del fanciullo, artt. 3 e 12. Convenzione per la protezione dei diritti dell'uomo e della dignità dell'essere umano, Oviedo 1997, artt. 5, 6 e 10. Carta dei diritti fondamentali della UE, Nizza 2000, artt. 1, 3 e 24. Carta Costituzionale, artt. 13 e 32. Codice Civile, artt. 2, 147, 333 e 348. Codice di deontologia medica, artt. 29, 33 e 34.

ated with an incorrect assessment of the long-term consequences of their choices (Partridge, 2013). It is conceivable, however, that there is a degree of different and age-related capacity and that some underage patients, even those suffering with psychiatric disorders, have good decision-making capacity (Mandarelli et al., 2016), although there are no data in forensic populations of minors.

3. Community based involuntary psychiatric treatment

In the case of a patient interned in REMS who refuses to adhere to treatment, how to behave? We might hypothesize at least two different situations: a) there are no conditions for compulsory treatment (TSO); (b) there are the conditions to apply a compulsory treatment i.e. involuntary civil commitment (TSO).

In the first case, when the patient's dissent to treatment is valid, and there are no conditions for urgent intervention, his/her will should be respected according to the right to self-determination. At the same time, it will be necessary to activate, within the medical-patient therapeutic alliance, which will be built in the meantime with the internship to recover the voluntary adherence to the treatment. If this approach fails, and if the legal requirements are met, a TSO should be implemented to protect the patient. However, we believe it is appropriate to relate this refusal to the criminal justice authority, considering the possible medium and long-term impact of a denial of treatment in terms of social dangerousness.

An obvious problem arises from the fact that the TSO in Italy does not distinguish forensic from non-forensic patients, and it was developed and structured for non-forensic patients. This limitation is found in the fact that the law provides for the possibility of performing the TSO for psychiatric reasons only at public or contract hospital (civil) facilities (Art. 33, Law 833 of 1978). Therefore, in TSOs for psychiatric reasons in a hospital stay, there can be no provision for REMS, which are considered as community and non-hospital structures.

However, the law provides for the possibility of an extra-hospital TSO, which could potentially fall within the healthcare facilities of REMS, in the event of urgent care and refusal by the interned patient. To our knowledge, extra-hospital TSO is an infrequently used procedure in Italy, although it is subject to specific indications and norms. The extra-hospital TSO needs a motivated proposal from a physician-although the plausible grounds for doing so are not clarified by the law- and the subsequent ordinance of the city mayor[12] (Articles 33 and 34, Law 833 of 1978). Extra-hospital TSOs should be considered in the case of clinically more manageable situations (Carabellese & Mandarelli, 2017), where there is no need for hospitalization. It is undoubtedly a coercive treatment approach that can be implemented, however, even within REMS, as well as in other contexts other than the hospital, with some benefits in terms of clinical management.

The duration of the extra-hospital TSO, like the hospital TSO, could be 7 days, however, Law 833 of 1978 provides clear procedural information only for hospital TSO (Article 35). The implementation of the extra-hospital TSO, as well as the hospital TSO, must be associated with initiatives aimed at ensuring the consent and participation of those who are subject to such compulsory measures (Article 33 of Law 833).

A second possibility concerns a patient interned in the REMS that poses refusal to treatment that is considered valid in terms of his decision-making ability, but which, at the same time, is associated with a concrete and imminent risk of violent behavior directed against others or against oneself. What to do in this case? Hospital or extra-hospital TSO in theory should not be practicable, as Law 833/1978 does not provide a criterion of danger for self or other, as a possibility underlying the coercive measure. An extensive interpretation of care and protection requirements, so that in this case a TSO should be carried out, for reasons that appear to be defensive medicine rather than legitimate grounds for care, does not appear to be sustainable.

Other assumptions that can be considered, as provided by the penitentiary system[13] – which is believed to be valid at REMS –, concern the possibility of physical isolation and restraint (Catanesi et al, 2010). These are hypotheses that have controversial aspects in psychiatry and are generally used as an extreme ratio, but if implemented in appropriate modes, they are useful in the treatment of aggressive and violent behavior. In the case of application of such physical coercive measures, an indication of the psychiatrist who directs REMS in a clinical record must be provided. it is necessary to proceed to such extreme interventions, according to the methods widely described in the literature, with a monitoring that must safeguard the psycho-physical integrity of the international, prevent any complications and respect for its personal dignity and to safeguard its rights.

12 Conferenza delle Regioni e delle Province autonome del 2009: Raccomandazioni in merito all'applicazione di accertamenti e trattamenti sanitari obbligatori per malattia mentale. Conferenza delle Regioni e delle Province Autonome, Roma 29 Aprile 2009. BURP 04/9/2009

13 Art 14-bis: "Possono essere sottoposti a regime di sorveglianza particolare… i condannati, gli internati e gli imputati: …b) che con le violenze o minacce impediscono le attività degli altri detenuti o internati…". Ed ancora (art. 14-quater): "… 4) in ogni caso le restrizioni possono riguardare: … le esigenze di salute...".
Per quanto attiene la contenzione fisica, l'Art. 41 (Impiego della forza e uso dei mezzi di coercizione) prevede che "Non è consentito l'impiego della forza fisica nei confronti dei detenuti e internati se non sia indispensabile per prevenire o impedire atti di violenza. Non può essere usato alcun mezzo di coercizione fisica che non sia espressamente previsto dal regolamento e, comunque, non vi si può fare ricorso ai fini disciplinari ma solo al fine di evitare danni a persone o cose o di garantire l'incolumità dello stesso soggetto. L'uso deve essere limitato nel tempo strettamente necessario e deve essere costantemente controllato dal sanitario".

4. The physicians' duty of care in non-consensual psychiatric treatment

Given the specific characteristics of patients undergoing a psychiatric safety measure, one must wonder whether doctors have a specific obligation to intervene, focusing on the polarity of "control" according to the doctrine of the duty of care. This is, of course, outside of those clinic situations that shape the assumptions for a TSO. The question arises mainly because of the specificity of the type of patient interned in REMS or, in any case, subjected to a psychiatric security measure.

The perpetrator of a crime with highly reduced or abolished responsibility and deemed socially dangerous, interned in the REMS, is not obliged by the judicial authority to comply with certain prescriptions or a specific personalized therapeutic rehabilitative project because of the risk of new offenses, a risk which is expression of the mental illness. He may oppose his dissent, if it is valid, to the treatment. This is the exercise of a fundamental right which, however, can in some sense confuse or frustrate the effectiveness of the "protection" requirement, another polarity inherent in the duty of care, which always falls on the health care professionals.

We deem that there are risks in terms of treatment and accountability associated with choices made in the interests of defensive medicine (Felthous, et al, in press), rather than being the result of weighted decisions and discussed within the care unit. In these situations, the comparison within the curating, multidisciplinary team and involving the magistrate should be the solution for decisions that are never simple nor risk-free.

In 2014, the "Working Group on the Guarantee Position" of the Italian Society of Psychiatry, referred to both the polarities inherent in the guarantee position, indicating that the more serious the state of the patients' incapacity and therefore their vulnerability, more so the patients should be "protected" by healthcare providers by fully assuming their duty to the protection of health and psycho-physical integrity.

More complexity is inherent in all those frequent cases in which the state of total or partial inability to protect one's own interests is well-known and has been appointed support administrator or another substitute decision-maker in relation to the consent to care. We refer to those cases in which the patient declares a dissent (legally ineffective) against a treatment decision which has been given by the substitute decision-maker. Such discrepancies can create significant difficulties, as well as ethical issues and, moreover, it could be difficult to allow a treatment that, while having a legally valid consent, would end up being coercive.

Conclusion

The closure of the OPGs in Italy and the legislative changes that led to the opening of REMS, have shown critical points that require further and appropriate regulatory action or practices that have yet to consolidate. Among the most obvious points of criticism, there is certainly the problem associated with the consent / denial of the individual therapeutic project prepared for the patient subjected to psychiatric security measures.

Such safety measures (detention: REMS; non-detention: supervised freedom).are compulsory and apply to different types of offenders, they include an individualized therapeutic-rehabilitative program, outlined in conjunction with the competent psychiatric services, with the dual purpose of care and control of the risk of criminal recurrence. The therapeutic program, however, is likely to face a violation of the irrevocable fundamental right to self-determination and freedom (Articles 2, 13 and 32 of the Constitutional Charter), creating a possible conflict between constitutionally guaranteed rights.

The right of every person to be cared for or not also corresponds to the right of individuals who make up the community to be protected by possible aggressive or violent behaviors associated with a mental disorder. Essentially, the coercivity of the security measure does not include a compulsory treatment counterpart. As previously discussed, the hypothesis of the TSO is not specific to forensic patients and concerns only urgent and acute situations. Temporary transfer of a socially dangerous patient to a civil hospital, as expected by the hospital TSO, however, presents intrinsic issues both for REMS and for the Hospital. The extra-hospital TSO could solve some situations that are not overly complicated, but there is also a regulatory hole about the implementation modalities.

Further complexity concerns the consent to the rehabilitation specific clinical populations such as sex offenders, burdened by very particular ethical implications, for which reason we believe that the involved healthcare should be specifically trained.

The correct application of the new post-OPG legislation seems to depend entirely on the will of the psychiatric forensic patient to adhere, or not, to the therapeutic program. This approach has the logical consequence that the psychiatrist may have to retain in the REMS acutely ill patients, at imminent risk of violent behaviors, with which it is not possible to provide a containment when there are no conditions for intra and / or extra-hospital TSO. Unless you resort to physical restraint or isolation, extreme solutions that always create severe discomfort in both psychiatrists and patients.

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Personality disorder treatment in a forensic setting and its application to the italian scenery

Il trattamento dei disturbi di personalità nel setting forense e sue applicazioni nello scenario italiano

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Abstract
Our present work represents a review of the scientific literature currently available on effective psychotherapeutic treatments for mentally ill offenders. What has come out from the review of the scientific literature on effective treatments focused on this specific subpopulation is the necessity of highly integrated therapeutic interventions that have to me administered in synergism by different health professionals and community services. Specifically literature states that it is essential to differentiate the forensic patient treatment plan (meaning both psychiatric and penal rehabilitation, antisocial behaviours, prevention of psychiatric and antisocial relapses, intervention on relapse risk factors, work opportunities..) on at least two macro levels: one mainly "institutional" community based, that implies a network cooperation among different services, what we call an enrollment in a community program (both clinical and judiciary) and the other one strictly "clinical" focusing on psychosocial, psychological (and psychotherapeutic) interventions that involve patients themselves and, when possible, their relatives. This paper will introduce a first section on available community treatments literature data and a second one focused on effective psychotherapeutic interventions that are currently suggested for mentally ill offenders. The theoretical frameworks taken into considerations belong to the most valuable and experienced authors on treatment and assessment of forensic psychiatric patients.

Key words: forensic psychiatric patients • integrated evidence based treatments • anti-social personality disorder • psychopathy

Riassunto
Il lavoro presentato rappresenta una revisione della letteratura scientifica attuale rispetto ai trattamenti psicoterapici efficaci per pazienti psichiatrici autori di reato. Ciò che è emerso da questa revisione della letteratura scientifica rispetto ai trattamenti efficaci per tale target di pazienti, è la necessità di interventi terapeutici ad alto livello di integrazione erogati in sinergia di diverse figure professionali e servizi sul territorio. In particolare, dalla letteratura si rileva che risulta necessario differenziare il piano di trattamento (inteso come riabilitazione psichiatrica e penale - condotte antisociali, prevenzione delle recidive psichiatriche e antisociali, interventi sui fattori di rischio di recidive, riabilitazione lavorativa, ecc.) del paziente psichiatrico forense su almeno due macro livelli: uno rappresentato da interventi di tipo prettamente "istituzionale", di tipo comunitario che implicano la collaborazione di rete di diversi servizi presenti sul territorio, in pratica una "presa in carico" da parte dei servizi territoriali (di tipo giuridico e clinico); e l'altro che riguardi prettamente il piano "clinico", quindi gli interventi psicologici (e psicoterapici) e psicosociali, che coinvolgano il paziente e, ove possibile, i familiari dei pazienti stessi. Tale lavoro quindi presenterà in una prima parte i dati di letteratura sugli interventi disponibili di tipo comunitario; la seconda parte si focalizzerà sugli interventi psicoterapici efficaci attualmente disponibili con i pazienti autori di reato. Sono state prese in considerazione i riferimenti teorici degli autori più esperti nell'ambito della valutazione e trattamento dei pazienti psichiatrici autori di reato.

Parole chiave: pazienti psichiatrici forensi • trattamenti integrati evidence based • disturbo antisociale di personalità • psicopatia

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Personality disorder treatment in a forensic setting and its application to the italian scenery

Introduction

In Italy the dismantlement of the Forensic Hospitals has modified the system of care and custody of offenders (Carabellese & Felthous, 2016) that are deemed affected by a psychiatric disorder and incompetent to stand trial.

The reference paradigm, aside from the ideology inherent to the reform, assumes that high intensive care along with psychiatric and psychosocial treatments should reduce the relapse risk in that specific population. For this reason these structures are exclusively run by health professionals and their safety should be guaranteed by similar sanitary procedures (Carabellese, 2017).

Substantially beside the noticeable care humanization established by the reform, it is necessary to evaluate weather this paradigm actually lays its ground on solid scientific basis and which treatments are electively administered to this clinical subpopulation to achieve the required efficacy both in in the sanitary and in the judiciary area.

It will be outlined a review, as exhaustive as possible, of the recent scientific literature regarding effective treatments for mentally ill offenders.

Sorting through the existing literature, it appears that the treatment approach for psychiatric patients convicted for a crime, authors of antisocial and/or violent behaviours, requires a multi-level therapeutic intervention delivered by different health care professionals and community services.

Most of the scientific literature derives from English speaking countries, with procedural models distant from the Italian reality.

It is essential to differentiate the forensic patient treatment plan (meaning both psychiatric and penal rehabilitation, antisocial behaviours, prevention of psychiatric and antisocial relapses, intervention on relapse risk factors, work opportunities) on at least two macro levels: one mainly "institutional" community based, that implies a network cooperation among different services, what we call an enrolment in a community program (both clinical and judiciary) and the other one strictly "clinical" focusing on psychosocial, psychological (and psychotherapeutic interventions that involve the patients and, when possible, their relatives.

This paper will introduce a first section on available community setting literature data and a second one on effective psychotherapeutic interventions on psychiatric offenders.

1. Forensic psychiatric community treatment

The program "Dangerous and Severe Personality Disorder" (DSPD) (Mullen, 2007) established by the British government represents a consistent and costly effort in Mental Health.

This program represents an attempt to face psychological and interpersonal challenges of psychiatric patients, affected by severe personality disorders, offenders with a high risk of relapse, that focuses primarily on reducing the risk of harming oneself and others. This broad scale project derives from the assumption that specific personality disorders could cause and support criminal behaviours.

The program states that patients with these specific psychopathological features should be correctly diagnosed and recognized as such, implying that by treating the disorder the risk of committing violent or criminal conducts decreases. Therefore the theoretical assumption that underlies it all suggests that if the criminal conduct relies on the personality disorder, treating the pathology consequently will reduce the misconducts. Cooke et all (2007) specify that individuals enrolled in the DSPD program are included when there is an acknowledged functional relationship between the personality disorder and the potential risk they represent for the entire community.

Similarly, studies that ascribe to genetic features the aetiological factors of criminal conduct, require further supporting data to acquire relevance and scientific reliability (Caspi et al, 2002).

According to this program, a crucial first step is represented by a correct assessment of the psychiatric offender showing a higher risk of relapse, specifically the following features are outlined as relevant in criminal relapse risk: being young, male, un-partnered, poorly educated with few work skills and the amount and versatility of prior criminality, having substance misuse, anti-social problems, antisocial attitudes and a criminal peer group. Being also diagnosed as psychopath indicates a higher risk of relapse and greater violence in the potential future aggressive conducts, when compared with misconducts acted by other personality disorders.

Psychopaths are identified as patients that do not modify their attitude, will not establish significative and respectful relationships with others, instead they persist on being predatory and manipulative towards others. Psychopathy level and relapse risk are measured with Psychopathy Checklist-Revised (PCL-R; Hare, 1991), the Historical Clinical Risk Management-20 (HCR-20 Webster et al, 1997) and the Violence Risk Appraisal Guide (VRAG, Quinsey et al, 2005).

The "typical" patients enrolled in the program is represented by a young man with a schizophrenic syndrome who misuses cannabis and alcohol, who is symptomatic, uncooperative with treatment, denying of illness, interpersonally callous and living a disorganised life in a high crime neighbourhood, then he is at risk of acting in an anti-social and violent manner.

The risk will be reduced by moderating or removing the substance misuse, by improving symptom control, by stable accommodation in a low crime neighbourhood, by structuring his day with meaningful activity, and working on his attitudes towards others (Mullen, 2006).

According to Cooke (2007) the clear separation of the un-

derlying personality vulnerabilities in psychopathy, and potentially their hierarchical arrangements, should allow the development of more focused and effective therapeutic interventions. Hodgins (2007) calls for an effort to identify specific treatments arguing that richer and more complete characterisations of the subtypes of persistent violent offenders would lead to the development of treatments that directly target deficits.

For example he distinguishes anti-socials who are unemotional since childhood and anti-socials who feel anxiety and/or suspiciousness. The first subgroup focuses on rewards and ignores punishments and social exclusion. The aim consists in inflicting as much pain and damages as possible to those considered adversaries. Influencing such people depends on offering them rewards they value and avoiding becoming embroiled in their hostile interpersonal relationships.

The second subgroup, anti-socials who show traits such as anxiety, suspiciousness and resentment, can be managed and guided towards rules acceptance by contemplating the possibility of losing something they care about.

Mullen (2007) reports that offenders may reduce their criminal conducts if helped in acquiring a larger repertoire of coping mechanisms and responses in the dedicated pursuit of personal goals stating that it is easier to add to the behavioural and attitudinal repertoire of the individual with personality disorder than to inhibit or remove ingrained approaches. Hope resides in Tyrer and colleagues' theory of changeability and plasticity of personality (Tyrer et al.2007).

Morgan et al (2012) reviewed about 12,154 research documents, regarding studies of the service providers to offenders with mental illness. The aim of the meta-analysis was to build a review focused on the effective treatments for offenders, taking into account all the different aspects involved (time, setting, type of intervention, research on the common risk factors that may cause offenders to dropout from specific programs**)**. Authors underlie as effective strategies those that are integrated and simultaneously target both psychiatric and forensic aspects, the strict integration of psychiatric treatments and substance abuse prevention.

Results suggest both the necessity of tailored intervention for mentally ill offenders and their effectiveness on several aspect of psychiatric, criminal and behavioural functioning. Particularly interventions with offenders with mental illness effectively reduced symptoms of distress, improving offender's ability to cope with their problems, and resulted in improved behavioural markers including institutional adjustment and behavioural functioning. Furthermore, interventions specifically designed to meet the psychiatric and criminal justice needs of offenders with mental illness have shown to produce significant reductions in psychiatric and criminal recidivism.

Among the highlighted treatment strategies the use of homework, preferential group settings as opposed to individual ones, and open admission policies that allow the admission of new treatment participants throughout the program, versus closed admission policies, appear to be the most beneficial.

Treatments are considered effective only if they target both forensic and psychiatric needs.

For the latter psychiatric rehabilitation has become the treatment of choice (Corrigan, Mueser, Bond, Drake, & Solomon, 2007) to develop offenders' fullest capacities through learning and environmental supports (Bachrach, 1992). The goal of psychiatric rehabilitation is to enable individuals to live independently by compensating for, or eliminating, functional deficits (IAPSRS, 1995).

In psychiatric rehabilitation there are six areas main areas of intervention of proven effectiveness (Meuser, Torrey, Lunde, singer &Drake, 2003):

1) **Collaborative psychopharmacology**: outcomes are improved when consumers are included in the medication decision- making formula (i.e., collaborate for shared decision-making).
2) **Assertive community treatment:** provision of services to consumers in their natural environment (e.g., community) rather than a clinical setting such as an outpatient clinic or psychiatric hospital.
3) **Family psychoeducation:** educate family members about mental illness and effects of mental illness, enhance interpersonal relations, and foster a supportive support system.
4) **Supported employment:** gain competitive employment and provide assistance as needed, regarding skill development and employment maintenance for job security.
5) **Illness management and recovery:** help consumers assume responsibility for their recovery such that they can manage their illness, seeking assistance as needed to obtain personally meaningful and satisfying life goals.
6) **Integrated dual disorders treatment:** service providers target issues of mental illness and substance abuse simultaneously in an integrated fashion rather than treating these issues as separate disorders.

Psychiatric rehabilitation has proven effective with psychiatric patients and preliminary findings with offenders are promising (MacKain & Mueser, 2009).

It appears also essential that treatment services, to be effective with regard to long-term functioning, originate while the offender is incarcerated (National Research Council, 2008).

Outcomes from treatments with non-mentally disordered offenders and psychosocial rehabilitation services for mentally ill patients suggest that services correctional rehabilitation oriented services would be effective for reducing criminalness whereas psychosocial rehabilitation oriented services would be effective at reducing symptoms of mental illness.

Very few treatments focused simultaneously on both psychiatric and forensic aspects, while the majority aimed to treat either AXIS I or AXIS II disorders (SDM IV-TR, APA 2000).

Regarding the indicated treatments it can be observed that the inclusion of homework, specifically homework that required the practice of new skills and behaviours, produced stronger positive effects than did programs that did not include homework or the practice of new skills and behaviours. Correctional treatments to be deemed as effective should be intensive in nature, include structured programming, incorporate cognitive–behavioural models or target criminogenic needs.

In spite of research highlighting the significance of the therapeutic relationship between the service provider and offenders, the majority of the studies reviewed did not include any discussion on the importance of this alliance.

Outcomes can be grouped into eight general categories: mental health symptoms, coping, institutional adjustment, behavioural functioning, criminal recidivism, psychiatric recidivism, treatment-related factors (e.g., therapeutic alliance), and

financial benefit; still it is not possible to firmly determine that treatments resulted in a reduction in criminal and psychiatric recidivism.

What is established though is that studies that focused both on psychiatric and forensic issues, significantly reduce criminal and psychiatric recidivism.

Main results suggest interventions with offenders with mental illness effectively reduce symptoms of distress, improving offender's ability to cope with their problems, and result in improved behavioural markers including institutional adjustment and behavioural functioning.

An effective program, after being discharged from forensic hospitals, is an assertive community treatment (ACT) model that provides psychiatric service, day treatment, and intensive psychiatric rehabilitation (i.e., psychosocial rehabilitation) services. Still it is essential that intervention programs specifically target the co-occurring issues of mental illness and criminalness.

Significant treatment for mentally ill offender should begin during incarceration and should grant continuity of care, switching from a correctional institute to a more rehabilitative one. This model is consistent with public health initiatives by contributing to lower health care costs by reducing the rate of psychiatric hospitalization (Mitton, Adair, McDougall, & Marcoux, 2005) as well as reducing access to general medical services (e.g., Gill, Mainous III, & Nsereko, 2000).

As for recovery it is intended the achievement of a greater level of independence, greater quality of life, improvement in symptoms management, in spite of the psychiatric disorder (e.g., Corrigan, 2007); it stands out as a policy shift, from a model of assisted functioning (e.g., assisted employment, assisted living) certainly applicable to offenders showing improvements in the co-occurring dimensions of mental illness and criminalness recidivism.

Outcomes form studies on the importance of therapeutic alliance between mentally ill offenders and their therapists, focused on criminal recidivism, are contradictory: DeSorcy (2017) suggests that working alliance is not significantly linked to outcomes of violent recidivism.

There is a greater likelihood of violent sexual recidivism if an individual shows specific psychopathic traits (Doren, 2008).

Other reviews examine how often and how consistently symptoms lead directly to criminal behaviour. First, crimes rarely were directly motivated by symptoms, particularly when the definition of symptoms excluded externalizing features that are not unique to Axis I illness.

Specifically, of the 429 crimes coded, 4% related directly to psychosis, 3% related directly to depression, and 10% related directly to bipolar disorder (including impulsivity). Second, within offenders, crimes varied in the degree to which they were directly motivated by symptoms. These findings suggest that programs will be most effective in reducing recidivism if they expand beyond psychiatric symptoms to address strong variable risk factors for crime like antisocial traits (Peterson,2014).

David Scott and his colleagues published in 2013 a review on the effectiveness of services that in the United States are strictly under Judiciary control, but administer sanitary treatments to mentally ill offenders: the so called criminal justice liaison and diversion (CJLD). According to the authors evidence indicates that these services can help to reduce criminal recidivism and improve mental health outcomes. They outline the key features of the interventions in these structures, known as *mental health court*- MCH,(Goodale 2013). Liaison services seek to identify offenders with a mental illness and link them to appropriate mental health services in the community. Most employ community psychiatric nurses to complete assessments and provide general guidance to criminal justice system staff, when required a full multidisciplinary team gets involved. These services follow a model of therapeutic jurisprudence. Key components include a separate court docket for offenders with mental disorders, a judge trained in mental health issues, and a "treatment team" of mental health and legal professionals. MHCs aim to divert offenders with mental disorders to appropriate services, encourage treatment compliance, and reduce recidivism (Petrila, 2005; Steadman, 2005; Balenko, 2001). Substance abuse represents the strongest risk factor in determining criminal recidivism and clients who had a dual diagnosis had committed more serious offenses (Hoff, 1999). Authors conclude that this service model may be an effective way to reduce time in jail for people with serious mental illness. The ACT intervention model help participants to respect treatment indications allowing them to improve their outcomes on recidivism and psychosocial functioning. Anyway authors emphasize that these treatments show more effectiveness in mentally ill offenders that did non experience detention, versus those who had.

The Swedish judiciary system introduced two modern principles: first, the attempt to abolish moral responsibility, atonement and punishment, and second the integration of psychiatric assistance into control systems (Svennerlind C, 2012).

Moving towards the Japanese system, after the 2005 reform, a psychiatric patient who commits a serious criminal offence is provided with intensive psychiatric treatment ascribing also great importance to society reintegration. The court panel, which consists of a judge and a specially qualified psychiatrist, plays a key role in the treatment procedure. Upon the agreement of the two panel members, the panel delivers a verdict that takes into account the outcome of psychiatric evaluation; possible verdicts are inpatient treatment order, outpatient treatment order (with mental health supervision), and no treatment order (Nakatani Y,2010).

Literature consistently reports that several personality disorders, Axis I diagnoses (Schizophrenia and Mood disorders) and substance abuse related disorders, are linked to different types of violent crimes. There are scarce results available on the type of interventions and effective therapeutic approaches for aggressive patients; still few available studies support the effectiveness of cognitive therapy (Ali, 2015; Kenworthy, 2008) and group therapies (Kenworthy, 2008) for aggressive behaviours.

Regarding the personality most frequently linked to psychopathic and antisocial traits and behaviours, Nioche in 2010 inquired for associations between psychopathy and personality disorders. Outcomes found out correlation mainly with the cluster B axis II (narcissistic, antisocial, histrionic, and borderline). Among those disorders, a particular link existed with the borderline personality disorder. The antisocial and paranoid personalities predicted the total score and the factor 2 of the PCL-R. Antisocial and narcissistic personalities predicted factor 1 underlining first the importance of impulsivity above all for the cluster B personality disorders and secondly, the im-

portance of considering impulsivity with antisocial (factor 2), narcissistic and paranoid characteristics. These results also outline treatment implications: the treatment may be adapted according to the comorbidities having an effect on psychopathy that is antisocial with paranoid personalities, and antisocial with narcissistic personalities.

Besides personality disorder other psychiatric diagnoses considered at risk for violent conduct are Schizophrenia and other psychotic disorders; nevertheless comorbid diseases with substance abuse and antisocial disorder appear to be more related to violent conducts. Some researchers argue that schizophrenic patients are more likely to commit crimes such as homicide, not because of actual acute symptoms, but mainly due to association with substance abuse (Richard-Devantoy, 2013).

Another well-acknowledged theory in the scientific world is that patients with psychopathic traits show higher risk of criminal recidivism (Hare, 2006), as well as it is established that patients with personality disorders and psychopathy are more frequent among men than women (Nicholls, 2005).

Regarding treatments focusing on psychopathological conditions such as those of patients diagnosed with antisocial personality disorder, borderline personality disorder and other personality disorder related to antisocial or aggressive behaviours, malignant narcissism and psychopathy, only in recent years forensic literature has started to offer intriguing hints that may lead to further researches, since, in spite of past acquisitions, it is still very scarce.

2. Psychotherapeutic interventions

The available described treatments mostly resulted out of few forensic studies.

Treatments focus mainly on borderline and antisocial personality disorders (Bateman, 2016). Bateman and Fonagy (Bateman, 2016; Bateman and Fonagy et al. 2008) focus on assessment of mentalization based treatment (MBT) in patients diagnosed with borderline personality disorder (BPD) and antisocial personality disorder (ASPD) in comorbidity with Axis I disorders (DSM-IV-TR, 2000). The most frequent comorbid psychiatric disorders in BPD are anxiety and affective disorders, with lifetime prevalence for these at approximately 85 %, followed by substance use disorders at approximately 79%. Co-existence of other psychiatric disorders in BPD ranges between 41–83% for major depression, 12–39% for dysthymia, and 39% for narcissistic personality disorder. Regarding antisocial personality disorder (ASPD), over 90% of those diagnosed with the condition have at least one other psychiatric disorder, at least 50% have co-occurring anxiety disorders and 25% have a depressive disorder. Both ASPD and BPD show particularly complex and severe form of personality disorder when high levels of both DSM Axis I and Axis II comorbidity are reported. The prevalence of individuals meeting both BPD and ASPD diagnostic criteria in British population is low (0.3 %), but it increases in forensic samples with a higher degree of dangerousness and violence.

Bateman highlights that in Section III of DSM 5 the two conditions share similarities in symptomatology and trait domains namely antagonism and disinhibition. Overlap includes marked impulsivity and unpredictability, difficulties with emotional regulation and controlling anger, disregard for safety of self, and behaviour that can be considered by others to appear manipulative.

These aspects can be viewed with different underlay perspectives. BPD conduct such behaviour with the intention of eliciting care and concern from others; while ASPD conduct it with the intention of gaining personal profit and power over others.

Bateman also explains the differences between the two disorders: ASPD tend to have an inflated self-image, whilst those diagnosed with BPD tend to have a negative and devalued self-image; those diagnosed with ASPD pose more of a risk to others due to their tendency towards interpersonal violence, whilst those diagnosed with BPD pose more of a risk to themselves due to their tendency to self-damaging and self-destructive behaviours; those diagnosed with ASPD tend to lack empathy and be indifferent to or contemptuous of the feelings and sufferings of others, whilst those diagnosed with BPD are more likely to display empathy.

Bateman, in spite the differences, states a specific hypothesis on the theoretical frame of the two diagnoses. Although they may be almost polar opposites, the prominent symptoms appear across diagnostic groups, and BPD in particular might be better understood as being at the core of personality pathology thus explaining the high levels of comorbidity with other personality disorders, including ASPD.

These considerations for the author strongly affect treatment. Bateman identified failures in social cognition associated with both personality disorders; in particular they both share deficits and distortions of mentalization (the process of making sense of the self and of others in terms of mental states e.g. beliefs, thoughts, feelings, desires). It appears that those with BPD do not mentalize properly in the context of attachment relationships, in which emotional arousal occludes the ability to accurately interpret their own and others' mind states particularly when the fear of real or imagined abandonment arises. Antisocial individuals show a more general and deeper impairment the BPD, including deficits in the recognition of basic emotions, and perform far worse than controls on subtle tests of mentalizing. Deficits in social cognition in general and the capacity to link mental states to behaviour in particular are commonly identified in association with antisocial behaviour. As for the ASPD aetiology, Bateman suggests the pathway to the disorder leading from an early child conduct disorder via alcohol abuse in early adolescence to compromised function (and maturational delay of the cognitive control system of which mentalization is a part.

Mentalization-Based Treatment is a psychotherapeutic intervention which specifically focuses on improving the capacity to mentalize; it has been shown to be effective for patients with BPD in reducing frequency of suicide, severe self-harm, and hospital admission as well as improving general symptomatology and social and interpersonal functioning (Bateman and Fonagy, 2009). While the presence of comorbid Axis II diagnoses appears to have a negative impact on outcomes for BPD patients undergoing standard clinical management, there has been preliminary work to suggest that MBT may be more beneficial for patients whose BPD is embedded in other Axis II personality disturbances, including that of ASPD (Bateman and Fonagy, 2013). The authors propose that mentalization model may be effective for addressing symptoms of ASPD as well as of BPD. Antisocial behaviour and violence tend to

occur, the authors explained, when an understanding of others' mental states is developmentally compromised (fragile) and prone to being lost when the attachment system is activated by perceived threats to self-esteem, such as interpersonal rejection.

Usually mentalizing reduces the risk of acting violent conducts ((Bateman and Fonagy, 2008) meaning that individuals with vulnerable mentalizing capacities can be at risk in situations of interpersonal stress.The authors support that improving the capacity to identify others' emotions and intentions may not only help social functioning but also reduce the risk of antisocial behaviour.

Mentalizing has been shown indeed to be a protective factor in people with tendency to develop violent traits (Taubner et al, 2013) and it has been shown that encouraging mentalizing also reduced school violence (Fonagy et al, 2005; Fonagy et al, 2009).

Bateman recent study (2016) compared patients with comorbid BPD and ASPD treated with MBT with those offered an outpatient structured protocol of similar intensity, but excluding mentalizing components in the United Kingdom.

Both the MBT and SCM groups presented with similar levels of anger at the beginning of treatment, but differed significantly by 18 months; while no significant changes between the two groups we measured in the interpersonal style. Self-rated hostility, however, decreased in both groups. Paranoia symptoms showed significantly more improvement at 18 months in the MBT group. Occurrence of suicide attempts, episodes of self-harm and hospital admissions registered also reduced in the group that received mantalization treatment. Anxiety and depression scales also scored significantly lower in the MBT group. MBT treated patients after 18 months show significantly higher levels of global and social functioning, as well as emotional regulation when compared to the standard care group. Authors then conclude that MBT in patients with comorbid ASPD and BPD reduce anger, hostility, paranoia, and frequency of self- harm and suicide attempts, as well as improve negative mood, general psychiatric symptoms, interpersonal problems, and social adjustment.

Another important data strongly suggest that this patient group value the intervention and adhere to the treatment protocol (dropout rates of 27% for MBT).

Talking about mentalization skill as essential to a good interpersonal, social and global functioning, several studies by Fonagy support a strong impairment in mentalization, social cognition and social sensitivity in ASPD subjects as opposed to offenders not diagnosed as ASPD.

According to Fonagy a treatment that focuses on these aspects may be effective with ASPD patients (Newbury-Helps, Feigenbaum, Fonagy, 2016).

The author also examines risk factors associated with antisocial behaviour in general and violence as mediated by intra-familiar factors, such as the quality of the parent-child relationship (Fonagy, 2004). In a developmental pathway, the risk of violence may be tied to child abuse in an attachment setting, mediated by a child ability to imagine other mental states.

The literature on Theory of Mind (ToM) in antisocial samples is limited despite evidence that the neural substrates of theory of mind task involve the same circuits implicated in the pathogenesis of antisocial behaviour(Dolan, 2004). For the majority of criminals with ASPD and psychopathy ToM abilities are relatively intact and may have an adaptive function in maintaining a criminal lifestyle. Key deficits appear to relate more to the lack of concern about the impact on potential victims than the inability to take a victim perspective. also the findings suggest that ASPDs with neurotic features may be more impaired in mentalizing ability than their low anxious psychopathic counterparts (Dolan, 2004).

Searching through recent studies Bernstein (2012) latest works contradicts the hypothesis that available treatments for offenders diagnosed with personality disorders result in discouraging outcomes. Bernstein underlies that psychopathic subjects represent an heterogeneous group both in the disorder aetiology and in the emotional distress they present. Bernstein differentiates between psychopathic patients that are emotionally unresponsive and highly emotional psychopathic patients, that, as a consequence, may be more responsive to treatment. This assumption opposes the dominant one on psychotherapies efficacy on psychopaths that may worsen their manipulative traits.

Bernstein, actually, started a still ongoing study in 2007 aimed to inquire after effective treatments for offenders with comorbid personality disorder.The author mainly focused on assessing treatment effectiveness on risk of criminal recidivism and on maladaptive personality traits, aiming to eventually, gradually, reintroduce the patient into the community. The study enrolled a sample of 100 patients diagnosed with antisocial, borderline, narcissistic, and paranoid personality disorder among seven Dutch Forensic Hospitals. Half of the sample underwent treatment with Schema Therapy and the other half underwent standard treatment *(Treatment as usual)*. The preliminary results (Bernstein, 2012) show that Schema Therapy reduces the risk of recidivism, helps to fasten the resocialization process and the patients community reintroduction, with less frequent need for supervision. Preliminary data, though encouraging, will be definitely assessed by 2018. Still Schema Therapy seems to effectively contrast the commonly shared idea that this population of patients are not treatable.The author extensively contrasts studies that suggest the psychotherapies may worsen the manipulative traits in antisocial/psychopathic conduct, arguing that often published works are biased by the assumption that these patients are not responsive to treatment, and consequently are not given specific treatments.

Another consistent data on Schema Therapy is represented by the Adherence to Treatment (Bamelis et al, 2013); it can be outlined that this intervention has moved forward, since its introduction by Jeffrey Young, so much as to prove its effectiveness in also in suicidal and self-harm behaviours.

3. How the psychotherapeutic approach to mentally ill offenders changes

As already stated, general attitude towards these patients is changing. Among the most important scientific contributions available in literature stands Kernberg's, that reflects on the possible and potential effectiveness of psychotherapeutic treatments and of social influences, once a malignant intrapsychic structure has established and consequently a pathological grandiose self-infiltrated with aggression dominates psychic function, in the absence of the moderating and maturing re-

liance on an integrated superego (Kernberg, 2004; 2006). According to Kernberg there are sufficient scientific evidences available to suggest that narcissistic personality with antisocial traits and the malignant narcissistic syndrome can be effectively treated. Similar evidences are still lacking, says Kernberg, for Antisocial Personality Disorder (ASPD).

Kernberg direct experience with these patients has lead to the standardization of a series of indications, guidelines, that regard the treatment of antisocial conducts and, especially, the prerequisites, or *conditio sine qua non*, that are mandatory to grant clinical treatment and that involve, the patient, his family and the social environment.

According to the author first it is essential to distinguish in case of severe aggressive behaviour of severe self-destructive behaviour, whether there is a life threatening risk for the patient or other figures involved, including the therapist. Kernberg suggests, if an aggressive ASPD is diagnosed, to engage the patient family, social services and the legal system for eventual warning duties. The prognosis for aggressive antisocial personality disorder is poor so the main therapeutic goal is to protect the patients himself, his family and society from his destructiveness. If a patient instead satisfies the criteria for ASPD, but does not present aggressive or exploiting behaviour that configures an immediate harm, the pressing need is for the comprehension of what lies behind the consultation request.

The request may have different genesis: it could originate by the family; it could be derived from the necessity of protecting himself from a recent lawsuit or criminal charges; the judge may ask an opinion to rule on the patient criminal responsibility; consultation is requested by the family or by community services to assess psychopathological conditions and to face the harm the patient is causing to the surrounding environment, or the patients is in a psychotic state.

These patients may show a chronic tendency towards robbery or exploitation of their family, they can be chronically violent without necessarily be life threatening or they can act conducts potentially illegal. Across the Italian territory in the residential forensic facilities (REMS) a common crime is familiar aggressiveness (maltreatment). In this matter the therapist faces the responsibility of being a family consultant, but also gets involved with psychiatric services and with legal figures.

It is essential, anyhow, not to allow to the patient to take advantage or profit by therapeutic connections to protect himself by legal consequences. Similarly the clinician should take all the necessary steps to guarantee his safety, including legal aid to check on potential responsibilities, as a mandatory prerequisite before any interventions on these patients and their families.

One essential precondition to start treatment is for the clinician to get sure that the patient agrees on the necessity of stopping any social connection that may be harmful for himself or others.

Kernberg says that psychotherapy with Antisocial Personality Disorder patients that are not aggressive requires an open communication with the patient and his family on the gravity of his conditions, the prognosis and the necessity of an open communication with the entire familiar system to monitor the patient compliance, starting from the assumption that every anti-social conduct should have stopped at the beginning.

This arrangement improves the likelihood of success in managing self-harm or violence towards others and in preventing selfish gains related to the therapeutic process.

According to Kernberg the prognosis of malignant narcissism is better than the one related to ASPD. One prerequisite is the strict surveillance of antisocial behaviours, an open communication with the family and the social system, the eradication of any personal gain, and the physical, social and legal protection of the therapist.

When treating patients with severe personality disorders, another tactical approach relates to certain general priorities that need to be taken up immediately. These priorities include, in order of importance: (1) suicidal or homicidal behaviour, (2) threats to the disruption of the treatment, (3) severe acting out in the session or outside, that threatens the patient's life or the treatment, (4) dishonesty, (5) trivialization of the content of the hour.

To complete the overview on malignant narcissism, scientific literature suggests that the patient profile is liable of dimensional interventions on specific aspects.

One of the main features of the treatment is its internal consistency: for instance, no unjustified absences can be tolerate, and the aim is to progressively reduce the access of the patient to angry emotions, usually employed to inflate his self-esteem or avoid to bare pain or suffering.

These coping strategies have to be opposed favouring the access to one emotional state and in this perspective Mentalization/Metacognitive strategies seem to be preferential (Bateman and Fonagy, 2010; Fonagy 2009). Deficits in mentalization are associated with several pathological conditions (Abu-Akel and Shamay-Tsoory,2011; Bateman and Fonagy, 2010) and many mantalization based treatments resulted effective in reducing dysfunctional behaviours and in mediating the psychopathic aspects.

Trying an Interpersonal Metacognitive approach on offenders with personality disorders, it is necessary to take into account that there are still no evidences that support it, but if this is the case, the following are some of the thoughts or questions a therapist may have in mind while approaching these patients with TMI:

1) What are the psychopathological conditions that are threatening the patient's wellbeing and integrity?
2) What are the psychopathological conditions that may turn out to interfere globally with therapy and specifically with therapeutic alliance?
3) What are the psychopathological conditions that are essential in prolonging the disorder?
4) What are the psychopathological conditions that represent the main cause of subjective pain and maladaptive functioning?

In answering the first question, we have to consider that auto reflection and differentiation process are highly compromised; that patient does not have the ability to access his emotional world and does not differentiate between fantasy and reality, between intrapsychic reality and objective reality. Dissociative fantasy regulates one's mental state and counteracts the feelings of emptiness; in this perspective the subject may benefit from interventions that increase and improve the insight on his emotional world without being necessarily being frightened by it. The therapist needs to act cautiously while exploring the patients' emotional world, being at risk of elic-

iting a negative counter-transference. The main issue while working with the patients is actually the identification of the dominant primary emotion. Still, this represents the first step to undertake that is to encourage auto reflection and highlight dysfunctional coping strategies that lack of efficacy in the long term. If the access to new forms of experience is blocked the patient remains trapped in his fantasies and actively rejected by others; context rejection and the constant seeking of sensational situations will endanger the patient that will get caught in a cycle that supplies, along with other factors, the disorder persistence. These patients get often involved in serious legal situations, tend towards acting out, underestimate the risk they face and that may end up interfering with treatment.

They are often the only accountable for the lack of assistance they experience, often due to the threats they make against their lawyer or therapist.

The second question faces the psychopathological aspects that may interfere with therapy, and more specifically with therapeutic alliance. In this perspective the tendency towards deception and being manipulative are the most accounted for therapeutic alliance. The patient is in fact constantly focused on getting admired by others (including the therapist) raising in the therapist the perception of a fake alliance, along with the feeling of being constantly under deceit or exploited; on the other hand raising in the patient himself a feeling of frailty whether the therapist should get too close to his emotional world. Anyway the therapist should reach an agreement with the patient, at the beginning of the treatment, about the opportunity of checking the accuracy of the acquired information through family or other sources, also the therapist, session by session, should highlight the patient style, in the hic et nunc of the relationship, to get him to understand how his strategies are interfering with the access to deeper and authentic mental and emotional material. What de facto happens in clinical practice is that the patient gets scared, not being able to cope with negative emotions, feeling his vulnerability, and quits therapy.

Answering the third question from a TMI perspective, searching for the factors that are essential in the disorder persistence, we can consider that the written above cycle of constant admiration seek, when failed, turns for the patient in a raging search of others' admiration. The tendency to swing between seduction and anger is the maintenance factor most frequently identified in the disorder. The patient who fails in getting others' admiration or in deceiving others, turns resentful and tends to isolate himself in a world of fantasies as a coping strategy while hurting.

Finally, as for the factor that represents the main cause of subjective pain and maladaptive functioning for these patients, it seems to be the failure in manipulating others. It appears striking in them the level of social impairment; they are often clumsy both on an interpersonal and on a social level, due to the metacognitive impairment and to the scarce ability to be empathic and intimate. Let us consider their assertion of greatness and search for admiration to understand the effect they arise in others, namely of exclusion, that in turn, generates in the patient severe rage displays.

The metacognitive approach takes into account all these preconditions, focusing on relationship, interpersonal cycle and metacognitive impairment.

Regarding specific interventions on forensic psychiatric populations, besides the studies already introduced on Bernstein and Schema Therapy, on Kernberg and the Transference Focused Psychotherapy, on TMI principles, other recent studies (Rosenfeld et al, 2012; Galietta & Rosenfeld, 2012; Tomlinson & Hoaken, 2017; Tomlinson, 2018) deal with the effectiveness of dialectical behavioural treatment of Marsha Linehan adapted to forensic patients.

Particularly DBT resulted effective in reducing aggressive behaviours, anger and hostility in a sample of forensic patients (Tomlinson, 2017); it is effective on overall symptoms (Galietta & Rosenfeld, 2012); it is effective in reducing the risk of criminal recidivism up to 55%, if applied within a "Risk-Need-Responsivity" framework in residential settings (Tomlinson, 2018).

Another interesting work by Rosenfeld (2012) compared indexes of relapse in a group of psychiatric patients convicted for stalking that were enrolled in a DBT program specifically adapted for them. The results indicates that DBT treatment is effective in reducing the risk of stalking recidivism compared to patients that drop out of the DBT program and to the general data on relapse available in literature.

For ASPD patients with comorbid substance abuse guidelines suggest to consider cognitive-behavioural group therapy to address impulsivity, interpersonal difficulties and antisocial behaviours.

For ASPD patients with a history of aggressive behaviours that are in residential settings, guidelines suggest CBT group therapy that focus on the reduction of aggressive and antisocial behaviour overall.

If CBT treatments are administered id essential to assess the risk level to calibrate the treatment intensity and duration. It is also necessary to provide support and encourage patients to avoid drop outs.

For patients in residential facilities or forensic settings that meet the criteria for psychopathy or ASPD it is recommended to take into account CBT interventions based on the reduction of aggressive and antisocial behaviour overall.

As for the population of adolescents patients, the effective treatments proposed (familiar therapy, parental skill training, group CBT interventions) prove to be statistically significant in reducing aggressive behaviours. Caldwell and colleagues (2006) compared an intensive treatment program in juvenile Treatment Centres for adolescents with a group that underwent treatment as usual. The costs were higher in the first group, but there was also a significant reduction of criminal recidivism and violent crime in the adolescents that belong to the first group.

Guidelines suggest to intervene on adolescents of 17 years of age or less with a history of aggressive conducts that are in correctional facilities with CBT groups that focus on the reduction of antisocial and aggressive behaviours.

Regarding patients diagnosed with ASPD in comorbidity with substance abuse, literature data on the effectiveness of treatments that tangle substance abuse are controversial (Wolver et al, 2001; Hesselbrock, 1991; NCCMH, 2007°; 2007b). It is anyway common opinion that treating the substance abuse in comorbidity with the ASPD is effective because of its role as risk factor in ASPD relapse; treating those aspects reduce consequently criminal conduct related to ASPD and to psychopathy (NICE, 2009).

Conclusions

Considering what we have described so far we can state that the treatments to administer in a forensic setting are specific according to homogeneous diagnostic groups.

Literature especially highlights patients with dual diagnoses as the most challenging so the key features in establishing a therapeutic path are Integration, Psychiatric Treatment, Psychosocial Rehabilitation, Forensic Rehabilitation.

Differing from what is nationally deemed appropriate the complexity of those therapeutic pathways should contemplate their entitlement entirely to specialists supported by a juridical staff.

Each structure should specify which standardized instruments are employed for diagnostic assessment and to assess recidivism risk.

It appears to be mandatory the employment of appropriate tools for assessing cognitive functions, IQ, personality profile, mentalization/metacognition level (such as IVAM, Semerari et al, 2008) and psychopathy. There is no scientific evidence that treatment itself may reduce alone the relapse indexes, the only real recidivism predictor so far is PCL-R.

As for the treatment programs for patients with personality disorders it appears essential that they have a high level of structuring and intrinsic consistency both on the theoretical model they rely on that on the psychotherapeutic approach they deliver. Treatment based on mentalization (MBT) and Schema Therapy are currently showing greater scientific evidence than other treatments so approaches that enhance mentalization and metacognitive functioning should be favoured.

We wish that this may soon happen nationwide.

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Psychiatric illness in incarcerated population

Il trattamento del malato di mente detenuto

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Abstract
The psychiatric incarcerated population has increased enormously in recent years. Most of them are homeless and suffering mainly from psychosis, often in comorbidity with substance abuse. Psychopathology, as well as the effect of substances or withdrawal, mediates the possibility of committing crimes again after release and their pathway in prison.
In this contribution, we will present possible treatments currently available in prison, both for psychopathology and detoxification from substances and alcohol, and their effectiveness. In addition, the characteristics of two particular populations, women and adolescents facing the prison experience, will be highlighted. Finally, an in-depth study on suicide and self-harming, transversal to psychiatric disease, gender or age, will propose both the size of the phenomenon and possible prevention or intervention options.

Key words: psychiatry • incarcerated population • women, adolescents • dual diagnosis

Riassunto
La popolazione psichiatrica in carcere é aumentata in modo imponente negli ultimi anni. La maggior parte di loro risulta senza fissa dimora ed affetta da psicosi, spesso in comorbiditá con abuso di sostanze. La psicopatologia, cosi come l'effetto delle sostanze o l'astinenza dalle stesse, mediano la possibilitá di commettere nuovamente crimini dopo il rilascio ed il percorso carcerario.
In questo contributo verranno presentati i possibili trattamenti attualmente disponibili in ambito carcerario, sia per psicopatologia che per detossificazione da sostanze ed alcool, ed efficacia degli stessi. Inoltre si evidenziano le particolaritá di due popolazioni particolari, ovvero donne ed adolescenti che affrontano la dimensione carceraria. In ultimo, un approfondimento rispetto al fenomeno del suicidio e dell'autolesivitá, trasversali rispetto alla patologia psichiatrica, al genere o all'etá proporrá sia le dimensioni che le possibili opzioni preventive o di intervento.

Parole chiave: psichiatria • popolazione carceraria • donne • adolescenti • doppia diagnosi

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Introduction

There are more than 10 million individuals in prison at any given time with more than 30 million circulating through each year (Fazel & Baillargeon, 2011).

Prisoners show higher rates of psychiatric disorders and researches highlight that in some countries there are more people with severe mental illness in prisons than psychiatric hospitals.

Generally speaking, risk factors for incarceration included prior incarcerations; co-occurring substance-related diagnoses; homelessness; schizophrenia, bipolar, or other psychotic disorder diagnoses; male gender; no medical insurance (e.g MedicAid); and belonging to a cultural minority. Risk factors for reincarceration included co-occurring substance-related diagnoses; prior incarceration; diagnosed schizophrenia or bipolar disorder; homelessness; and incarceration for three or fewer days (Hawthorne et al., 2012).

The seriousness of the problem and the proportion of psychiatric patients that contributes to incarcerated sample, require an in-depth evaluation.

1. Psychiatric patients and incarceration

Mentally ill patients are entering the criminal justice system at alarming rates, representing a significant percentage of those incarcerated (Collins, Avondoglio, & Terry, 2017). Persons with mental illness and co-occurring substance abuse disorders are incarcerated a disproportionately high rates in comparison to the general population (Rock, 2001). Diagnoses were predominantly in the schizophrenia spectrum with 70% also actively abusing substances at the time of incarceration (Munetz, Grande, & Chambers, 2001).

Nearly two thirds (65.0%) of inmates had a DSM-IV Axis I or Axis II disorder. Personality disorders were the most common disorders (51.9%), followed by anxiety (25.3%) and substance use disorders (24.9%). Over one third of inmates (36.6%) had comorbid types of disorder. The most common comorbid types of disorders were substance use disorders plus personality disorders (20.1%) and anxiety disorders plus personality disorders (18.0%) (Chen et al., 1999; Piselli et al., 2015).

People affected by mental illness who commit a crime might face incarceration or admission into the forensic psychiatric circuit. Persons affected by severe mental illness who are incarcerated (I-SMI) have less schooling; they more often reported suicide attempts and violent and non-violent crimes; and they had a higher level of comorbidity involving Cluster B personality disorders and substance-use disorders. Forensic-hospitalized SMI persons were more likely to have been receiving psychiatric follow-up before hospitalization. Lifetime suicide attempts, non-violent crimes, and psychopathic traits were higher among I-SMI individuals than among forensic-hospitalized SMI individuals. In contrast, receiving regular psychiatric follow-up was associated with forensic-hospitalized SMI individuals (Dumais, Cote, Larue, Goulet, & Pelletier, 2014).

Former inmates had a greater mean number of previous hospital stays than other patients ($t = -2.13$; $df = 305$; $p = 0.03$) and were more likely to visit the emergency room or be re-hospitalized within 3 months of discharge (Prince, 2006).

Psychiatric illnesses show different connotation among general inpatients, forensic and incarcerated patients. For example, compared to schizophrenics, forensic schizophrenics are more severely clinically impaired, showing higher rates of comorbid alcohol and substance disorder, more suicide attempts, had more previous hospitalizations, and were younger at disease onset (Landgraf, Blumenauer, Osterheider, & Eisenbarth, 2013).

Furthermore, psychiatric pathologies seem to mediate the type of offence. It is illustrative the relevance that the rate of sexual crimes among individuals with schizophrenia is relatively low. Studies indicate significant differences distinguishing schizophrenia sex offenders from schizophrenia non-sex offenders, the former of whom were more likely to be married, employed, non-heterosexual (homosexual and bisexual orientations) and demonstrated less hospitalization, antisocial personality, substance abuse, negative symptoms and overall illness severity (Alish et al., 2007).

An appropriate psychiatric follow up seems effective in reducing psychiatric relapses as well as reincarceration. In fact, patients whose first service after release from incarceration was outpatient or case management were less likely to receive subsequent emergency services or to be reincarcerated within 90 days.(Hawthorne et al., 2012)

Mentally disordered offenders produced criminal thinking scores on the Psychological Inventory of Criminal Thinking Styles (PICTS) and Criminal Sentiments Scale-Modified (CSS-M) similar to that of non-mentally ill offenders. Collectively, results indicated the clinical presentation of mentally disordered offenders is similar to that of psychiatric patients and criminals (Morgan, Fisher, Duan, Mandracchia, & Murray, 2010).

Treatment options might be reduced in the prison context (Ehret et al., 2013). Fazel and collegues (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016) highlighted that the number of medication trials conducted in prisons is particularly low. They detected some studies on ADHD medications that showed an improved global functioning and increased likelihood of abstinence from amphetamine after release. Similarly, controlled trials on psychological therapies in prisoners are more than those on medications, but are typically small and involve a wide variety of interventions (e.g., cognitive behavioral [CBT], interpersonal, dialectical behavioural [DBT], meditation- based, and group therapies) with inconsistent findings.

2. Dual diagnosis

Dual diagnosis, that is by definition the "condition of suffering from a mental illness and a comorbid substance abuse problem", is frequently reported among inmates. Substance and alcohol dependence is high among incarcerates with a general prevalence of about 56% for alcohol dependence, 49% for opiate dependence and 61% for cocaine dependence (Lewis, 2011).

People with co-occurring disorders have the most substantial criminal histories and the highest rates of institutional charges, transfers to segregation while incarcerated, and reconvictions.

Moreover, having a substance use disorder appeared to be the key factor contributing to poorer correctional outcomes for offenders with mental disorders (Wilton & Stewart, 2017).

Seventy-eight percent of the homeless inmates with a severe mental disorder had co-occurring substance-related disorders. Inmates with dual diagnoses were more likely to be homeless and to be charged with violent crimes than other inmates (McNiel, Binder, & Robinson, 2005). 30% of the inmates who were homeless had a diagnosis of a mental disorder during one or more episodes (McNiel et al., 2005).

Some protective factors seems linked to a reduction of reincarceration rate in addicted prisoners. Two factors, in particular, are associated with a reduced likelihood of incarceration: friendships with individuals who did not use substances (OR=.19) and substance use treatment engagement (OR=.60) (Luciano et al., 2014)

Furthermore, drug-involved prisoners exhibit more health problems and greater rates of chronic health problems than prisoners who have not used drugs (Leukefeld et al., 2002).

Detoxification might be problematic within the prison context and the provision of such treatment services is variable. Alcohol and opiates are the two most common and problematic substances for detoxification management in prisons. A poor offering of such treatment might imply serious adverse outcomes, for example the management of withdrawal. It has been attested that only 34% of US jails offer any detoxification treatment (Oser, Knudsen, Staton-Tindall, Taxman, & Leukefeld, 2009), implying that about one million arrestees annually are at risk of untreated withdrawal from alcohol, including delirium tremens and its associated high mortality(Hasin, Stinson, Ogburn, & Grant, 2007).

Opiate substitution and CBT-based relapse prevention therapies should be made available to all prisoners. Evidence support their efficacy and long lasting effects after release.

The management of opiate withdrawal in prison is generally symptomatic, and mostly based on detoxification rather than maintenance. Some systematic review (Duthe, Hazard, Kensey, & Shon, 2013)confirm the efficacy in reducing withdrawal severity using long-acting opioids (Amato et al., 2013). Further evidence highlighted an equivalent clinical effectiveness for detoxification between methadone and buprenorphine (Leeds Evaluation of Efficacy of Detoxification Study –LEEDS). A further study compared dihydrocodeine and buprenorphine demonstrating comparable effectiveness for acute opiate detoxification (Sheard et al., 2009). On the basis of this evidence, all prisoners should be offered acute detoxification on arrival.

Many psychological treatments for substance misuse are available, some of them analyzed on a prison-based [therapeutic communities (TC), CBT, and motivational interviewing (MI)]. In particular, if followed by aftercare in the community most effective at reducing relapse and re-incarceration (Mitchell O, 2007). MI is esteemed the best evidence-based treatment for alcohol misuse.

A variety of CBT-based therapies studied in prison populations with substance misuse demonstrate effectiveness compared to drug and alcohol education or no treatment.

Furthermore, other treatment demonstrated reductions in recidivism, for example Reasoning and Rehabilitation (R&R), a 35-session CBT program focusingon prosocial attitudes, emotion regulation and self-control, and interpersonal problem solving (Tong LSJ, 2006).

There is also good evidence for the medication assisted therapy (MAT), which combines pharmacological treatments (including methadone, buprenorphine and naltrexone) and psychological approaches. Studies showed significant positive outcomes of MAT on reoffending (d=0.47) and drug use (d=0.38) (Koehler JA, 2014).

Methadone maintenance therapy (MMT) has been implemented in many countries. MMT decreases heroin use and enhances treatment retention compared to non-pharmacologic treatments (Mattick, Breen, Kimber, & Davoli, 2009).

Starting methadone prior to release is significantly more effective for treatment retention, reduced drug use, and reduced reoffending than either counselling alone or simple referral to MMT upon release (Kinlock, Gordon, Schwartz, Fitzgerald, & O'Grady, 2009; Rich et al., 2015).

A number of program evaluations have demonstrated reduction in opiate use following release when individuals were started during incarceration (Gordon et al., 2014; Magura et al., 2009). Some RCT evidence supports the use of intramuscular naltrexone as an alternative to methadone (Lobmaier, Kunoe, Gossop, Katevoll, & Waal, 2010).

3. Adolescents

Adolescence is a key but potentially fragile period of life that might require special attention. Most of the psychiatric disorders have their onset during adolescence and delinquent behaviors, often influenced by peers, start to be displayed (Margari et al, 2015).

Almost half (43.6%) of hospitalized adolescents have a history of juvenile justice involvement. Significant predictors of juvenile justice involvement included being male, parental legal history, family substance abuse history, disruptive disorder, cocaine use, being sexually active, and having a history of aggressive behavior (Cropsey, Weaver, & Dupre, 2008).

Substance and alcohol abuse play an important role, both as a component of peer association in delinquency and an incentive to commit crimes in order to obtaining substances.

Due to age characteristics, dependence, its treatment and crime are mediated accordingly. For example, adolescents use significantly less inhalants than nonminority (McGarvey, Canterbury, & Waite, 1996)

Psychopathology influences and modulates substance

abuse. Indeed, incarcerated adolescents showing a negative mood report higher levels of alcohol use, higher levels of use-related consequences for both alcohol and marijuana, greater use of both substances to regulate mood states, and more use of avoidant coping (Turner, Larimer, Sarason, & Trupin, 2005)

Some therapies have been applied for the treatment of addicted incarcerated adolescents. Among those, motivational interviewing demonstrated the best efficacy in adolescents incarcerated for driving while intoxicated with lower rates of re-offence (Stein et al., 2006).

4. Women

Women are considered a special population deserving greater attention. Psychopathologies are, in general, gender mediated and their presentation or characteristics vary accordingly (Catanesi, Carabellese, La Tegola & Alfarano, 2013; Carabellese et al, 2015).

Incarcerated women have higher rates of depression than both community samples and incarcerated men (Gunter, 2004). Women prisoners show an higher risk of suicide compared to male prisoners (with relative risks typically more than 6 compared to the general population).

Forty-three percent of participants met lifetime criteria for a serious mental illness, and 32% met 12-month criteria; among the latter, 45% endorsed severe functional impairment. Fifty-three percent met criteria for ever having posttraumatic stress disorder (PTSD). Almost one in three (29%) met criteria for a serious mental illness and PTSD, 38% for a serious mental illness and a co-occurring substance use disorder, and about one in four (26%) for all three in their lifetime (Lynch et al., 2014).

The severity of borderline personality disorder (BPD) and antisocial personality disorder (ASPD) both were associated with drug dependence, but BPD was not associated with alcohol dependence. After controlling for ASPD severity, BPD severity was no longer associated with drug dependence. None of the BPD features was uniquely associated with alcohol or drug dependence after controlling for ASPD. A co-occurring BPD diagnosis was associated with mood disturbance and experiential avoidance among substance-dependent participants. An ASPD diagnosis was associated with an earlier age at first arrest, along with greater childhood abuse and severity of alcohol dependence (Chapman & Cellucci, 2007).

Female inmates have a greater treatment need, yet most inmates do not participate in treatment while incarcerated. Females were significantly more likely to participate in prison drug treatment than males, but severity of drug problems predicted participation in treatment, as for males. For males but not females, race was associated with prison treatment participation, and among those with drug abuse or dependence, females with co-occurring mental health problems were more likely to participate in treatment (Belenko & Houser, 2012).

Providers described optimal aftercare for women as including contact with the same provider before and after release, access to services within 24-72 hours after release, assistance with managing multiple social service agencies, assistance with relationship issues, and long-term follow-up (Johnson et al., 2015).

Findings suggest that there are aspects of incarcerated addicted with major depression women's social networks that are amenable to change during incarceration and post-release and provide insight into treatment targets for this vulnerable population (Nargiso, Kuo, Zlotnick, & Johnson, 2014).

5. Suicide and Self-harm

Suicide and self-harm are more common in prisoners than community-based persons of similar age and gender (Fazel et al., 2016). The relative risks of suicide in male prisoners is around 3-6 compared to the general population, with a higher risk in women prisoners (relative risk typically more than 6).

Of the suicide victims with some mental health contact, 95% had a substance abuse history, 70% displayed agitation or anxiety prior to the suicide, and 48% had a behavioral change. Common stressors preceding the suicide were inmate-to-inmate conflict (50%), recent disciplinary action (42%), fear (40%), physical illness (42%), and adverse information (65%) such as loss of good time or disruption of family/friendship relationships in the community. Forty-one percent had received a mental health service within 3 days of the suicide (Way, Miraglia, Sawyer, Beer, & Eddy, 2005).

An elevated risk of suicide was observed among inmates with major depressive disorder (relative risk [RR] = 5.1, 95% confidence interval [CI] = 1.9-13.8), bipolar disorder (RR = 4.6, CI = 1.3-15.9), and schizophrenia (RR =7.3, CI = 1.7-15.9). The highest overall risk was present in those inmates with a nonschizophrenic psychotic disorder (RR = 13.8, CI = 5.8-32.9) (Baillargeon et al., 2009).

The relative risk shows important differences between countries (from reported suicide rate of 179 per 100,000 prisoners in France, whereas most countries report around 100-150 per 100,000). Interestingly, another outlier is the US where suicide rates in local jails are 41 per 100,000, and in state prisons 16 per 100,000, 80 per 100,000 in U.S. local jails and 25 per 100,000 in U.S. state prisons, but no clear explanation have been identified and no correlations with incarceration rates or general population suicide rates have been detected (Fazel, Grann, Kling, & Hawton, 2011; Statistics., 2015). A possible explanation may root in a difficulty in identification due to misclassification of suicides as accidents, unknown or natural deaths, and reluctance in some countries to characterize self-inflicted deaths in custody as suicides. These reasons led Fazel and colleagues to suggest that all-cause mortality in prison may be a better proxy than official suicide rates for international comparisons when including countries where suicide reporting in prisons has not been validated.

Contextually, analysis of self-harming in prison is appropriate. It is an important cause of morbidity, but studies focused on this issue are less than those on suicide.

A recent epidemiological study in English and Welsh prisons found that in the previous 12 months in custody, 5-6% of men and 20-24% of women self-harmed. Risk factors include younger age and short sentences, and there is evidence that self-harm clusters in certain prison settings. (Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014) Near-

lethal self-harm has been shown to be a valid proxy for completed suicide in prison.

In terms of interventions for the management of suicide and self-harming prison, the studies have indicated the importance of adequate screening for suicide risk with comprehensive care planning based on identified risk on arrival to prison. Several guidelines for suicide prevention have recommended early screening of prisoners at first reception to custody, actions taken in response to positive screening, and ongoing risk monitoring (Konrad et al., 2007). Moreover, multidisciplinary information sharing and decision-making are emphasized along with appropriate mental health treatment. Another recommended intervention has been training of suicide risk assessment and management, often focusing on communication skills. Staff training and environmental safety (e.g., removal of potential risks such as ligature suspension points) are highly recommended.

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Aggressive and antisocial behaviour in childhood and adolescence: psychopathological and clinical considerations

Condotte aggressive ed antisociali nell'infanzia e nella adolescenza: alcune riflessioni cliniche e psicopatologiche

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Abstract
In Childhood and Adolescence, conduct problems and antisocial behaviour are largely widespread and the most common reason for referral to public and private mental health professionals. Aggressive and defiant behaviour is not pathological itself, but is part of normal functioning, particularly at some specific ages, and a component of human nature. Therefore, deciding when aggressive or antisocial behaviour needs clinical intervention is a challenge, especially across developmental stages when the plasticity of mental functioning has an impact on the fluency and instability of the diagnosis. In this paper, we are going to consider psychological, emotional and interpersonal features of children and adolescents displaying a psychopathological conduct, beyond behaviour and acts, which, according to a clinical perspective, could be more useful and should address effective interventions.

Key words: aggressive behaviour • conduct problems • callous-unemotional traits • antisocial behaviour • childhood and adolescence

Riassunto
In età evolutiva, i problemi di comportamento e antisociali sono piuttosto diffusi e costituiscono la principale ragione per cui ci si rivolge ai professionisti della salute mentale sia pubblici che privati. Le condotte aggressive e devianti non sono psicopatologiche di per sé, ma sono una componente costitutiva dello sviluppo normativo, in particolare in specifiche fasi evolutive, e dell'essere umano. Stabilire quando queste condotte necessitino di interventi rappresenta una sfida, ancor più in età evolutiva, quando la plasticità del funzionamento mentale si riflette nella fluidità e instabilità delle diagnosi. In questo lavoro, prendiamo in considerazione, oltre alle condotte, gli aspetti psicologici e affettivo-interpersonali di bambini e adolescenti con psicopatologie del comportamento, che si mostrano in una prospettiva clinica di maggiore utilità per orientare interventi efficaci.

Parole chiave: condotte aggressive • problemi della condotta • tratti *callous-unemotional* • comportamenti antisociali • infanzia e adolescenza

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1. Aggressiveness, violence and antisocial behaviour

The tendency to give a psychopathological meaning to any form of human aggressiveness can be considered a *prejudice* based on the defensive or moralistic disavowal of uncomfortable and generally disapproved aspects that are instead fundamental and universal components of the human behaviour. These components are there even when they remain unexpressed and are functional to growth and existence. This happens both in case of reactive aggressiveness, which belongs to a more defensive and hot-blooded nature, as well as in case of proactive aggressiveness, which is linked to a more predatorily and cold-blooded nature.

"Aggressiveness" is a polysemy that can define the basic energy of a personality, which aims to survival and reproduction, it can identify a defensive conduct in response to a real or imagined threat, or it can refer to a destructive attitude or to a tendency to oppress others.

Less clear, but nonetheless equally relevant, is its relational meaning, already included in its etymology (*ad-gredior* means "go against" and implies a recipient) and tangibly verifiable in the fact that the aggressiveness, when translated into action, is towards the outer world, towards an object (being animated or not), with an outburst that makes the object the depository of the aggressive rush. Although in a wider framework, it can be traced also for the self-harm and self-aggressive behaviours (both physical and psychological), implicating that the own body is used like a "sign" acting as mediator in the relationship with the external object (Saussure, 1916) and expresses violence and aggressiveness[1]. In this context it is the other person that perceives distress and pain, to the point that, in a more specifically clinical and psychopathological framework, it is more frequent - if not the norm - that it is someone different than the aggressive subject that expresses concern and seeks counselling or various nature of intervention (educational, psychiatric and psychological, legal).

To be complex and inclusive of different parts, a definition of aggressiveness should be referred both to the destructive, violent and offensive dimension, and to aspects of assertiveness autonomy and self-affirmation. On the other hand, the denial of our own aggressive and antisocial side and the extreme, excessive cohesion to the social conformism represents a relevant counterpart and deserves just as much attention and clinical analysis[2].

A different scenario is provided when these aspects are a constant, predominant and common pattern, which permeate the personal identity and the relational and social environment, leaving very little space for other aspects of the existence, compromising and preventing the possibility for the person to adapt to the environment, causing undeniable pain and distress to her/himself and others.

Aggressiveness and *Violence*, even if strictly connected, are not synonyms (Sabatello & Stefanile, 2016). Violence (from the Latin *Vis*, strength) is not an instinctive phenomenon and it is oriented to a scope; moreover, it represents only one of the possible results of aggressiveness and it is a phenomenological concept that adds further qualitative connotations to the behaviour, since it implies a relationship between subject and object characterized by the use of the physical strength, power struggle, prevarication, oppression and damage. *Antisociality* and *Deviance* add further connotations which, even if acknowledged in the psychopathological field, refer to a legal and etic setting, as they suggest an antithesis and/or a derailment from what is considered social, from what is legally established and accepted. *Delinquency* is an important subcategory of the antisocial and deviant behaviour, with the particularity that it is the society which considers them illegal and, as a result, the definition changes through time and cultures.

There is no traceable cut-off or cleavage point which could help identify when aggressive conduct or clear antisocial actions in childhood and adolescence are linked to a psychopathological condition, becoming a *necessarily arbitrary* choice (Moffitt et al., 2008). This choice is even more reliable and effective if guided by a clinical evaluation that is accurate, including multiple aspects, phenomenological and psychopathological, but also developmental and subjective, and environmental and cultural[3].

Conduct disorders are a "multifactorial pathology", which implicates many factors (i.e. genetic-constitutional, psychological, environmental and social), each one with specific weights in relation to different developmental ages. Empirical researches suggest that behavioural disorders are

1 "*If it is accepted that all behavior in an interactional situation has message value, i.e., is communication, it follows that no matter how one may try, one cannot not communicate. Activity or inactivity, words or silence all have message value: they influence others and these others, in turn, cannot not respond to these communications and are thus themselves communicating*" (Watzlawick, Beavin & Jackson, 1967, p. 49).

2 Christopher Bollas (1989) proposed the concept of "normotic illness" or "normotic personality": "*A normotic person is someone who is abnormally normal. He is too stable, secure, comfortable and socially extrovert. He is fundamentally disinterested in subjective life and he is inclined to reflect on the thingness of objects, on their material reality, or on 'data' that relates to material phenomena*" (p. 320).

3 In the range of human behaviour and conduct the limit between normal and pathological cannot be easily defined. In any case, it has to do with social norms and with the local dominant culture, with a *cultural bias* that must be taken into consideration (Sabatello, 2010).

based on a genetic vulnerability that could however (and luckily for the treatment's likelihoods) be essential but not enough. In fact, these genetic factors need to run themselves into different environmental (negative) events to develop, and lose their expressive potential without this *nature-nurture* encounter. The assumption that a gene-environment interaction is unavoidable in psychopathology appears in the whole scientific literature (Rutter, 1997; Caspi & Moffitt, 2006; Dodge & Rutter, 2011), in terms of different forms of *gene-environmental interplay*[4]. Although it is important to know the weight genetic influences have on conduct disorders, in a clinical framework it appears even more useful to recognize that they are modifiable (improving or worsening) interacting with environmental factors, including healthcare interventions and treatments.

2. Between Scylla and Charybdis. The diagnosis of Conduct Disorders in Childhood and Adolescence

A certain degree of aggressive and antisocial behaviour is a constitutive aspect of children's and teenagers' development, which defines physical and social existence. After all, we could say the same about the majority of the psychopathology symptoms. Aggressiveness, likewise violence and antisocial attitude, is not a defined clinical-diagnostic entity and it is not a prerogative of externalizing disorders, as they can appear in a number of different clinical conditions with different degrees of importance. Empirical studies do not define a standard that could help differentiate psychopathological situations nor we have a threshold or cleavage point that could help distinguish normal from pathological aggressiveness. Moreover, antisocial behaviour cannot be merely reduced to aggressive display, as it has instead a much more complex configuration. Explaining all antisocial conducts with mental disorder is also a frequent misjudgement. As mentioned earlier, defining a certain degree of antisocial conduct as psychopathological, linked to a conduct disorder or to an oppositional defiant disorder, is an *inevitably arbitrary choice* and it is a result of a "social contract" more than a medical definition (Foucault, 1972, 1974-75, 1975-76).

The way a particular behaviour is expressed changes considerably in relation to age. Defining when an antisocial conduct requires a professional intervention can be challenging. This is even harder during childhood and adolescence, when the plasticity of the mind is reflected in the fluidity and instability of a possible diagnosis and its psychopathological meaning. Making a diagnosis in childhood and adolescence could be like trying to hit a "moving target" (Borum & Grisso, 2007).

Between Scylla and Charybdis as in between the risk of normalising and underestimating early signs of distress and the equally relevant risk of medicalization and stigmatization of behaviours that might happen in a normal developmental period and have an adaptive function, with clear iatrogenic damage. This results in the importance of an accurate diagnosis, the relevance of an assessment of the general adaptation processes and of the specific characteristic of each developmental phase (Rutter & Taylor, 2002).

Before defining a behaviour as atypical or problematic, we need to determine aspects such as *degree* (seriousness and frequency of the antisocial actions in comparison with children of the same age and gender), *pattern* (variety of the antisocial acts and of the context within they take place), *persistence* (duration in time) and *impact* (child's distress and social impairment; destructive behaviour and harm towards others) (NICE, 2013).

In terms of development, the first aggressive and antisocial behavioural ways, which are considered as "normal", are traceable at a very early age. The child begins showing physical aggressiveness (*overt*) by the end of the first year of life, when he acquires the necessary motor coordination skills in order to complete actions such as pushing, pulling, hitting, kicking etc. (Tremblay et al., 1999, 2004). A "Curve of Aggressiveness" has been identified in normal development, which envisages two peaks in two different developmental stages of life. The first, less renown, is traceable around the second-third year of life (the "*terrible twos and threes*"). At this stage, displays of aggressiveness and oppositional behaviour are very common and parents find it hard to deal with them (Nagin & Tremblay, 1999); on this subject, the Canadian psychologist Richard Tremblay (2000) has depicted a very evocative image: if two-year-old kids were to have the same size of an adult, they would be extremely dangerous when they hit or when they get angry.

With the progressive acquisition of linguistic and social competencies, we assist to a gradual decrease of aggressive overt behaviours and – at the same time – to the beginning of other forms of aggressiveness, more subtle and hidden (covert) (Loeber & Schmaling, 1985; Tremblay et al., 2004). On the contrary, if a consistent pattern of aggressive behaviour - in association with other individual or environmental factors - remain, this might reveal an early form of mental disorder and a psychopathological risk of emotional and/or behavioural dysregulation that could even lead to a more

4 Genetic factors can whether increase individual vulnerability to environmental adversities (*gene-environment interaction: GxE*), or be involved in the origin of them (*gene-environment correlation: rGE)*. There are three main types of rGE: (a) *passive* correlations, when, for instance, a genetic risk factor models parenting such as conditioning child environment, in order that the child is passively subjected to environmental characteristics; (b) *active* correlations, when a certain genetic trims promote specific behaviours, in order that the individual actively searches for an environment compliant with his own behavioural/temperamental features (e.g. affiliation with deviant peers in adolescence); (c) *evocative* correlations, when a behaviour influenced by genetic factors elicits specific environmental responses (e.g. it is more likely that children with difficult or aggressive temperament may evoke aggressive responses by parents or peers: see the Patterson's *Coercion Model*, 1982). An example of gene-environment interaction (GxE) was proposed by Caspi and colleagues (2002). In a genetic-molecular perspective, they found that individuals exposed to childhood maltreatment, interpersonal violence or neglect show a higher risk to develop antisocial or conduct disorders if they have the low-activity variant of monoamine oxidase-A (or MAO-A "low") genotype than maltreated children with high-activity variant (or MAO-A "high") (Kim-Cohen et al., 2006).

evident deviant behaviour in pre-puberty (Loeber & Farrington, 2000)[5].

The second, more famous peak happens during the teenage *turmoil*, when the aggressiveness takes off again, after years of decline and latency. In Adolescence, deviant behaviours must necessarily be framed within an ampler tendency to carry out transgressive and antisocial behaviours (Rutter, Giller & Hagell, 1998), and within a neurobiological vulnerability linked to lack of control of impulses (Rapaport et al.,1999; Chambers & Potenza, 2003). In fact, adolescents' impulsiveness has a neurobiological basis strictly related to the different maturation timing between different structures of the brain: on the one hand those structures that lead to immediate action, which pull the trigger, and are already mature at age of 12-13 years, on the other hand, those that are used to inhibit a behaviour, increasing its control and evaluating its consequences (frontal cortex), that mature around 20-22 years old (Steinberg, 2008, 2009, 2014). The adolescent's *ad-gredior* is often a *trans-gredior* that, on the one hand, can seem pathological and dysfunctional, but, on the other hand, in normative situations, it allows the developmental process, the "go beyond" concept that is also contained in the etymology. After all, transgression is a universal aspect of the Adolescence, age in which the relationship with educational and social norms are reviewed and generally called into question. As a consequence, it can be challenging to discern when the youngster is expressing a desire to grow and be independent and when he is instead showing a sign of personal, family and social distress. In this phase, most of the times the antisocial behaviour is just temporary, nonetheless it might represent the first step towards a stabilisation of the deviant behaviour (De Leo, 1998). These "peaks of aggressiveness" are highly adaptive aspects and are functional to growth and to fulfil the developmental tasks. It is in fact significant that they show up in two moments of life in which, with the necessary phenomenological and age related differences, the individual is pushed to complete developmental transitions in which the need to stand out and grow necessarily has to go through a process of differentiation from others and an increase of the explorative impulse, in spite of the uncomfortable implications for parents, that are often worried and even alarmed (and it is not rare that they require professional counselling). Under a developmental prospective, these peaks match respectively the last step of the separation-individuation process, as identified by Mahler, Pine and Bergman (1975) in the first two years of life, and, in adolescence, the second individuation process (Blos, 1967), or subjectivation (Cahn, 1988) and the development of motivational/emotional systems[6] (MacLean, 1990; Panksepp, 1998; Liotti, 2005). In an age-normative developmental context, the enactment of aggressive behaviours has more to do with assertiveness, differentiation and self-individuation, than with destructiveness such as violation or harm to others. Nonetheless, in our opinion, in psychopathological (but also in not psychopathological) conditions it is always possible to trace both these aspects, since every evolutionary thrust towards self-affirmation has in its own core a destructive component (towards the previous equilibrium) and the same aggressive and destructive symptoms include (dysfunctional) attempts of self-affirmation.

> *If there is an overall message from our 30-year study of individual adaptation, it is that persons develop. We are not simply born to be who we become. Our patterns of adaptation and maladaptation, our particular liabilities and strengths, whether and how we are vulnerable or resilient — all are complex products of a lengthy developmental process. Likewise, the forms of psychopathology that any of us show are developmental outcomes. […] Psychopathology is not a condition that some individuals simply have or are born to have; rather, it is the outcome of a developmental process. It derives from the successive adaptations of individuals in their environment across time, each adaptation providing a foundation for the next* (Sroufe, 2009, p. 179).

The psychopathology comes from a sequence of individual adaptations to the environment through time; each of them forms the basis for the successive (Cicchetti, 1990; Sroufe & Rutter, 1984; Sameroff & Emde, 1989; Cicchetti, Toth, 2009). The making of a diagnosis of conduct disorders only means that - at that stage in time - child is behaving according to specific criteria. It is a pure *phenomenological* and *tautological* description and it does not involve the causes of that particular case. The child can spontaneously change his conducts and – in just a short amount of time – may not display the criteria that brought to the diagnosis or it could instead evolve to more severe psychopathological outcomes.

An approach based on developmental psychopathology is clinically more useful and aims to show how the critical factor is the failure to accomplish developmental phase-specific tasks. The right execution of these tasks is, in fact, evidence of the necessary self-fulfilment under a neurocognitive, affective, relational and environmental profile. The failure to face and succeed through the different phases and developmental tasks can determine a condition

5 Empirical research described in children at the age of 3-4 years an oppositional temperament, characterized by changing mood, irritability and regulation problems, which is associated with later aggressive and violent behaviour (Bates, Bayles, Bennett, Ridge, & Brown, 1991; Loeber & Farrington, 2000; Keenan, 2001). This behavioural style was related to specific emotional response patterns (i.e. low anger control, lack of fear and poor social control: Eisenberg, 2000). On this basis, some environmental negative interactions can take place, enhancing the risk of developing hostile, aggressive or negative behaviour and, later, more severe conduct problems (Romani, 2010). This difficult temperament can be considered as an early and previous constitutional factor for an emotional and behavioural condition, which in turn produces a low internal emotional control and difficulties to attend age-related developmental tasks (i.e. learning ability and social skills). If this individual vulnerability occurs with the exposure to negative environmental responses, it can lead to a developmental pathway in which dysfunctional behavioural patterns are gradually reinforced and can become chronic.

6 As puberty and sexual maturation progress, the primacy of attachment motivational system, biologically predetermined to regulate parent-child interactions, decreases, while an *agonistic* system arises, appointed to organize adult relationships, with a peak of maturation during adolescence (Stevens & Price, 1996).

of suffering within that specific phase and/or a risk of future distress. We also need to look at the developmental meaning of aggressive and deviant acts, placing them in context with specific developmental needs.

A deviant behaviour is generated when genetic factors, environmental aspects and life events braid a negative relationship and sum up, causing a condition of maladjustment. If it is to be considered a maladjustment or an adaptation, it mainly depends on the point of view. The concept of *maladjustment* comes from an external point of view of the observer, but if we consider the individual personal point of view it could be considered an *adaptation* to the environment[7], probably the best (and maybe the only) solution the person has found or what he thinks this is up to this moment. In addition, what appears to be specific to behavioural disorders is the fact that the person itself presents generally the distress as something that belongs to the outside and to others (i.e. out of the person). A depressed or anxious child or adolescent "feels" the pain (*egodystony*) and expresses his limitation, by his own way, though the pain; this does not happen in an oppositional child or an adolescent with behavioural issues (*egosyntony*). It is the other person who suffered the violence and aggressiveness or the social, legal environment that points out the distress, drawing the limit. More than the presence or the intensity of this behaviour, it is the pattern of these actions towards the other and the context that gives meaning to the externalizing construct (Sroufe et al, 2005)[8]. Keeping this vision in mind, helps providing a more complex overview, which is beneficial to clinical work with children and adolescents.

3. Phenomenology of conduct problems: diagnostic systems and longitudinal studies

Some aggressive and antisocial behaviour may be manifested in many (if not in all) mental disorders; nevertheless, in specified disorders they represent the psychopathological nucleus of them, that in childhood and adolescents correspond to the macro-category of *conduct disorders*.

The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders*, edited by American Psychiatric Association (DSM-5: APA, 2013), includes a section called "Disruptive, Impulse-Control, and Conduct Disorders", referred to clinical pictures of emotional and behavioural dysregulation resulting in aggressive and destructive conducts, violation of other's rights, and authority conflict[9]. The specified diagnostic categories for children and adolescents are Oppositional Defiant Disorder, Explosive Intermittent Disorder, and Conduct Disorder.

Oppositional Defiant Disorder (ODD) concerns a specific recurring and pervasive pattern of hostile, negative, defiant and oppositional behaviour, together with anger and/or irritability; the onset usually occurs very earlier (e.g. preschool age). *Conduct Disorder (CD)* consists in a repetitive and persistent pattern of behaviour in which the basic rights of others and the fundamental societal norms and rules are violated, including: aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules. It is further possible to distinguish different subtypes of CD, based on different onset-age (i.e. *childhood-onset*, prior to age of 10 years; adolescent-onset, after to age of 10 years), on current severity (i.e. referred to the behaviour's amount of damage and offense), and on the presence or not of *limited-prosocial-emotions* (LPE). The specifier LPE included in DSM-5 is an important novelty, that permits to identify a specific subtype of children with CD, characterized by stable and pervasive (i.e. displayed in multiple relationships and settings) features. It is connected to the concept of psychopathy and includes at least two of the following characteristics: lack of remorse or guilt, callous-lack of empathy, unconcerned about performance, and shallow or deficient affect.

In the *International Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10: WHO, 1990), conduct disorders are included into the section entitled "Behavioural and emotional disorders with onset usually occurring in childhood and adolescence". Compared to DSM-5, ICD-10 reduces the relevance of dissocial disorder's early-onset and increases the significance of personality traits as compared with behaviours; moreover, it requires that social conflicts and deviance, individually and without personal pain (e.g. décalage of relational, social or scholastic abilities), would be not considered as psychopathological conditions. *Conduct Disorders* consist in a repetitive and persistent pattern of dissocial, aggressive, or defiant conduct, which should amount of more serious behaviour than age-appropriated social expectations (e.g. ordinary childish mis-

7 In his paper *The Antisocial Tendency* (1956), Donald Winnicott explains aggressive and antisocial expressions as reactions to experiences of deprivation or loss. Lacking a trusted environment, the child is not able to repair his destructive impulse, which is acted in reality through violent actions. In this perspective, aggression is conceived as a request for help and containment, and as a "*urge to seek for a cure by new environmental provision*" (p. 313).

8 A moral philosopher would say that the difference, at equal behaviours, is in the purpose. In the book "*Would You Kill the Fat Man?*" (2013), David Edmonds introduces an interesting journey across moral philosophy starting from an ethical dilemma: "*A runaway train is racing toward five men who are tied to the track. Unless the train is stopped, it will inevitably kill all five men. You are standing on a footbridge looking down on the unfolding disaster. However, a fat man, a stranger, is standing next to you: if you push him off the bridge, he will topple onto the line and, although he will die, his chunky body will stop the train, saving five lives. Would you kill the fat man?*". The question may seem bizarre, but has baffled moral philosophers for almost half a century and more recently has come to preoccupy neuroscientists, psychologists and other thinkers as well. As the author shows, answering the question is far more complex than it first appears, and the way we answer it tells us a great deal about right and wrong.

9 Compared to DSM-IV-TR (APA, 2000), Attention Deficit Hyperactivity Disorder is not included in this part, but in the new section of Neurodevelopmental Disorders, characterized by emotional and behavioural dysregulation without aggressive and hostile conducts toward the others. This is an important restatement of the diagnostic category: thus, disruptive behaviour and conduct disorders focus on conflict and violence tendency, which may develop by a predisposition to impulsivity, inattention or hyperactivity, but transcend it.

chief or adolescent rebelliousness). Even though diagnostic descriptions, such those of DSM-5, are mainly based on behavioural aspects, in the subtypes of ICD-10 can be retraced also contextual and relational characteristics with the distinction between disorders confined to the family context, unsocialized or socialized conduct disorders. In ICD-10, the *Oppositional Defiant Disorder* is considered as a milder and earlier form of conduct disorder, which does not include delinquent acts or the more extreme forms of aggressive or dissocial behaviour, restricted to defiant, disobedient, disruptive behaviour. Furthermore, two additional categories are included: *Mixed disorders of conduct and emotions*, characterized by the combination of behavioural problems with overt and marked symptoms of depression, anxiety or other emotional upsets (i.e. *Depressive conduct disorder*, as the main clinical picture), and *Hyperkinetic disorders*, marked by the coexistence of hyperactivity and conduct symptoms[10].

Longitudinal studies on developmental pathways of deviancy over time, as *Dunedin Multidisciplinary Health and Development Study* and *Pittsburgh Youth Study*, are classical but still actual, by reason of their validity and capability to build taxonomies that are widely shared, evidence-based, and adopted by diagnostic systems, inspiring continuously following researchers.

The Dunedin Study is an epidemiological research conducted by the group of Terrie E. Moffitt and Avshalom Caspi in collaboration with New Zealand researchers (in fact, Dunedin is a New Zealand's city) to study the causes and the course of developmental physical and mental health problems. By the analysis of morbidity's variations of disorders and their susceptibility to environmental risk factors, Moffitt proposed a developmental theory of antisocial behaviour (Moffitt, 1993, 2003, 2006; Moffitt & Caspi, 2001), based on the concept of *heterotypic continuity*[11] to explain the spectrum of behavioural variations during different ages. This study identified a dual taxonomy of antisocial behaviour, consisting in two types characterized by different psychopathological constructs, psychological and biological antecedents, and developmental features: *Life-Course-Persistent* (LCP) and *Adolescent-Limited* (AL) antisocial behaviours. If considering their phenomenological presentation, it might be difficult to distinguish them (i.e. the clinical manifestation may be identical), they could be discerned by longitudinal assessment (Moffitt, 2006; Frick & Viding 2009). LCP group shows antisocial behaviour during childhood and during the overall life course (*childhood-onset* or *early-starter*), and it seem to be more strongly related to neuropsychological (e.g. deficits in executive functioning) and cognitive (e.g. a lower QI) impairments, more temperamental and personality risk factors (i.e. impulsivity, attention dysfunctions, and problems in emotional regulation), more severe problems with peers group, and probably (but not exclusively) dysfunctional families. In addition, they often have attention-deficit/hyperactivity disorder (ADHD) symptoms (Carabellese et al, 2016; Margari et al, 2015), which forerun conduct problems and represented an early marker and an important risk factor for more severe psychopathological outcomes (Waschbusch, 2002). AL group presents a pattern of antisocial and deviant behaviour (i.e. it generally consists, differently to LCP, in crimes against proprieties, as violation or destruction) that begins and, in most of cases, ends during adolescent period (*adolescent-onset*), without antecedents in childhood or persistence in adulthood (*adolescent-limited*); it appears to be more influenced by social and environmental conditions (e.g. affiliation to deviant group), without neuropsychological impairments. The classification of antisocial subgroups based on the age of onset has a strong predictive validity; nevertheless, recent studies suggest that adolescent-onset group would be limited at this age only in their antisocial behaviour, since it would present different outcomes in adulthood, more than previously supposed (NICE, 2013). Following researches have suggested that about half of those with a childhood-onset would not persist in their antisocial behaviour into adulthood, pointing to the need to recognize another subgroup with early onset and *childhood-limited* (CL: Odgers et al., 2008); however, for this subgroup, the psychopathological condition, further than be resolved over time, would evolve into different and various problems (e.g. depression, social isolation and to be dependent on others: Wiesner, Kim & Capaldi, 2005). Additionally, it has been proposed to identify an additional subgroup, even though rare, characterized by *adult-onset* (Elander et al., 2000) antisocial behaviour (i.e. violent and coercive), that generally develops only after the onset of psychosis (Hodgins,Viding, & Plodowski, 2009), substance abuse (Brook, Whiteman, Finch, & Cohen, 1996), sexual offences (Barbaree & Marshall, 2008) or associated with psychopathy (Rutter, 2012).

The *Pittsburgh Youth Study*, directed by Rolf Loeber (Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998), examined the factors associated with delinquency onset, identifying different developmental pathways. According to this study, the onset of severe forms of delinquency would not be concentrated in early childhood, but would progressively emerge up to 14-15 years old, often forerun by various, not necessarily antisocial, problems. Loeber and colleagues suggested that these different antisocial *pathways* could express specified deviance models or refusal of social rules, but also that temperamental, personality and environmental factors could determinate behavioural patterns that are only apparently different as they share an antisocial hint. "Delinquency careers" (different groups with specified paths, identified by the nature of antisocial attitude, actions, and behaviour) include: (1) an *authority conflict pathway*, that starts prior to the age of 12 and occurs earlier with stubbornness, following with defiance/disobedience, and after with authority avoidance (i.e. truancy, running away from home, staying out at night); (2) a *covert pathway*, that stars prior to the age of 15 with minor deviant behaviour (i.e. lie, petty theft) and carries on with property damage (i.e. vandalism and fire-setting), moderate antisocial acts

10 The revision of ICD, as of now updating (the publication of ICD-11 is expected in 2018), results to get closer to DSM-5, with the section "Disruptive behaviour or dissocial disorders", including *Oppositional defiant disorder* and *Conduct-dissocial disorder*. Moreover, ICD-11 introduces a subtype of ODD "with limited prosocial emotions", not included in DSM-5 (cf. https://icd.who.int/dev11/l-m/en).

11 The concept of *heterotypic continuity* (or behavioural coherence) suggests that conduct problems are expressed with a range of behaviours which are modified with growth and developmental stages, according to functional correspondence parameters.

(i.e. fraud, pick-pocketing), and later serious delinquent acts (i.e. car theft, burglary); (3) an *overt pathway*, that stars with minor aggressive behaviour (i.e. annoying others, bullying) and continues with physical fighting, and then with severe violent acts (i.e. rape, attack, strong-arm).

4. *Beyond* behaviour: psychological, emotional and interpersonal aspects of antisocial and psychopathic conducts

The diagnostic systems and longitudinal taxonomies categorise antisocial acts and conduct disorder purely in behavioural terms, overlooking any explicit reference to psychological and relational aspects. As a consequence, these mental disorders are described with terms that appear closer to legal categorizations than psychiatric, just like conducts that violate regulations more than with psychopathological meaning, with ethical concern about acts and a sort of "dehumanization" of the acting person.

Violence, deviancy and aggressive behaviours are purely phenomenological concepts that hint at a tendency of the individual to take action, they describe *what a person does*. So, using only this level of assessment brings to a diagnosis that is essentially *tautological*. Looking at the behaviour only, without going beyond what is openly displayed, shows a peculiar correspondence – almost a *collusion* – with the pathological core of the behavioural psychopathology: the tendency to translate into action (acting out) and the transfer on what is other than self (object or person to whom the action is directed) of aspects that are instead part of the individual psychic world.

When we go from the "official diagnosis" to the clinical one, staying at this level is reductive and useless. The core of the therapy of these psychopathological conditions must be inverting the externalization process by rebuilding the relationship of the individual with the emotional and relational world, which goes beyond the actions and considers human and subjective aspects. An important step in this direction has been taken by introducing the possibility, within the DSM-5, to indicate the presence of *limited-prosocial-emotions* (LPE), naming in a less stigmatizing way as *callous-unemotional* (CU) traits. In doing so, it has recognized well-known clinical evidences, which have been confirmed empirically in 30 years of scientific literature, around the existence of psychopathic features in childhood and adolescence and the identification of a subgroup that shows different genetic, cognitive, emotional and social aspects, with autonomous aetiology and pathogenesis and evident clinical implications (Frick, Ray, Thornton, & Kahn, 2013).

The interest and the debate around antisocial and psychopathic behaviours in childhood and adolescence starts with the work of Frick and colleagues (Frick, O'Brien, Wootton, & McBurnett, 1994), which has then been taken up and examined in depth by Forth (1995) and Lynam (1996), in the nineties. The interest has then increased in the last 15 years, as showed by the number of articles on the subject (Frick, 2000; Caspi & Shiner, 2006; Lynam et al., 2009; Frick & Viding, 2009; Salekin & Lynam, 2010).

Despite the reluctance to refer to psychopathy in childhood and adolescence, with the ethic and practical implications involved, we cannot identify its onset as sudden, once the adulthood approaches. Both the clinical experience and the empirical research clearly indicate that the prior symptoms can be already identified in this early phase, anticipating what will be a psychopathic profile in adulthood (Robins, 1966; Farrington, 2005; Frick & Viding, 2009; Sabatello, 2010; Sabatello & Stefanile, 2016)[12].

Callous-unemotional traits (CU) are considered as the core of psychopathy (Cleckley, 1941; Hare, 2003) and they identify, among children and adolescents with early conduct and antisocial psychopathologies, a subgroup of individuals with distinct temperamental, emotional, cognitive, interpersonal and family features. These traits have a consistent behavioural *pattern* that include: *indifference towards others, superficial affectivity, lack of empathy, no sense of guilt or remorse, tendency to take advantage of others, lack of responsibility for the consequences of their actions, deficit of relational capability, deceptive use of aggressiveness* (Sabatello & Stefanile, 2016).

In childhood and adolescence, as in adulthood, antisociality is organized along two axes, depending on the type of displayed aggressiveness: an *impulsive* axis, in which the aggressiveness is mainly reactive (this is the real antisocial behaviour, responsible of the most common crimes) and it

12 The American psychiatrist Hervey M. Cleckley, in his *The Mask of Sanity* (1941) proposed for the first time a clinical systematic depiction of psychopathy. The author refused to reduce psychopaths to criminals and pointed at the ability to conceal themselves behind a face of normality as the subtlest and most dangerous feature; beyond their mask they hide low levels or lack of empathy and sense of guilt or honesty, egocentrism, glibness, tendency to manipulation, failure to learn from previous experiences and to feel object-love, which are clear only if carefully observed in different settings. Not all people with psychopathic traits undertake criminal careers, and often they appear well-adjusted and above suspicion (e.g. the *White Collars*; Hare, 2003; Neumann, Hare & Newman, 2007; Lishner et al., 2012).
In the nineties, starting from Cleckley's descriptions, Robert Hare developed and, at a later time, revised the *Psychopathy Checklist Revised* (PCL-R: Cooke, Michie, Hart & Hare, 1999), an effective and reliable method to assess psychopathic characteristics. Later, he develops the PCL-Youth Version for children and adolescents (Forth, Kosson & Hare, 2003; Sabatello, Abbate & Spissu, 2013). Based on findings from factorial experimental studies, Hare (1991, 2003) proposed a multidimensional structure of adult psychopathy, inclusive of three conceptually separated, but inter-correlated domains. An *interpersonal* domain, consisting of grandiose-manipulative traits (i.e. *narcissism*) characterized by verbal and manipulative abilities, superficial charm, egocentricity and glibness. An *affective* domain, consisting of callous-unemotional (CU) traits marked by lack of empathy and guilt, with short-lived emotions. A *behavioural* domain, consisting of daring impulsive traits like irresponsibility, proneness to boredom, novelty seeking and antisocial behaviour. Psychopathy arises as a disorder with high stability over-time, low sensitivity to treatments, and high recidivism risk (Ogloff, Wong & Greenwood, 1990; Shine & Hobson, 2000; Salekin, 2008). This construct becomes important especially in the legal setting, for assessing of personality and of possible measures for individual (i.e. the probation's assessment in adult or juvenile criminal trial), considering his connections with violent acting and the high risk of recidivism (Edens, Campbell, & Weir, 2006).

suggests impulsiveness and no ability to control the explosive response (emotional and behavioural dyscontrol); a *cold blooded and insensible* axis, in which the aggressiveness is sadistic and predatory (this is the psychopathy, responsible of the most serious crimes), in which the behaviour is generally linked to a damage of the social and emotional processes, with lack of empathy and prosocial emotions. Some authors locate antisociality and psychopathy along a continuum, as they consider psychopathy a more serious declination of antisociality (Coid & Ullrich, 2010); others consider them as two different configurations (Hare, 2003; Cooke, Michie & Skeem, 2007).

In terms of developmental pathways, although it might seem simplistic, it may be representative to divide children and adolescents with aggressive and violent behaviours in two categories, based on physical and psychological temperature and/or in terms of full vs. empty. On one side, we have a "too hot" polarity, that involves a failure to develop an adequate emotional regulation, that brings to more impulsive aggressive or antisocial behaviours during intense emotional arousal (full) and prevents the child from understanding the consequences of his own actions (almost an emotional eruption that clouds the mind). On the other hand, a "too cold" polarity that prevents the development of an adequate level of empathy, guilt and other aspects of conscience (empty), which bring to a more severe aggressiveness of planned and deceptive nature.

The construct of Emotional and Affect regulation (Bion, 1962; Winnicott, 1971; Fonagy & Target, 2001; Trevarthen, 2001), is widely used in the attempt to explain impulsive polarity of conduct disorders, with the continuous research of a regulation (i.e. dyadic regulation, or regulation by others) through action and externalization. Nonetheless in the psychopathic pattern this concept appears just as much relevant, as in those cases it is shown an exceeding regulation (i.e. self-regulation) that brings to a calcification or freeze of the emotions (and of their physiologic correlates), neutralizing the intersubjective contribution of what is else from self (we could say that inter-subjectivity becomes *inter-objectivity*).

Children and adolescents with antisocial or conduct disorders which refer to a "hot" or "impulsive" pathway (not significant levels of CU traits) show an excessive environmental sensitivity (*fearful-type*) and over-reactivity towards neutral or ambiguous stimulus that are wrongly interpreted (*mislabelling*) as threatening, hostile or dangerous; in general, there is no premeditation in their action, acting-out is linked to a low tolerance and frustration, lack of regulation of the emotional and behavioural responses to emotional stimulus, increase of physical excitement and levels of arousal, deficit of the inhibitory functions (Hubbard, McAuliffe, Morrow, & Romano, 2010; Qiao, Xie, & Du, 2012). The emotional and behavioural consequence of these aspects is a loss of control that brings the internal world to "explode" in actions and conducts that are difficult to manage. These children feel bothered, provoked and they hit as reacting, often thinking that something unfair happened to them (they frequently feel they are victims of other people). In more general terms, we could define a subgroup that shows a highly reactive temperament in combination with an inadequate experience with socialization. This mix causes a failure in the development of the necessary skills that regulate the emotional and behavioural response (Frick & Morris, 2004; Blair, 2010) and produce antisocial actions driven by an "affective rage" (Panksepp, 1998). These children and adolescents might feel some level of anxiety and, later, some remorse for these actions, but they would still be not able to refrain from repeating them, since they are not able to learn from the experience (Frick, 2016). Some etiopathogenetic studies show that these behaviours are less influenced by genetics and are rather affected by environmental factors, such as hostile and/or coercive parenting style (Waschbusch, 2002; Hare & Neumann, 2008; Frick & Viding, 2009; Frick et al., 2013).

Of a completely different nature is the subgroup of children and adolescents with conduct problems and psychopathic traits, characterized mainly by aspects of deficiency or absence, both with respect to feelings (*callousness*) as well as physiological and emotional response (*unemotional*). The phenomenological outcome can be expressed either as lower levels of prosocial behaviour or as higher level of antisocial conduct, but this last result must not be taken for granted, since psychopathy, even in developmental age, might not openly display deviant behaviours and might hide behind socially accepted appearances, without showing conduct psychopathologies (Kumsta, Sonuga-Barke & Rutter, 2012; Musser, Galloway-Long, Frick & Nigg, 2013). When they do result in antisocial conducts[13], these children and adolescents display a pattern of pathological behaviour which is more stable and aggressive, associated to an increased risk of early delinquency, more severe antisocial acts, maintenance of behavioural disorders while growing into an adult age and a low response to treatment, that suggests the presence of a specific aetiology for this group of individuals (Frick et al., 2003, 2005, 2013; Lynam & Gudonis, 2005). Even if the psychopathic behaviour more often displays an instrumental and proactive aggressiveness ("quite-bite attack": Panksepp, 1998), children and adolescents with high CU traits, in certain circumstances might use some reactive forms of aggressiveness (Frick & White, 2008).

Studies highlight an increased relevance of *genetic influences* in this kind of antisocial behaviour (Taylor et al., 2003; Viding et al., 2005, 2008; Bezdjian, Tuvblad, Raine & Baker, 2011; Hicks et al., 2012). The weight of this kind of influences is estimated at around 42% and 68% (Frick et al., 2013) and they could explain the early onset and the stability through time (Blonigen et al., 2006; Fontaine, Rijsdijk, McCrory, & Viding, 2010). There are also types of psychopathy that result from early traumatic or environmental negative experiences (Marshall & Cooke, 1999; Caspi et al., 2002; Krischer & Sevecke, 2008), for which painful emotional aspects are cleared from the mind through *autotomic processes* (Imbasciati, 1998) as these aspects are not essential to survival, in terms of adaptation process; it is frequently found in adopted children or adolescents, especially if severely abused at an early age.

CU traits can be identified and measured as early as 4-year-olds (Dadds et al., 2005; Ezpeleta et al., 2012). Empirical findings, following the recent information about the

13 Research has found that prevalence rates for elevated levels of CU traits in children with conduct problems have ranged from 12% to 46% (Rowe et al., 2010; Kahn et al., 2012).

different and individual empathy skills and around the first years of life, have suggested the existence of even earlier signs, that can be considered more as "CU conducts" (associated to lower levels of sense of guilt, or of empathy, and to forms of proactive aggressiveness) than as proper CU traits, given the early stage of development, at 2-3-year-olds (Goffin et al., 2017; Waller et al., 2017). Researches on these early signs are still very young, but they are also very promising especially for the contribution they can give if used in such early stages of development, when these aspects are still malleable and yet to become permanent.

Several empirical evidences show alterations in the processing of emotions and external inputs that could explain the failure of negative reinforcement in the treatments (Masi et al., 2014). These children and adolescents barely react to the environment and they present anomalies in terms of lack of physiological and emotional response to inputs of different nature (i.e. *fearless type*: Frick & White, 2008), with a reduced autonomic responsiveness when they look at pictures of people in distress (Blair, Colledge, Murray & Mitchell, 2001) and impairment in the facial recognition of fear and sadness (Blair, et al., 2001; Marsh & Blair, 2008), but also of other emotions conveyed through different sensory systems (e.g. vocal cues: Dawel, O'Kearney, McKone & Palermo, 2012). The under-reactivity has been confirmed by a number of experimental researches, which have found anomalies in terms of deficiency of the main physiologic and neurobiology indicators (i.e. heart rate, HPA system and cortisol response, circuits connected to the amygdala and the prefrontal cortex: Loney et al., 2006; Sondeijker et al., 2008; Jones et al., 2009; De Wied et al., 2012; Marsh et al., 2013). Their callousness towards others is well represented through the insensitivity to others' distress cues (Kimonis et al., 2006; Viding et al., 2012) and to punishment (Blair et al., 2001; Paradini et al., 2003). It is also shown through the glorification of aggressiveness, which is considered a reasonable way to reach a goal, is described in positive and profitable terms and is considered a way to dominate and take revenge in social conflicts (Pardini, Lochman & Frick, 2003; Chabrol, van Leeuwen, Rodgers & Gibbs, 2011).

In terms of empathy skills, there is an evident struggle with both main elements of the construct identified by Baron-Cohen (2011). On the one hand, there is a deficit in terms of *recognition,* as in the ability to acquire two points of view (double-minded) in order to understand others' cognitive and emotional condition (*cognitive empathy*). On the other hand, there is a deficit in terms of *response* to others' thoughts or feelings with a congruent emotion (*emotional empathy*).

These individuals appear to belong to a presocialized emotional world (Meloy, 2001), where the intersubjective aspect of relationships disappears and, if it is present, it is reduced to instrument for personal aims and, like that, it is dehumanized. It appears linked with narcissistic dimension which, as many argued, represents the functional and affective core of psychopathy (Kernberg, 1998; Meloy, 2001; Hare, 2003). Freud, in the paper *On Narcissism: An Introduction* (1914), suggested a link between narcissism and criminality by the concept of projection as defence mechanisms through the criminal, such as the narcissistic, would try to protect his own identity. One of the main contribution on narcissism's theory was proposed by Otto F. Kernberg (1992, 1998), who includes antisocial and psychopathic behaviour on psychopathological narcissism as a primitive variant. Kernberg suggests an antisocial and psychopathic behaviour's continuum, which starts out by antisocial acts as part of symptomatic neurosis (e.g. adolescent rebellion), and arrives at the most severe extreme represented by pathological narcissism and, after, antisocial and psychopathic personality disorders. Antisocial and psychopathic subjects are not able to develop object relations and lack ethic; they represent the most serious and less tractable form of borderline personality organization, characterized by a fragmented identity, pathological internal object relations and primitive defence mechanisms.

Some authors identify, as the core of psychopathy, a basic emotional deficit, consisting of callousness, insensitivity and lack of empathy (Baron-Cohen, 2011). It would result in a sort of dehumanization, with a destruction of the own's (well represented by physiological and emotional "coldness") and other's vital aspects (*humus*). Nevertheless, aggressive and antisocial acts keep necessarily a relational aspect, even in their most extreme forms: the *anti-social* is based on recognizing previously a *social,* as prerequisite that is firstly taken on and later distanced. The distance from the social is acted by behaviours, but also emotional and interpersonal conditions, that are put out and against it, breaking and destroying it.

Some of these characteristics appear also in cases of severe predatory aggression or of psychopathic dominance's glorification, anyway subtending a proposal of contact and proximity to others, even though based on interpersonal destructiveness and damage. It suggests a paradox: to get into a relationship by destroying the relationship and keeping so an essential aspect of dependency on others. The predator needs the prey to exist, as well as the dominant needs the dominated. With regard to it, some authors (Glasser, 1986; Music, 2016) refer the concept of "core complex", as a state of mind in which individual can bear neither closeness nor separation from the object, that is trackable in many aggressive patients, in particular those with sadistic or perverse traits. Attempting to go out of the paradox, these individuals use destructive or sadistic acts that, by the dominance on the object, allow the coexistence of distance (destruction) and closeness to other person and the control of it. As related to transgression, lack of limits and reject of confines, some psychoanalytic authors connect some forms of violent acts with perversion proposed a link between (Cohen, 1992; Kernberg, 1992; Racamier, 1992)[14].

14 Otto Kernberg (1992) identifies a relational style characteristic of pathological narcissism and other severe form of psychopathology, and names it as "perversity". In comparison with perversion, this quality of object relation has a higher level of perfusion, which goes beyond the sexual dimension and reveals the subjection, conscious or unconscious, of affection, dependence and sexuality to aggressiveness. Stanley Cohen (1992) refers to perversion as a form of misuse acted to avoid the responsibility of own internal conflicts; these conflicts are placed out of the self, in the victim that is dehumanized and reduced to the partial object's level. The abuser aims to control the other person and to deny its distinction and au-

The basic theme of dependency is a further key point of psychopathy's psychoanalytic theories. Nancy McWilliams (2011) identifies the *hostile dominance*, the tendency to dominate and manipulate others and the refusal to be subjugated and to depend on them, as the core feature of psychopathy. That refusal represents a reaction toward profound emotional experiences of dependency and the attempt to deal with the resulting ancestral angst, which is rejected in this way. Nevertheless, as Lingiardi (2005) argued, a real independence rests on the ability to depend on other people and to allow them to depend on us. Therefore, instead of dependent-independent, it would be better to consider the continuum between healthy and pathological dependencies. Pathological would be forms of dependency that are "not negotiable" or the extreme and deceptive presumptions of independency: from a desperate research of others, considered as only regulators of the self, to an escape from them, considered as threat for the own entirety.

5. Interventions and Treatments

In childhood and adolescence, conduct problems are largely widespread and the most common reason for referral to public and private healthcare professionals in Western countries (NICE, 2013). In terms of age-related psychopathology's continuity and/or discontinuity, studies have suggested a developmental course from oppositional defiant disorder to conduct disorder, and, in a significant minority, to antisocial personality disorder. Of course, this trajectory is not certain, nevertheless it generally occurs that antisocial adults had prior disruptive or impulsive conduct problems during childhood or adolescence. We do not see the opposite happen: most children with oppositional defiant disorder do not develop either conduct disorder, or antisocial personality disorder, even though they are at high risk for other psychopathologies (e.g. anxiety and depression: Robins, 1966; Moffitt et al., 2002; Rowe et al., 2002; Lahey et al., 2005). Therefore, psychiatric classification of conduct disorder has a prognostic validity as well; it is one of the rather few cornerstone of psychiatric knowledge, even though it appears quite simplistic to draw solid lines between child psychopathology and its continuum in adulthood.

Conduct problems in childhood and adolescence show a wide heterogeneity and high rate of comorbidity with other disorders (Blair, 2013; Frick et al., 2013; Caspi et al., 2014). In clinical practice, a pure and exclusive diagnosis of disruptive behaviour disorder is very rare, since it is mostly in comorbidity with other psychopathological conditions (Nock, Kazdin, Hiripi & Kessler, 2007), as attention deficit/hyperactivity symptoms, learning disabilities, or anxiety. In the juvenile offender population involved in criminal justice services, it has been observed a high comorbidity (more than 50% of cases) with other mental health problems, including internalizing disorders and substance use disorders (Essau & Cheng, 2009). Most recent studies have instead suggested much more significant comorbidities, showing a marked relation between attention-deficit/hyperactivity disorder (ADHD) and conduct disorder, both in terms of comorbidity (approximately one-third of boys with severe ADHD go on to develop a CD: Beauchaine, Hinshaw & Pang, 2010) and in terms of risk (the presence of ADHD predicts worsening of CD symptoms: Pardini & Fite, 2010); therefore, impulsivity and hyperactivity would be strong drivers towards early-onset conduct disorders.

Conduct disorders in childhood and adolescence are becoming more frequent in Western countries and place a large individual, social and economic burden, involving not only healthcare and social services, but also many sectors of society (i.e. family, schools, police, criminal justice system). Currently, less than a fourth of them receive specific helps (Vostanis, Meltzer, Goodman & Ford, 2003) and much of these interventions are likely to be ineffective (Scott, 2007).

Before selecting and starting therapeutic programs, clinicians should necessarily know psychological features, particular vulnerabilities (e.g. cognitive disabilities, psychiatric comorbidities, other conditions as alcohol or substance use/abuse), possible risk factors and compensatory resources (i.e. individual, relational, familiar); that in order to evaluate pertinence and relevance of the health care program, to decrease the possibility of failure, and to reduce the risk of iatrogenic damage caused by improper interventions.

As it is shared and repeatedly proved by systematic literature, assessments and intervention programs for conduct problems based on a complex perspective are clinically effective than others; it means to maintain different levels of analysis, including *multisystemic* (aimed both to individual and to his contexts), *multimodal* (inclusive of different forms of interventions) and, if necessary, *multidisciplinary* (involving various professionals). In addition, it has to be adjusted to the real means, as available economic and professional resources, which, even though outside of clinical considerations and ethics, unavoidably condition the decisions.

There is a wide range of intervention models for disruptive and deviant behaviour in childhood and adolescence. Some could be focused on particular characteristics of disorder (e.g. intrapsychic conflicts, cognitive dysfunctions, social and relational disabilities, dysfunctional family interactions), others on several levels at the same time. Some could target to the only child, others could extend to the family and/or the context (e.g. school, peer group) too.

Overall, it could be identified a general trend which concurrently occurs between developmental stages and targets of interventions and is quite unrelated to the particular paradigm or theoretical orientation of the professional or the service: it consists in a path from interventions principally aimed to environment of the child (e.g. family for preschooler) to a gradual engagement of the child and later the adolescent, as he/she develops and gets new and autonomous abilities.

Engagement of the family system is particularly impor-

tonomy. Nevertheless, the outcome is that the pervert depends on and is not able to separate himself from the victim. Racamier (1992) describes the perversions as forms of pathological dependency, as stable defensive patterns that resist changing by reason of their role in defending from destructiveness and in preserving the object's need. He argues that the leading purpose of perverse action would be trampling on the truth and manipulating for own purposed objects or persons, aiming primarily to protect from pain and avoid all internal conflicts.

tant for this group of children, both because drop-out from treatments is high (i.e. between 30 and 40%: NICE, 2013), and because parental psychopathological conditions are quite common (i.e. depression, alcohol and drugs abuse, violent and/or conflicted relationships), requiring to be treated. In addition, when the case is particularly severe or it is considered worthwhile, also other interventions could be added (i.e. interventions at school, involving social services or placement in residential child care institution).

Family-based interventions, psychoeducational and/or therapeutic ones, aim to modify and support abilities and behaviours (e.g. parental skills), or relational functioning of the family.

Parent Training (PT) is directed by improving parenting skills (Scott, 2008) and modifying parental practices which, according to research, contribute to conduct problems (i.e. pattern of negativistic, hostile, punitive or disapproving attitudes of parents, that, rather than discourage child's deviant behaviour, increase and reinforce what they aim to remove). PT interventions are rather aimed to encourage more positive and functioning interactions, in order that both parents and children may experience enjoyable and playful situations, encouraging a secure and mutually sensitive relationship. Evidences have suggested that PT would be effective for children up to about 10-years-old.

Family therapy includes treatments with the common denominator to engage the whole family system, according to the hypothesis that child or adolescent's conduct problems are based on family interaction and relational patterns which maintain or increase problems; for this, family have to be included in treatment, as both critical and essential agent/target of change. Strategic Family Therapy, Functional Family Therapy, Multisystemic Therapy and Multidimensional Treatment Foster Care are some of the more studied therapeutic programs for conduct disorders. They aim to improve family functioning, based on a combination of social learning, cognitive and systemic-relational approaches.

Strategic Family Therapy (SFT) assumes that conduct problems originate from family dysfunction and represent, at the same time, the family attempt to find or preserve own balance, so they are reinforced. SFT focus interventions on the structure and the cohesion of the family, intended to modify dysfunctional organization, interaction patterns and attitudes of thought shared by the family, and encourage adaptive and functional familiar hierarchy and patterns of mutual affective involvement.

According to *Functional Family Therapy* (FFT), conduct problems are conceptualized as form of communication with specified own function within the family system, supported and maintained by mutual interactions between all members of the family. The therapy aims to transform family interactions and beliefs, improve more functional communication patterns and promote the development of particular skills both for the child and the parents (Alexander & Robins, 2011).

Multimodal form of interventions are directed to the whole ecosystem, or *milieu*, where the child or adolescent lives, and have the therapeutic aims of modifying the surrounding environment in order to modify individual problems.

Inspired by the Ecological Systems Theory (Bronfenbrenner, 1979), the theoretical assumption of *Multisystemic Therapy* (MT), is that individual, family, school, peer group and community are interconnected systems, mutually influenced. Therefore, it is essential to aid the totality, not some parts (Henggeler et al., 2009; Manders et al., 2013). Using systemic family therapy and cognitive-behavioural therapy techniques, therapeutic acts aim to deal with problems and encourage resources of the child's environment, by the assumption of multidimensional nature of severe antisocial behaviour.

Multidimensional Treatment Foster Care (MTFC) is an intensive intervention that implicates a change of the contest: the child/adolescent with conduct problems is temporarily taken away of his/her environment and placed with specially trained *foster carers*; at the same time, interventions on other systems (e.g. school) and on parents (e.g. promoting skills) are provided (Liabo & Richardson, 2007).

As children grow-up, the opportunities of child-focused interventions increase, maintaining, if possible, those focused on parenting or family. Most *evidence-based* programs for conduct disorders make use of cognitive-behavioural methods to increase social abilities (e.g. *Social Skills Training*, aimed to promote social behaviours that facilitate and support positive responses from environment), the control negative feelings and moods (e.g. *Anger Coping* or *Management Training*, intended to the learning of self-monitoring and management of emotions, by identifying triggers of anger and aggression), the problem solving abilities (e.g. *Problem-solving skills-training*, helping children to understand the link between their own behaviour and connected consequences, and to elicit behaviours that facilitate prosocial outcomes). Those programmes may be suggested to individual or groups, and in clinical or school settings.

Interventions based on psychodynamic model (including attachment theory), even though less supported by scientific measures and empirical evidences, are widely used in practice and clinically effective.

Furthermore, recent studies and clinical considerations point at specific forms of interventions for children and adolescent with *callous-unemotional* traits. Although working with this group is a challenge, due to their poor response to many traditional treatments (Hawes, Price & Dadds, 2014; Bakker, Greven, Buitelaar & Glennon 2017), they are not "intractable", as it was once thought, if treatments are tailored to their unique/specific cognitive, emotional, motivational and interpersonal features (Frick, 2016; Wilkinson, Waller & Viding, 2016). Most recent research suggests a certain effectiveness for interventions that encourage positive parenting (e.g. use of positive reinforcement to encourage prosocial behaviour), than those that discourage negative parenting[15], and for reward-oriented approaches

15 Research on *parenting practices* (empirically measurable familiar construct) have focused mainly on negative parenting (i.e. harsh, coercive and inconsistent), linked for so long with much seriousness of disruptive behaviour in childhood and adolescence (Burke, Loeber & Birmaher, 2002; Viding, Fontaine, Oliver & Plomin, 2009; Pasalich, Dadds, Hawes & Brennan, 2011). Recent studies suggest that developmental pathways of children with high risk for CU behaviour could be modified by promoting positive parenting (i.e. warmth, responsiveness, sensitiveness), suggesting this as a target for interventions (Hawes, Dadds, Frost & Hasking, 2011; Muratori et al., 2016; Waller et al., 2017).

that increase empathic abilities (Hawes & Dadds, 2005; Caldwell, Skeem, Salekin & Van Rybroek, 2006). They include both traditional treatments for conduct disorders (Blair, 2013), as the *Coping Power Program* (Lochman & Wells, 2002; Muratori et al., 2017), and some recent and promising interventions specifically set for this group of children and adolescent, as the *Coaching and Rewarding Emotional Skills Module* e the *Emotion Recognition Training*. Coaching and Rewarding Emotional Skills Module (CARES: Datyner, Kimonis, Hunt & Armstrong, 2016) is a brief emotional training program, oriented to dealing with empathic deficits in the processing of negative emotions; it is addressed to children with conduct problems and CU traits from three and half to eight years old, associated to parent management training programs. *Emotion recognition training* (ERT: Dadds et al., 2012), based in part on the *Mind Reading* (Baron-Cohen et al., 2004), was originally developed for autism treatment and proposed in association with parent training (i.e. *Family Intervention for Child Conduct Problems*) by a software allowing to explore more than 400 emotions; it aims to promote identification and interpretation's abilities of emotional expression in an interpersonal context.

Conclusions

When working with children and adolescents with behavioural disorders, we believe that clinicians should consider three fundamental requirements, besides the chosen therapy methods and procedures.

The first one consists in a personal disposition to avoid simplistic and deterministic explanations of these clinical disorders and to keep in mind their *complexity*. In order to do so, a deep knowledge of different features is needed (i.e. multifactorial etiopathogenesis, developmental course, individual characteristics, specific needs and vulnerability, and intrapsychic and interpersonal dynamics).

The second requirement is the curiosity towards the persons in front of us, who express their vulnerability and resources in a unique way through aggressive and deviant behaviours (*subjectivity*). The third and last requirement is *intersubjectivity*, which is an essential part of the clinical practice of these disorders, where the construction of a subjective self and the emotional regulation are as impaired as in severe behavioural pathologies. In this scenario, the main clinical purpose with these children and adolescents consists in dealing with these impairments, in detouring from an inside-to-outside psychological path, which is typical of aggressive and antisocial acts, by aiming to an outside-to-inside route (from objectivization to subjectivization), and by developing a relationship based on the encounter of two subjectivities (intersubjectivity). "The self-organization of the developing brain occurs in the context of a relationship with another self, another brain" (Schore, 1996; Schore & Schore, 2011). The subjectivity aspects can be built through the intersubjectivity, for which the clinical context could be a strong propeller.

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Treatment for sex offenders in prison. The experience of the intensified treatment unit in Milano-Bollate prison

Il trattamento dei rei sessuali in carcere. L'esperienza dell'Unità di Trattamento Intensificato nella Casa di Reclusione di Milano-Bollate

Paolo Giulini • Laura Emiletti

Abstract
According to the latest statistical data by Istat (the Italian Central Statistics Institute)[1], in Italian prisons 2352 inmates have been arrested for sex offences (1466 Italians and 866 non-Italians). Of these 1466, 1241 have undergone final judgment. More recent data show that of a total of 54.000 inmates in Italian prisons, 3.444 are incarcerated for sex offences, and 369 of them are waiting for trial. In 2000, sex offenders were the 1.5% of the total inmates, with a peak in 2010 when they 8,5% while in 2016 they went back down to 6,5%[2]. Yet the social response to sex offending is not related to the number of crimes, but to a subjective feeling of insecurity. Public opinion is characterized by ambivalent necessities, i.e. by the psychological need for revenge and indemnification on the one hand, and by the offender's expiation on the other and often wants the offender to be chased away, repressed, isolated from society. From this point of view any other approach to the offence that is not restrictive is considered to be pointless and inadequate, not proportionate to the damage that has been caused. Treatment ideology is often regarded as too permissive, as an attempt to minimize the seriousness of the event-offence, the responsibility and the guilt of the offender. In reality, custodial sentences have been proven to be unsatisfactory and inadequate as the sole form of defence and compensation towards victims and society in general, if it is understood from a mere indemnifying point of view. We have to think about other levels of intervention strategies and prevention, including a rehabilitating approach, centred on the treatment of sex offenders, with a view to their reintegration into social life.

Key words: treatment field • sex offenders • prison • benevolent control

Riassunto
Secondo l'ultima rilevazione Istat disponibile[1], tra i detenuti presenti negli Istituti penitenziari italiani 2.352 sono quelli arrestati per reati sessuali (1.466 italiani e 866 stranieri). Di questi 1.466, 1.241 sono stati condannati in via definitiva.
Dati più recenti mostrano che su un totale di 54.000 detenuti nelle carceri italiane, 3.444 sono stati incarcerati per reati sessuali, e 369 di questi sono in attesa di giudizio. Nel 2000, i sex offenders erano l'1,5% del totale dei detenuti, con un picco di presenza nel 2010 con l'8,5%, mentre nel 2016 la percentuale è scesa al 6,5%[2]. La risposta sociale in tema di aggressione sessuale tuttavia non sembra essere collegata ai numeri del delitto ma al senso soggettivo di insicurezza. L'opinione pubblica è contrassegnata da necessità ambivalenti, cioè dal bisogno psicologico di vendetta e risarcimento da una parte e di espiazione del reo dall'altra, riconoscendosi spesso nella volontà di allontanare, reprimere ed emarginare il delinquente rispetto alla società. In quest'ottica ogni altro approccio al reato che non sia restrittivo è visto come inutile e non adeguato, non proporzionato al danno inflitto. L'ideologia trattamentale viene frequentemente etichettata come permissivista, come un tentativo di minimizzare la gravità del fatto-reato, la responsabilità e la colpevolezza dell'autore. In realtà la pena detentiva, intesa in una mera ottica retributiva, si è dimostrata essere insufficiente ed inadeguata come unica forma di tutela e risarcimento nei confronti delle vittime e della società in generale. Occorre pensare a strategie di intervento e prevenzione ad altri livelli, che includano un approccio rieducativo, incentrato sul trattamento e sulla riabilitazione degli autori di reati sessuali, in vista del loro reinserimento nella vita di comunità.

Parole chiave: Campo del trattamento • rei sessuali • carcere • controllo benevolo

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1 Istat data, 2006.
2 Data from Dipartimento dell'Amministrazione Penitenziaria, September 2016.

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1. The project

The project of implementation of the Intensified Treatment Unit (UTI) was presented first in 2005 by the Association Centro Italiano per la Promozione della Mediazione[3] and jointly financed by Lombardy Regional Council and the Province of Milan. Today, it has reached its twelfth year and it provides for a specific rehabilitating intervention operating with a logic of synthesis, combining sentence and treatment, which need to be considered complementary and not alternative to each other. The attempt is to reduce both risks of recidivism (to protect society) and individual suffering (to protect the person). This is a challenge aimed at demonstrating that a scientific and systematic rehabilitation approach is an ethical and effective way of protecting the community, reducing victims and preventing deviant behaviours.

The starting point is the acknowledgement of the anomalies and peculiarities characterizing sex offenders. These anomalies and peculiarities must be taken on, knowing that different psychopathological profiles, specific personality features and complex behaviour dynamics can be found at the basis of sex offences, following an etiological model aimed at the multi-factoriality of aggressive behaviours, and needing specific and diversified interventions. "Sex offender" is a criminological category or label that corresponds to different and variable psychological or psychopathological profiles.

This method of intervention integrates into a criminological view, at the centre of which we find the event-offence and the possibility of recidivism, and it originates from a cognitive-behavioural theoretical reference, where sex offences are conceived as a sexualisation of aggressiveness. The therapeutic approach provides for psychological interventions aimed at obtaining evolutionary changes of personality and behaviour, structured as group meetings, together with other expressive activities.

The aim is to use the period of detention to elaborate the committed offence and begin a process of cure that starts from the awareness of the offence and of the dynamics underlying it and from the offender's assumption of responsibility. UTI as a container of the treatment activities is therefore a physical place that, with the structured and planned progress of the treatment, can also turn into a mental space in which offenders can receive a *benevolent* pressure or encouragement to work on themselves and change (Emiletti, Giulini, Scotti, 2016); this work does not end when the sentence is served, but must find successively a possibility of continuity and consolidation in the community within what we call "treatment field" (Giulini, & Emiletti, 2011).

3 Italian Centre for the Promotion of Mediation, or CIPM. For more information about the Association visit our website <www.cipm.it>, or send an e-mail to cipm.milano@gmail.com.

2. The construction of the treatment field. The internal part

UTI is a section for attenuated custody, where an intensive treatment programme could be undertaken, in accordance with art. 115, paragraph 4, Presidential Decree 230/2000, according to which «for convicts and inmates who are not relevantly dangerous, for whom particularly significant treatment interventions are proven to be necessary, a regime of attenuated custody can be implemented, either in autonomous institutes or in sections of the institute assuring a wider execution of treatment activities [...] Convicts with relevant physical and psychic pathologies […] can be assigned to autonomous institutes or sections of an institute assuring a regimen of intensified treatment [...] The suitability of treatment programmes aimed at rehabilitation is assessed with appropriate methods of evaluation research.»

A separate section for attenuated custody was necessary in order to obtain an environment where one could work with privacy and serenity, and where during detention a quality of life adequate to the treatment and to the specificity and difficulty of the work being carried out could be guaranteed. 248 convicts were taken in during the eleven-year project. UTI is a place physically separated from the other sections and reserved for convicts who decided to participate in the Project; here not only spaces but also the social workers and prison officers are specifically assigned to the Unit.

It is a place where attention is primarily focused on the quality of life and on the suitability of the environments and spaces of treatment «in a context of sharp penal differentiation so as to allow, for particular types of inmates, forms of care in which both people and environments become part of treatment» (Giulini, Vassalli, & Di Mauro, 2003, p. 441). The decision to use a separate section, where the possibility to meet or contact other inmates who are no longer engaged in a work of revision and critical re-elaboration of the offence are reduced, springs from the necessity to guarantee convicts a greater sense of security, serenity and "intimacy". These are fundamental elements for a living and treatment environment where the dignity of the subject comes first. Through the formula of attenuated custody the convict obtains a sense of responsibility in regard of his behaviour and his decisions, because the low levels of surveillance leave a higher degree of discretion, self-management and freedom of movement inside the section and the institute. This allows the UTI team to ratify a treatment pact with each convict. With his signature the convict commits himself to respecting the regulations of the Unit and possibly to proposing modifications or extensions to these regulations, and to starting an individual process of reflection, self-criticism and criticism of the offence he has committed.

The treatment process is divided into modules that rep-

resent stages and evolutionary lapses that the subject must go through in the course of treatment. On the one hand they mark individual growth in regard to the aims of the project, on the other they mark the continuity of the commitment regarding the regulations and common life within the Unit. The treatment lever behind the voluntary nature of adherence to the Project and of the signature of the contract by convicts is represented by life and custody conditions in the Unit, different and better than those of protected sections in other correctional institutes, and by the regime of autonomy characterizing the Unit. Moreover, general opportunities and treatment opportunities provided by the Project are important, because they ensure that custody actually becomes not merely a moment of restriction, but also one of re-socialization, and that it is not a synonym for *hibernation* inside Protected Sections.

2.1 *The selection and evaluation phase*

Convicts are assigned to the Unit following their request to join the Project, which is aimed at adult sexual aggressors who have undergone at least a first degree sentence. At first only requests from those who demonstrated a minimum acknowledgement of their offence and of their deviant sexual problems were received; subsequently the Project was also extended to total deniers, as long as they presented requirements of treatability, on the basis of criminological, clinical and psycho-diagnostic evaluations.

The preliminary evaluation phase takes place in the protected sections of the Institutes where the convicts are in custody, before the potential transfer to the Unit, through a consultation during which certain data are recorded: socio-demographic data, the legal position and the individual position of the subject regarding the offence. After the selection and transfer to Bollate prison, the central moment of the work is individual assessment, aimed at obtaining a valid and exhaustive description of the functioning and of the personality features of the subject, and at evaluating actual treatability. The assessment phase is considered to be essential for the observation of the convict, in order to obtain the deepest possible knowledge of the subject's personality and consequently plan personalized forms of intervention.

Indeed, two further tools are used to complete the observation of the convict, the report on phantasmatic activity and the team report on manifest variables. The former is a computer questionnaire that each convict completes every day at the same time. Questions refer to stressful events, negative emotions connected to stressful events and consequent sexual fantasies (divided into deviant and non-deviant, invasive and non-invasive). The monitoring of deviant phantasmatic activity aims at checking the effectiveness and the results of the treatment, both for an individual feedback for the subject and for an evaluation internal to the project, as well as for research purposes. The team report on manifest variables is a computer tool to evaluate every single convict according to 5 variables. Every two months all the social workers evaluate each convict according to these. Each variable is divided into five levels: adherence to the Unit's rules, request for help, anger management, basic social ability techniques, sense of responsibility towards the offence and aggression cycle. This is the first application in Italy of an evaluation tool by a therapeutic team within a community.

The tools employed for psycho-diagnostic assessment include a projective test (The Rorschach Test), personality tests (MMPI-2 or MCMI-III), IQ tests (WAIS-R, Culture Fair or Eta-Beta), the Denial Grid edited by André Mc Kibben and anamnesis.

Although sex offenders present different personological and psychopathological profiles, in accordance with the international literature, some common aspects in all sex offenders can be outlined: i.e. relational deficits, empathy deficits, cognitive distortions, use of denial and minimization mechanisms in regard of their offence. There are other aspects where differences and individual variables can be found, i.e. the extent to which the examination of reality is compromised, the presence of traumatic events in the subject's medical history, the quality, intensity and ability to control emotions, and the subject's intellectual level.

Generally psychological interventions that are aimed at obtaining evolutionary changes in personality and behaviour tend to proceed on two different levels. On the one hand we have the direct treatment of psychic and behaviour functioning and processes, which are more strictly correlated to the violent action: these interventions are mostly behavioural and they are recommended for the treatment of compulsive symptoms. On the other hand, we have the treatment of profound psychological dynamics, which are not directly linked to the offence, i.e. psychotherapeutic, psychodynamic and cognitive techniques, both individually and as a group; it is recommended for subjects whose deviant sexual behaviour isn't ascribable to compulsive aspects, but rather to a precocious deviant personality structure. With both kinds of intervention a psycho-pharmacological support can be used; frequently sexual aggressiveness is the epiphenomenon of an Axis I or Axis II mental pathology. In these cases pharmacological intervention is aimed mainly at containing psychiatric symptoms (i.e. compulsivity, anxiety, mood disorders, psychotic episodes) that may interfere and compromise therapeutic work.

2.2 *Staff*

The working methods used during the project are derived from a vision that is mainly criminological: from this point of view the intervention focuses on the event-offence and on potential recidivism.

The cognitive-behavioural model interprets the offence as a sexualisation of aggressiveness (and not the other way round). For more recent approaches, such as the Good Lives Models, offence is instead a dysfunctional way to reach common, basic, human needs where other and more functional ways are excluded (Ward, & Marshall, 2004; Xella, 2011).

In the structuring of the treatment the acquisition of further social competences and abilities on the one hand, and the understanding of anticipatory processes of the offence on the other, are both crucial to preventing recidivism. The Bollate project follows these treatment guidelines, yet the team has a multidisciplinary aspect to it and uses both psycho-dynamic and socio-educational methods. The multi-professional team, where different methods and forms of knowledge coexist, works with an eye to the constant

integration and the enrichment of know-how. The team gathers for an internal meeting every two weeks, which gives the team members the opportunity to confront each other and discuss both individual cases and the progress of the project as a whole. Thus the single professionals have the opportunity to explain and discuss possible doubts or problems. The Unit's team, external to the other professionals in the Institute, constantly interfaces with the latter in meetings for reflection and training, as well as when assessing individual cases. With regard to the organization of the observation activity, it has been established that the UTI team should be part of the Observation and Treatment Group (G.O.T.) and report on the progress of the cases, so that during institutional meetings it becomes easier to understand the criminological and intra-psychic aspects that led the convict to committing the offence in the first place. The institutional educator assigned to the Unit is the intermediary between the Unit and the other professionals who take care of the convicts: they are part of the prison's educational section, of the judiciary surveillance and of the offices of external penal execution. The prison officers are also constantly involved in the work of the Unit; officers who serve in the Unit have been selected among those who made an explicit request, so that only staff members that are authentically motivated to work with this particular type of convict work in the UTI. Once they have been selected, these officers take part in specific training and awareness meetings, in order to make the Unit a serene and motivating workplace for all, convicts, officers, and professionals.

2.3 *The intervention*

The treatment setting is mainly group therapy; a working procedure that offers opportunities for indirect learning, confrontation and mutual support. Conductors, who avoid putting themselves on the same level as them, make dialogue between participants possible; furthermore the role of the conductors is to allow participants to speak freely, although from time to time they try to liven up the debate; conductors facilitate the circulation of debate. A central factor in this type of group work is the alternation between individual aspects, i.e. the single person's own aspects, and group aspects, those common to all. This alternation is natural and occurs spontaneously within the group, but the conductors sometimes intentionally enter the debate to refer back to something one subject told the group to stress how an individual experience can be common to other people inside the group. Or, with an opposite process, they may isolate specific aspects of a subject to point out important peculiar aspects.

The body of knowledge coming from the experience of the Canadian Pinel Institute in Montreal is introduced in the conduction of the groups as a "third party": this scientific tradition is expressly referred to (also with the support of a supervisor's periodic visit to Italy[4]) in order to identify and name in a non judgmental way typical aspects emerging from working with sexual aggressors, such as for example denial and minimization strategies and risk factors in general. Thus a space focused on sex offenders has been set up, managed by André McKibben, to whom staff can refer to, aware that they are not bearers of autonomous knowledge or operating practices in the field. Thanks to the continual reference to this "third party", therapists can intensely and critically review their work, without becoming accusative and contributing to the creation of an atmosphere of trust and productive work.

Participation to groups is compulsory and is regulated by the contract, signed by subjects, which states the aims of the group, the rules and the working methods; the definition of procedures, schedules and contents constitutes the frame within which group work must be confined.

Signing the contract ratifies a sort of "alliance" between staff and convict, so that subjects cannot be passive receivers of the contents of the treatment, but must commit themselves to participating actively and positively, being open to dialogue and exchange, so that they may obtain some benefits and improvements, not only in regard to the contents of the group work, but also for the development of new abilities, of their self-awareness and self-confidence (Bandura, 1997).

The group is a very powerful multiplier of maturing processes, it takes advantage of interactions between participants and is characterized by high levels of dynamism. The treatment provides for the integration of different procedures, not all of which are specifically related to sexual offences. Together they aim at preventing recidivism, also through an improvement of the person's quality of life and lifestyle: «indeed, sex offenders are chronically dealing with difficulties concerning different areas of their lives. In the same way as in quite different pathologies, such as alcoholism or diabetes, for instance, for which there is no cure but there can be remission» (Aubut et al., 1993, p. 153).

Therefore, there are no claims of complete and durable recovery. The treatment is conceived as a proposal made to the person, who is given the opportunity to understand, redefine and therefore modify the meaning he has been giving to his existence up to that moment, an opportunity to re-elaborate his offence and thoroughly understand its dynamics and consequences.

Different professionals and different theoretic tendencies have made the structuring of an articulate treatment programme possible. This is what characterized the team and what opened the door to diversified educational and clinical work.

The calendar regulating the weekly organization of the Unit is given to all convicts; it includes all programme activities and has to be followed precisely by staff and users alike, because concentration and continuity of interventions are two fundamental aspects for the success of the treat-

4 This is Canadian Criminologist André McKibben, who has directed for years research and treatment at the Pinel Institute and subsequently in April 2009 was commissioned by his country's Minister of Justice to start the first experience of "therapeutic prison": around fifty sex culprits underwent a 16-month programme in a prison entirely dedicated to the treatment, the Roche Percée Penal Institute in Gaspésie, a remote region in Northern Quebec.

ment. Activity centres around three socio-educational groups, complemented by other types of intervention, such as physical, creative and expressive activities, in order to make the treatment as complete and effective as possible, especially by keeping in mind individual variability and heterogeneity of problems and needs, as mentioned above[5].

Audio-visual equipment has often been used within group work: i.e. films or documentaries dealing with violence, sexual aggression and victimization have been shown with the purpose of offering food for thought and elaboration opportunities concerning the matters under discussion and the personal histories of subjects. As mentioned before, the aim of the treatment is to reduce the risk of episodes of recidivism, also by identifying deviant sexual fantasies and anticipatory factors that precede the criminal event, by developing the most suitable and effective coping strategies and stress and anger management strategies and through ability and social skills training and the correction of cognitive distortions. Marshall defines programmes like these "aggression-related": they provide for a series of "aggression-specific" activities linked with a series of characteristics that are typical of sexual aggressors.

The treatment intervention as such proceeds with an intensified rhythm of work just after the three-month evaluation period, when those who are eligible for treatment are selected. Intensive treatment lasts six months.

During the last month preceding discharge from UTI, risk assessment is carried out using two specific tools: Static-99 R for the evaluation of static risk factors, and Stable 2007 for the dynamic stable risk factors. Because these two scales are not validated for the Italian population, we use recidivism risk scores as internal data that, together with the observation data, allows us to have an overall framework in which we can identify both risk and protection factors for a better risk management and a better planning of the treatment intervention necessary for that single person, in order not to transform the evaluation into a mere tool of social control.

Inmates are informed about their vulnerability to recidivism risks, and on resources that can be activated to cope with it.

After the phase of intensive care, the convicts who have been treated in the Unit are transferred to the common sections of the prison in order to favour their integration with the so-called common convicts in those sections. This phase is considered to be an integral part of the treatment project for two specific aims and purposes. The first challenge concerns the demolition of a prison subculture, according to which any contact between sex convicts and the "common" ones entails an aggressive and punitive act against the former. In fact, other convicts refuse any type of life in common with sex convicts. Therefore the prison administration has created special prison sections that are isolated and separated from the rest of the prison, the so-called "protected sections", for convicts who have been accused or sentenced for sex offences, together with other categories of convicts who need protection, for example police informers, convicts who were members of police forces and trans-sexuals. The attempt to demolish this subculture is also a form of treatment for the population of common convicts, because it increases the assimilation of the principle of legality, as there is no hierarchy among offences and every convict must have access to equal rights during the duration of the sentence. Yet the current protected regime, where sex convicts serve out their sentence, is often a factor of collusion with other dysfunctional or even psychopathological aspects underlying the behaviours of sex offenders.

Let's take into consideration that many among these subjects are deprived at the level of communicative and relational skills and often do as much as they can to obtain a sort of isolation, reproducing the basic climate of their malfunctions and deviances, therefore strengthening that specific condition of closeness, inaccessibility, and rancor that we have defined as «detention hibernation» (Giulini, Vassalli, & Di Mauro, 2003). In this case it is important that the sex convict who has undergone treatment experiences what he has learnt during the intensified treatment, particularly any time he comes into contact with possible frustration and relational experiences marked by refusal and mistrust. He must be able to generalize what he has learnt, in order to mediate and manage his impulsive reactions, using adequate coping strategies and checking in a practical way and with the help of the social workers the value of his acquisitions and of his new resources, aiming at increasing his self-esteem. Yet stigmatization and refusal towards sex offenders are present also within free society: so sex offenders must activate the ability to reintegrate socially, i.e. they must take responsibility for the destructive aspects of their past behaviours, without assuming victimizing attitudes, aiming at remediation, in a more resourceful and aware relationship with the others.

For this reason many sex offenders who have undergone treatment after the sentence or during an external sentence execution also must be taken care of with continuity. This is why the team that has been working at the UTI has taken active steps to create a specialized Service in the community to manage and treat violent and sexually violent behaviours.

3. The construction of the treatment field. The external part

In March 2009 the Safety Department of Milan City Council officially instituted the Presidio Criminologico Territoriale (PCT)[6] thus legitimizing the specificity of the interventions of evaluation and treatment that had been activated within the Service for Social and Penal Mediation of the Safety Department itself. The idea derives from an operative tradition and methodological process in violence prevention that confronts the management of situations of conflict to prevent their escalation and the ensuing detri-

5 Weekly activities include a group on communication and social abilities, a group on recidivism prevention, a group on conflict management the section assembly, the activation of working skills, sexual education, physical activity, art-therapy, EMDR.

6 District Criminological Centre.

mental outcomes of possible acting-outs as sole outlets for the conflict. This also applies to clinical-estimative and treatment interventions for subjects involved in conflicts. Thanks to the interest in prevention and to the clinical structuring, interventions for the cure and control of violent behaviours have evolved and have become more structured and specialized. The necessity to create an operative pole to take care of the authors of violent behaviours and that at the same time works towards preventing them, derives from a perspective of reparative justice; as a matter of fact «constituting an aid on the territory singles out the community as an active resource and not only as a beneficiary of social protection through the rehabilitation and the re-integration of the offender» (Emiletti, Giulini, & Scotti, 2016).

The PCT continues to use *a model of clinical-criminological intervention, which by definition is interdisciplinary and integrated*, which identifies an operative specificity of the team both regarding the experience of the UTI and the complexity of the situations dealt with which are a combination of juridical, social, sanitary and educational aspects.

Since 2009 the service has taken care of 309 offenders, for the most part accused or condemned for sexual offences, domestic violence or stalking; the offenders currently in treatment are 147, with 29 new comers in 2016.

At present at the PCT a constant activity of psycho-diagnostic evaluation and risk assessment is carried out, together with criminological interviews, four weekly therapeutic groups for sex convicts, a support group for relatives of sex offenders (Garbarino, Giulini, in this review)[7], the Circles of Support and Accountability, and individual care with different clinical tools, such as EMDR and Finn's Therapeutic Assessment (Finn, 2007).

A challenge that is more and more important for this Service is the ability to structure intervention protocols aimed at preventing possible acts of secondary victimization after the sentence has been served. Such acts can occur particularly within families, when victims risk encountering their perpetrators; the latter may not be able to reveal their responsible truth and therefore damage it all the more with cumbersome guilty feelings that definitely cancel out any attempt to solve the devastating trauma suffered by the victim of sexual abuse.

The PCT represents an important reference on the territory as it brings continuity to the treatment begun while in prison: «an authentic treatment field has been developed, to which the sex convict is introduced not only for the treatment intervention, but also to favour a contact and an alliance with an external resource that becomes a reference point both in the sense of *benevolent control* on the territory and in the prospect of implementing the offender's relational, working and social resources, in order to work for a change and improvement towards a more functional and adaptive lifestyle» (Giulini, & Emiletti, 2011). For example, from this perspective, the Service launched a restorative justice experience originating in the social practices of Canadian Mennonite pastors, by constituting the "Circles of Support and Accountability," (Goulet, 2009). Some citizens belonging to voluntary associations occupied in the detention field are selected, trained and supervised by professionals from the treatment team and by social workers of PCT: the aim is creating a Circle for each convict who has taken part in the treatment, who according to the team may need to be accompanied in the community after the sentence has been served. For each Circle three volunteers are trained; first they meet and acquaint themselves with the convict in prison, just before he is released; then they decide whether they want to sign a contract that binds them to track the ex-convict for a one-year period once he is no longer in custody. Thus the convict becomes the *chief member* of the Circle and in turn commits himself to meeting once a week the other three members and turning to them in times of hardship; he is also taken care of at the PCT. It is basically the actuation of a mechanism of that *benevolent control*, prompting the former convict at risk of recidivism to continue treatment and supporting him informally rather than clinically.

4. Project evaluation and non-treatment activities

The project has been set up and is supervised by the Philippe Pinel Institute of the University of Montreal, an institution that has been dealing with similar treatment interventions for sex offenders for years. Furthermore, for several years, the Research Centre on Education Technologies at Milan's Università Cattolica del Sacro Cuore (Director Prof. Paola di Blasio) has coordinated the evaluation activity through a qualitative gathering of treatment data and through the observation ofactivities. Moreover, the team deals with various research activities, also in cooperation with other specialists, on characteristic features of sexual aggressors and of intra and extra-mural treatment work with this particular typology of subject, aiming at developing and implementing theoretical knowledge and comparing it with existing international experience and literature. Lastly, we must underline the training work carried out by our staff in favour of other professionals, working in other detention institutes or in services that deal with taking care of sex offenders. Their aim is to reproduce similar experiences in other structures too and making the work with these convicts even more useful and effective, both for the sex offender convicts themselves and for society; it is conscientiously conducted by trained staff who are aware of the peculiarities characterizing sex offenders and their deviant behaviours.

In this perspective, CIPM has contributed to the establishment of CoNTRAS-TI[8], an association that aims at implementing a national coordination among those who work in the research and in the treatment of sexual aggression. Associations, institutions, treatment centres, and experts have come together to develop a culture in which treatment for sex-offending is at its core. The interest is to encourage

7 Garbarino F., Giulini P., "Working with sex offenders relatives as a tool in the *treatment field*", in this review.

8 National Coordination for the Treatment and Research of Sexual Aggression – The Italian Contribution, Association founded in October 2017. For further information or for subscribing write to segreteriacontrasti@gmail.com.

collaboration between CoNTRAS-TI and governmental Institutions, in order to promote a climate of public sensitivity towards sex offenders, their treatment, and their re-entry into society. Currently, in Italy, projects for the treatment of sexual offenders, both in detention and in the community, depend on uncoordinated personal initiatives, which make any treatment programme discontinuous and insufficient. The activity of CoNTRAS-TI aims at implementing a network for the prevention of sexual abuse by developing scientific research and treatment practice based upon clinical evidence and inspired by international guidelines, and at designing new strategies and practices to influence national decision-making and policies regarding the monitoring, assessment, treatment, and the re-entry into the community of those individuals convicted for sex crimes, and who may still be at risk of re-offending. Furthermore, it will encourage the development of a preventive culture, especially primary prevention, so that it could be possible to identify early enough those high-risk cases and provide them with the necessary support to have access to elective programmes or measures designed to evaluate and prevent the risk of sexual aggression being committed. This is in line with the Lanzarote Convention (art. 7), which invites Parties to implement specific monitoring mechanisms, especially for the prevention of child sexual exploitation, and to prevent sexual aggression at its bud.

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Working with sex offenders relatives as a tool in the "treatment field"

Il lavoro con i familiari dei sex offender come strumento trattamentale

Francesca Garbarino • Paolo Giulini

Abstract
In the construction of a "treatment field" both intramural and larger community treatment resources are fundamental. The treatment field creates an alliance between treatment experts and external, community resources such that a "benevolent social control" is favoured.
From this perspective, it is crucial to extend responsibility to the relatives of sex offenders through a narrative process. The aim is to help the relatives both acknowledge and accept the resultant pain stemming from the commission of the crime by their relative, along with the consequent stigmatization. It is a process that favours shame and guilt, but provides a beneficial contrast against the frequent defence mechanisms of denial and minimization of the violent acts, which tend to mimic the same defence mechanisms shown by the sex offenders themselves. This process then reinforces the therapeutic alliance and builds a collaboration that fosters a genuine exchange within familial relationships and the beginnings of a benevolent pressure towards the offender that acts as a treatment leverage.

Key words: sex-offenders • abusers' relatives • support group • treatment

Riassunto
Nella costruzione del "campo del trattamento", fondamentale è la presa in carico intramuraria e sul territorio, che permette di estendere l'alleanza al trattamento e di favorire un "controllo sociale benevolo".
E' significativa, in tale prospettiva, l'estensione della presa in carico ai parenti degli autori di reato, nel servizio territoriale, nell'ambito di gruppi di parola rivolti agli stessi.
Si mira ad incontrare e accogliere la sofferenza conseguente alla commissione del reato e alla stigmatizzazione connessa, favorendo un'elaborazione rispetto alla vergogna, ai sensi di colpa e alla frequente attivazione di meccanismi difensivi di negazione e minimizzazione rispetto agli agiti violenti, che tendono a colludere con quelli messi in atto dai rei. Ciò rafforza l'alleanza terapeutica e la costruzione di una collaborazione che favorisce uno scambio autentico nell'ambito dei rapporti famigliari e l'attivazione nei confronti del congiunto di una pressione benevola che funge da leva trattamentale.

Parole chiave: autori di reati sessuali • familiari dei sex-offender • gruppo di supporto • trattamento

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Introduction

The consequences of sexual abuse often affect, both directly and indirectly, more than one victim, especially among those closest to the victim and the abuser. We have learned from our clinical experience that the relatives of the abuser need a space to think and elaborate what happened, and this can become an essential part of the abuser's treatment.

Taking into account these considerations, two years ago we created a support group for sex offenders' relatives.

The group meets at the "treatment field", a bridge between the prison and the community, a place that follows the principles of Restorative Justice, and prevents relapse.[1] This "field" is made up of two spaces, both physical and mental, which are hereby described separately for explanatory reasons.

This "treatment field" was realized in Milan by the CIPM Association at the "*Unità di Trattamento Intensificato"* at the Milano-Bollate prison and the *"Presidio Criminologico Territoriale"*.

The Unità di Trattamento Intensificato (UTI) for sexual offenders was created in 2005. Treatment can take place in "independent institutes or sections of institutes that guarantee an intensified treatment" in accordance with article 115 of DPR 230/2000 of the Italian Law (Giulini & Xella, 2011).

The application of the law also exercises a symbolic function and can produce a reversal effect in the offender, in the sense that it defines the negativity and damaging effects of his behavior, thus eroding the minimizations and denials, that sex offenders frequently resort to.

However the sole penalty of detention, with its, often formal, assumption of responsibility, however, tends to be a mere "freezing" of simply suppress the underlying issues. The voluntary access to a treatment program by the sex offender, aims to help in the recognition of violent behaviors towards the victim and the acknowledgement of his responsibility. Such responsibility is understood, etymologically, as a possibility of "responding to someone in terms of past actions", meaning responding and internalizing one's own actions (Bonazzi, 2014).

The treatment experience inside the prison has shown us how the end of the sentence and the release represent a moment of "void", both for the convict and the professional, as the treatment itself is suddenly interrupted.

This is why the idea of "treatment field" was introduced, not only as a physical place where treatment could go on to foster reflection and emotional experience, but also as a *bridge* between prison and community. The treatment can continue at the Presidio Criminologico Territoriale of the Comune di Milano[2].

In this way, the violent offender feels a sort of pressure to get treatment, and thus a process of prevention is created, in which the offender is not only treated, but is also put in a position of creating an alliance with both the treatment experts and the external resources, thus creating a form of *benevolent control*. The word "benevolent" highlights that an opportunity is handed to the offender, an action that is protective without being invasive, a resource and not a limitation, a chance of implementing his own relationships, social and working resources to change toward a more functional way of life (Giulini & Emiletti, 2011).

The offense, as a violation of the law, represents a breach of the bond, with oneself and with the others, by the subject, which, by integrating his actual responsibility, finds its singularity and can be part of the social bond rather than alienate oneself and thus risking relapse of the crime.

The treatment is aimed at restoring the social bond, even from a preventative perspective[3].

The Presidio Criminologico Territoriale (PCT) is the reference point for treatment and for the management of critical situations that the offenders can encounter when the time comes for them to be reintroduced into family and community. In a Restorative Justice's perspective, the Presidio gets the community involved as a part of the resources that can help the offender to be reintroduced in his environment. During the treatment all the main actors on the territory are involved: all the institutions, magistrates, law enforcement, social services, volunteers, families and pro-

1 The concept of "treatment" is provided for by judicial system, as a means of either enforcing the execution of a sentence or the safety measure aimed at re-education of the convict.

2 The Presidio Criminologico Territoriale (PCT) was founded in 2009, as a service offered by the Municipality of Milan– Departement of Security, based on the clinical experience of the UTI workers and in line with the Services of the Mediation Center, the Psychotraumatological Service for the support of the victims, all those Services of the local Municipality are managed on a bid bases by CIPM, an organization that has operated in the field of helping victims of violent crimes since 1999. The necessity to create a thrid pole to operate with the authors of violent crimes to prevent the risk of recidvism, is part of a perspective of Restorative Justice. The Services operate in connection with one another and with projects inside the correctional facilities. This is an added value, especially because the delicate and complex nature of the situations dealed with.

3 Criminological research shows that isolation constitutes a risk factor for (a further) committing of a crime both for the victim andfor the offender. The theory of social linkages also highlights the importance of this involvement of the offender within a network of relationships (see, I. Merzagora Betsos, *Uomini violenti, I partner abusanti e il loro trattamento*, Raffaello Cortina, Milano, 2009).

fessionals that could be a resource for the offender, are put into a position of being able to intervene in their own specific ways. Among these interventions operated by volunteers, speaking of Restorative Justice, the experiences shared by the Mennonite pastors in Canada, The Circles of Support and Responsibility are particularly important[4].

The treatment is conceived in an interdisciplinary perspective, where all the different institutions work together to help the offender: from the judicial to the treatment field, to the social aspect. Balier refers to such a system speaking of *"intercontenance"*[5] between institutions that has great therapeutic value (Balier, 1999).

The PCT takes charge of the offender with a series of actions that constitute a model of intervention both clinical and criminological, therefore interdisciplinary and integrated. This is the key element that characterizes the work done jointly by the two working teams (UTI and PCT) and that constitutes an added value, especially as it comes to situations that are complex and delicate, where juridical, social and educational aspects come together.

1. Why a group for the offenders' families?

The relatives of sex offenders often show up at the PCT, mostly to accompany their family member who has been accused of sexual misconduct, hoping to facilitate their treatment. In some other cases, they contact the Psychotraumatology Unit for sex crime victims. During these meetings with them, the social workers often recorded some common problems and the same need for support.

The relatives of sex offenders find themselves in a traumatic situation, because in most cases they knew nothing about what was going on, as well as they ignored the consequences of the abuse, such as arrest and incarceration of their family member. When it comes to the crime itself, the relatives usually oscillate between blaming and, the opposite, denial. The tendency to deny, or to minimize what has happened even when the crime is blatant, is a very common defence mechanism that mirrors the one used by the offenders themselves: combined, these reactions can undermine the treatment.

Among the reasons that facilitate this denial process, the most common are: the hope that there won't be recidivism, the fear of losing custody of their children, the shame and the embarrassment towards what the rest of society will think. Denial, seen in a cognitive perspective, is a functional tool to deal with shame and with the fear of being rejected by society. There is also the desire of deleting the painful memory. If we look at it in a psycho-dynamic perspective, denial is used as a defence mechanism to maintain emotional stability and psychological integrity. Often, as a matter of fact, the two things go hand in hand, and the prevalence of one of the two aspects is based on personality factors (Giulini & Pucci, 2011).

If the family has to deal with criminal procedures for the first time, the relatives can also feel confused and unsure about what to expect or do in these situations.

The arrest can be a humiliation for the relatives of the sex offender, especially if it is shown on popular media, as it often happens with this type of crimes. The partners of sex offenders can feel uneasy at work or in public, and their children can be bullied at school. Often the feelings of a sex offender's partner oscillate between love and loyalty, rage and reject. This is especially true for those partners who decide to stay in the relationship with the sex offender.

The sudden unemployment of the sex offender and the consequent reduction of income can worsen their everyday lives. Legal expenses can be devastating, especially if added to the costs of the detention. Further consequences affect the children of incarcerated sex offenders who, even when they are not the direct victims of the abuse, report having feelings of fear, anxiety, guilt, solitude, and shame. Some studies[6] show that children of incarcerated fathers often do poorly in school or drop out of it altogether, are at risk of teenage pregnancy, substance abuse and delinquency. There are no specific studies about children of incarcerated sex offenders.

Ciavaldini (2011), based on the description of the families of sex offenders, demonstrates the necessity of a therapy tool aimed at "re-establishing a psychic bond that gives every member of the family the chance of mentalizing the happenings well enough to avoid action" (p. 25).

Other studies show that relationships within the families of sex offenders – not specifically incest offenders - present certain characteristics, especially in the case of sex offenders

4 The "*Circle of Support and Responsability – C.S.R.*" is formed by three volunteers, educated and supervised and in contact with PCT, who take responsibility and are in charge of supervising the sex offender at risk of recidivsm during a parole period and for a year after leaving prison. They help the sex offender with re-entering society and they give him support and a place to talk about his difficulties. In a pseudo-friendly context and with regualr weekly meetings, the volunteers develop a multi-disciplinary approach with the other services present on the territory. On the other hand, the offender has to take part to weekly meetings at PCT. This intervention operates in the sphere of Restorative Justice, through which the participants take responsibility in the tournée towards re-integration in society and was developed by the Mennonite pastors in Canada. These groups, who have been active in Quebec for the past 10 years, have demonstrated a drastic reduction of recidivism (See: A. Scotti, P. Giulini, "Giustizia riparativa in azione: i circoli di sostegno e responsabilità", in G. Buono, M. Pompa (eds.), *Recovery &Territorio. Idee ed esperienze in riabilitazione psicosociale,* Roma, Alpes, 2017, pp. 235-251).

5 The translation of the word *"intercontenance"* could be "in-containing".

6 See: M.E. Muscari, "How Can I Help the Family of a Convicted Pedophile?" - Medscape - Oct 23, 2007, in *Children of parents in jail or prison: issues related to maintaining contact*, University of Pittsburg - Office of child development, a University community collaboration - Special report January 2011, issue of OCD's newsletter Development. See also: *Breaking the taboo: Supporting the families of sex offenders*, Feb. 13, 2013., conference organized by 'Action for Prisoners' Families'. Visit the website: Familylives.org.UK- "Action for Prisoners' and offender's Families".

that have perpetrated crimes against minors (Becker-Blease, Friend & Freyd, 2006; Briere, Runtz, 1989; Bolen, 2001), incestuous fathers and rapists. Homosexual paedophiles are more likely to have been victims of physical and sexual abuse in their childhood, compared to heterosexual paedophiles and non-sexual violent offenders.[7]

Another study shows that the childhood of a future sex offender is characterized by situations that deeply affect their ability to develop affection and feelings, which, in the best of cases, appear to be somewhat frozen (Chemin et al., 1995).

On the other hand, the study quoted above shows that "the most frequent defence mechanism of sex offenders is the repression of affection. This primary defence mechanism is dictated from early childhood by the environment around the child, in other words by his immediate family. The stronger is the repression, the higher is the risk of denial and splitting and the most open is the channel of action" (Ciavaldini, 1999, p. 177). In the long run, this results in an inability to regress and in a great difficulty to rely on institutions.

Ciavaldini (1999) observes "affection as a vector and memory of family relations has roots in the exchange between generations, is inscribed in the somatic and functions as an indicator of the relationship, cataloguing it as more or less familiar". He concludes that taking care of these subjects, who have problems to build up relations that can organize their core identity, brings up the question of working throughout the dimension of their affections: "Affection is the key element of a treatment that aims to re-introduce these subjects in a dimension of humanity that they find to be disturbing because it was negatively impacted by an unreliable family circle. Mobilizing their repressed affections will give them the ability to generate real bonds and will make them feel grounded in their personal story" (Ciavaldini, 2001). Taking care of the family of these subjects complies with the idea of "bringing together different aspects - judiciary, social, and medical – as a part of a treatment alliance. "Family – Ciavaldini says - is the primary institution of healing, law and re-insertion". The "in-containing" institutional work allows "to address, to reprocess and to re-write the unreliability factors in a story that can become inter-subjective"[8]. From a trans-generational point of view, considering the traumatic and symptomatic aspects of the family facilitates the identification of the mechanisms that caused the symptoms to emerge in a given subject.

2. How does the group work?

In light of all of the above considered, we have created a support group to answer the need for help expressed by the families of sex offenders in treatment, knowing the importance of acting even in the contest where the dysfunctional dynamics that brought the offender to commit a crime were formed, the same contest where he'll go back after serving his sentence.

The group aims to give the offenders support through opening up and verbalizing what they feel and what they are going through. The group meets every two weeks and is co-guided by a criminologist and a therapist. The group is open to the relatives of sex offenders, as the dynamics that are present within the family of origin of the sex offender are likely to be repeated later, in the so-called "acquired" families.

The offenses perpetrated by the sex offender can have taken place inside or outside the family.

The relatives that participate to the group, that started to meet in 2015, are more or less 15. The group is open to new participants, which can join at any time. Participant's age ranges from 30 to 70, they are well integrated from a social, economic and working point of view. Their education level is middle-lower to upper-middle. No one has a criminal record. During the preliminary interviews, they expressed feelings of suffering and difficulties in managing their situation, and showed interest in participating to the group.

7 M. Tardif, H. Van Gijseghem, *La perception des figures parentales des pédophiles étérosexuels et omosexuels: réalité factuelle ou virtuelle,* Bulletin de psychologie, n. 52(5), 443, Sett.-Ott., pp. 597-604, Bruxelles, 1999. A study conducted on 176 incarcerated sex offenders compared to violent non-sexual offenders show significant alterations in the emotional sphere (A. Ciavaldini, "Passivation et mobilisation des affects dans la pratique analytique avec le délinquant sexuel", in *Rev. Française psycanalitique*, 5, pp. 1775-1784, Paris, 1999-1). In particular, it shows the coldness shown by the subjects in front of the death of a parent (more than one in three sex offedners declared to be unaffected by the death of their father, one in six about the death of their mother) as well as humiliations expereinced as children (rapists were usually humiliated by their mothers, incstouos fathers by their fathers). Some other recurring facts were traumatic separations during the sexual offender's childhood (25% of sexual offenders have been adopted before the age of 12) and show insecurity in their lives as children. (C. Balier, A. Ciavaldini, M. Girard-Khayat, *Rapport de recherche sur les aggresseurs sexuels,* Direction Générale de la Santé, Paris, 1996).

8 A. Ciavaldini, ivi, p. 34. The development of such a mediatization of the meeting can not be done if the therapist is clearly inscribed in the cultural milieu (C. Balier, *op. cit.*, 1999). The enrollment dimension in the milieu is currently recognized as a necessity in therapeutic work with sexual aggressors. It implies an interdisciplinary operation that foresees that all the institutions with which these subjects deal with, have to work in alliance, a combination that goes further than a mere 'interlock'; this interinstitutional work will be governed by professionals who will manage all the aspects. In this work of the institutions, the burden of the intrertransfert that generates the empowering of such subjects, in particular the effects of denial and division, will be revealed. The *'in-containing'*, which makes every institutional framework a pole of support for the other, is the institutional function that allows the transition from the containment phase to the process of transformation. *'In-containing'*, therefore includes a mourning job for each professional, resulting in a certain impotence, a mourning that leads the professional to be one among the others, which means, not to be effective since the others are. This mourning process is what Balier calls "sublimation of destruction" (C. Balier, *ibidem*, 1999) and at family level implies the acknowledgement of the family as an institutional entity made of different members to be respected as such" (B. Savin, "Sujets auteurs d'incidents", in A. Ciavaldini, C. Balier, *Aggressions sexuelles: patologies, suivis thérapeutiques et cadre judiciaire,* p. 36, Paris, Masson, 2000).

The goals of the group are similar to those for the offenders, as they are based on the fact that both the offenders and their families show the same defence mechanisms of denial and minimization. One of the goals is to create awareness of the crimes that their relatives have committed, a better understanding of their own psychic movements, and a reflection about their possible responsibility.

Furthermore, their goal is to find answers to their questions regarding the crime committed by their relative, which will result in increased closeness and can lead them to "gently push" the sex offender to keep going with their treatment, as well as benignly checking on what could be seen as signals of relapse[9]. Before entering the group, the relatives are shown the journey that the sex offenders will go through, either in prison or outside at the Presidio Criminologico Territoriale. The aim is to show the "treatment field" which also the group belongs to, being conducted in the same place as the sex offenders'.

The group is conducted after the model developed by Inshelwood (1989), an author who refers to psychodynamic concepts. This model, which we also use to treat the sex offender, is articulated in two parts, one of support and one of expression. The person receives psychological support, as well as guidance to verbalize what has happened and to express the traumatic aspects of the situation (this is very similar to *Good Lives Model*) (Ward & Marshall, 2004).

This support aims to improve the quality of interpersonal relations which will help the person getting closer to those parts of themselves and of their relative that they see as negative.

The work done with the relatives has to be balanced between the two levels of treatment (support and verbalization), addressing also the problems connected to traumatic factors in the family context and the deviant behaviour of their family member. Listening to the experiences of other people in a similar situation helps the participants to better tolerate the emotional turmoil they are feeling, mitigates the tension, helps to understand one's feelings and cope with the crime, solves incomprehension and prevents possible conflicts. It's important to help the relatives to better understand their own feelings of impotence, guilt, denial or compassion, or even hate, towards their relative who has committed the crime (Coutanceau & Smith, 2011).

This is not psychotherapy, and neither is an counselling aimed to give advice. Of course these persons will ask for advice, but it's important not to answer them directly in order not to create a situation of dependency from the "expert" which wouldn't help to cope and elaborate their internal conflicts. After a while, when a certain level of trust has been created, asking questions can lead to a deep reflection. In the best cases, the work done by the group leads the participants to question themselves and to reach awareness of their own conflicts, which sometimes brings them to ask for a psychotherapy.

Considering the defence mechanisms that often characterize these persons on the affective level and considering the experiences of sex offenders' treatment, which has highlighted the importance of empathy in order to create alliance and trust, a welcoming atmosphere is crucial. When they first enter the group, many participants declare to be worried about this new experience. At the end of the first meeting, everyone expressed relief for the welcoming atmosphere and for the chance they had to share their experiences, when otherwise they feel deeply lonely.

The first meetings are always characterized by deep sorrow and rage, feelings that are welcomed and understood by the group and that are elaborated as part of the traumatic experience lived because of the crime.

The participants are invited to reconstruct the crimes committed by their family members, in order to fight the desire to forget them and the tendency to minimize them, as well as verbalizing their suffering in order to facilitate an authentic communication with the authors of the crime.

The group members often remark they didn't notice the existential and psychological difficulties their sex offender relative was experiencing and didn't realize he was committing abuses.

In the perspective of dealing with the crime, it's important to stimulate a reflection about the consequences of the crime on the victims and about feeling empathy for them.

The relatives have to be supported in order to make informed decisions when evaluating if they want to stay in the relationship with the offender or else they want to leave him. To help with this decision, it's important to share information about the treatment the sex offenders are undergoing. If the abuse has happened within the family, the partners can have a key role in preventing secondary victimization; they have to develop the resources needed to deal with the situation and to comprehend this type of crime. Less isolation means better resilience and a better ability to protect for example, one's children[10]. The sex offender and the relatives, if they are involved in a court procedure, are interested in the development of the procedure itself. The trial is the last and crucial step of the judiciary procedure. The lawyers of the unit inform the relatives about the different steps the sex offender will go through during the trial. It's important to stimulate a reflection about the expectations and implications of the trial, which often makes rage and guilt resurface.

9 In the treatment at UTI there is a group dedicated to preventing recidvism that, modeled after the *relapse prevention* (W.D. Pithers, "Relapse prevention with sexual aggressors: a method for maintaining therapeutic gains and enhancing external supervision", in W.L. Marshall, D.R. Laws, H.E. Barbaree, *Handbook of sexual assault: issues, theories and treatment of the offender,* New York, Plenum Press, 1990, pp. 343-361.) concentrates on the identification of risk factors and alarming signals that might suggest a relapse in the deviant sexual conduct.

10 If the victim is a minor, Social and Juvenile Services are actively involved in taking care of and protecting them. When the victim has reached adulthood, there is a risk of secondary victimization. In these cases the group may have a significant role in precluding further victimization. This is in line with the Commission Implementing Regulation (EU) No 29/2012 of 13 January 2012, Art. 12, which establishes minimum standards in matters of rights, assistance and protection of victims of crime and enhances the experience of reparative justice, such that they do not risk secondary victimization. This Directive was acknowledged by the Italian Legislators with the Legislative Decree n. 212/2015.

When the movie "Un altro me"[11], a documentary that followed the journey of the UTI during a whole year of work, came out, the participants decided to watch it.

The reaction was positive and stimulated reflections about how the treatment of the offenders integrates the pathway their relatives are going thorough. It was noticed, in particular, the attention given in both cases, to the expression of emotional aspects.

The ability of empathizing and communicating is of key importance in sex offenders' treatment (Marshall, Anderson, & Fernandez, 2001) especially because of the rigid defence mechanisms against the feelings of trust and empathy.

Some participants to the group have highlighted how this has helped to form a new way of communicating with their sex offender relative, which resulted in a more authentic relationship and in a sort of mending of the break that the crime had created between them.

Seeking authenticity in communication helps the relative relate to the sex offender in a way that avoids the risk of manipulation and distortion of reality the offender is likely to employ.

This "mending", as the participants call it, is an example of the restorative or, as Garapon (et al., 2001) would say, of the "rebuilding" value of the relationship taken by the group. In this sense, the group activity with the relatives, who often are indirect victims, and the treatment activity with the sex offenders can be considered experiences of Restorative Justice.

In a perspective of preventing recidivism, the effects of a better form of communication and of the rebuilding of the relationship with the sex offender can constitute a form of protection to avoid risks such as the defence mechanisms of denial and social isolation.

Here is a case study to better understand the characteristics and the dynamics of the group.

Mario has joined the group following the advice of the psychologist who is following his teenage daughter, who has revealed that her paternal grandfather has sexually molested her. He says his father has always been very authoritarian with his kids and that, in the past, he has tried to seduce his daughter-in-law. He states that the well-being and tranquillity of his daughter is his first priority, and that he has reported the abuse as soon as the girl told him about it because he wanted she was sure that she was protected and believed, which he considered fundamental for her growth. Mario has been asked by the police not to confront his parents in order to not interfere with the investigation. While meeting with the group, he expressed his doubts about being able to keep his relationship with his father because of his rage, which he couldn't act on, together with the worry that the abuse could happen again, and, in the end, he decided to interrupt his relationship with both the parents.

After a few months, two days after the arrest of his father, Mario invited his 71-year-old mother to participate to the group. His mother reported she was confused and in pain because her life, which she knew and loved, no longer existed and she wondered about her husband's personality. She stated that she no longer knew how to act with her children, her grandchildren and her husband. She felt deeply guilty because she never suspected anything and didn't intervene.

During the meeting, Mario expressed his rage towards both his father and his mother.

Both the group and Mario himself have recognized that his mother was very strong and brave for showing up there. She has acknowledged, in return, the strength of her son, and has finally understood why her children had drifted apart from her husband and consequently from herself. Hearing his own mother holding herself responsible for what had happened, Mario told her that he might, one day, start speaking to his father again. The woman was very worried about her husband because of his health conditions, his age and the fact that they had taken care of each other for 55 years. She said she didn't feel like leaving him. Other women in the group, wives or girlfriends of sexual offenders, have said how they have decided to stay with their men, with several difficulties, how they have however told their partner that they couldn't guarantee that they could stand the situation in the future, and how staying with them doesn't mean they justify their actions and, on the contrary, that their actions have created a deep sense of betrayal and sorrow that isn't easy to deal with.

Mario's father has stated that he isn't interested in participating to group treatment.

We think the experience in the group with the relatives of sex offenders can represent a good approach in criminological treatment, and a good system characterized by an inter-disciplinary and integrated work with the institutions in order to spare the victims, the offenders themselves and society a relapse.

11 This documentary was filmed during the year 2014-2015 inside a correctional facility of the *Unità di Trattamento Intensificato (UTI),* in occasion of the meetings with the offender and between the professionals, during the groups' treatments. The film, produced by Graffiti Doc in Torino, was directed by Claudio Casazza and won an award at the Festival Internazionale dei Popoli in Firenze in 2016, at the Festival del Documentario Italiano in 2017 and the festival Cinema di Ischia. It is distributed by Lab80.

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