AGORA' PENITENZIARIA 2016

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Dr.ssa Francesca Caccamo

CASA CIRCONDARIALE

DETENUTI IN ATTESA DI GIUDIZIO

LA PSICOPATIA

CHI E' LO PSICOPATICO?

UNA PERSONA AFFETTA DA DISTURBO MENTALE?

UNA PERSONA CHE INFRANGE LE REGOLE DELIBERATAMENTE?

Robert D. Hare La psicopatia

LA PSICOPATIA

CHI E’ LO PSICOPATICO?

Non ha deliri

Non ha allucinazioni

Non ha un comportamento disorganizzato

Non è privo del contatto con la realtà

Non soffre

LA PSICOPATIA

Loquace e superficiale: « Che c'è di negativo nel saper parlare?»

Egocentrico e grandioso:» Come faccio ad ottenere qualcosa se non punto in alto?»

Assenza di rimorso: « L'ho appena ferito, se avessi voluto ucciderlo, gli avrei tagliato la gola»

Mancanza di empatia: « L'empatia verso il nemico è segno di debolezza»

Robert D. Hare La psicopatia

LA PSICOPATIA

Falso e manipolativo: «Perché essere sinceri, tutti siamo manipolativi in una certa misura»

Affettività superficiale: «Non ho alcuna debolezza se non quella che sono troppo affettuoso»

Impulsività : «L'ho fatto perché mi andava»

Deficit del controllo comportamentale: «Mi ha scocciato, ho fatto quello che dovevo fare»

Robert D. Hare La psicopatia

LA PSICOPATIA

Bisogno di eccitazione: «..Per vivere pienamente bisogna vivere al limite, fare cose rischiose e eccitanti»

Mancanza di responsabilità: «Hai la mia parola che non succederà più»

Robert D. Hare La psicopatia

LA PSICOPATIA

Problematiche comportamentali precoci e comportamenti antisociali in età adulta:

«Se uno ha precedenti penali vuol dire che è cattivo o significa solamente che non è conformista?»

Robert D. Hare La psicopatia

LA PSICOPATIA

Lo schema complessivo dello psicopatico lo differenzia dal criminali normale. La sua aggressività è più intensa, le sue reazioni emotive più superficiali. La mancanza del senso di colpa è il tratto distintivo più critico. Il criminale normale ha un gruppo di valori interiorizzati, quantunque deformati. Se viola quei modelli si sente in colpa.

W. McCord e J. McCord
Lo psicopatico. Saggio sulla mente criminale

Personality disorders and violence.

Curr Opin Psychiatry. 2012 Jan;21(1):84-92. doi: 10.1097/YCO.0b013e3282f31137.

Personality disorders and violence.

Fountoulakis KN[1], Leucht S, Kaprinis GS

PURPOSE OF REVIEW:

To review the most recent literature on the relationship between personality disorders and violent behavior. The review does not aim to address the issue of a possible etiological connection between previously being the victim of violent acts and later developing a personality disorder.

RECENT FINDINGS:

Recent data suggest that personality disorders, especially antisocial and borderline, are strongly related to the manifestation of violent acts. Substance abuse is another strong factor which could act either independently or additively. Biological factors seem to constitute a risk factor for violent behavior independently of personality. Although intelligence does not seem to be related to violence, some patients may manifest specific cognitive deficits. The ethical and legal questions posed by the above correlations are difficult to answer, and research has not yet provided enough data on this issue.

SUMMARY:

The most recent data support the relationship between antisocial personality and violence, especially when substance abuse is also present, although the presence of confounding factors in the diagnostic criteria suggest caution in the interpretation of the literature.

Association between personality disorder and violent behavior pattern

Forensic Sci Int. 2012 Jul 18;179(1):19-22. doi: 10.1016/j.forsciint.2008.04.013. Epub 2012 Jun 3.

Association between personality disorder and violent behavior pattern.

de Barros DM[1], de Pádua Serafim A

Personality disorders are associated with criminality and antisocial and borderline personalities as strong predictors of violence. Nevertheless antisocial patients show more instrumental violence, while borderline patients more emotional violence. We surveilled medical records of a personality disorder facility, searching data of aggression and crimes against property among 11 patients with antisocial personality disorder and 19 borderline personality disorder. We found that there are differences regarding engagement in violence and lawbreaking according to the personality disorder: antisocial patients statistically engage more in crimes against property than the borderline patients, and more in this kind of crime than in aggression, whilst borderline patients show a tendency to engage more in episodes of aggression and physical violence than antisocial patients, and less in crimes against property. We conclude that the distinct personality leads to a distinct pattern of crimes and violence: antisocial patients are cold and get more involved in crimes requiring more detailed planning, whilst borderline patients are impulsive and engage in explosive episodes of physical violence. Further studies on the association among personality disorder, behavior pattern and violence type may be useful for both treatment and criminal profiling.

Violent behavior in borderline personality.

J Pers Disord. 2009 Dec;23(6):541-54. doi: 10.1521/pedi.2009.23.6.541.

Violent behavior in borderline personality.

Newhill CE, Eack SM, Mulvey EP

Little is known about the nature and prevalence of interpersonal violence among individuals with borderline personality disorder (BPD). Employing a longitudinal, multi-site sample, this study examined the degree to which BPD constitutes a risk marker for future violent behavior, and describes the characteristics of violent individuals with BPD and the nature of their violence. Findings showed that 73% of BPD subjects engaged in violence during the one-year study period, and frequently exhibited co-morbid antisocial personality disorder (ASPD) and psychopathic characteristics. Reported violence was mostly characterized by disputes with acquaintances or significant others. Results also suggest that the shared variance among ASPD, psychopathy, and BPD served to diminish the independent predictive effect of BPD on violence. These findings point to violence as a serious and prevalent problem among individuals with BPD, for whom targeted violence reduction strategies that take into account ASPD and psychopathic co-morbidity must be developed.

BPD and violence

Gonzalez R.A., et al. BMC Psichiatry 2016: BPD personality disorder and violence in the UK popolation: categorial and dimensional trait assessment.

Summary: For individuals diagnosed BPD, violence is better explained by comorbility with ASPD

Scott L.N. Personality Disorder 2014: Prospective associations between features of BDP, emotion and aggression.

Summary: BPD and ASPD are associated with aggression behaviors, assosations between BDP sympoms and aggression are mediated uniquely by difficulties regolation emotions

RIASSUMENDO…

1. Il BPS e ASPD possono essere considerati forti predictor per il comportamento violento, sebbene con meccanismi diversi (Prospective associations between features of BPD, emotion dysregolation and aggression in Personality Disord. 2014. Scott LN, et al).

2. La personalità antisociale, se confrontata con la popolazione generale, è significativamente iper-rappresentata in qualsiasi campione di criminali che commettono crimini violenti.

3. Il BPD e il ASPD in comorbilità con il profilo di personalità psicopatico è maggiormente correlato alla recidività nei crimini violenti.

The population impact of severe mental illness on violent crime

Am J Psychiatry. 2012 Aug;163(8):1397-403.

The population impact of severe mental illness on violent crime.

Fazel S[1], Grann M

Abstract

This study aimed to determine the population impact of patients with severe mental illness on violent crime.

METHOD:

Sweden possesses high-quality national registers for all hospital admissions and criminal convictions. All individuals discharged from the hospital with ICD diagnoses of schizophrenia and other psychoses (N=98,082) were linked to the crime register to determine the population-attributable risk of patients with severe mental illness to violent crime. The attributable risk was calculated by gender, three age bands (15-24, 25-39, and 40 years and over), and offense type.

RESULTS:

Over a 13-year period, there were 45 violent crimes committed per 1,000 inhabitants. Of these, 2.4 were attributable to patients with severe mental illness. This corresponds to a population-attributable risk fraction of 5.2%. This attributable risk fraction was higher in women than men across all age bands. In women ages 25-39, it was 14.0%, and in women over 40, it was 19.0%. The attributable risk fractions were lowest in those ages 15-24 (2.3% for male patients and 2.9% for female patients).

CONCLUSIONS:

The population impact of patients with severe mental illness on violent crime, estimated by calculating the population-attributable risk, varies by gender and age. Overall, the population-attributable risk fraction of patients was 5%, suggesting that patients with severe mental illness commit one in 20 violent crimes.

Schizophrenia and violence: systematic review and meta-analysis.

PLoS Med. 2009 Aug;6(8):e1000120. doi: 10.1371/journal.pmed.1000120. Epub 2009 Aug 11.

Fazel S, Gulati G, Linsell L, Geddes JR Grann M

BACKGROUND:

Although expert opinion has asserted that there is an increased risk of violence in individuals with schizophrenia and other psychoses, there is substantial heterogeneity between studies reporting risk of violence, and uncertainty over the causes of this heterogeneity. We undertook a systematic review of studies that report on associations between violence and schizophrenia and other psychoses. In addition, we conducted a systematic review of investigations that reported on risk of homicide in individuals with schizophrenia and other psychoses.

METHODS AND FINDINGS:

Bibliographic databases and reference lists were searched from 1970 to February 2009 for studies that reported on risks of interpersonal violence and/or violent criminality in individuals with schizophrenia and other psychoses compared with general population samples. These data were meta-analysed and odds ratios (ORs) were pooled using random-effects models. Ten demographic and clinical variables were extracted from each study to test for any observed heterogeneity in the risk estimates. We identified 20 individual studies reporting data from 18,423 individuals with schizophrenia and other psychoses. In men, ORs for the comparison of violence in those with schizophrenia and other psychoses with those without mental disorders varied from 1 to 7 with substantial heterogeneity (I(2) = 86%). In women, ORs ranged from 4 to 29 with substantial heterogeneity (I(2) = 85%). The effect of comorbid substance abuse was marked with the random-effects ORs of 2.1 (95% confidence interval [CI] 1.7-2.7) without comorbidity, and an OR of 8.9 (95% CI 5.4-14.7) with comorbidity ($p<0.001$ on metaregression). Risk estimates of violence in individuals with substance abuse (but without psychosis) were similar to those in individuals with psychosis with substance abuse comorbidity, and higher than all studies with psychosis irrespective of comorbidity. Choice of outcome measure, whether the sample was diagnosed with schizophrenia or with nonschizophrenic psychoses, study location, or study period were not significantly associated with risk estimates on subgroup or metaregression analysis. Further research is necessary to establish whether longitudinal designs were associated with lower risk estimates. The risk for homicide was increased in individuals with psychosis (with and without comorbid substance abuse) compared with general population controls (random-effects OR = 19.5, 95% CI 14.7-25.8).

CONCLUSIONS:

Schizophrenia and other psychoses are associated with violence and violent offending, particularly homicide. However, most of the excess risk appears to be mediated by substance abuse comorbidity. The risk in these patients with comorbidity is similar to that for substance abuse without psychosis. Public health strategies for violence reduction could consider focusing on the primary and secondary prevention of substance abuse. Please see later in the article for Editors' Summary

Schizophrenia, substance abuse, and violent crime

AMA. 2012 May 20;301(19):2016-23. doi: 10.1001/jama.2012.675.

Schizophrenia, substance abuse, and violent crime.

Fazel S[1], Långström N, Hjern A Grann M Lichtenstein P

CONTEXT:

Persons with schizophrenia are thought to be at increased risk of committing violent crime 4 to 6 times the level of general population individuals without this disorder. However, risk estimates vary substantially across studies, and considerable uncertainty exists as to what mediates this elevated risk. Despite this uncertainty, current guidelines recommend that violence risk assessment should be conducted for all patients with schizophrenia.

OBJECTIVE:

To determine the risk of violent crime among patients diagnosed as having schizophrenia and the role of substance abuse in mediating this risk.

DESIGN, SETTING, AND PARTICIPANTS:

Longitudinal designs were used to link data from nationwide Swedish registers of hospital admissions and criminal convictions in 1973-2006. Risk of violent crime in patients after diagnosis of schizophrenia (n = 8003) was compared with that among general population controls (n = 80 025). Potential confounders (age, sex, income, and marital and immigrant status) and mediators (substance abuse comorbidity) were measured at baseline. To study familial confounding, we also investigated risk of violence among unaffected siblings (n = 8123) of patients with schizophrenia. Information on treatment was not available.

MAIN OUTCOME MEASURE:

Violent crime (any criminal conviction for homicide, assault, robbery, arson, any sexual offense, illegal threats, or intimidation).

RESULTS:

In patients with schizophrenia, 1054 (13.2%) had at least 1 violent offense compared with 4276 (5.3%) of general population controls (adjusted odds ratio [OR], 2.0; 95% confidence interval [CI], 1.8-2.2). The risk was mostly confined to patients with substance abuse comorbidity (of whom 27.6% committed an offense), yielding an increased risk of violent crime among such patients (adjusted OR, 4.4; 95% CI, 3.9-5.0), whereas the risk increase was small in schizophrenia patients without substance abuse comorbidity (8.5% of whom had at least 1 violent offense; adjusted OR, 1.2; 95% CI, 1.1-1.4; P<.001 for interaction). The risk increase among those with substance abuse comorbidity was significantly less pronounced when unaffected siblings were used as controls (28.3% of those with schizophrenia had a violent offense compared with 17.9% of their unaffected siblings; adjusted OR, 1.8; 95% CI, 1.4-2.4; P<.001 for interaction), suggesting significant familial (genetic or early environmental) confounding of the association between schizophrenia and violence.

CONCLUSIONS:

Schizophrenia was associated with an increased risk of violent crime in this longitudinal study. This association was attenuated by adjustment for substance abuse, suggesting a mediating effect. The role of risk assessment, management, and treatment in individuals with comorbidity needs further examination.

Homicidality in schizophrenia: a replication study.

Am J Orthopsychiatry. 2011 Jan;73(1):74-7.

Homicidality in schizophrenia: a replication study.

Schwartz RC[1], Reynolds CA, Austin JF, Petersen S.

Abstract

This study attempted to replicate the results of R. C. Schwartz, S. Petersen, and J. L. Skaggs (2001) by testing predictors of homicidality in a new sample of participants with schizophrenia. Results of multiple regression analyses showed that manic symptoms and substance abuse were significantly positively correlated with more extreme homicidality. Global Assessment of Functioning scale ratings were significantly negatively correlated with ratings on homicidality. Finally, men displayed significantly heightened homicidality as compared with women. These findings lend support to the hypothesis that clinicians should pay particular attention to evaluating homicidality in patients who are male, have schizophrenia, who abuse substances, who show acute manic symptoms, and whose global functioning has recently declined.

Risk of homicide and major mental disorder: a critical review

Encephale 2009 Dec;35(6):521-30. doi: 10.1016/j.encep.2009.10.009.
Richard-Devantoy S, Olie JP,Gourevitch R

INTRODUCTION:

Tragic and high profile killings by people with mental illness have been used to suggest that the community care model for mental health services has failed. It is also generally thought that schizophrenia predisposes subjects to homicidal behaviour.

OBJECTIVE:

The aim of the present paper was to estimate the rate of mental disorder in people convicted of homicide and to examine the relationship between definitions. We investigated the links between homicide and major mental disorders.

METHODS:

This paper reviews studies on the epidemiology of homicide committed by mentally disordered people, taken from recent international academic literature. The studies included were identified as part of a wider systematic review of the epidemiology of offending combined with mental disorder. The main databases searched were Medline. A comprehensive search was made for studies published since 1990.

RESULTS:

There is an association of homicide with mental disorder, most particularly with certain manifestations of schizophrenia, antisocial personality disorder and drug or alcohol abuse. However, it is not clear why some patients behave violently and others do not. Studies of people convicted of homicide have used different definitions of mental disorder. According to the definition of Hodgins, only 15% of murderers have a major mental disorder (schizophrenia, paranoia, melancholia). Mental disorder increases the risk of homicidal violence by two-fold in men and six-fold in women. Schizophrenia increases the risk of violence by six to 10-fold in men and eight to 10-fold in women. Schizophrenia without alcoholism increased the odds ratio more than seven-fold; schizophrenia with coexisting alcoholism more than 17-fold in men. We wish to emphasize that all patients with schizophrenia should not be considered to be violent, although there are minor subgroups of schizophrenic patients in whom the risk of violence may be remarkably high. According to studies, we estimated that this increase in risk could be associated with a paranoid form of schizophrenia and coexisting substance abuse. The prevalence of schizophrenia in the homicide offenders is around 6%. Despite this, the prevalence of personality disorder or of alcohol abuse/dependence is higher: 10% to 38% respectively. The disorders with the most substantially higher odds ratios were alcohol abuse/dependence and antisocial personality disorder. Antisocial personality disorder increases the risk over 10-fold in men and over 50-fold in women. Affective disorders, anxiety disorders, dysthymia and mental retardation do not elevate the risk. Hence, according to the DMS-IV, 30 to 70% of murderers have a mental disorder of grade I or a personality disorder of grade II. However, many studies have suffered from methodological weaknesses notably since obtaining comprehensive study groups of homicide offenders has been difficult.

CONCLUSIONS:

There is an association of homicide with mental disorder, particularly with certain manifestations of schizophrenia, antisocial personality disorder and drug or alcohol abuse. Most perpetrators with a history of mental disorder were not acutely ill or under mental healthcare at the time of the offence. Homicidal behaviour in a country with a relatively low crime rate appears to be statistically associated with some specific mental disorders, classified according to the DSM-IV-TR classifications.

Comorbid personality disorders and violent behavior in psychotic patients

Psychiatr Q. 2014 Mar;85(1):65-78. doi: 10.1007/s11126-013-9273-3.

Comorbid personality disorders and violent behavior in psychotic patients.

Volavka J.

Schizophrenia without any comorbidity confers a modest, but statistically significant elevation of the risk for violence. That risk is considerably increased by comorbid antisocial personality disorder or psychopathy as well as by comorbid substance use disorders. These comorbidities are frequent. Conduct disorder and conduct disorder symptoms elevate the risk for aggressive behavior in patients with schizophrenia. Violence among adults with schizophrenia may follow at least two distinct pathways-one associated with premorbid conditions, including antisocial conduct, and another associated with the acute psychopathology of schizophrenia. Aggressive behavior in bipolar disorder occurs mainly during manic episodes, but it remains elevated in **euthymic** patients in comparison with controls. The risk of violent behavior is increased by comorbidity with borderlinepersonality disorder, antisocial personality disorder, and substance use disorders. These comorbidities are frequent. Borderline personality disorderand bipolar disorder are related in their phenomenology and response to medication. These two disorders share a tendency to impulsiveness, and impulsive behavior, including impulsive aggression, is particularly expressed when they co-occur.

RIASSUMENDO…

La maggioranza delle persone affette da patologie mentali non commette crimini violenti.

La letteratura internazionale è però sufficientemente orientata nel sostenere un aumentato
rischio per comportamenti violenti legato alla presenza di patologie mentali rispetto alla
popolazione generale (Schizofrenia, Disturbi dell'Umore, Disturbi di Personalità).

I soggetti con disturbi mentali hanno una maggiore probabilità di compiere crimini violenti rispetto alla popolazione generale anche quando non abusano di sostanze; nelle psicosi schizofreniche, tuttavia, il rischio è maggiore se in comorbilità con DPA, psicopatia e abuso di sostanze.

Non è chiaro quanto l'abuso di sostanze abbia effetto aggiuntivo o vi sia anche una interazione che aumenti ulteriormente il rischio di crimine violento.

Non pochi pazienti con grave patologia mentale precedentemente alla commissione di reato non avevano ricevuto adeguato trattamento terapeutico.

Bipolar disorder and violence.

Psychiatr Q. 2001 Summer;72(2):119-29.

Bipolar disorder and violence.

Feldmann TB.

Violent behavior presents many social, legal, and clinical problems. A number of models have been developed to explain violence, representing a variety academic disciplines and theoretical orientations. Unfortunately none of these approaches have led to a comprehensive understanding ofviolence and aggression. The issue of violence is particularly perplexing in connection with the role of psychiatric disorders as contributing factors. Several psychiatric conditions, including bipolar disorder, have been implicated with increased rates of violent behavior. This paper examines various models of violence, influences on violent behavior, and violence associated with psychiatric disorders. Particular attention is devoted to the connection between bipolar disorder and violence.

Characteristics of person with severe mental illness who have been incarcerated for murder.

J Am Acad Psychiatry Law. 2008;36(1):74-86.

Characteristics of persons with severe mental illness who have been incarcerated for murder.

Matejkowski JC, Cullen SW, Solomon PL

Abstract

In this descriptive study, we analyzed data collected from multiple state agencies on 95 persons with severe mental illness who were convicted of murder in Indiana between 1990 and 2002. Subjects were predominantly suffering from a mood disorder, were white and male with a high school education or equivalent, were living in stabilized housing, and, to a lesser degree, were involved in significant intimate and familial relationships. Rage or anger, overwhelmingly directed toward intimate or familial relations by the use of a firearm or sharp object, was the most frequently mentioned motive for murder. Most of those studied had been raised in households with significant family dysfunction, had extensive histories of substance abuse and criminality, and had received little treatment for their mental and substance use disorders. Findings are contextualized and compared with similarly descriptive studies of nonlethal violence and persons with a mental illness; hospitalized, schizophrenic and psychotic murderers; and homicide offenders outside the United States.

Prevalence of involvement in the criminal justice system during severe mania and associated symptomatology.

Psychiatr Serv. 2012 Jan;63(1):33-9. doi: 10.1176/appi.ps.201100174.
Christopher PP, McCabe PJ Fisher WH

OBJECTIVE:

This study sought to determine the prevalence of criminal justice involvement during episodes of mania and to identify whether specific manic symptoms contribute to this risk.

METHODS:

Data from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions, a nationally representative sample of noninstitutionalized U.S. adults (N=43,093), were analyzed to determine the rate of legal involvement (being arrested, held at the police station, or jailed) of individuals with bipolar I disorder during the most severe lifetime manic episode.

RESULTS:

Among the 1,044 respondents (2.5%) who met criteria for having experienced a manic episode, 13.0% reported legal involvement during the most severe manic episode. Unadjusted analyses found legal involvement more likely among those with episode-specific symptoms of increased self-esteem or grandiosity, increased libido, excessive engagement in pleasurable activities with a high risk of painful consequences, having six or more criterion B manic symptoms, and having both social and occupational impairment. The risk was lower among those with hypertalkativeness or pressured speech. When analyses adjusted for other manic symptoms and static variables, males, those with a first episode at age 23 or younger, and persons with mania-associated social indiscretions, excessive spending or reckless driving, and both social and occupational impairment were at greater risk.

CONCLUSIONS:

A large percentage of persons experience legal involvement during a manic episode, and it is associated with specific symptoms of mania. Efforts to reduce such involvement among persons during manic episodes may be enhanced by focusing attention and resources on this high-risk group.

Criminal behaviour and violent crimes in former inpatients with affective disorder.

J Affect Disord. 2009 Sep;117(1-2):98-103. doi: 10.1016/j.jad.2008.12.007. Epub 2009 Jan 24.

Graz C, Etschel E, Schoech H, Soyka M.

BACKGROUND:

Several studies have reported criminal and violent behaviour in people with schizophrenia but few have investigated the association between affective disorders and violent behaviour.

METHODS:

Inserire testo

Were viewed the national crime register for records of criminal offences committed by 1561 patients with affective disorders treated between 1990 and 1995 in the Psychiatric Hospital of the University of Munich. The sample was divided into patients with bipolar I disorder, manicdisorder and major depressive disorder. Sociodemographic and other risk factors for non-violent and violent criminal behaviour were analysed.

RESULTS:

Sixty-five (4.16%) patients had been convicted in the 7 to 12 years after discharge (307 cases). The rate of criminal behaviour and violentcrimes was highest in the manic disorder group: 15.7% (14 of 89) were listed in the national crime register and 5.6% (5 of 89) were convicted of physical injury offences. Violence and criminality were comparatively rare in patients with major depressive disorder: only 1.42% (10 of 702) committed violent crimes. Male gender was a substantial risk factor for non-violent and especially violent behaviour: the rate of violent crimes was six times higher than in females. Marital status appeared to influence the prevalence of later delinquency: separated, divorced and widowed patients committed offences more frequently. A history of substance use problems before clinical treatment was reported by 21.2% (329 of 1561) of the sample. A wide range of different crimes were committed, with defalcation, theft and fraud being the most frequent. Twenty-one cases of physical assault and one case of later homicide were recorded. In contrast to other forensic studies, we did not find a significant effect of substance abuse on the risk of later delinquent behaviour.

CONCLUSION:

The frequency of criminal behaviour and violent crimes in individuals with affective disorder depends on much more than just the diagnosis. This study may stimulate further research to identify psychopathological predictors for future violent and criminal behaviour.

Violence in schizophrenia and bipolar disorder.

Psychiatr Danub. 2013 Mar;25(1):24-33.

Violence in schizophrenia and bipolar disorder.

Volavka J

BACKGROUND:

Although most psychiatric patients are not violent, serious mental illness is associated with increased risk of violent behavior. Most of the evidence available pertains to schizophrenia and bipolar disorder.

METHODS:

MEDLINE data base was searched for articles published between 1966 and November 2012 using the combination of key words 'schizophrenia' or 'bipolar disorder' with 'aggression' or 'violence'. For the treatment searches, generic names were used in combination with key words 'schizophrenia' or 'bipolar disorder' and 'aggression' No language constraint was applied. Only articles dealing with adults were included. The lists of references were searched manually to find additional articles.

RESULTS:

There were statistically significant increases of risk of violence in schizophrenia and in bipolar disorder in comparison with general population. The evidence suggests that the risk of violence is greater in bipolar disorder than in schizophrenia. Most of the violence in bipolar disorderoccurs during the manic phase. The risk of violence in schizophrenia and bipolar disorder is increased by comorbid substance use disorder. Violence among adults with schizophrenia may follow at least two distinct pathways-one associated with antisocial conduct, and another associated with the acute psychopathology of schizophrenia. Clozapine is the most effective treatment of aggressive behavior in schizophrenia. Emerging evidence suggests that olanzapine may be the second line of treatment. Treatment adherence is of key importance. Non-pharmacological methods of treatment of aggression in schizophrenia and bipolar disorder are increasingly important. Cognitive behavioral approaches appear to be effective in cases where pharmacotherapy alone does not suffice.

CONCLUSIONS:

Violent behavior of patients with schizophrenia and bipolar disorder is a public health problem. Pharmacological and non-pharmacological approaches should be used to treat not only violent behavior, but also contributing comorbidities such as substance abuse and personality disorders. Treatment adherence is very important for successful management of violent behavior.

Bipolar disorder and violent crime: a systematic review

Arch Gen Psychiatry.2010 Sep;67(9):931-8. doi: 10.1001/archgenpsychiatry.2010.97.
Fazel S Lichtenstein P, Grann M, Goodwin GM, Långström N

CONTEXT:

Although bipolar disorder is associated with various adverse health outcomes, the relationship with violent crime is uncertain.

OBJECTIVES:

To determine the risk of violent crime in bipolar disorder and to contextualize the findings with a systematic review.

DESIGN:

Longitudinal investigations using general population and unaffected sibling control individuals.

SETTING:

Population-based registers of hospital discharge diagnoses, sociodemographic information, and violent crime in Sweden from January 1, 1973, through December 31, 2004.

PARTICIPANTS:

Individuals with 2 or more discharge diagnoses of bipolar disorder (n = 3743), general population controls (n = 37 429), and unaffected full siblings of individuals with bipolar disorder (n = 4059).

MAIN OUTCOME MEASURE:

Violent crime (actions resulting in convictions for homicide, assault, robbery, arson, any sexual offense, illegal threats, or intimidation).

RESULTS:

During follow-up, 314 individuals with bipolar disorder (8.4%) committed violent crime compared with 1312 general population controls (3.5%) (adjusted odds ratio, 2.3; 95% confidence interval, 2.0-2.6). The risk was mostly confined to patients with substance abuse comorbidity (adjusted odds ratio, 6.4; 95% confidence interval, 5.1-8.1). The risk increase was minimal in patients without substance abuse comorbidity (adjusted odds ratio, 1.3; 95% confidence interval, 1.0-1.5), which was further attenuated when unaffected full siblings of individuals with bipolar disorder were used as controls (1.1; 0.7-1.6). We found no differences in rates of violent crime by clinical subgroups (manic vs depressive or psychotic vs nonpsychotic). The systematic review identified 8 previous studies (n = 6383), with high heterogeneity between studies. Odds ratio for violence risk ranged from 2 to 9.

CONCLUSION:

Although current guidelines for the management of individuals with bipolar disorder do not recommend routine risk assessment for violence, this assertion may need review in patients with comorbid substance abuse

Mania, homicide and severe violence.

Aust N Z J Psychiatry. 2012 Apr;46(4):357-63. doi: 10.1177/0004867411433217. Epub 2012 Jan 5.

Mania, homicide and severe violence.

Nielssen OB, Malhi GS Large MM

BACKGROUND:

Mania has been reported to be a risk factor for aggression and violence in psychiatric hospitals, but the extent of any association between mania and severe interpersonal violence in community settings is not known.

AIM:

To examine the association between mania and severe violence in a series of patients found not guilty by reason of mental illness (NGMI).

METHODS:

A review of the court documents of those found NGMI of offences involving severe violence, including homicide, attempted homicide and assault causing wounding or serious injury, in New South Wales between 1992 and 2008. Results: Twelve of 272 people found NGMI were in a manic state when they committed a severe violence offence. Ten were diagnosed with schizo-affective disorder and two with bipolar disorder. Three patients were in the depressed phase of schizo-affective disorder and there were no patients in the depressed phase of bipolar disorder.

CONCLUSION:

Mania, in particular the manic phase of bipolar disorder, is not strongly associated with severe violence.

Homicide is strongly correlated to depression and not to mania

Encephale. 1992 Jan;18 Spec No 1:89-90.

Homicide is strongly correlated to depression and not to mania

Bénézech M[1], Bourgeois M.

Abstract

Typical manic episodes could be the cause of penal infractions, usually benign. In contrast, forensic studies show a close relationship betweendepression, suicide and homicide. Killers (16-28%) are often depressed when they commit a crime. In the UK and USA, 4-35% of killers commit suicide immediately after their crime. Assessment of a depressed patient must include an evaluation of the risk of homicide as well as the risk of suicide. The past history of depression and suicidal attempts, the presence of depressive symptoms and suicidal ideas, are good predictors of impending danger of aggression and sometimes of homicide.

Homicide and bipolar I disorder: a 22-years study

Forensic Sci Int. 2012 Apr 10;217(1-3):113-8. doi: 10.1016/j.forsciint.2011.10.037. Epub 2011 Nov 16.

Homicide and bipolar I disorder: a 22-year study.

Yoon JH, Kim JH Choi SS Lyu MK Kwon JH Jang YI Park GT

BACKGROUND:

Non-serious offenses in manic phase have been mainly studied in patients with bipolar disorder. However, some authors reported that depressive phase is related with the violent and homicidal manifestations of bipolar disorder.

AIMS:

We investigated the characteristics of homicide by the polarity of mood episode in patients with bipolar I disorder.

METHODS:

Among the offenders who were sentenced to undergo treatment at the National Institute of Forensic Psychiatry from October 1987 to January 2008, a total 219 offenders whose final diagnoses were bipolar I disorder based on DSM-III-R and DSM-IV were selected. Retrospective medical chart review was performed for characteristics of mood episodes. Descriptions of offenders were supplemented by review of the written records of the police or prosecutors.

RESULTS:

The general rate of total offense was higher in the manic phase than in the depressive phase (86.8% vs. 13.2%). However, the rate of homicide was higher in the depressive phase than in the manic phase. The victims of homicide were more likely to be family members of the patients in depressive phase than in manic phases (96.2% vs. 63.9%, $p=0.001$). However, parricide was committed only in manic phases. Altruistic motivation of homicide was significantly higher in depressive phase (34.6% vs. 0%, $p<0.001$) whereas impulsivity was the most common one in manic phases.

CONCLUSIONS:

The risk of offenses, particularly homicide for family members, should not be overlooked in the depressive phases of bipolar I disorder

RIASSUMENDO…

Non è chiara la relazione tra crimini violenti e Disturbo Bipolare.

1. Gli episodi maniacali misti o ipomaniacali non sono risultati significativamente associati ad un aumentato rischio per comportamenti violenti rispetto agli episodi depressivi.

2. Gli episodi maniacali con abuso di sostanze non sono risultati significativamente associati ad un aumento del rischio per comportamenti violenti se confrontati con gli episodi depressivi e abuso di sostanze.

3. Gli studi forensi evidenziano frequentemente la stretta relazione tra depressione-omicidio-suicidio; più di recente, anche gli studi più squisitamente clinici, mostrano una correlazione statisticamente significativa tra fasi eutimiche o depressive e comportamento violento.

ANALISI DEL CAMPIONE

SONO STATI RECLUTATI 34 DETENUTI DALL'INIZIO DI DICEMBRE 2013 DI ETA'COMPRESA TRA 24 E I 61 ANNI.

TUTTI IN TRATTAMENTO PSICOFARMACOLOGICO.

CRITERI DI INCLUSIONE

CRITERI DI ESCLUSIONE

ANALISI DEL CAMPIONE

CRITERI DI INCLUSIONE

1. I DETENUTI CON DIAGNOSI DOCUMENTATA DI PATOLOGIA PSICHIATRICA

2. I DETENUTI CONOSCIUTI DAI SERVIZI TERRITORIALI CSM

3. I DETENUTI CONOSCIUTI DAI SERVIZI TERRITORIALI SERD IN COMORBILITA' CON PATOLOGIA PSICHIATRICA

4.I DETENUTI CONOSCIUTI DA ENTRAMBI I SERVIZI

ANALISI DEL CAMPIONE

CRITERI DI INCLUSIONE

5. I DETENUTI OGGETTO DI RICOVERI VOLONTARI PRESSO STRUTTURA PUBBLICA O PRIVATA O IN REGIME DI TSO

6. I DETENUTI PRECEDENTEMENTE INTERNATI

7. I DETENUTI OGGETTO APPL. ART112 DPR 230/2000

8. I DETENUTI CON SOPRAVVENUTA PATOLOGIA MENTALE

ANALISI DEL CAMPIONE

CRITERI DI ESCLUSIONE

1. I DETENUTI PROVENIENTI DA ALTRO ISTITUTO IN TRATTAMENTO PSICOFARMACOLOGICO IN ASSENZA DI ANAMNESI PSICHIATRICA E NON CONOSCIUTI DAI SERVIZI TERRITORIALI

2. I DETENUTI CON PROBLEMATICHE DI CONDOTTE CRIMINALI

ANALISI DEL CAMPIONE

3. I DETENUTI CON DIGNOSI PRINCIPALE DI TOSSICODIPENDENZA

4. I DETENUTI OGGETTO DI COMPORTAMENTI STRUMENTALI ESTERIORI DI MINACCIA E DI VIOLENZA

5. DETENUTI IN STATO DI DISAGIO INTRACARCERARIO (sciopero della fame, autolesionismo funzionale, sottoposti a commissione disciplinare, sottoposti a disposizioni di sorveglianza non sanitaria, tradotti per ragioni di ordine e sicurezza….)

ANALISI DEL CAMPIONE

FONTI INFORMATIVE:

EQUIPE SANITARIA
CARTELLA CLINICA
CSM
SERD
DAP
PAZIENTE

SCALE DI VALUTAZIONE

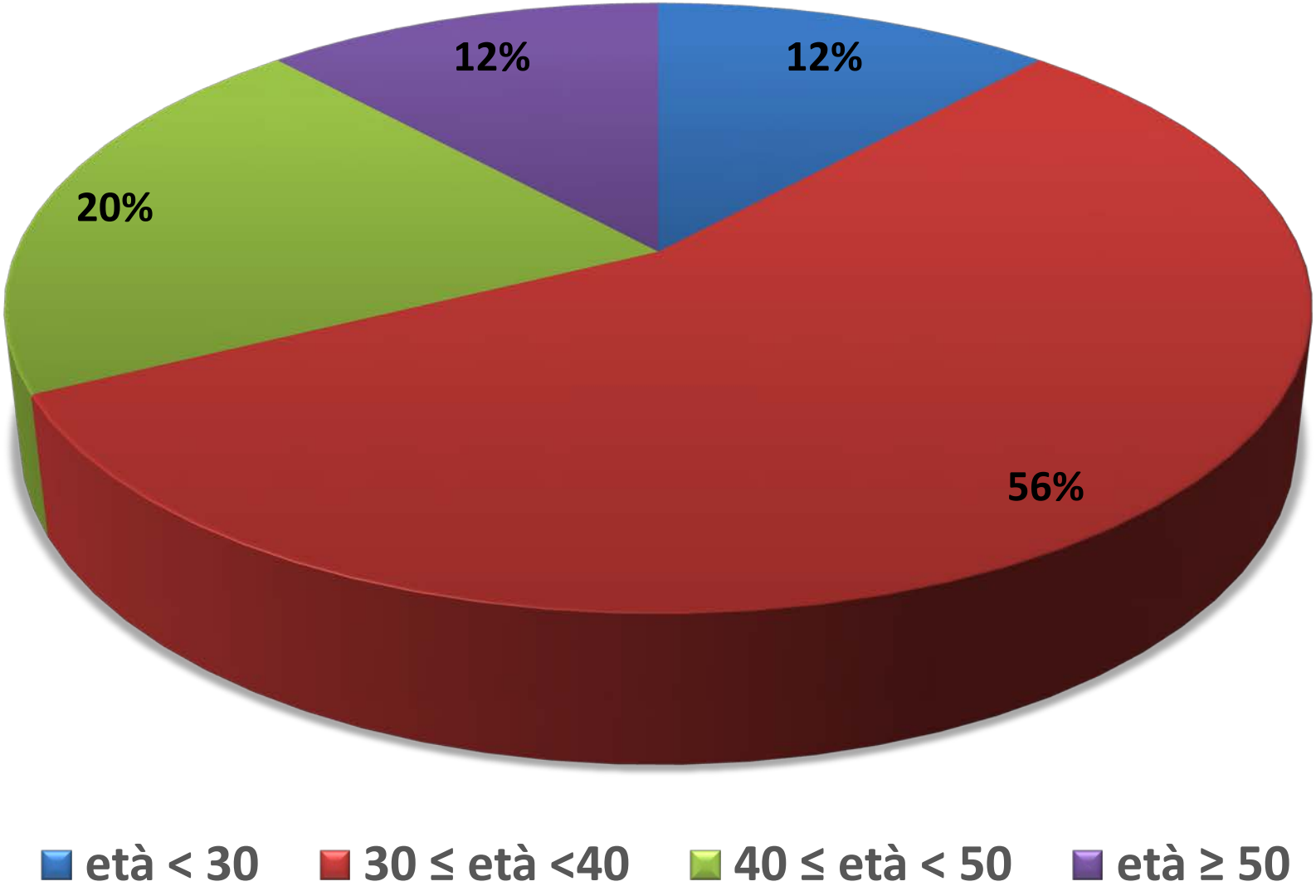
SONO STATE SOMMINISTRATE LE SEGUENTI SCALE AL BASELINE E DOPO 30 GIORNI:

BPRS

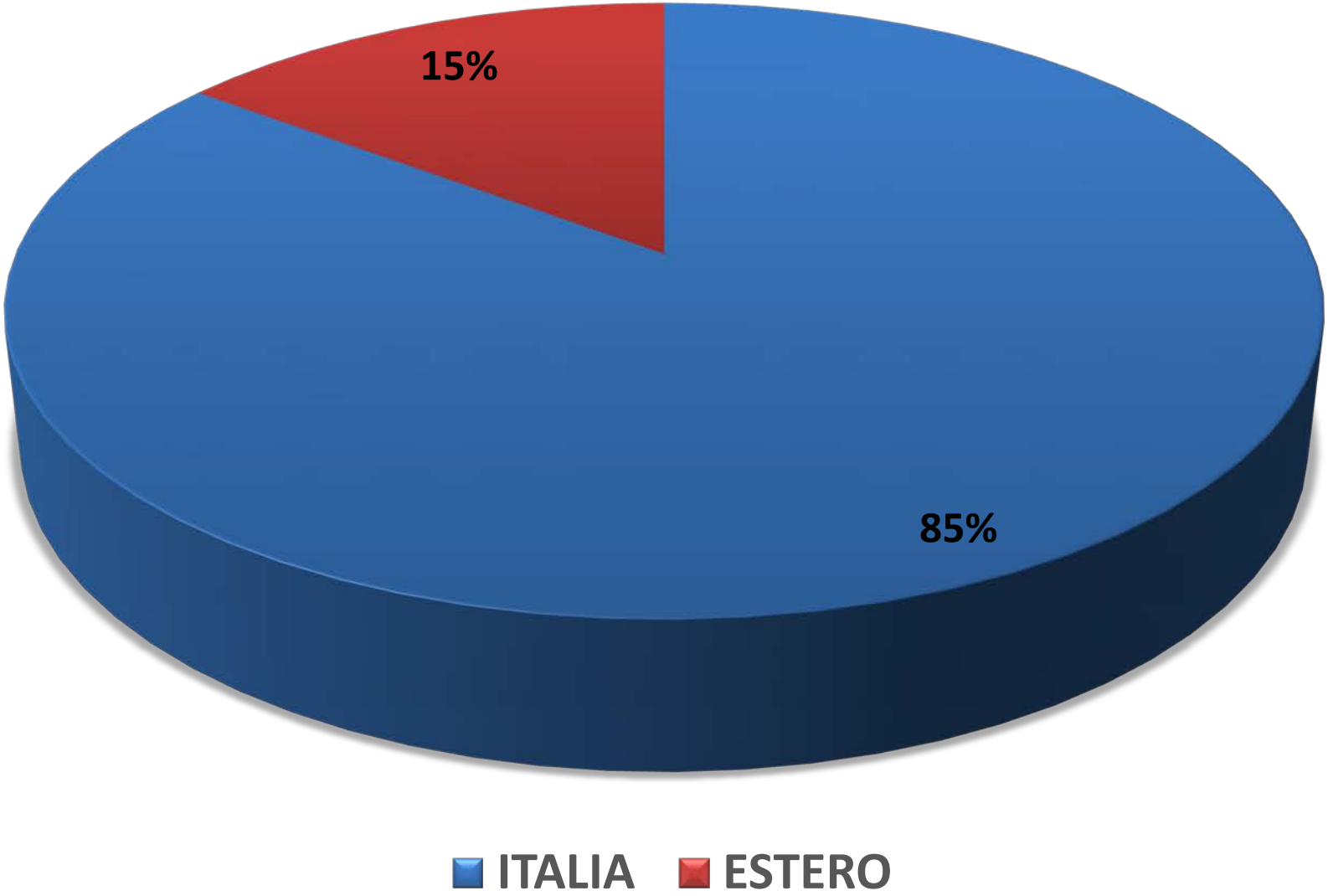
MOAS

HAM-A

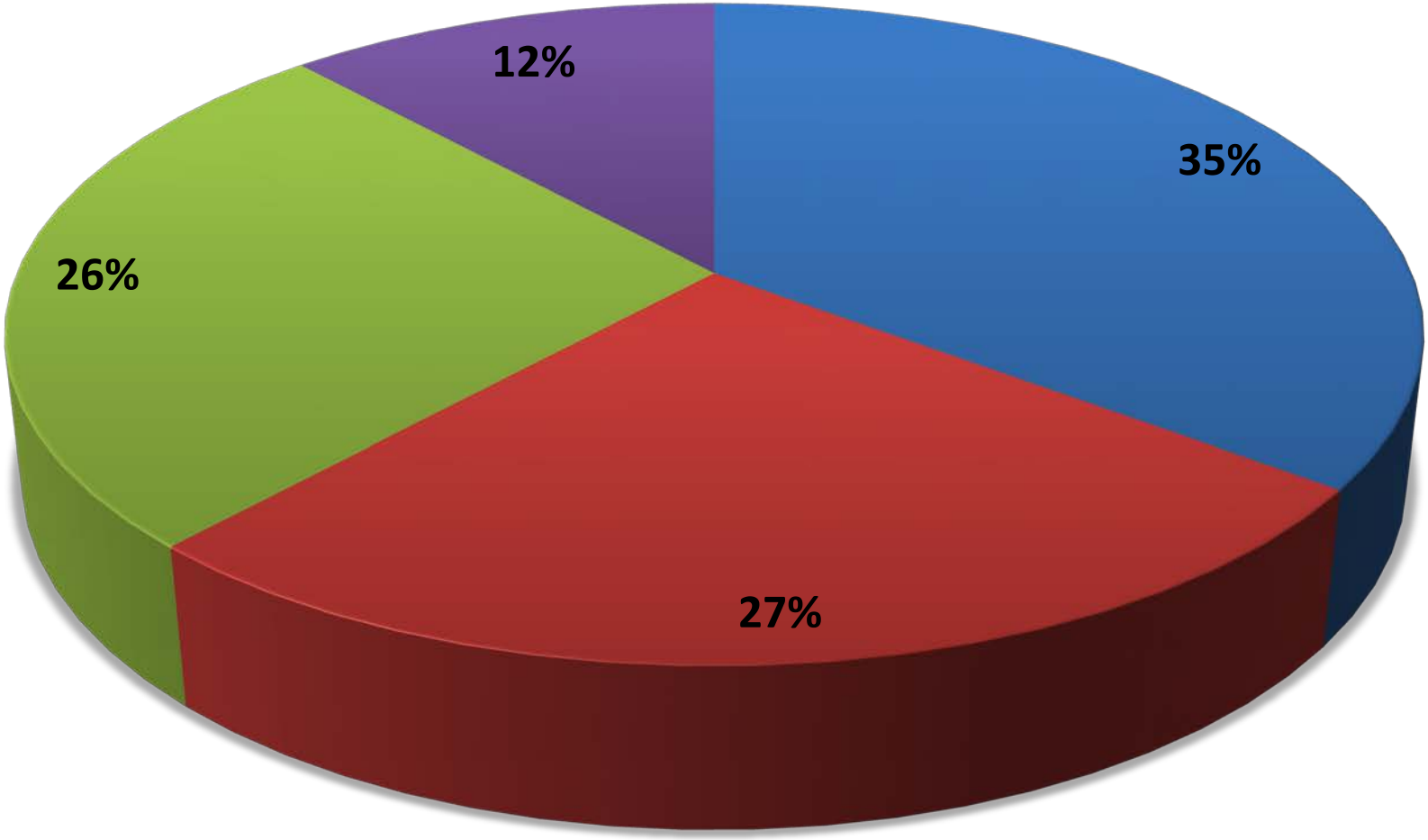
Distribuzione dei pazienti per fascia d'età



Distribuzione dei pazienti per nazionalità

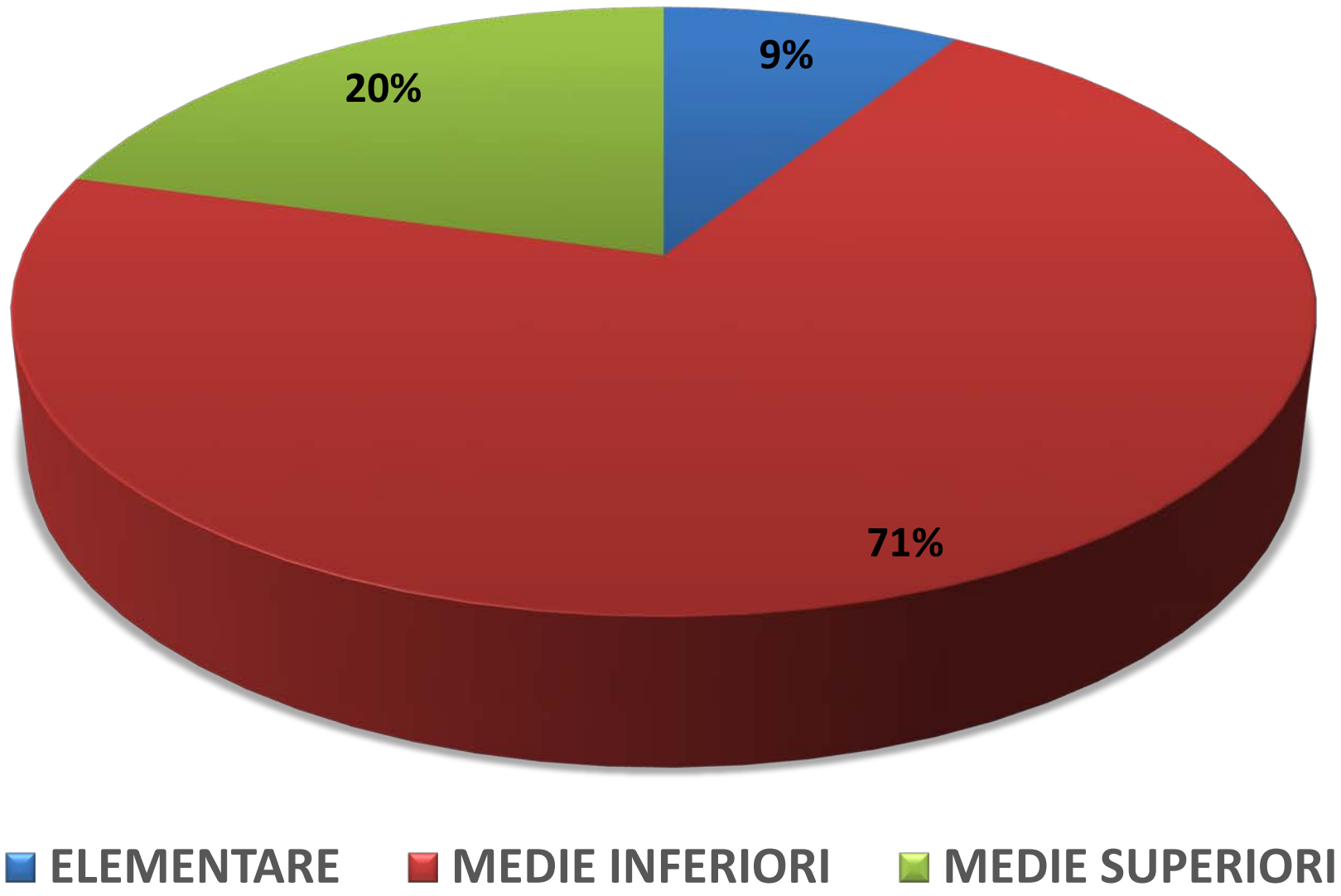


Distribuzione dei pazienti per stato civile

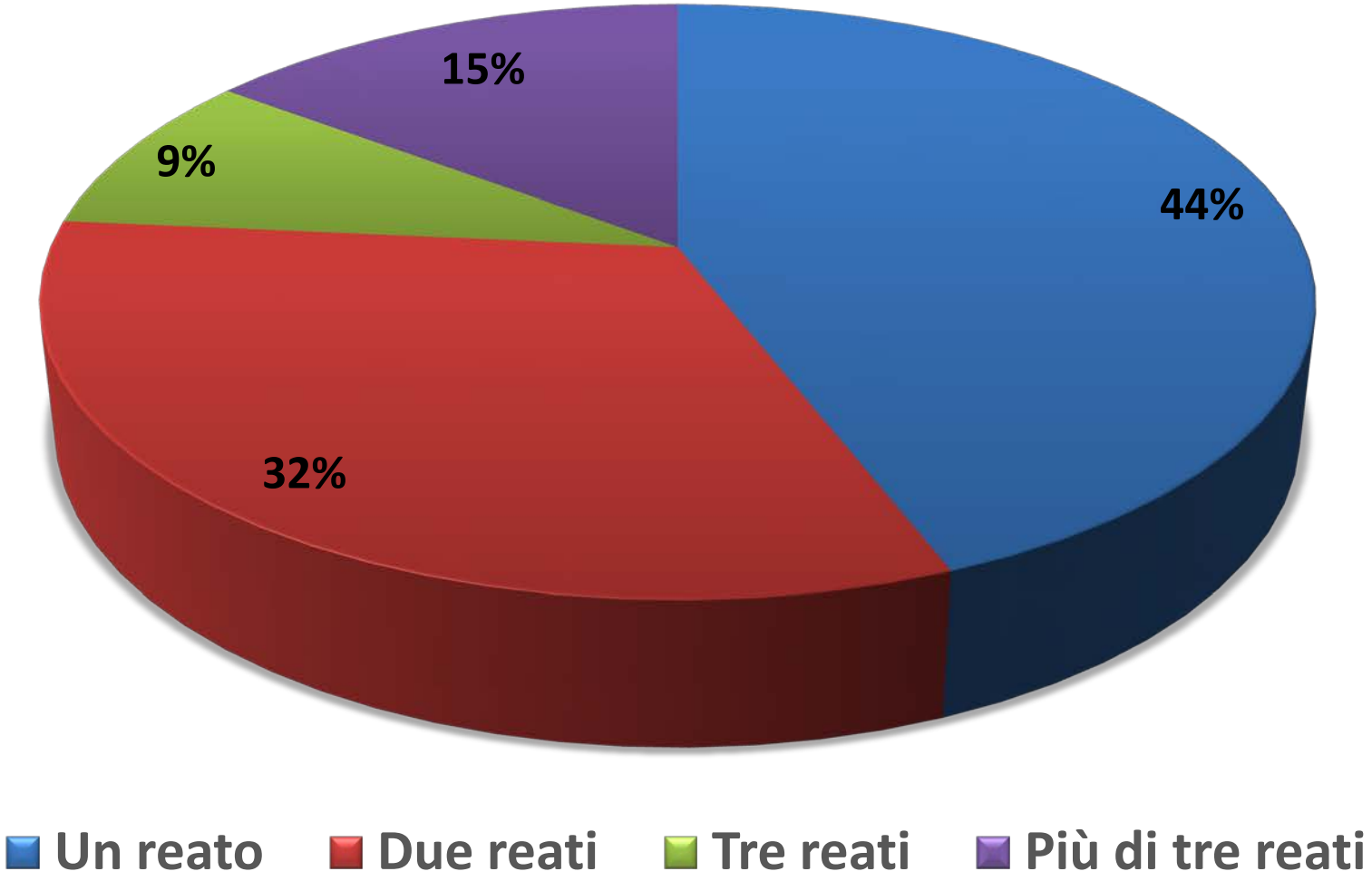


CELIBE CONIUGATO SEPARATO CONVIVENTE

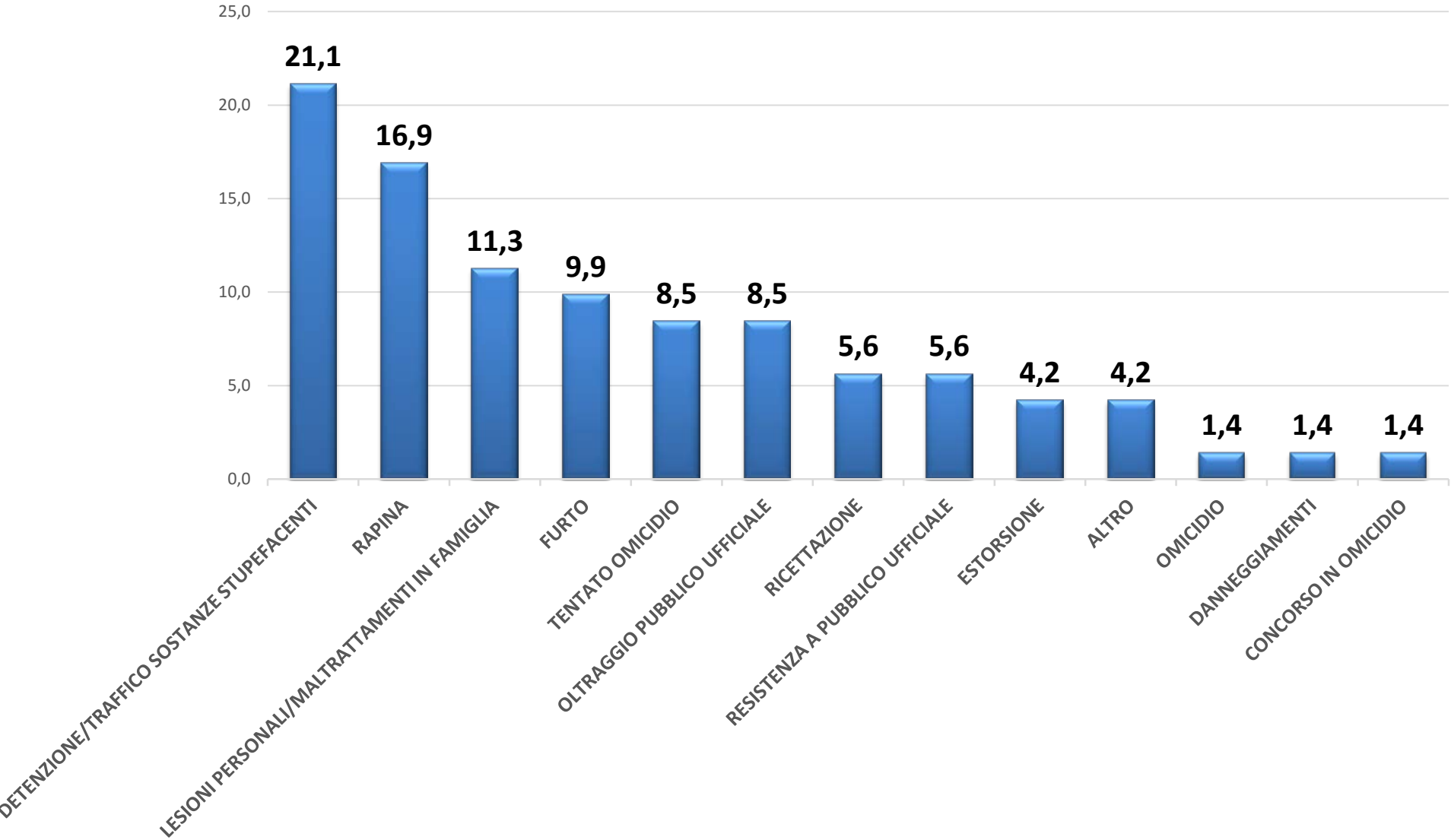
Distribuzione dei pazienti per scolarità



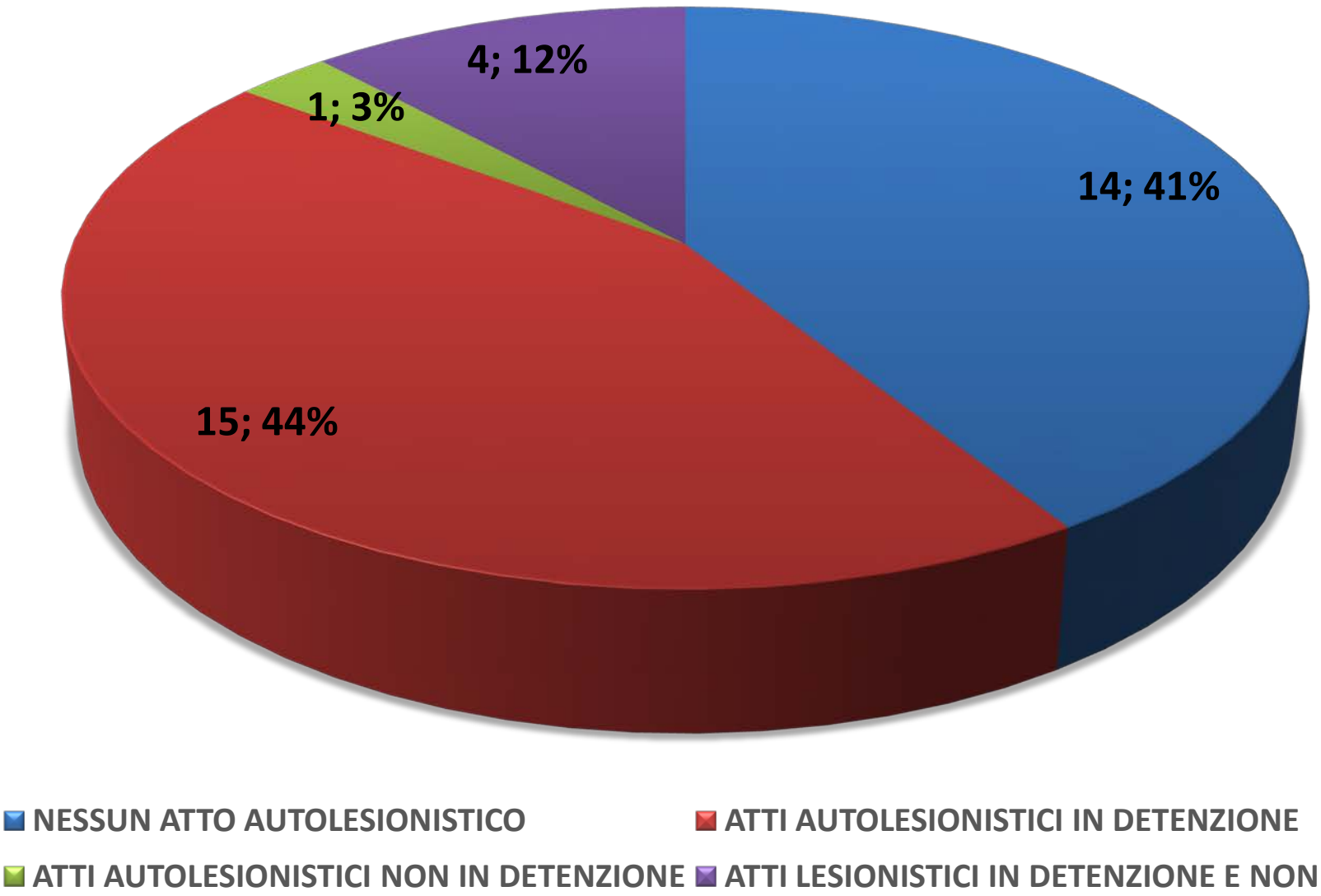
Distribuzione dei pazienti per numero di reati commessi



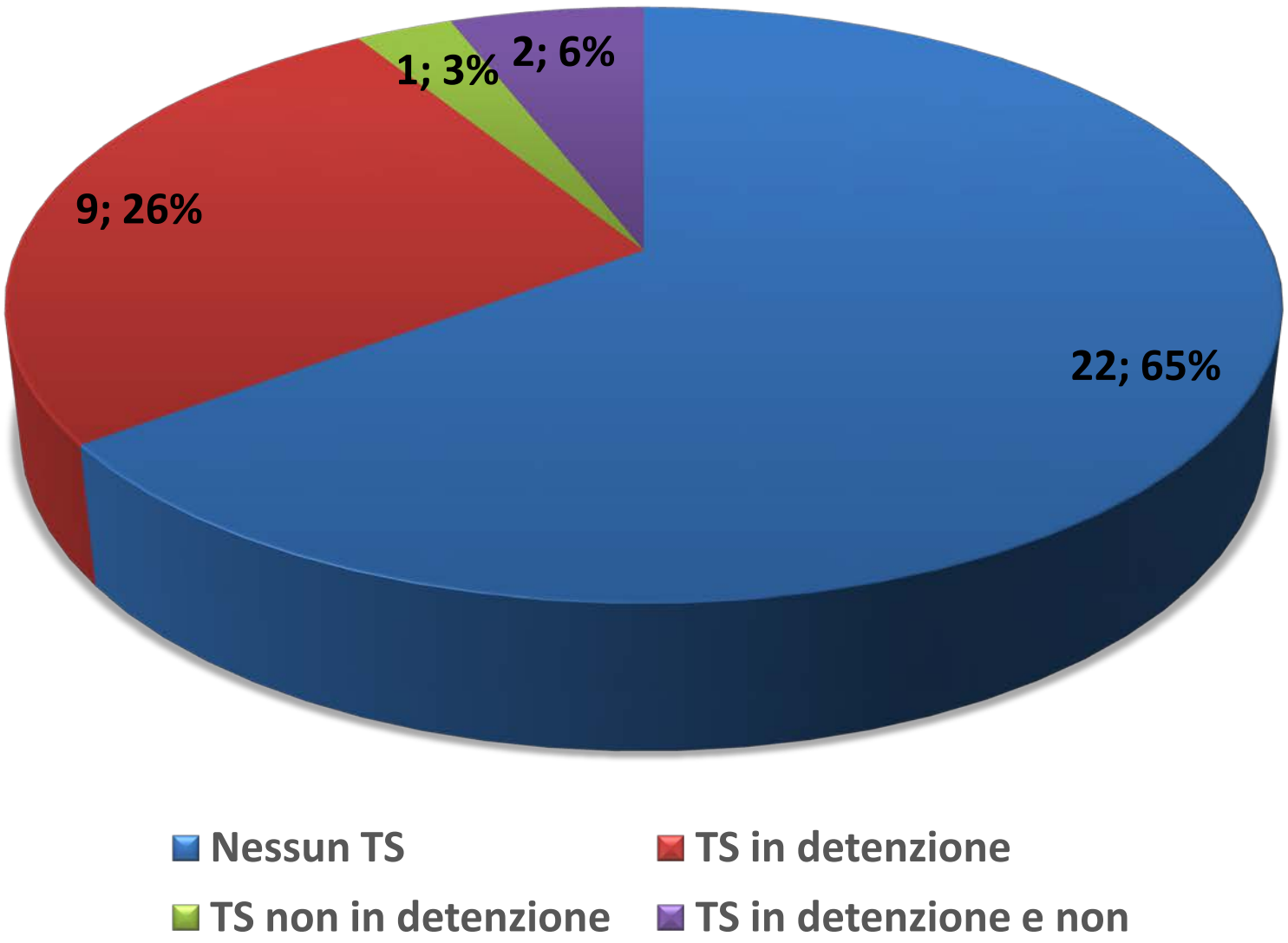
Reati commessi

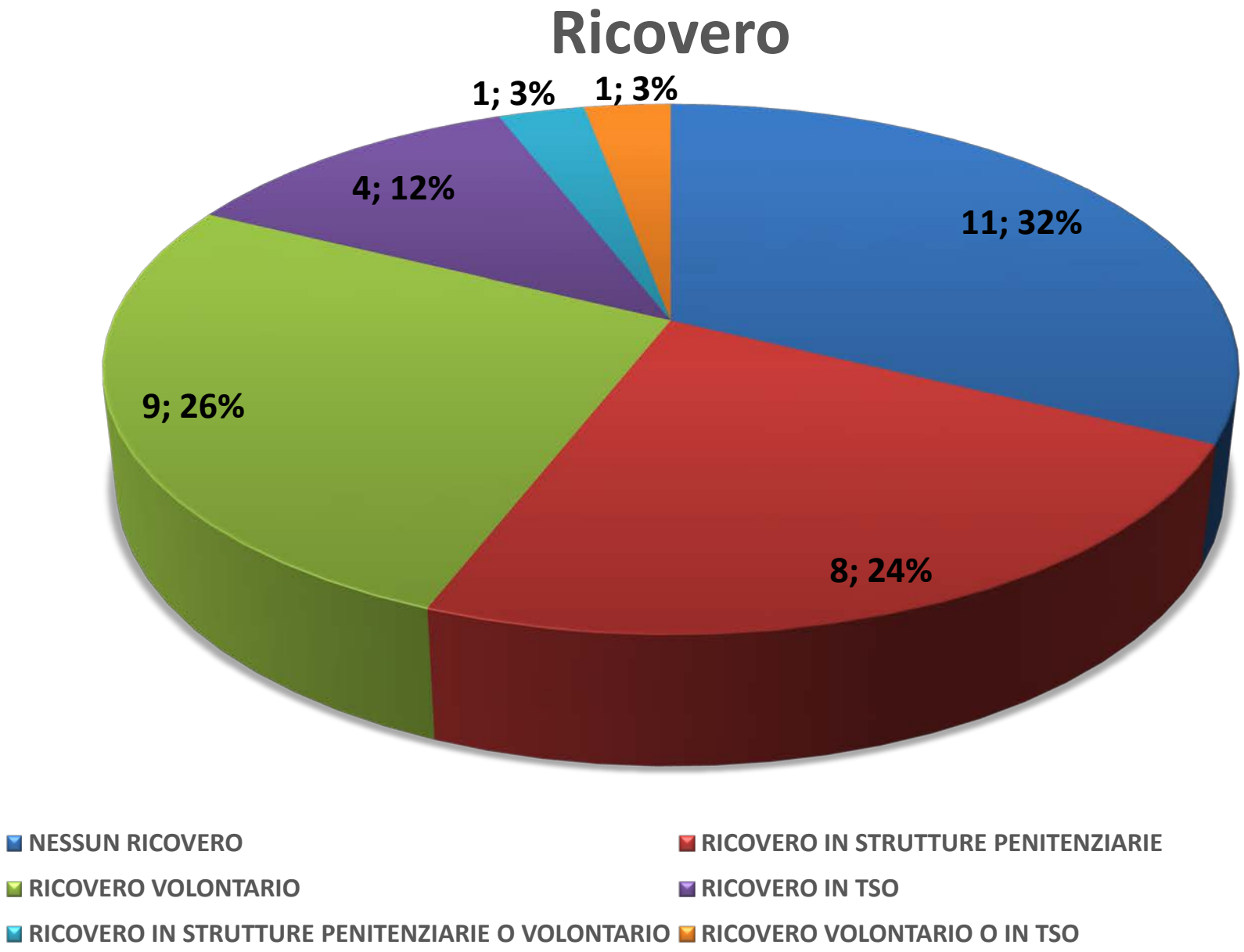


Autolesionismo

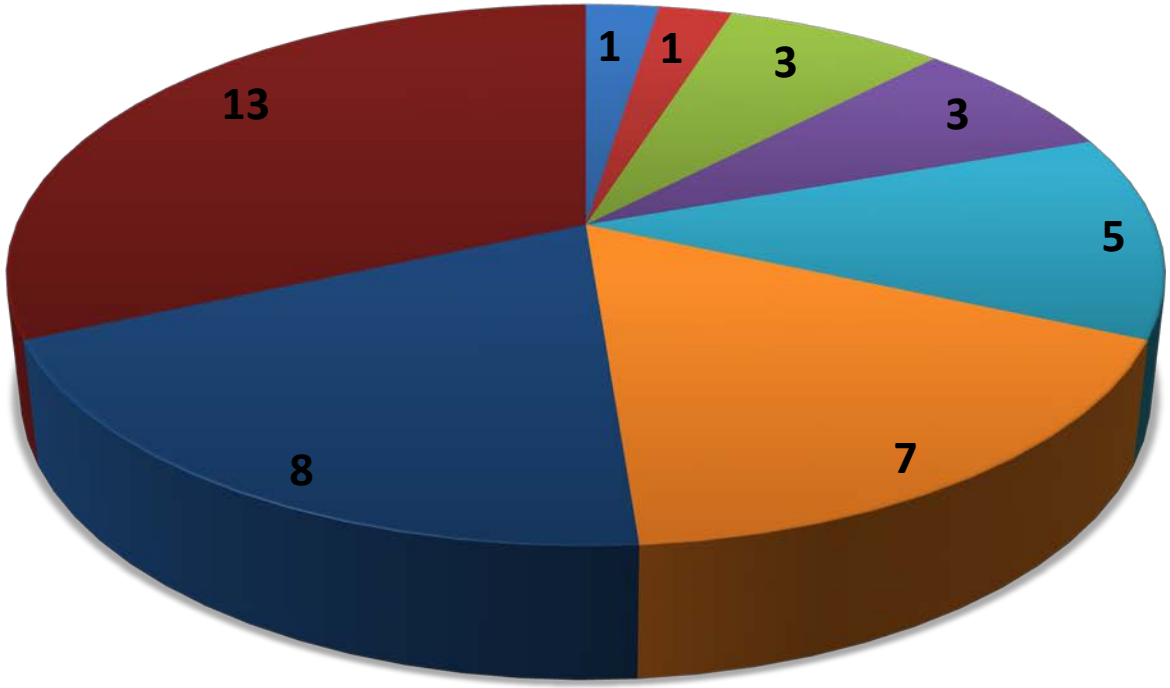


Tentativi di Suicidio (TS)

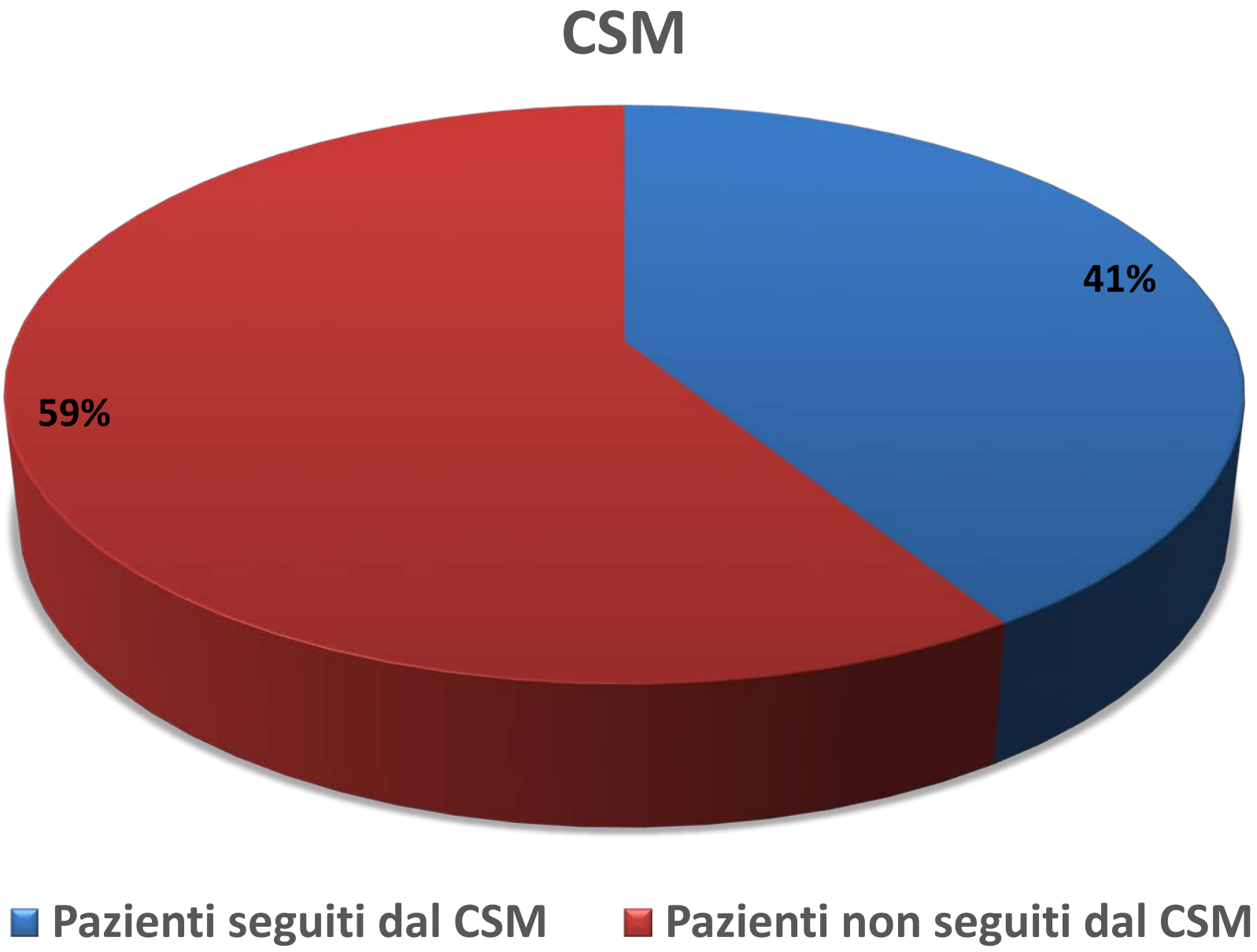


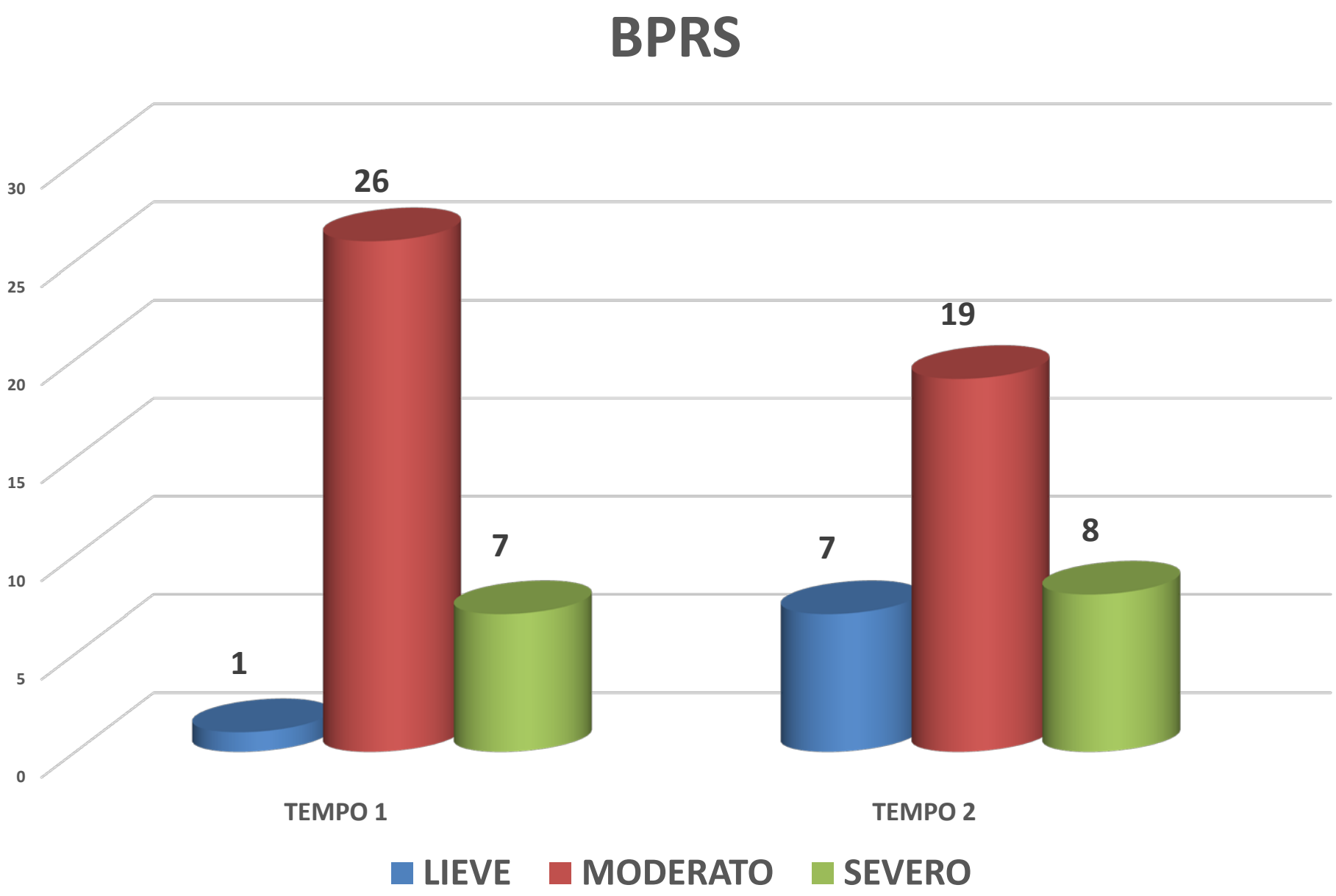

Ricovero
1; 3%
1; 3%
4; 12%
11; 32%
9; 26%
8; 24%
NESSUN RICOVERO
RICOVERO IN STRUTTURE PENITENZIARIE
RICOVERO VOLONTARIO
RICOVERO IN TSO
RICOVERO IN STRUTTURE PENITENZIARIE O VOLONTARIO
RICOVERO VOLONTARIO O IN TSO

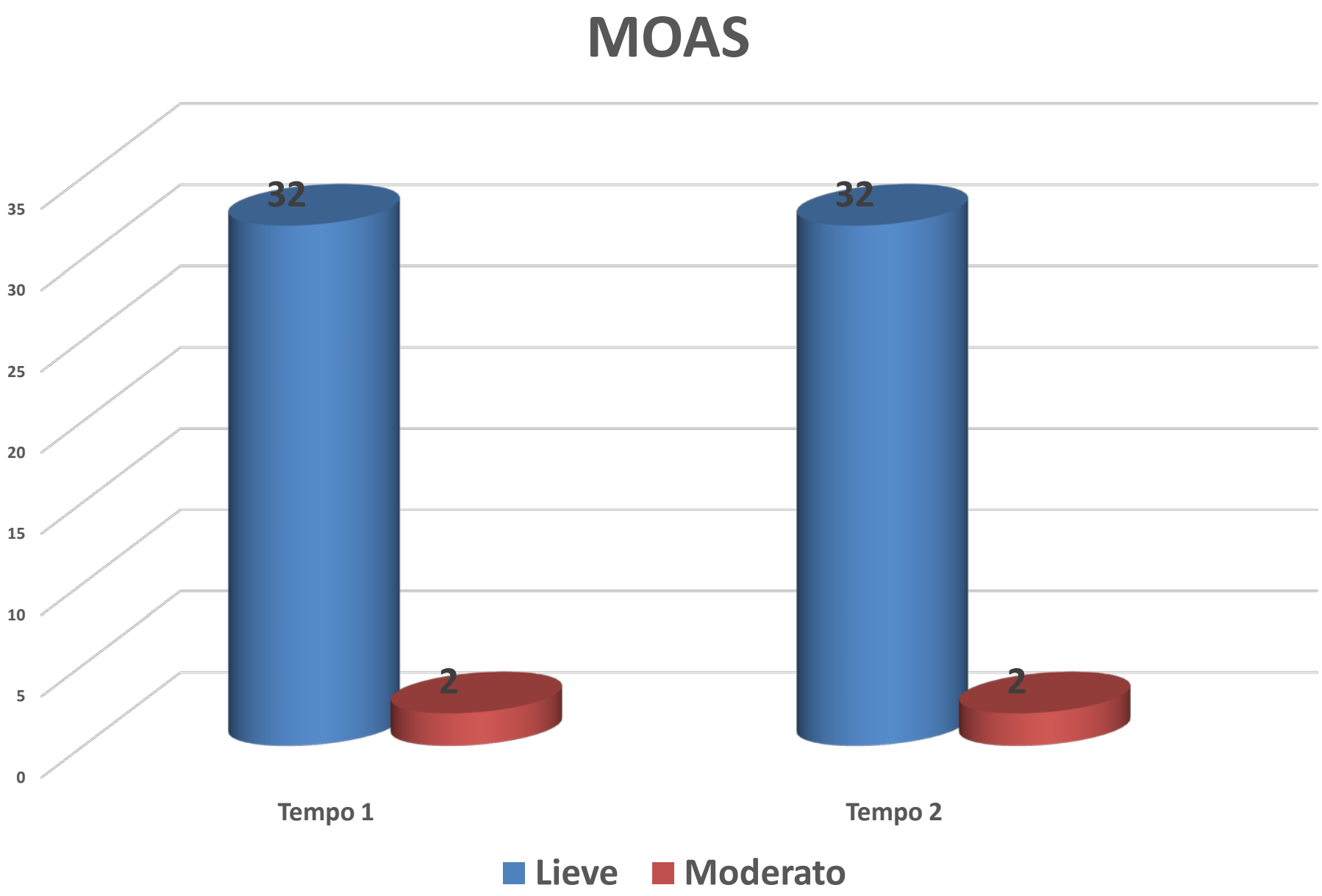
Diagnosi

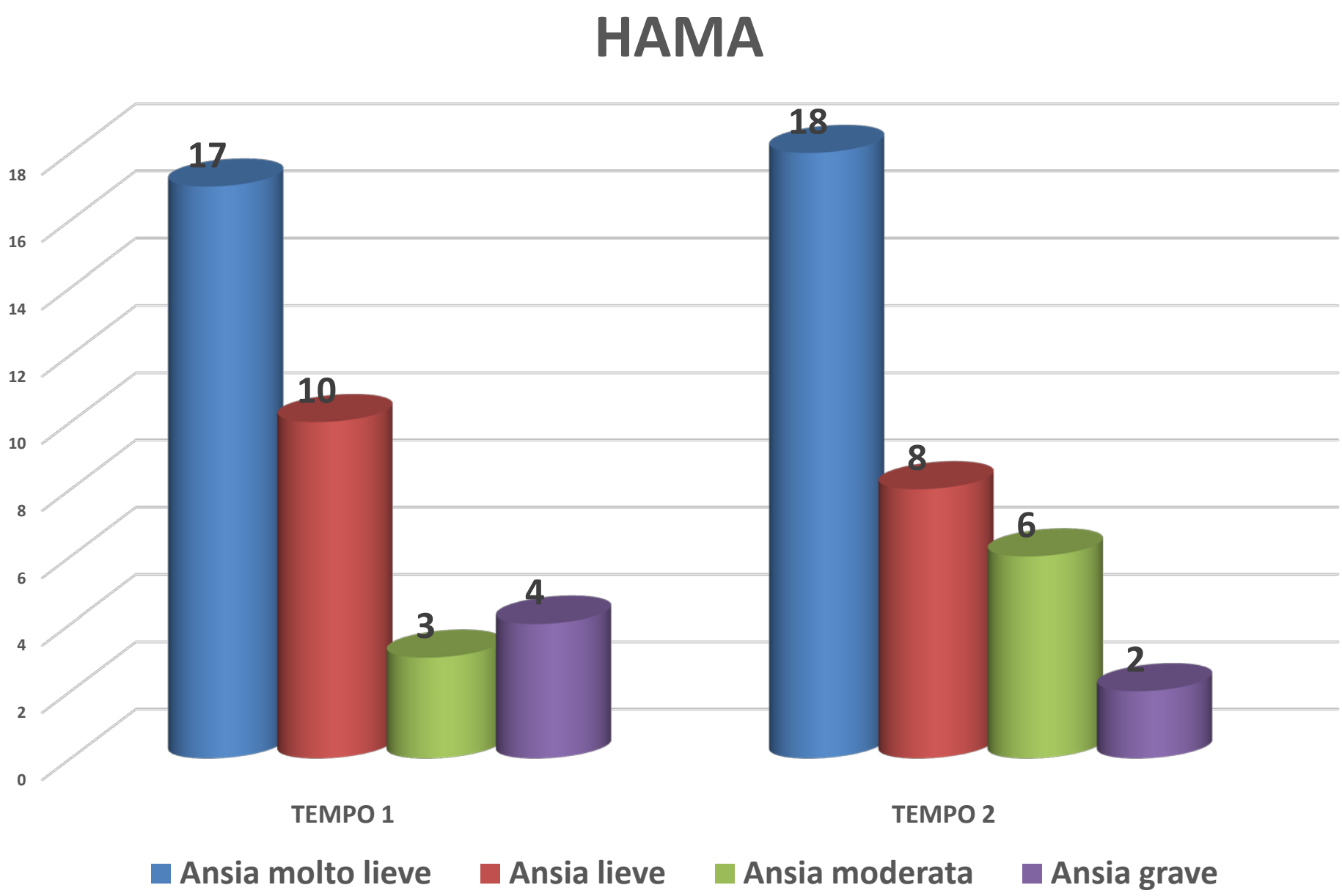


- RITARDO MENTALE LIEVE
- DISTURBO PARANOIDE DI PERSONALITA'
- PSICOSI SHIZOFRENICHE
- DISTURBO DEPRESSIVO
- PSICOSI AFFETTIVE
- DISTURBO DELL'ADATTAMENTO DEPRESSIVO
- DISTURBO DI PERSONALITA' BORDERLINE
- DISTURBO DI PERSONALITA' ANTISOCIALE

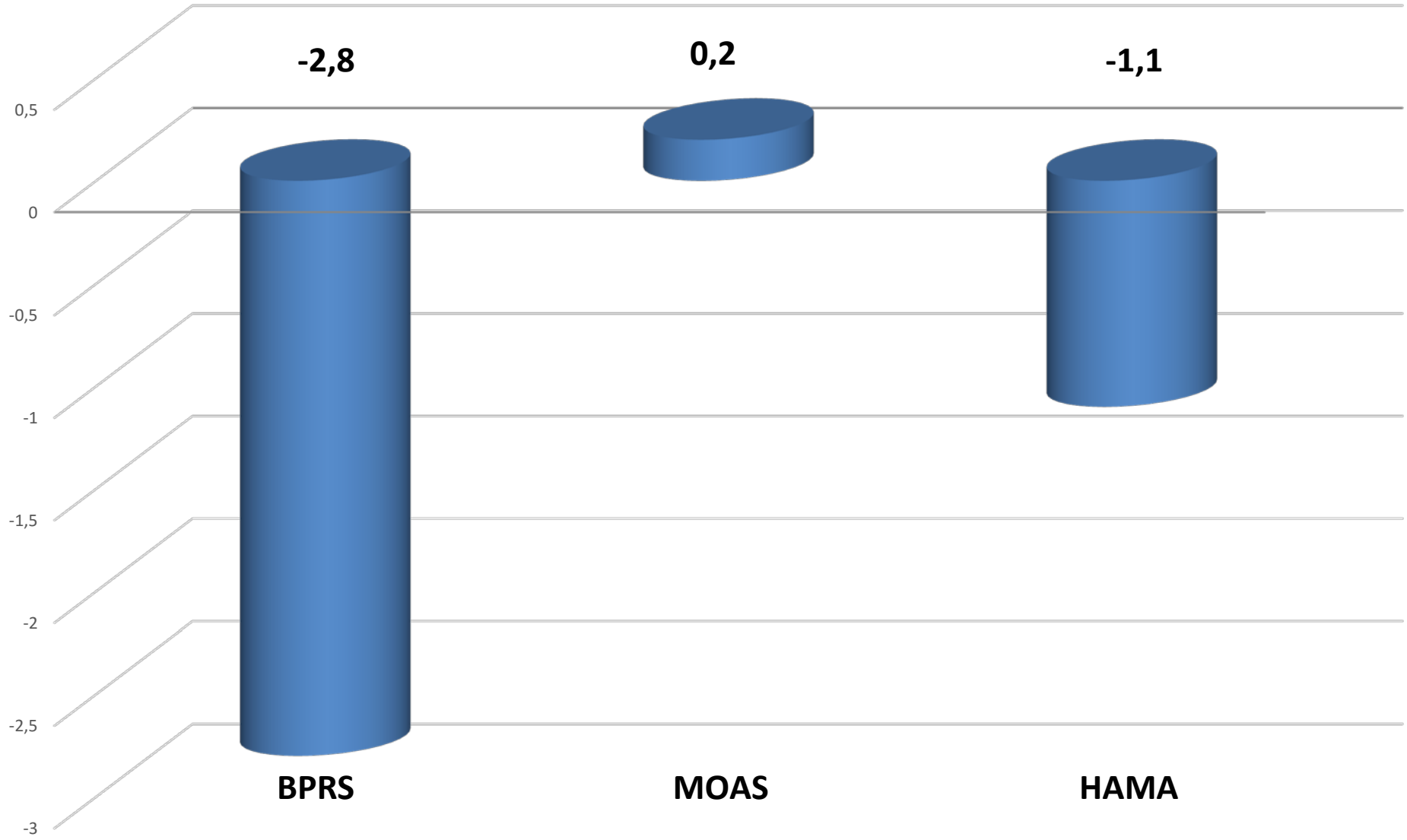

CSM
41%
59%
Pazienti seguiti dal CSM
Pazienti non seguiti dal CSM


BPRS
30
25
20
15
10
5
0
26
19
7
7
8
1
TEMPO 1
TEMPO 2
LIEVE
MODERATO
SEVERO

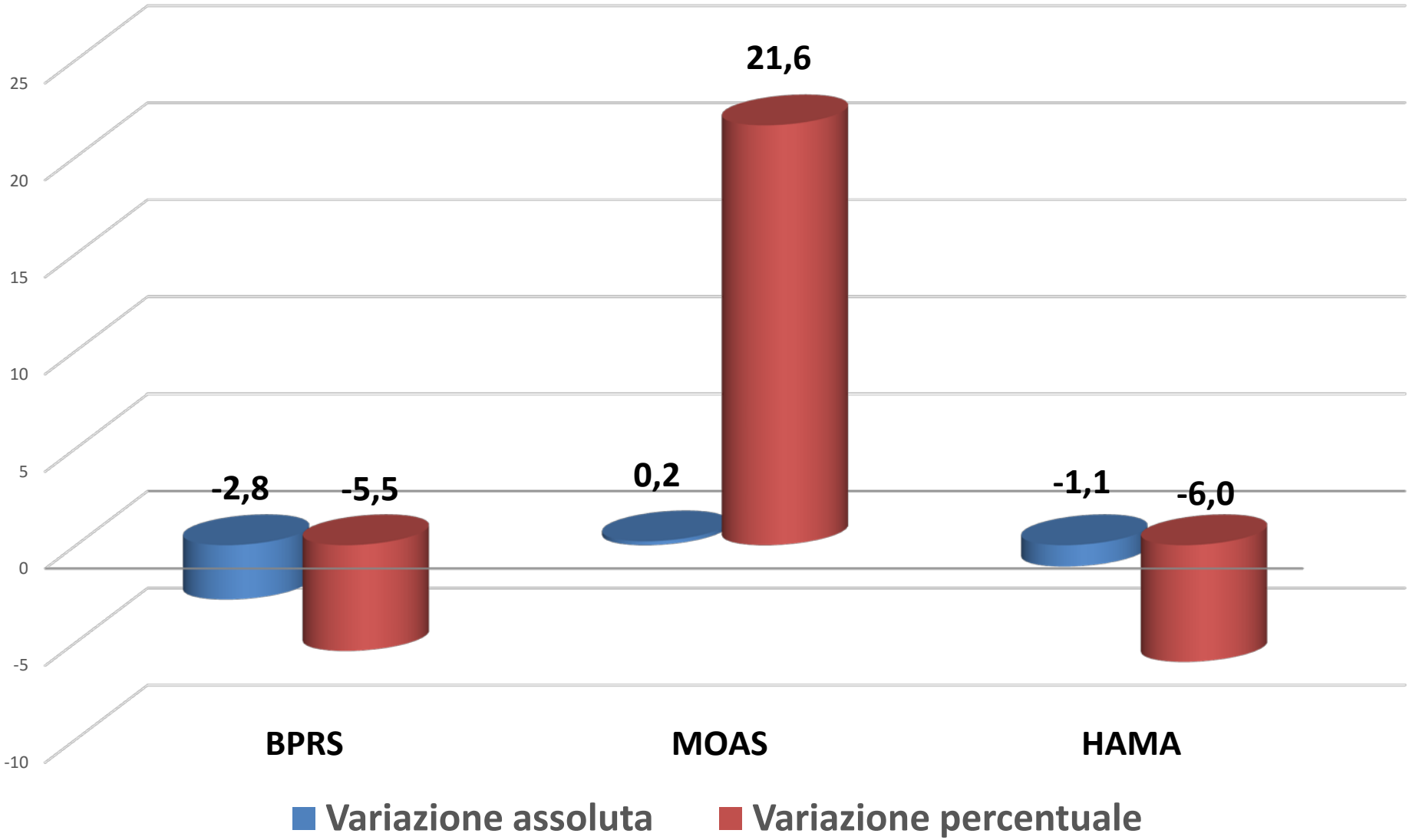

MOAS
35
30
25
20
15
10
5
0
32
2
32
2
Tempo 1
Tempo 2
Lieve
Moderato


HAMA
18
16
14
12
10
8
6
4
2
0
17
10
3
4
18
8
6
2
TEMPO 1
TEMPO 2
Ansia molto lieve
Ansia lieve
Ansia moderata
Ansia grave

Variazione degli indici dal tempo 1 al tempo 2



Variazione degli indici dal tempo 1 al tempo 2



….Un po’ di chiarezza

CONCLUSIONI

Dei 71 detenuti «intercettati» come pazienti psichiatrici sui 640 totali ne sono stati valutati 34: è quindi difficile valutare lo stato della salute mentale in questa popolazione detenuta osservata.

L'analisi preliminare dei dati indica un generale miglioramento rispetto alla BPRS e alla HAMA ma non riscontrabile nella MOAS. L'aggressività media dei pazienti tende a salire passando da T1 a T2 (+0.2%)

CONCLUSIONI

E’ ragionevole ipotizzare che punteggi aumentati alla MOAS al T2 possano dipendere da variabili esterne quali:

Caratteristiche dell’ambiente restrittivo

Rapporto tra interventi di area Sanitaria e area Trattamentale

Posizione giuridica del detenuto

Garanzia di accessibilità a tutti i trattamenti

Criteri per l’ inserimento lavorativo interno all’Istituto

CONCLUSIONI

...Tornando a noi

Al momento, non ci sono, programmi di cura dedicati, validati dalla letteratura internazionale che possano intervenire nello specifico sui comportamenti violenti dei pazienti psichiatrici in ambiente penitenziario.

Il 59% dei ristretti presso la C.C. di Velletri, non ha mai ricevuto idoneo trattamento prima della commissione del reato.

Carcere di Velletri
Detenuti produttori di vino. ***Corriere della Sera, 16-04-2004***

«Fuggiasco» o «Sette Mandate»: il vino dei carcerati al supermarket

I vini del carcere di Velletri arrivano al supermercato. Da oggi le etichette «Quarto di luna», «Le sette mandate» e **VELLETRI**

«Fuggiasco» o «Sette Mandate»: il vino dei carcerati al supermarket

I vini del carcere di Velletri arrivano al supermercato. Da oggi le etichette «Quarto di luna», «Le sette mandate» e «Fuggiasco» sono sugli scaffali delle Coop di Lazio e Toscana. Arrivano dunque al grande pubblico i vini frutto di un progetto di recupero sociale e reinserimento lavorativo. Le nuove etichette sono state presentate al Vinitaly di Verona da Giuseppe Makovec, direttore della Casa Circondariale. I nomi sono volutamente autoironici: si tratta di vini prodotti da una cooperativa d i detenuti di Velletri (Cooperativa Lazzaria), i primi autorizzati a portare sull' etichetta il sigillo della Repubblica Italiana. Ieri l' iniziativa è stata annunciata alla presenza dell' enologo Marcello Bizzoni (foto). I VINI DEI CARCERATI nei supermercati della Coop da oggi.

Corriere della Sera 16-04-2004