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Mental Health, Social and Cultural Welfare in the Post COVID-19 Era: Challenges, Opportunities, and Paradigm Shift

Guest Editors:

Dr. Emanuele Caroppo

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Prof. Dr. Alessandra Sannella

Deadline for manuscript submissions:
closed (30 June 2023)

Message from the Guest Editors

The tragic COVID-19 syndemic is destined to profoundly change health systems globally. Additionally, in mental health, the value of territorial and proximity public health, capable of multidisciplinary interventions centered on the concept of “budget of health”, recovery, and supported housing as overcoming long-term care structures, has further emerged. Growing demands for mental health, urgent social protection, and better public health systems have posed critical challenges in both economic and service delivery capacities. This Special Issue aims to collect papers capable of accurately analysing the current situation and offering useful tools to policy makers to imagine and redesign the future of health policies in terms of mental health, cultural, and social welfare. We welcome studies, reviews, or further articles on all aspects related to topic.

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Special Issue

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Editor-in-Chief

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Message from the Editor-in-Chief

Addressing the environmental and public health challenges requires engagement and collaboration among clinicians and public health researchers. Discovery and advances in this research field play a critical role in providing a scientific basis for decision-making toward control and prevention of human diseases, especially the illnesses that are induced from environmental exposure to health hazards. *IJERPH* provides a forum for discussion of discoveries and knowledge in these multidisciplinary fields. Please consider publishing your research in this high quality, peer-reviewed, open access journal.

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Article

1000 Days: The "WeCare Generation" Program—The Ultimate Model for Improving Human Mental Health and Economics: The Study Protocol

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Abstract: Introduction: The COVID-19 pandemic stressed the necessity of a new resilience of the human population and health system. The "WeCare Generation" program is a new proposal of territorial intervention, with a new paradigm, on the diseases of the human body and mind. Background: In recent decades, the independent strands of investigation on brain plasticity and early trauma consequences have demonstrated that traumatic experiences in the period from pregnancy to the age of 3 years have an enormous impact on an individual's future development, and both physical and mental health. Research shows that adverse child experiences (ACEs) are associated with a strong risk of conditions such as: harmful alcohol use, smoking, illicit drug use, high body-mass index, depression, anxiety, interpersonal violence, cancer, type 2 diabetes, cardiovascular diseases, stroke respiratory diseases and, as a consequence, to a high financial cost in Italy and also across Europe (1–9% GDP) and the USA (total annual costs estimated to be USD 581 billion in Europe and USD 748 billion in North America). All this suggests that an early intervention on that traumatized-slice of population leads to multiplied savings. Methods: A multi-center, randomized, controlled trial was designed. The parents of the future neonatal population (from pregnancy to delivery) with trauma will be enrolled, and randomized to treatment, or control arm. The article describes in detail how the primary outpoint (cost to the national health system), and some secondary outpoints, will be collected. Discussion: An overall rate of return on investment (ROI) statistically significant 13.0% per annum with an associated benefit/cost ratio (BCR) of 6.3 is expected as the primary outcome of the "WeCare Generation" program. Our proposed model predicts a new medical paradigm aiming to empower new generations, with a strong return on economy and health.

Keywords: adverse childhood experiences; prevention; trauma; economic; welfare; child; gross domestic product; pregnancy; parental trauma

1. Introduction

In the past two years, the COVID-19 pandemic had a strong impact not only because of the effect of the virus on the human organism, but also as a global traumatic event. Significant changes in lifestyles with deleterious consequences on physical and mental health, the development of anxiety and depressive symptoms in the general population, deterioration in life satisfaction, the considerable aggravation of the psychic and physical conditions of patients already suffering from mental disorders, and widened health inequalities and inequities, represent just a small portion of the outcomes of this worldwide event [1–9].

Trauma represents for the individual a psychically unaddressed situation that elicits and unconsciously 'repeats' past traumas [10]. A decisive factor, therefore, for individual resilience, is how well past traumas, especially those involving childhood, have been processed. On the other hand, a reliable and caring environment during childhood is a basic element of resilience [11].

As a global tragic event, the COVID-19 pandemic has posed a serious threat to global mental health [8,9]. The current evidence and published literature related to previous epidemics suggest that mental health issues may arise after the peak of the pandemic [6], with increased prevalence among the vulnerable population and people with risk factors [3]. Currently we observe an exponential increase in mental illnesses especially in the adolescents, but also of the adult and early childhood ages [8–10]. Growing demands for mental health, urgent social protection, and better public health systems have posed critical challenges in both economic and service delivery capacities [4–6].

Starting from scientific evidence, it is possible to hypothesize an area-based preventive-curative model that could lead to a significant decrease in the risk of developing major mental and physical disorders and simultaneously could guarantee economic savings. In such perspective, the designed program should favor an enhanced resilience and productivity of the population with an inter-generational effect. The "WeCare Generation" is based on a new proposal of territorial intervention, with a novel paradigm of prevention and care of the diseases affecting the human body and mind. It aims to increase human potential in both health and productivity in the most plastic period of a whole life cycle, intervening on early trauma, and empowering new generations, with a strong economic and health return.

The Program proposes a workable model to detect and treat trauma on parental couples with their newborn until their 3rd year of life in order to improve physical and mental health with a high rate of welfare and socio-economic return.

In today's routine standard care, there is no pathway for the early diagnosing and treatment of trauma. Usually, the effects on the newborn emerge during later stages of development, often in adolescence or adulthood. In addition, trauma is not adequately considered as an important risk factor for numerous physical diseases.

The program consists of a psychological treatment protocol for traumatic events through the use of Eye Movement Desensitization and Reprocessing (EMDR). In addition, a schedule of repeated home visits by parental coaches is planned. EMDR is an integrative psychotherapy approach that has been extensively researched and proven effective for the treatment of traumatic events and its consequences, such as Post-Traumatic Stress Disorder (PTSD) [12]. It consists of a therapy that focuses on memories of traumatic and/or stressful experiences contributing to mental disorders or psychological problems and enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences.

Background

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0–17 years) [10]. ACEs include physical abuse, sexual abuse, psychological abuse, physical neglect, psychological neglect, witnessing domestic abuse, having a close family member who misused drugs or alcohol, having a close family member with mental health problems, having a close family member who served time in prison, and parental separation or divorce on account of relationship breakdown. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. However, ACEs can be prevented [10].

The Adverse Childhood Experiences study [11] and the subsequent body of research provide compelling evidence that the risk of adverse health consequences increases as a function of the number of categories of adversities adults were exposed to in childhood.

ACEs have in Europe and in Italy a prevalence of about 20% [13]. Traumatized individuals and their children require an amount of resource from the welfare and health system. ACEs are an important risk factor for various mental, physical, and social [14–17] conditions in infancy and adulthood and they have a significant impact with a high financial cost in Italy and also across Europe (1–9% GDP) and the USA (total annual costs estimated to be USD 581 billion in Europe and USD 748 billion in North America) [18,19].

Furthermore, there is independent research showing the effectiveness to invest in the period from pregnancy up to the age of 3 of the child, for a very high return (13–18%) [20]. This is in fact the period of major human brain plasticity, in which the bound with the caregiver (and the trauma) has a huge imprinting on the epigenetics [21–23] and neurological-behavioral organization of the child [24–26].

Parental functioning and attachment are in fact impaired by ACEs [27] and there are many studies focusing on the rebound of ACEs on the subsequent newborn generation [28–30].

Finally, some follow up studies show that many health and social conditions (also associated with ACEs) are clustered and a slice of about 20% of the population seems to “consume” 80% of welfare resources [31,32]. All this suggests that an early intervention on that traumatized portion of population leads to multiplied savings.

However, there is a lack of reliable follow-up studies on how much interventions on mothers/parents (improving interaction and parental care) can affect the development of children in social and economic terms [33,34]. Furthermore, there is little consideration on the treatment of parents’ internal emotive distorted relationships due to their own traumatic experiences during childhood. It is known that parental care functioning is a co-regulator of infant physiological and emotional homeostasis Understanding parental regulation of the infant’s immediate neurobehavioral functioning within the context of attachment quality, that may provide insights into the complex processes during early life, initiating the pathway to pathology [35].

We propose a workable model to detect and treat ACEs on parental couples with their newborn until their 3rd year of life, that could improve physical and mental health of the population, with a potential high rate of health and socioeconomic return.

In particular, the trauma treatment is designed to heal the internal attachment relationship within parents [36] and within the child, often distorted by traumatic experiences. The hypothesis is that this treatment could positively affects the quality of parental care.

2. Materials and Methods

The study has been designed as a multi-center randomized no-mask controlled trial and is at the same time an economic and health research. It will involve a total of 19 obstetrical recruitment centers in Lombardy in the province of Monza Brianza (16 territorial and 3 hospital points) and will be headed by a central coordinating group located in Carate Brianza (led by three professionals: O.U., C.V., and M.G.).

2.1. Inclusion Criteria

All families with an Adverse Childhood Experience before or during pregnancy (delivery included) will be consecutively enrolled in the study. Single parents will also be included.

2.2. Exclusion Criteria

Families with major language barriers, adopted children, or in which a member participates in other studies will be excluded. Neonates with fetal hydrops and major congenital anomalies diagnosed during pregnancy or established at the time of delivery, fetal hydrops, and major congenital anomalies of one sibling will be also excluded.

2.3. Recruitment

Usually, in the public health care system in Lombardy, a pregnant woman, together with the father-to-be, in the first trimester of pregnancy, requests the first meeting with the midwife to perform an initial anamnestic collection and measure the first parameters. This is the gateway to the 'birth pathway' already routine in Italy.

The program will be proposed to all parents accessing ASST Brianza birth points in the three years 2023–2026 through the first Obstetrical Booking meeting, at the time of booking.

The midwife will inform the couple that a study is being conducted on prevention in the first three years on the effect of parental and perinatal trauma and will propose consent to the study. Sufficient time will be allowed for consent.

If the couple adheres to the study, socioeconomic data will be collected through an instrument already used in previous studies approved by the Italian National Institute of Health [37]. In this scale the economic condition is ranked from 1 to 4 as follows: (1) serious problem (debts, cannot pay rent, etc.); (2) some problems (limitation of daily expenses, cannot afford vacations); (3) more modest standards, but no particular difficulties; and (4) medium to high (home ownership, vacation, etc.). A psychologist will collect the traumatic aspects by applying appropriate instruments together with the midwife.

2.4. Trauma Detection

During the interview with the psychologist, the segment of the population of traumatized parents will be surveyed. Trauma screening will be done with the ACE questionnaire (standardized for adverse childhood experiences) and the Trauma History Questionnaire (through a semi-structured interview by the psychologist).

A score ≥ 2 on the ACE questionnaire or the presence of even one trauma factor on the Trauma History Questionnaire will lead to those parents being considered as 'traumatized' in our study.

The same semi-structured interview will be repeated later at 28 weeks' gestation and at 10 days of the infant's life to make sure to detect other potential adverse events that have occurred.

It will be explained to enrolled subjects that if trauma is present or was detected they will be included in the study and randomized into the control or treatment arm.

2.5. Randomization

Eligible mothers/couples will be allocated to one of the two arms (treated or experimental, and control) by block randomization. A software has been designed to automatically generate a randomization code and to obtain, at each birth point, a balance between subjects with premature births or labor trauma and age of mothers ($\leq$16 years, 17–39 years, $\geq$40 years). An ad-hoc randomization software will be available for each birth point, on a password-protected specific website. The randomized code sequence will be blinded for all midwife, psychologist and anyone involved in the study. The randomization of each mother/parent will take place as soon the ACEs will be detected: at initial meeting if trauma has already occurred, or at the first visit after ACE.

2.6. Sample Size

In the 19 obstetrical recruitment centers involved in this study, the number of deliveries is about 3500, of which about 80% (2800) have no exclusion criteria, every year. Of these 2800/year, about 20% (560) will have ACE.

A recruitment time of 3 years is suggested and about 1680 mothers/parents will be expected to be included in the study (840 per arm, Intention to Treat population).

Assuming a loss to follow-up (drop-out) of about 40% between pregnancy and three 3 years of the child's life, complete data for about 1008 mothers/parents will be expected (per protocol population)

2.7. Monitoring and Data Collection

All the data will be collected using the ad-hoc website. At the end of data collection, the data will be downloaded in a single dataset for the analysis. The statistician will be blinded. Data of all pregnancies will be collected from initial meeting with the obstetrician to birth. The data will be collected to 3 years of age if the mother/parents will be included in the study. Figure 1 shows the study design. Each birth point will adopt its protocol for pregnancy management with the exception of the psychologist interviews.

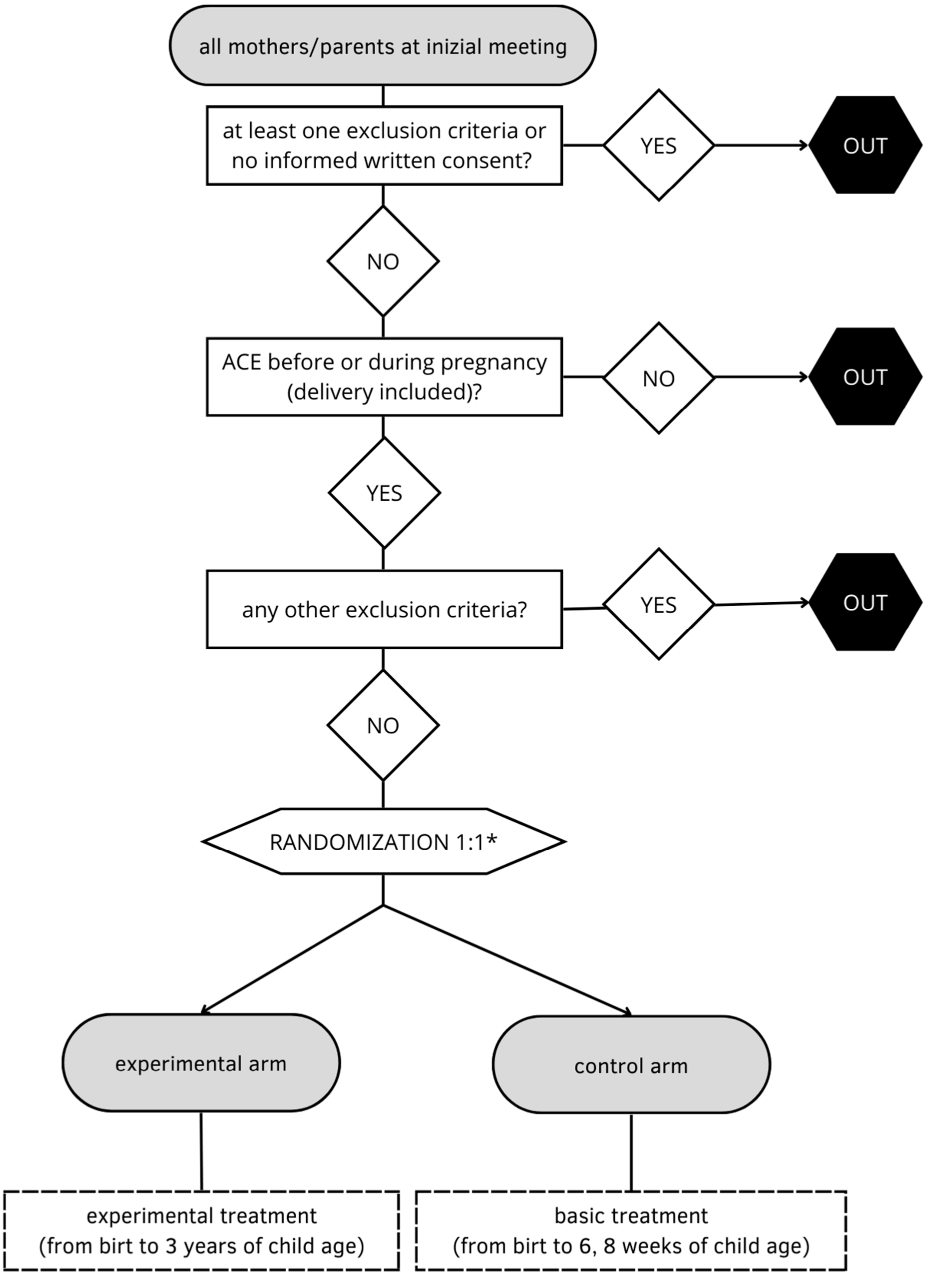

Figure 1. Study design. * Randomization will take place, as soon the ACEs will be detected.

2.8. Ethical Considerations

Standard care, defined by the regional health system, will be provided to all infants and families, regardless of whether or not they participate in the study. This study could demonstrate a protective effect of early intervention on families with trauma, which consequently also leads to savings in health care spending. If so, it could be the impetus for redefining standard care in the regional health care system. Enrolled subjects will sign informed written consent. The whole process will be conducted in accordance with the Declaration of Helsinki. The research protocol has been approved by the local Brianza Ethics Committee (Monza, Italy). The Ethics Committee is an independent body responsible for ensuring the protection of the rights, safety, and well-being of trial subjects and for providing public assurance of that protection. The anonymity of study participants will be ensured through an algorithm of assigning a code to each individual.

2.9. Intervention

2.9.1. Control Arm

The control group will follow the 'routine birth pathway', which already exists in the Lombardy region and is developed from the beginning of pregnancy until about 6 to 8 weeks after delivery, and is coded and different according to the risk of the pregnancy. Survey of the variables of interest will be done through the tax code and telephone interviews.

2.9.2. Experimental Arm

Additional treatment from pregnancy up to 3 years of the child will be added to the basic treatment that controls also receive.

The "treatment protocol" for traumatized parents and their children will be common for all the obstetrical recruitment centers. It consists of 3 parallel lines of support, which are home visiting, parent groups, and focal treatment of the traumatic experience.

The home visiting, conducted by the parenting coach, will last 1 h, and will have a scheduled frequency depending on the period. The purpose of the visits will be mainly to strengthen the parent-child relationship. The new figure of the parenting coach will be a kind of "aunt or uncle" or "grandmother or grandfather" and will try from the beginning to establish a bond of trust with the new parents. This professional figure will accompany at the territorial domestic level the couple of parents in the period extending from pregnancy until the third year of life of the newborn.

A protocol of training and monthly psychological supervision for this figure has been prepared. The protocol explains also in detail the support activities such as listening, psychoeducation, coordination, and the accompaniment of the couple at various stages from pregnancy to the third year of life. The parent groups will be carried out every three months from pregnancy to the first 3 years of the child's life for a total of 15 sessions. They will be held by a psychologist experienced in group therapy with the aim to promote the couples' internal resources and to process the individuals' internal relationships with their own father and mother. Last, but not least, the focal treatment of trauma will be realized through 20 individual Eye Movement Desensitization and Reprocessing (EMDR) sessions on the unprocessed traumatic target. The treatment will be will be chosen, on the basis of common protocols, depending on the type of trauma and the needs of the mother and father.

2.10. Training

To standardize data collection and treatment among the various obstetric and birth points scattered throughout the territory, we drew up a selection, based on specific characteristics of the providers involved in the study. For the latter, we also designed training and used guiding protocols.

EMDR therapy is a structured evidence based therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories.

EMDR treatment itself is already standardized through protocols and various stages of trauma processing and allows for its uniform execution among different therapists. As for group meetings, there will be a protocol that specifies for each meeting the procedure to be conducted, the psychoeducational goals, and the targets to be addressed [38].

The psychologists involved in the study (those involved in the administration of the ACE questionnaire and the trauma history questionnaire or those who will treat the parents) must be, at a basic level, already accredited in psychotraumatology in the EMDR association (first and second level) and must have at least 2 years of working experience in psychotraumatology.

Psychologists who will be in charge of group meetings must additionally have certification for group EMDR therapy from the association.

The parental coach will be subjected to some tests (ACE score, Adult Attachment Interview) to measure his attachment patterns and the absence of important unprocessed trauma cores. A formal assent of the parental coach to be supervised by a psychologist about his internal feelings that might arise during his home visiting intervention is equally important. The parental coach will conduct an eight-meeting training aimed at conveying the methods of home visiting, codified by a special protocol.

2.11. Primary and Secondary Endpoints

The purpose of our study is to estimate the association between early intervention on parental trauma and possible savings in health care costs (primary endpoint).

There are also some important secondary social-healthcare endpoints. Several birth points from a large geographical area of the Lombardy region (Brianza) coordinated by a central core will be involved in the study. Treatment of parental trauma will be in addition to the routine 'birth pathway' that is, a set of routine interventions that are already in place and scheduled in Lombardy. The group of parents supplemented with trauma treatment will be compared with the untreated control group performing only the routine intervention.

Treatment and data collection for the primary and secondary outcomes of the study will be harmoniously grafted into the interventions already scheduled in the Italian Health System (obstetric bookings and controls, pediatric health control, vaccination appointments).

With an early-trauma base intervention we expected a short- and long-term impact on the life cycle and on the next generation newborn [39–41] on several levels: healthcare level (differences in the whole range of morbid physical and mental conditions associated with ACEs [42], in biological markers [43], in personal skills [44], and in the capacity for resilience [45]); economic level (an economic difference in terms of savings in health, school support and social expenditure [46], a difference in productivity [47], saving for the National Health System [48,49]); and social sphere (difference of outcomes related to daily functioning, work and need for social support [46,50]). The primary outcome is represented by the welfare-related health costs from birth to 3 years of life. The computerization of health care data in Lombardy, allows, through the tax code, to deduct health care services performed, and medications prescribed and globally deduct the subject's health care costs. Costs will be tracked through the individual infant's tax code until age 20, with successive steps: every 6 months until age 3, then 4, 5, 8, 11, 14, 17, and 20 years.

Secondary outcomes are welfare-related health costs from trauma detection to delivery and difference in the development of ACEs-related diseases and conditions.

During the follow-up it will be possible to detect the main ACEs-related diseases: children exposed to higher psychological stress have been shown to have higher risk of common diseases of childhood, including otitis media, viral infections, asthma, dermatitis, urticaria, intestinal infectious diseases, and urinary tract infections. Childhood adversities have also been associated with greater risk of adult chronic conditions, including cardiovascular disease, stroke, cancer (excluding skin cancer), asthma, chronic obstructive pulmonary disease, kidney disease, diabetes, overweight or obesity, and depression, as well as increased health risk behaviors [14–16].

- Besides, it will be possible to describe difference concerning the number of children with secure attachment (at 18 months of age) [51]; differences in developmental scales (Bayley scale at 6, 18, 36 months) [52]; social outcome certification for handicap, need educator at school or home, disability certification, social-welfare benefits, skipped daycare days and sick days, how many workdays lost by parents due to parental care, number of accidents (home and non-home), prescription-drug fills, injury-insurance claims, and criminal convictions [53].

3. Conclusions

An overall rate of return on investment (ROI) statistically significant 13.0% per annum with an associated benefit/cost ratio (BCR) of 6.3 is expected as the primary outcome of the "WeCare Generation" program. These expectations are derived from the available scientific evidence [54–56].

ROI is one of the most widely used balance sheet indicators by investors and entrepreneurs to shed light on a company's ability to deploy resources efficiently.

In other words, ROI measures the amount of money a company can generate after investing in any activity regardless of the type of funding sources used.

The benefit-cost ratio (BCR) is a profitability indicator used in cost-benefit analysis to determine the viability of cash flows generated from an asset or project. The BCR compares the present value of all benefits generated from a project/asset to the present value of all costs. A BCR exceeding one indicates that the asset/project is expected to generate incremental value.

The expected outcomes of the study are a statistically significant economic return and an improvement in the health of the treated population.

The economic results will be useful to increase the impact on welfare policy.

If European health systems will invest in the first thousand days of life, according to equity and effectiveness criteria, they will empower new generations, with a strong economic and health return.

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Institutional Review Board Statement: The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the local Brianza Ethics Committee (Monza, Italy, 1 September 2022).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study will be available on request from the corresponding author.

Conflicts of Interest: The authors declare no conflict of interest.

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Article

A Treatment Model for Young Adults with Severe Mental Disorders in a Community Mental Health Center: The Crisalide Project and the Potential Space

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Abstract: In line with priorities set by the Italian Ministry of Health and international literature, the "Crisalide project" provides specific care pathways aimed at young adults (YA) with severe mental disorders (SMD). As described in Materials and Methods, it consists of three lines of activity: transition to adult mental health services (TSMREE/CSM 17–19); Diagnostic, Therapeutic, and Assistance Pathways for Young Adults (PDTA-YA); high-intensity treatment center for young adults "Argolab2 Potential Space". The aim of the study is to assess the results relating to the first three years of implementation of this clinical-organizational model (2018/2020) according to the process indicators identified by the ministry. Among the population aged 18–30 under treatment, results show increased prevalence (30%) and incidence (26%); 0% treatment conclusions due to the expiration of the conventional time limit; 0% involuntary hospitalizations (TSO); 0% STPIT hospitalizations; 0% repeated hospitalizations; 0% hospitalizations in the common mental disorders diagnostic group. Among the population of Argolab2 Potential Space, 45.4% have resumed studies; 40.9% have had a first work experience; 22.7% have obtained educational or training qualifications, and 18.2% live in independent houses. At a time when the academic literature underlines the terrible impact of the COVID-19 pandemic on this population, the present study confirms that specific treatment processes for young populations are a protective factor.

Keywords: public mental health; recovery in mental health; cultural welfare and mental health; rehabilitation in mental health; early psychosis; personalized medicine in mental health; young adults

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1. Introduction

The present study describes the organizational model and its theoretical framework, based on good practices in treating young adults (YA) with severe mental disorders (SMD) in a Community Mental Health Center (CSM) located on the outskirts of Rome. The aim of this study is to investigate the first results in model implementation, taking into account the three-year period between 2018 and 2020. Where possible, the results are compared with the indicators set up by the Italian Ministry of Health and data from the national Information System for Mental Health (SISM), year 2020. The main critical issues emerging from SISM concern poor planning and insufficiently differentiated requests.

The undifferentiated response is a key element in the historical path of psychiatry. In fact, the first psychiatric revolution that took place during the Renaissance overcame the magical religious beliefs about the origin of mental illness, leading it to a clinical–natural level. The second revolution, with the closure of the asylums and the complex cultural path underlying the reform (Law 180/1978, Law 833/1978), made possible the current community-based model of mental health care. The most recent literature data suggest how the timely interception of mental distress and appropriate interventions [1] represent the third revolution, as elements that often allow the resumption of the developmental pathway—disrupted by the first psychotic episode—and that avoid chronicization.

The Italian Ministry of Health defines "patients at onset": "those under 30 years who had their first contact with the Mental Health Department (DSM) in the year of assessment and whose first ever psychiatric contact, if detected, is not older than two years" [2] (p. 6).

The average age of onset of mental disorders is between 15 and 35 years; however, the most important and recent cohort studies have found that the median age of onset is 22 or 23 years [3,4], that falling within the competence area of the CSMs. "The correlation between long DUP (duration of untreated psychosis) and poor outcome in the first years of illness has been systematically shown" [5] (p. 88), [6].

In the National Action Plan for Mental Health (PANSM), interventions on the onset of mental disorders are considered a priority need and, in its introductory part, a model is recommended that guarantees accessibility to services, early intervention and continuity of care, individualized projects, care pathways with different level of assistance according to the patient's needs, and flexible services oriented towards needs and people. The recommended methodology emphasizes the importance of working with intervention projects that are differentiated and specific for each age group [7] (p. 4).

Indeed, for over a decade, the academic literature has underlined the need to improve the quality of care for young people who transfer from Children and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). It is a crucial element given the high risk of falling through the gap between services, with treatment interruption and severe consequences on outcomes [8,9]. On the other hand, "transfer to AMHS would arguably provide the benefit of appropriate mental health care and minimize harm from untreated disorder" [10] (p. 2).

In line with the above and with the PANSM indications, there are a number of key priority themes to consider in defining the treatment: timeliness and planning of the intervention, consequent implementation of the therapeutic pathway in its various articulations (pharmacological, psychotherapeutic, rehabilitative) and their necessary integration.

In terms of the intervention timing, it should be considered that the time period between 3 and 5 years following the psychotic onset is defined as "the critical period", as it is deemed crucial for the future of those suffering from psychosis. The data show that what happens in this phase determines the course and prognosis of the disorder. All guidelines agree on continuous and intensive treatments in this phase [11].

Research on recovery in psychiatry has intensified in recent years. Certainly, the positive outcomes of intensive and specific interventions in first-episode psychosis have greatly contributed to increasing research in this direction. However, neither the organization of public services nor the treatments provided are in line with the latest findings. Several years ago, Saraceno already pointed out how, despite the diversity of diagnoses and the variety of theoretical models, treatments carried out by mental health services are few and always repetitive, and are not tailored to the real needs of patients. Therefore, we must reflect on this lack of specificity in psychiatry to understand how to intercept the real variables that change the real life of real people [12].

However, the above indications set up by the ministry find one of the main limits to their implementation in the serious lack of human resources that afflicts the current organization of Italian public mental health services. For 728,338 psychiatric patients assisted by specialist services, the total workforce within the public psychiatric units currently amounts to 28,807 units. Of these, 18.4% are doctors (psychiatrists or doctors with other medical specialties), 6.7% are psychologists; nurses are the most represented professional figure (44.8%), followed by auxiliary staff (11.2%), educators and psychiatric rehabilitation technicians (7.5%), and social workers (4.0%) [13] (p. 44). The shortage of personnel is also characterized by an even more serious shortage of personnel with specific skills: the percentage of doctors, psychologists, and psychiatric rehabilitation technicians is dramatically lower than the percentage of nurses.

"The available data on the activities of Mental Health Departments and services for neuro-psychic disorders in childhood and adolescence seem to indicate a lack of planning in care pathways. Such a situation, attributable to a not sufficiently differentiated request, creates the danger of a use of resources that is not appropriate to the complexity of the users' needs. In many cases, users with severe disorders receive care pathways similar to those received by users with common disorders and vice versa. To this analysis we must add the evidence for a growing criticality related with the human resources in the services" [7] (pp. 6–7).

The PANSM identifies three clinical-organizational models capable of guiding the care process through interventions with increasing intensity depending on the patient's needs: "(a) collaboration/counselling: a way of working, organized between DSM and general practitioners or between Hospital Unit of Child and Adolescent Neurology and Psychiatry (NPIA), pediatricians, psychological or social services and schools, for users who do not require ongoing specialist care; (b) specialist intervention: a treatment pathway for users who require specialized treatment but not complex and multi-professional interventions; (c) taking charge: an integrated treatment pathway for users who have complex needs and require a multidimensional assessment and the intervention of different professional profiles" [7] (p. 7). These three models were applied to all CSM patients.

The "Crisalide" project was launched in 2018 to reduce the gap between the ideal treatment model proposed by the guidelines and the actual organizational reality of public mental health services, taking into account the high criticalities of the social context in which it takes place, as indicated by WHO [14] and addressed later. Its main objective is to reduce early institutionalization and the consequent chronicization of mental disorders. In order to identify treatment pathways that are appropriate to SMD and respect the priorities of treatment for the YA age range, the Crisalide project is structured along three lines of activity:

- Transition to adult mental health services (TSMREE/CSM 17–19);
- Diagnostic, Therapeutic, and Assistance Pathways for Young Adults (PDTA-YA);
- High-intensity treatment center for young adults "Argolab2 Potential Space".

2. Materials and Methods

2.1. Transition to Adult Mental Health Services (TSMREE/CSM 17–19)

In our DSM organization, services for children and adolescents are aimed at the 0–18 age range. Therefore, the transition to adult services coincides with a stressful phase that involves the entrance in the adult world and the corresponding consolidation of the self. "This can be a source of considerable stress for young people and their families, as family and social roles must be renegotiated to accommodate the young person's developing sense of autonomy" [15] (p. 5).

A first critical issue arises from the different organization of CAMHS and AMHS. In fact, CAMHS mainly follow the criterion of the age range (0–18 years) and not that of the specificity of treatment needs. As a major study points out, "neurodevelopmental disorders were the most frequent diagnostic group (up to 81%) for people seen at CAMHS from 46% of countries". Hence, "the heterogeneity in resource allocation does not seem to match the epidemiological burden for all diagnoses including physical and intellectual disabilities, neurological disorders, substance abuse" [9] (p. 715), while AMHS deliver differentiated services for these disorders. Therefore, to guarantee a treatment pathway that is the most appropriate for diagnosis and implemented in appropriate services, there is a need to reassess cases at the age of 18, so that a greater diagnostic accuracy is gained.

Another critical issue, specific to our CSM catchment area, is the rate of children and adolescents placed by the social services in residential care: it is the highest rate in Rome [16] and implies the occurrence of early institutionalization. Although it happens because of mainly socio-economic reasons, it represents a risk factor on account of which, due to a lack of adequate resources, the request for placement into residential care is repeated even after the age of 18 and young people improperly come to the attention of psychiatric services. Furthermore, as indicated by the Ministry of Health: "particular attention must be paid to the transition of under-age subjects when they turn 18 years of age. In this regard, specific protocols must be developed between NPIA services and DSM services so that the transition occurs in the least traumatic way possible. Transition must be made at the time most suitable for the individual, even if it occurs after the age of 18. When the conclusion of the care relationship is expected to happen within 12 months, it is necessary to continue the treatment at the NPIA services even after the age of 18. In planning the transition, analyzing the opportunity of implementing a care plan outside the Adults Mental Health Services, using other resources, is also recommended" [2] (p. 29).

To pursue these objectives, a TSMREE/CSM protocol has been defined for the 17–19 age range. The protocol has been enriched with further key elements. Indeed, the CAMHS contact person and AMHS contact person have regular monthly meetings to discuss and monitor the pathway of patients who are about to turn 18 years of age. The need for collaboration/counselling, specialist intervention, or taking charge is assessed through an accurate presentation of the life story, the therapeutic pathway, and the psychometric assessments carried out. If the treatment criteria specified by the Ministry of Health for treatment at the CSM (addressed later) are met, an appointment is made with the patient and the CSM specialist who will be the clinician of that patient. If the adolescent does not meet the criteria for treatment at the CSM (non-psychiatric diagnoses), the CAMHS contact person will refer the patient to the most appropriate adult service. In case of doubt, a further diagnostic examination is carried out; psychodiagnostic or instrumental investigations are requested and, if needed, a joint assessment interview involving the patient, the CAMHS contact person and the AMHS contact person is implemented. If the adolescent is reluctant or has communicated to the clinician practical difficulties in accessing the adult service, one to three joint interviews are planned to manage any questions or obstacles and offer support for change, following the specific recommendations of NICE [17].

Cases between the ages of 17 and 18 that come to the attention of the TSMREE for the first time or are hospitalized in the NPIA wards and whose treatment is unlikely to end within 12 months are referred to the CSM. The joint assessment is carried out and the taking over by the CSM occurs, if appropriate, at the time of the agreed discharge. This process makes it possible to avoid a further transition due to the bureaucratic limit of 18 years. In fact, the TSMREE should intervene with the adolescent as a minor, but it would refer the patient to the CSM after a few months, given the age of majority and the criterion of continuity of care.

2.2. Diagnostic, Therapeutic, and Assistance Pathways for Young Adults (PDTA-YA)

Within the three care models applied to all CSM patients, the Diagnostic, Therapeutic, and Assistance Pathways for Young Adults (PDTA-YA) attempt to integrate the need for treatment with the priority for intensive and specific interventions for SMD in young adulthood.

The inclusion criteria are as follows:

1. Aged between 18 and 30 years;
2. Absence of moderate or severe mental retardation;
3. Exclusion of organic psychoses;
4. Absence of substance addiction;
5. Fulfillment of the criteria for one of the following ICD-9 diagnoses: (1) schizophrenia spectrum disorders; (2) affective psychosis, and (3) severe personality disorders.

Regarding severe personality disorders, particular attention is paid to the indications provided by the Ministry of Health guidelines: "abnormal behaviors are only one aspect of severe personality disorders, that, in the absence of specific psychopathological alterations, do not present diagnostic value nor are they indicative of usefulness of psychiatric interventions" [2] (p. 27).

The PANSM guidelines recommend to include severe personality disorders with repeated self-harm and/or suicide attempts; at least three hospitalizations and/or placements in residential facilities within a year, or one hospitalization lasting more than one month; previous care in NPIA and repeated school and/or work failures; and impaired social and/or interpersonal functioning. Regarding borderline personality disorder, "studies on early interventions suggest that the timely initiation of treatment may reduce the most serious manifestations and improve outcomes" [2] (p. 32). These PANSM indications concerning treatment pathways allow to overcome the requests for social control addressed to psychiatry and to carry out appropriate and specific interventions based on the most current knowledge. Furthermore, "there is no single feature that differentiates SIP (substance-induced psychosis) from PPD (primary psychotic disorder) in a young patient using substances, and it is often only the presence or absence of psychotic symptoms during prolonged periods of abstinence–if this can be achieved—that will definitively determine the need for ongoing treatment of psychosis. That said, there are some clinical features that may point to one etiology over another" [18] (p. 7). As a result, the differential diagnosis between SIP and PPD is required to implement the right pathways and avoid chronicization due to an ongoing psychiatric treatment of psychotic symptoms induced by substances.

Patients who fulfill the criteria have an initial interview with the psychiatrist within 1–7 days, depending on the urgency.

Clinical cases are discussed in fortnightly 90 min meetings, structured as an accredited Continuing Medical Education course (ECM). All the professionals of the service participate in these meetings. The clinician proposes a case to talk about based on two criteria: 1. development of PDTA-YA after the first interviews, or 2. reassessment of PDTA-YA, for cases already in treatment and in need of new therapeutic interventions. The case presentation is required to focus on the individual and family history, seen in relation to the psychic development pathway.

In fact, the name of the project ("Crisalide", chrysalis) refers to Winnicott's question: "Is it possible to describe not only the dragonfly, but also the process of metamorphosis and, indeed, the chrysalis itself? That would indeed be good" [19] (p. 250). The choice of the name condenses several observations from which several methodological choices arise. The first methodological choice is the specificity of this age group. The pioneer of adolescent psychoanalysis, Peter Blos, had defined adolescence as a "second individuation", referring to the developmental process (separation-individuation process) [20]. His insight is currently confirmed by neuroimaging showing that "adolescence is one of the most dynamic events of human growth and development, second only to infancy in terms of the rate of developmental changes that can occur within the brain. In fact, there are characteristic developmental changes that almost all adolescents experience during their transition from childhood to adulthood. It is well established that the brain undergoes a "rewiring" process that is not complete until approximately 25 years of age" [21] (p. 451), [22]. Therefore, the image of the chrysalis in Winnicott's words represents the theoretical background underlying the ongoing attention to the psychic process in the development of the subject; this theoretical framework helps to take into account the specific dynamism of the adolescent/young adult and to understand the psychopathological dimensions. In this regard, the concept of subjectivation is to be considered a valid point of reference in the process approach to the understanding of complex psychic phenomena. Indeed, the term subjectivation represents an important encounter between philosophy and psychoanalysis; in fact, it connects Foucault's definition of the normative devices of knowledge-power that act on subjective life by providing it with concrete ways of self-designation, already present in society and culture of a given era [23], and the definition of subjectivation suggested by adolescent psychoanalysis, that is a process of knowledge and self-definition of the self [24]. This theoretical link offers great possibilities for the development of a psychosocial perspective in the various articulations of the path from adolescence to young adulthood; in this developmental pathway, the ongoing process of integration of previous achievements and new skills, due to the growth potential and the innate maturation push, tends to guarantee the continuity of the Ego experience in order to facilitate the emergence of a stable sense of social self [25]. SMD are clear and serious expressions of the impasse of this troubled process. These theoretical assumptions, just mentioned here for reasons of synthesis, are needed to provide further knowledge tools that facilitate the understanding of psychic events and help to formulate a hypothesis about when the breakdown that blocked the developmental pathway occurred. Hypotheses based on knowledge and understanding of psychic phenomena are a valuable contribution to reducing the levels of anxiety that arise between a mental health professional and a patient with a severely altered relationship with reality. This approach enables the clinician to overcome the narrow view of symptoms or behaviors as something to intervene on using a mere psychopharmacological treatment or hospitalization, and opens a more complex perspective that may realize a biopsychosocial model as defined by the WHO. This is even more important if we consider the heterogeneous training of professionals working in mental health services, a heterogeneity due to roles and functions (psychiatrists, psychologists, nurses, and social workers) and to the theoretical orientation (cognitivism, phenomenology, family systems therapy, psychoanalysis, etc.). Creating a common culture oriented to the specificity of the intervention, within a heterogeneous and generalist cultural environment, is a central factor of cohesion of the working group that facilitates communication through notions expressed in a shared language understandable to all.

Furthermore, sharing within the group of professionals helps to reduce the experiences of loneliness and helplessness that are often reflected between patient and clinician; these experiences are even more negative when they concern young patients, especially in circumstances such as suicide attempt, self-harm, and destructive acting out. The maintenance of the working group, the culture of organizational well-being, and the specificity of training are issues that, although important, are still too neglected in public health institutions. As reported by a huge body of research, they are protective factors for care professionals in the prevention of burnout and also have a positive impact on patients, improving treatment outcomes [26–29].

PDTA-YA include two types of projects: combined and integrated, to be built according to individual needs. The combined project consists of an individual psychological path and psychopharmacological treatment, based on specific needs and aimed at achieving the best possible balance between efficacy and side effects. It is widely confirmed that the metabolic and extrapyramidal effects represent the main causes of pharmacological treatment interruption and of relapses that worsen the prognosis; “significant differences between treatments were found in the categories of sleepiness/sedation, increased sleep duration, akinesia, weight gain, ejaculatory dysfunction, extrapyramidal-symptoms, and amenorrhea” [30] (p. 218). Indeed, physical and intellectual performance and body image play a central role in this period of life in which the representation of the body self and the representation of the social self are consolidated. Attention to the most dynamic time in life after infancy, in terms of rate of developmental changes that can occur within the brain [21], must correspond to attention to information, discussion, and regular renegotiation of pharmacologic prescription. As indicated by the National Institute of Mental Health, “guideline-based use of medication optimizes the speed and extent of recovery, as well as acceptance of pharmacologic interventions. Medical care of young people during the early stages of mental illness is considerably different in style and content compared to approaches used in older individuals with established illness” [31,32].

Historically, “standard treatment (ST) for psychosis consists primarily of antipsychotics, hospitalization, social rehabilitation, and different types of supportive therapy” [33] (p. 1). We know that antipsychotic drugs have only moderate effects on positive symptoms and no demonstrable effect on negative symptoms [34]. Regarding the individual psychological path, we have decided to propose weekly interviews in order to guarantee continuity and regularity and facilitate the building of a good therapeutic alliance, according to the indication for intensive treatment and the continuity of the intervention. Concerning the theoretical framework, most of the CSM therapists have a psychoanalytic or phenomenological background, while a small part of the team is made up of cognitivist or family systems therapists. Beginning with a major Cochrane systematic review [35], the most recent studies comparing the efficacy of different psychotherapy models agree that there is no evidence to support one model having a greater impact than another on positive outcome [36–42]. On the other hand, all studies and treatment indications agree on the efficacy of specific and integrated treatment models for the young adult population with SMD. Therefore, the combined treatment project (psychopharmacological and psychological) represents the minimum treatment proposal on which, depending on the personalized needs, other pathways and professional figures are inserted in order to outline an integrated treatment project: family therapy; parental counselling; support for autonomy; social service and possible referral to the high-intensity treatment center for young adults described in the following paragraph.

2.3. High-Intensity Treatment Center for Young Adults "Argolab2 Potential Space"

The PANSM indicates that most patients at onset require "a care pathway that may however be characterized by different assistance intensities depending on the disorders, contexts, and developmental phases, and not only based on complexity and severity. As a consequence of the above, longitudinal monitoring of development is much more frequent than a single episode of care, because developmental disorders change in time and over time along complex and specific lines, and rehabilitation is an indispensable component of the care process" [7] (p. 8). The PANSM considers "rehabilitation" as strictly related to "contexts and developmental phases".

These observations overlap with the analysis of the real-life context of the population we are dealing with. This area, located on the eastern outskirts of Rome, is the most disadvantaged in Rome and other Italian cities, as shown by several social indicators. It has 257,000 inhabitants, 35% of whom are under 30 years, an average age lower than that of the other Roman municipalities. Between 27 and 30% of the population has a primary school certificate or no educational qualification and only 5% are graduates; the cultural opportunities (cinemas, theaters, and libraries per percent of residents) are 0.01–0.07%; 6% drop-out of lower secondary school; the rate of young people aged 15 to 29 unemployed or out of the educational system (NEET + 15%), and the rate of families with economic and social hardship (up to 7.5%) is at a maximum [43].

It is well established that "the early stages of psychosis, including the prodrome, often feature educational/occupational difficulties and various symptoms and signs, that can render or keep youths 'Not in Employment, Education or Training' (NEET). Conversely, NEET status itself may increase risk of illness progression and impaired functioning, and impede access to appropriate services for psychosis" [44] (p. 1401). There are no data that accurately establish a causal relationship between low social indicators and psychosis, but there is strong evidence for an unfavorable correlation with the course of the disorders. Furthermore, data from the academic literature agree in identifying the interruption in studies, social withdrawal, and the loss of interpersonal and cognitive skills as dramatic outcomes of psychosis when not treated in an intensive and timely manner, and point out that the earlier the onset is, the worse the outcomes are.

In 2020, these remarks led to transforming an old day center into the "Argolab2 Potential Space for Young Adults", a semi-residential facility, open eight hours a day and managed by a team made up partly of third sector employees, partly of public employees.

Argolab2 offers various activities such as support for educational and employment attainment, carried out through personalized consultations and individual lessons, in contact with public schools. "Supported Employment/Education (SEE) services help clients return to work or school and achieve their personal goals. Emphasis is on rapid placement in a work or school setting combined with coaching and support to ensure success" [45] (p. 120). To foster greater autonomy, Argolab2 supports study and employment recovery through consultancy implemented at the office, with no coaching in the actual setting in which these activities take place. When it is necessary to provide coaching in the actual work environment, internship projects are carried out with the assistance of the CSM social workers.

A band was born from music theory lessons and instrumental practice; journalism gave rise to a monothematic four-monthly magazine that reflects youths' curiosity about current events and their context of life; a web radio created podcasts and carried out interviews. Other activities are theater, street art, video making, sport, and care for the environment. The teaching of the main disciplines is provided by professionals in the specific sector (expert artisans or artists) and not by mental health professionals; the latter mainly deal with difficulties with interpersonal relationships, facilitate autonomy, and monitor progress or any critical issues encountered by youths in their real life. Each activity is aimed at promoting a real learning of skills, according to personal inclinations and curiosities, and at encouraging and supporting new experiences and the exploration of cultural elements. As underscored by a WHO recent scoping review [46] (p. 4): "the aesthetic and emotional components of arts activities can provide opportunities for emotional expression, emotion regulation and stress reduction. Emotion regulation is intrinsic to how we manage our mental health. Cognitive stimulation when engaging in the arts can provide opportunities for learning and skills development, and it is not only associated with a lower risk of developing dementias but also interrelated with mental illness such as depression. Social interaction while participating in the arts can reduce loneliness and lack of social support, which are both linked with adverse physiological responses, cognitive decline, functional and motor decline, mental illness and premature mortality".

This feature strongly shapes the activities of Argolab2 Potential Space for Young Adults, whose name stems from Winnicott's concept of Potential Space: "where there is trust and reliability is a potential space, one that can become an infinite area of separation, which the baby, child, adolescent, adult may creatively fill with playing, which in time becomes the enjoyment of the cultural heritage. The special feature of this place where play and cultural experience have a position is that *it depends for its existence on living experiences*, not on inherited tendencies" [47] (p. 108). "Playing and cultural experience are things that we do value in a special way; these link the past, the present, and the future; *they take up time and space* [. . .] The baby's confidence in the mother's reliability [. . .] makes possible a separating-out of the not-me from the me" [47] (p. 109). The chosen name summarizes the attention to the developmental pathway that tends towards the continuity of internal experience, arriving at subjectivation and autonomy, seriously undermined in psychotic experiences.

YA participate in individual and group meetings. Group participation is crucial when it comes to organizing cultural events aimed at their community and its enrichment. The community sees YA active in proposing what they have learned and returns them a more cohesive and skilled image of themselves.

Argolab2, the other part of the name, is connected to the image of the institutional container in which this experience may occur. It takes the symbol of the ship *Argo* from mythology, not so much for the challenge that led the young anti-heroes to fetch the Golden Fleece, as for the specific features of the ship construction. In fact, the ship Argo was built following the detailed indications of the goddess Athena to be resistant, fast, and able to actively participate in the adventures of the large crew [48]. Thus, the chosen name intends to express the desire that skills may be made available to everyone, in coherence between the theory and practice of the organizational model, by a public institution capable of supporting, holding, and responding in a dynamic way.

Referrals to Argolab2 are decided during the clinical discussion meetings described in the previous paragraph and concern all patients of the 18–30 age group under treatment with a specific attention to personal development needs, according to the Crisalide project, and to situations of severe social withdrawal and disruption of everyday activities. Argolab2 is located in an apartment in public housing, among others houses, not far from the CSM.

In an initial interview, the service manager provides the young adult with all the information on the functioning of Argolab2 and on current projects, and proposes a week of exploration and participation to the various workshops and a second appointment to discuss which interests have emerged and decide the frequency of participation (from 2 to 5 times a week).

During the restrictions imposed by the COVID-19 pandemic [49], Argolab2 maintained regular activities in compliance with the anti-COVID-19 rules, providing YA with devices to guarantee remote activities and allow them to resume or continue their studies.

In order to prevent the institutionalization related to the stagnation of care pathways, the duration of treatment at Argolab2 is 5 years for each young adult, a time consistent with what has been defined *the critical period* following the psychotic onset.

Once a week, there is a meeting of the service team that involves coordinators and nurses and during which, in addition to organizational issues, information on the life stories of the YA recently referred to Argolab2 and the observations on the pathway of those already attending it are shared. Updates on the pathways are regularly shared with the CSM clinicians. Once a month there is an extended meeting that also involves the expert artisans/artists and focuses on the activities and events to be carried out. Expert artisans/artists do not know either the diagnoses or the stories of the YA they teach; thus, learning focuses on young adults' resources and not on their disorder and takes place in a relationship that is as natural as possible; furthermore, such a methodological position guarantees YA respect for their privacy and allows them to be free to make themselves known according to what they wish to share. The training of the Argolab2 team occurs every two months and consists of organizational consultancy aimed at acquiring an understanding of the organizational and social group dynamics, the interaction between tradition, innovation and change, and the relationship between the organization and its social context. These meetings may help a team highly heterogeneous in terms of training and roles to focus on goals and enhance the creative potential that lies in the differences between group members, according to the Tavistock approach.

3. Results

The International Classification of Diseases, 9th edition (ICD-9-CM; World Health Organization), was used to assign psychiatric diagnoses. Diagnoses were grouped according to criteria corresponding more to the model implemented. The first three diagnostic groups consisted of the severe diagnoses covered by the model described (Table S1). The other groups received other treatment pathways and was included for comparison, in addition to some data concerning the total population of CSM patients.

3.1. Transition to Adult Mental Health Services (TSMREE/CSM 17–19)

The mental health information system used by the CSM does not allow to digitally collect information about the line of activity 17-19 years; therefore, data shown in Table 1 come from a paper database. In 2018, there were 21 referrals from the TSMREE, and, once they reached the age of majority, the CSM took charge of them all. In 2019, there were 13 referrals: the CSM took charge of 6 (46.2%) of them; 4 (30.7%) had a joint assessment, undertaken by TSMREE and CSM together, and conclusion of treatment by the age of 19, and 3 (23.1%) were referred to other services because they did not have a psychiatric diagnosis. In 2020, there were 12 referrals from the TSMREE: the CSM took charge of 8 (66.7%) of them; 1 had a joint TSMREE/CSM assessment and conclusion of treatment by the age of 18, and 3 (25%) were referred to other services because they had disorders other than psychiatric ones. The average age of youths referred by TSMREE decreased slightly from 2018 to 2020: from 19 to 18.4 years.

Table 1. TSMREE/CSM (17-19)—Distribution by diagnostic group. The bold indicates total.

	Referrals from TSMREE			**CSM**			**TSMREE/CSM**			**Referrals to Other Services**		
Diagnostic Group	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
Schizophrenia spectrum disorders	3	1	2	3	1	2	0	0	0	0	0	0
Affective psychosis	2	2	2	2	2	2	0	0	0	0	0	0
Severe personality disorders	3	3	4	3	3	4	0	0	0	0	0	0
Common mental disorders	10	2	2	10	0	0	0	1	1	0	1	1
Other disorders	1	2	2	1	0	0	0	0	0	0	2	2
No psychiatric disorder	1	3	0	1	0	0	0	3	0	0	0	0
Unknown diagnosis	1	0	0	1	0	0	0	0	0	0	0	0
Total	**21**	**13**	**12**	**21**	**6**	**8**	**0**	**4**	**1**	**0**	**3**	**3**
%	100	100	100	100	**46.2**	**66.7**	0	**30.7**	**8.3**	0	**23.1**	**25**
Mean age	**19**	**18.7**	**18.4**									

3.2. Diagnostic, Therapeutic, and Assistance Pathways for Young Adults (PDTA-YA)

Table S2 shows data on each year treated prevalence, distributed by gender and diagnosis; medicolegal medicine consultations are excluded. "Treated prevalence in a certain year is given by the number of patients with at least one contact during the year with the services of the Mental Health Departments" (SISM) [13] (p. 50).

The number of prevalent patients aged between 18 and 30 and with severe diagnosis increased by 30% (from 49.5% in 2018 to 79.3% in 2020) and the categories of no psychiatric disorder and unknown diagnosis disappeared. In 2018, the categories of common mental disorders, other disorders, no psychiatric disorder, and unknown diagnosis accounted for 50.4% of the treated patients in this age group. The gender distribution of the different diagnostic groups in the YA population reflected the epidemiology of the population data: prevalence rates were substantially the same in males and females, with severe diagnoses more frequent in males, except for affective psychosis that had higher rates in females; the female gender was less represented here due to the earlier onset in males. The mean age was 25.

Distribution by nationality of treated prevalent YA patients remained constant in the given period. In 2018–2020, Non-Italian YA patients were on average 18.7%. (Table S3)

Treated incidence concerns patients who had contact with the CSM for the first time ever in the year (new cases) [13] (p. 66). Data refer to incident population that actually received interventions, excluding medicolegal medicine consultations (Table S4). Incident YA patients with SMD who were treated at the CSM showed an average increase of 26%, in 2019-2020. In 2018, 62.2% of incident YA patients had diagnoses not belonging to SMD groups.

In the given period, the percentage of incident YA patients out of the total population of incident patients increased by 9.3%: in 2020, 28.8% of incident patients were under the age of 30. The percentage of incident YA patients with SMD increased by 6.1% over the three years. The mean age of the total incident population decreased by 10.5 years, while the mean age of the incident YA patients remained constant, which was 23 years (Table S5).

In the comparison between the three years, both the therapeutic projects (planning of a care pathway based on the patient's needs and agreed with the latter) and the treatment profiles (actual care pathway measured through the interventions carried out) of an integrated type aimed at YA with SMD increased, both in the incident population and prevalent population, as shown in Figure 1.

Over the three years, the percentage of interventions delivered to total population with SMD and YA population with SMD increased, as shown in Figure 2.

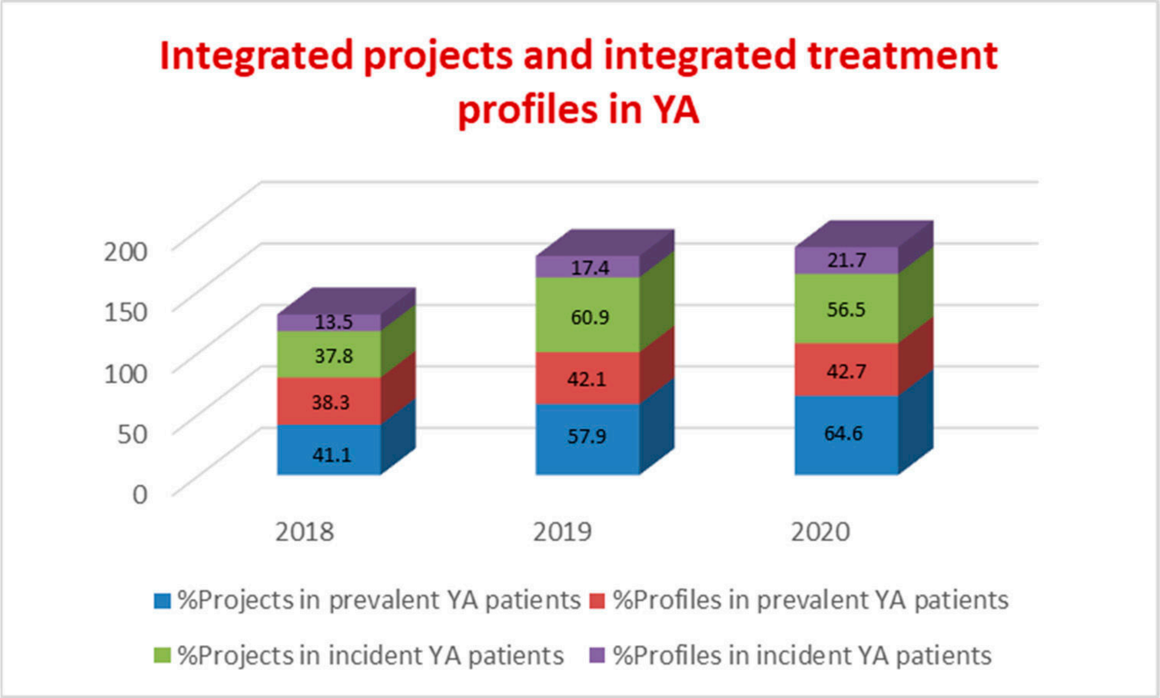

Figure 1. Prevalent YA patients and incident YA patients—Integrated projects and integrated treatment profiles.

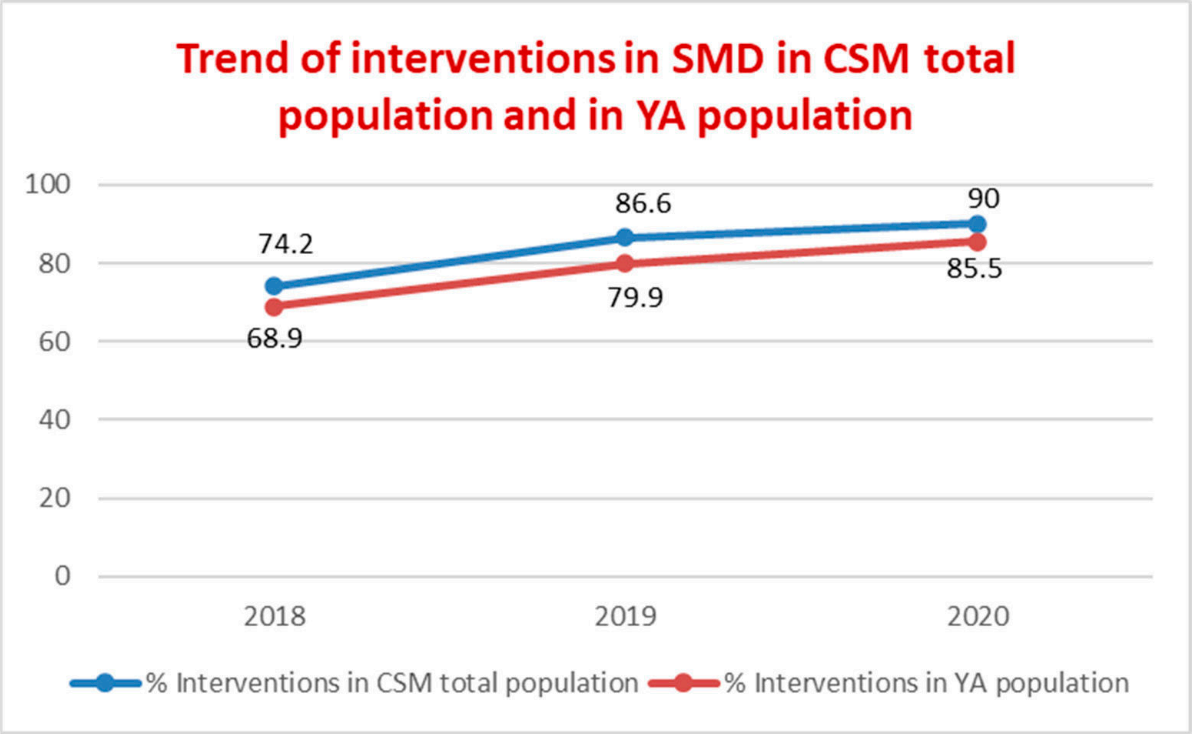

Figure 2. Trend in percentage of psychiatric, psychological, psychoeducation, or social interventions delivered to CSM total population with SMD and to YA population with SMD per year.

In our mental health information system, conclusions of treatments due to the expiration of the conventional time limit refer to conclusions occurring because for a 90-day period no intervention has been delivered to the patient and recorded in the information system. Overall, conclusions of treatments in prevalent YA patients fell by 24% (from 51%

in 2018 to 27% in 2020); conclusions due to the expiration of the conventional time limit were reduced by 30% (from 51% in 2018 to 21% in 2020). No patient with SMD had a conclusion of treatment due to the expiration of the conventional time limit or referral to other mental health services due to conditions not falling under the competence of the CSM (Figure 3).

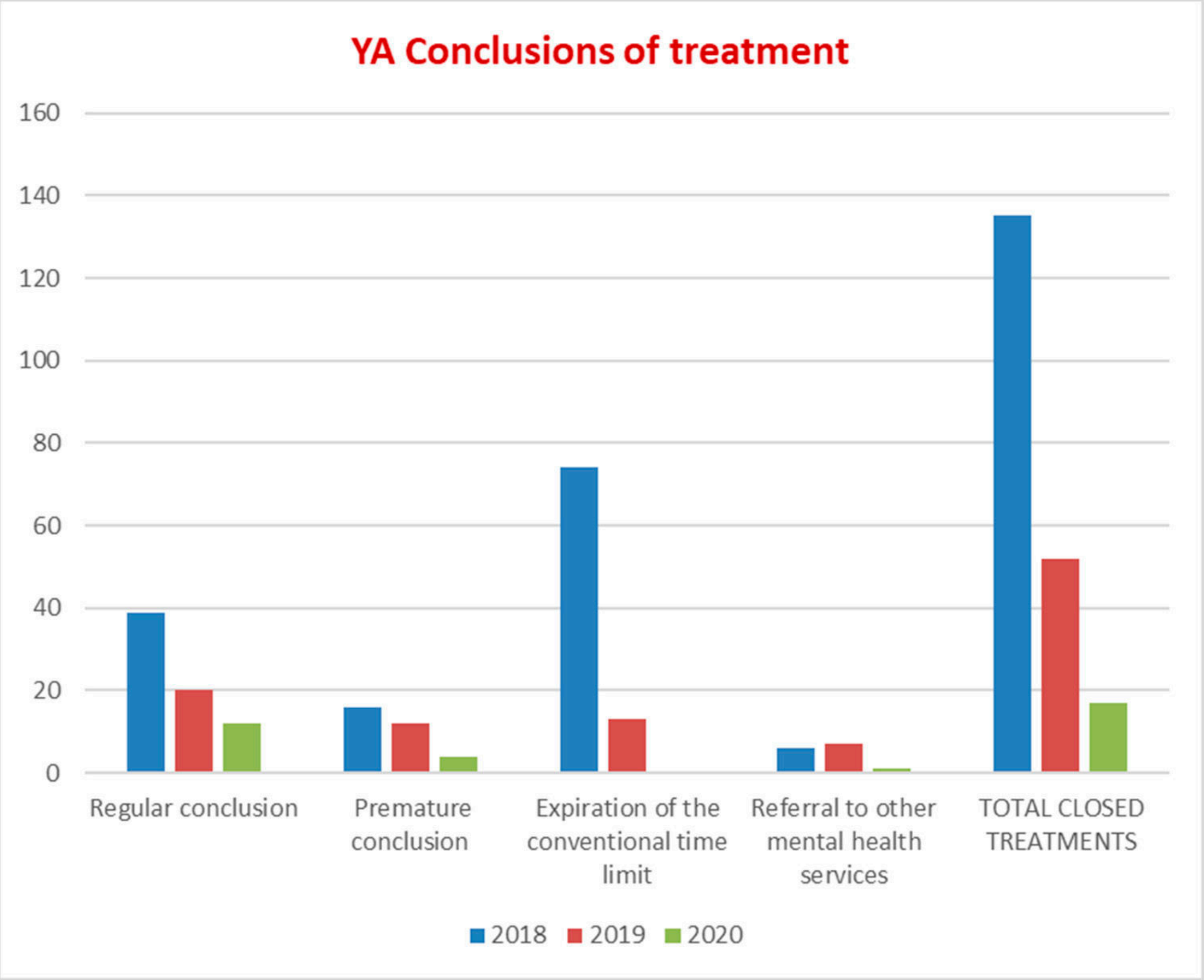

Figure 3. YA conclusions of treatment.

In the Italian mental health system, the SPDC (General Psychiatric Unit for Diagnosis and Care) is a psychiatric ward within the general hospital where voluntary and involuntary inpatient treatments are implemented 24 h a day. The STPIT (Facility for Territorial Intensive Psychiatric Treatment) delivers inpatient treatments to those patients who, at the time of discharge from SPDC, are deemed to have to continue a voluntary hospitalization, in a still very complex healthcare context; STPIT is also intended for the voluntary hospitalization of people whose conditions are less severe than those admitted to SPDC, but who in any case require hospital care.

Figure 4 shows the trends in hospitalizations among the YA population in the given period. In 2018, the total number of hospitalizations in SPDC was 29, of which 1 was a TSO (involuntary psychiatric treatment). In Italy, TSO is governed in accordance with articles 33, 34, and 35 of Law 833/1978, according to which a citizen may be forced to health interventions in hospital against their will "only if there are psychiatric alterations such as to require urgent therapeutic interventions, if the latter are not accepted by the patient, and if there are no conditions and circumstances that allow to adopt timely and suitable out-of-hospital health measures”. The distribution by diagnosis of the number of hospitalizations was homogeneous. It is worth noting that, from 2018 to 2020, the trend in YA hospitalizations had a progressive reduction of up to 6%. In 2018, 10 patients with SMD received multiple hospitalizations in SPDC and 3 were admitted also in STPIT (mean length of stay in STPIT 30.5 days); in 2019 and 2020, there were no repeated hospitalizations, no hospitalizations in STPIT, nor TSOs. The mean length of stay in SPDC progressively decreased from 15 to 10 days. Hospitalizations of patients belonging to the common mental disorders diagnostic group were 6 in 2018 and fell to 0 in the following two years.

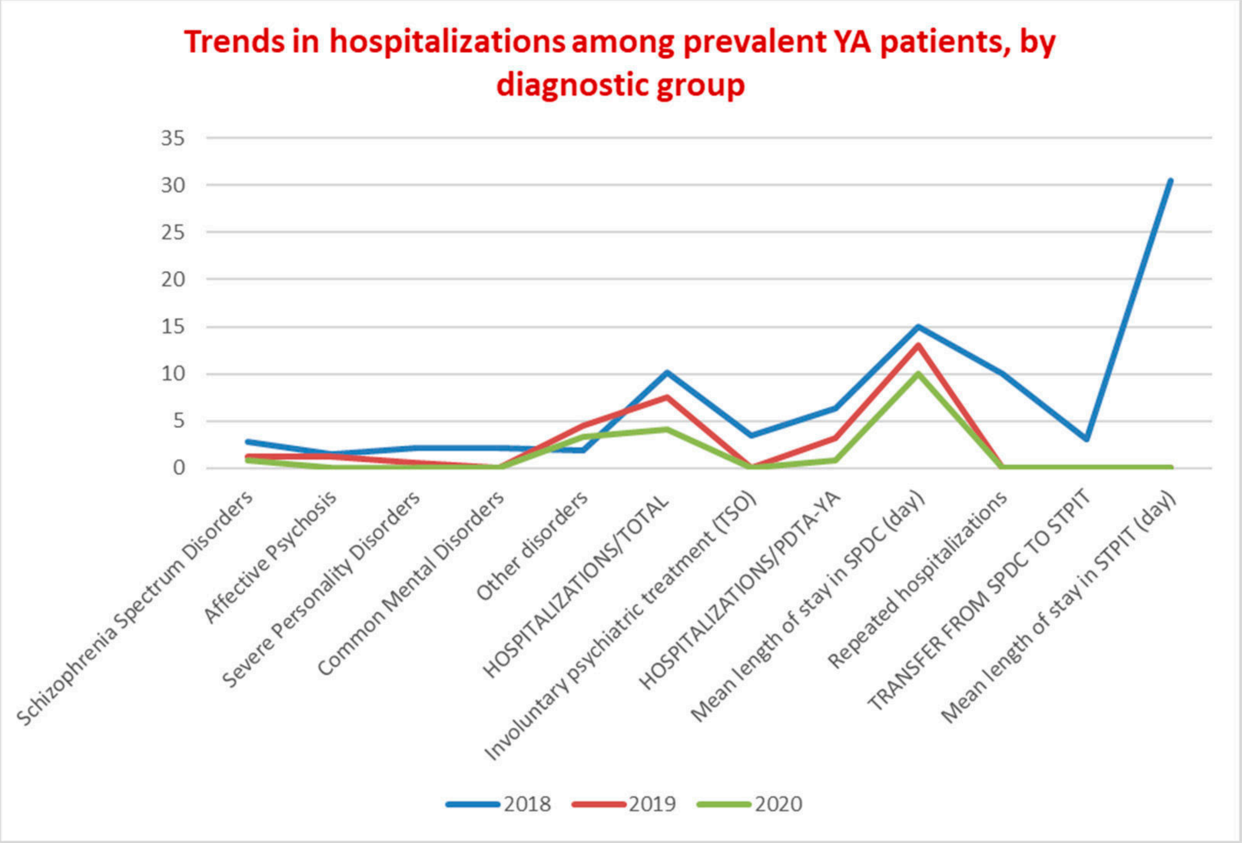

Figure 4. Trends in hospitalizations among prevalent YA patients, by diagnostic group.

3.3. High-Intensity Treatment Center for Young Adults “Argolab2 Potential Space”

Data from the high-intensity treatment center for young adults “*Argolab2 Potential Space*” refer to the period from 2020 (year of its launch) to July 2022. Resumption of school and/or work and housing autonomy are data not digitally collected by our current mental health information system and were recorded in a paper database. In the given period, the total number of patients accepted at Argolab2 was 22. The mean age was 24 years. Males were 41% and females were 59%; diagnosis distribution by gender corresponded to epidemiology. Italian patients were 63.6% and non-Italian patients were 36.4%. As for the diagnostic groups, 50% belonged to the schizophrenic spectrum, 27.3% to severe personality disorders, and 22.7% to affective psychosis (Table S6). The Mean Global Assessment of Functioning scale (GAF) score at baseline was 55.

Figure 5 shows the trend in hospitalizations. Before accessing Argolab2, the total number of hospitalizations in NPIA and/or SPDC received by the 22 young patients was 25: 3 had never been admitted to a psychiatric ward, 19 had been admitted one to five times to NPIA and/or SPDC (114%). After accessing Argolab2, one patient was admitted in SPDC once (4.5%).

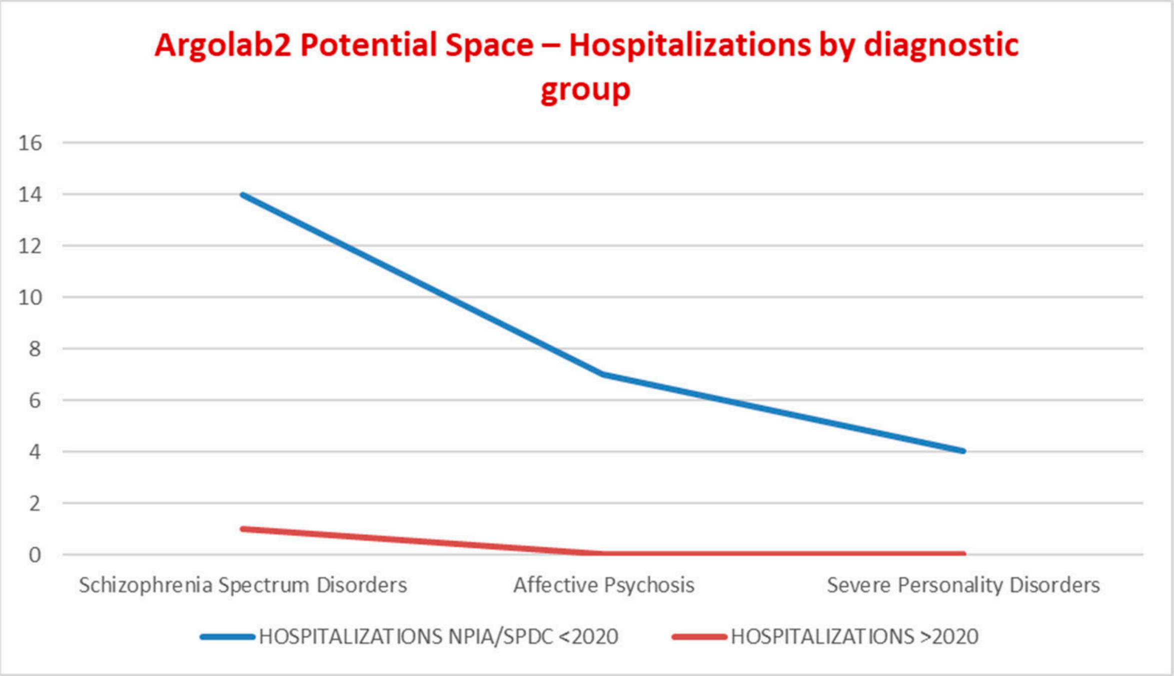

Figure 5. "*Argolab2 Potential Space*"—Hospitalizations by diagnostic group.

Before attending Argolab2, 100% lived with their family of origin; after 2020, 18.2% lived independently (Figure 6). At the time of accessing Argolab2, 72.7% had interrupted their educational courses and work activities for a period between 6 months and 3 years. After 2020, 45.4% resumed their studies; 40.9% had their first work experience; 22.7% obtained educational or training qualifications; 18.2% started an internship supported by CSM (Figure 7).

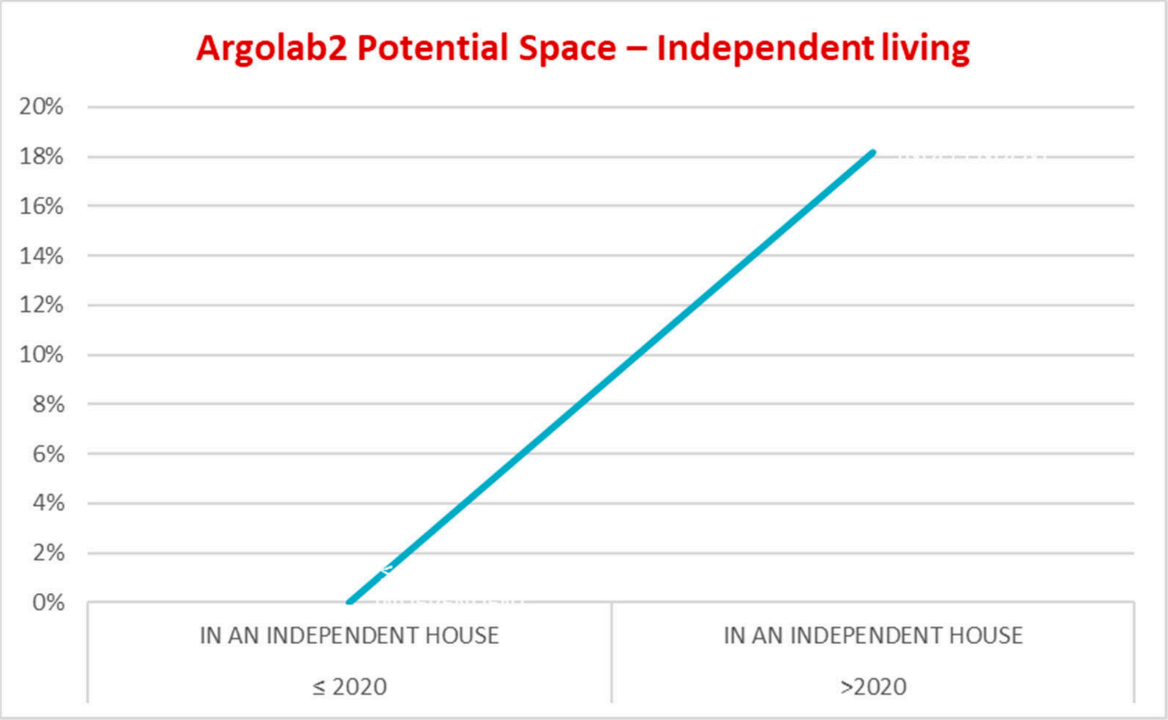

Figure 6. "*Argolab2 Potential Space*"—Independent living.

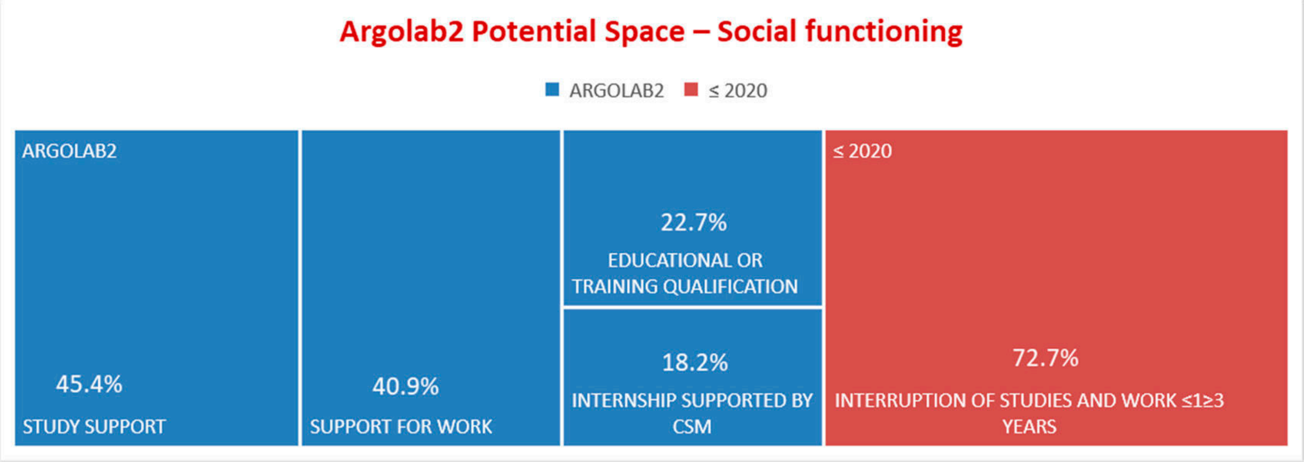

Figure 7. "*Argolab2 Potential Space*"—Social functioning.

4. Discussion

The present study explored the trends in the main treatment indicators to assess the efficacy of the clinical-organizational model implemented as described in the Materials and Methods paragraph.

Data on TSMREE/CSM 17–19 showed that, in 2018, 100% of the referred cases made a transition from TSMREE to CSM at age 18, regardless of diagnosis. The implementation of the model showed that, in 2019, 30.7% had a joint TSMREE–CSM assessment and consequent conclusion of treatment by the age of 19. In 2020, 25% were referred to other services after an in-depth diagnostic assessment. That demonstrates a more specific and differentiated percentage trend of referrals, as suggested by the guidelines. In addition, as required by an early intervention [1], a reduction from 19 to 18.4 years in the mean age of cases in the transition phase was observed. In 2019 and 2020, due to a strong collaboration between the two services, as advocated by the guidelines [2], the conclusion of treatment by the age of 19 was made possible in five cases.

PDTA-YA data show a sharp increase in prevalence (30%) and incidence (26%) of YA with SMD, with a mean age in incident patients of 23 years, equal to the median age of the first psychotic episodes. These data suggest an improvement in the interception of YA in an initial period of their psychopathological manifestations. The data for the higher presence of young male adults confirm this result; in fact, epidemiologically, in CSMs, the female population is more represented for common mental disorders and for a higher age, while the onset of most psychiatric disorders is earlier in men, especially with regard to SMD. The percentage of incident YA patients out of total incident patients seeking help from CSM increased by 9.3%; the reduction in the mean age of total CSM incident patients (34.5 years) and the rate of 28.8% for the incident patients under the age of 30 in 2020 represent, for the PANSM guidelines, indicators that enable the early recognition of SMD to be assessed. The rate on non-Italian nationality for YA, both at the CSM (18.7%) and at Argolab2 (36.4%), is much higher than the national mean (4.6%) of foreign patients treated at the CSMs, represents another paramount indicator to assess the accessibility of the non-Italian population to mental health services [13]. Therapeutic projects and treatment profiles of an integrated type for YA with SMD increased, both in the prevalent patient population and incident patient population, by an average of 20% compared to 2018 (Figure 1). In addition, there was an overall increase in the number of interventions in both populations with SMD, with an average of 15 interventions per YA patient (Figure 2). Integrated projects and profiles consist of interventions delivered to a patient by several professionals and are an important indicator of the intensity of care provided to new patients with SMD. In 2020, the national average of interventions for this patient group was 3.1 [13] (p. 100). The administrative conclusions of treatment due to the absence of interventions—for 90 days in the DSM, for 180 in the national information system—provide valuable information on the capacity of the services to maintain a continuity in care pathways: in the YA population treatments, the conclusions of treatment due to absence of interventions for 90 days decrease by 30% (21% in 2020; national rate of 80.4% with no interventions for 180 days). It should be noted that, at the national level, the time interval without interventions that determines the conclusion of the treatment is double compared to the DSM criterion. Moreover, the rate of such conclusions equal to 0 in YA with SMD is even more significant data (Figure 3). The overall reduction in the conclusion of the treatment (24%), excluding those for an agreed termination (regular conclusion), has a direct correlation with an increase in the continuity of care pathways. In 2019 and 2020, TSO = 0; STPIT hospitalizations = 0; trend of reduction in voluntary hospitalizations in SPDC was up to 0.8% of the total, and the reduction in the mean length of stay (10 days) represent PANSM indicators that evaluate the timeliness, describe the capacity of community-based services to guarantee effective continuity of care after the hospitalization and are measures of the therapeutic efficacy of rehabilitation programs developed by CSMs [13].

In 2019/2020, repeated hospitalizations = 0 are an indicator that underline the adequacy with which the community services treat patients discharged from acute care facilities. In the last two years of the given period, diagnostic accuracy and specific treatment resulted in hospitalizations = 0 in the common mental disorders diagnostic group (Figure 5). In 2020, young adults attending the Argolab2 Potential Space averaged 25 hospitalizations and 3 repeated hospitalizations. Between 2020 and 2022, one voluntary hospitalization was needed. It should be noted that young adults attending Argolab2 suffer from the most severe symptoms and have the lowest level of social functioning compared with the total population treated at the CSM (mean Global Assessment of Functioning scale GAF score at baseline was 55). The Argolab2 intensive treatment model showed positive results: 45.4% resumed their studies; 40.9% had their first work experience; 22.7% obtained educational or training qualifications; and 18.2% lived independently (Figure 6). The resumption and conclusion of study and work paths and the achievement of housing autonomy occurred within 2 years, considering the critical period of the psychotic onset within which "Psychological and psychosocial treatments should be core elements and should be used to assist resolution of enduring positive and negative symptoms, the management of secondary comorbidity, and the promotion of recovery and positive mental health. Recovery work should emphasize the need to find meaning and develop mastery in relation to the psychotic experience" [11] (p. 123).

5. Conclusions

In this study, the focus on hospitalizations is not related to mere health economics or to simple adherence to the indicators. Hospitalizations, especially in this period of life, represent traumatic disruptions of the natural developmental pathways, and are mainly aimed at managing crises through pharmacological interventions. This approach misses the chance of encouraging the process of signification of psychic manifestations that, albeit in a catastrophic way, signal the need for an internal transformation, as the etymology of the word crisis teaches us. Therefore, it is of primary importance to invest in the training and capacity of the community care environment to contain crises by restoring meaning and trust in the continuity of existence. As research shows: "Antipsychotic drugs have been shown to be effective against psychotic symptoms, however, long-term therapy with antipsychotics is associated with a range of side effects, poor adherence and high rates of medication discontinuation. Most patients, even those with a good response to medication, continue to suffer from disabling residual symptoms, impaired social and occupational functioning, and a high risk of relapse" [50] (p. 2).

The presence of hospitalizations in the other disorders diagnostic group leads to reflect on the quantity of conditions that, although in absence of a severe psychiatric diagnosis, come to the attention of psychiatric wards. It is worth noting that this diagnostic group includes the pathologies that, according to the Ministry of Health, do not fall within primary psychiatric competence (substance addiction, antisocial personality disorder, moderate and severe mental retardation). Psychiatric interventions in these categories have medicolegal implications that make them aimed at the mere management of behaviors, with the result of undifferentiated and non-specific responses that represent a historical involution of psychiatry. Furthermore, diagnostic inappropriateness is likely to lead to an improper use of scarce professional resources, eliminating the possibility of investing them in effective treatment pathways. The age-specific needs of people who face their first psychotic experiences should lead to ponder on the so-called "rehabilitative" practices and on the training of those who provide them.

The word rehabilitation evokes the retrieval/restitution of skills/abilities that the individual had but which have been reduced or lost due to the mental disorder onset. However, if we reflect on the need for and importance of confrontation with the peer group as a subjectivating agent [51], on the role of school or the first work experiences, and on participation in social life, our attention necessarily shifts to something new that is about to happen in the life of the young adult, deconstructing the old model of skills achieved and then lost due to mental disorders. The is something new that the young adult could not actively access before, because still a "child", and that then does not occur or is interrupted in the bud, due to the developmental breakdown. Therefore, the term rehabilitation is misleading.

The youth population, especially in socially disadvantaged contexts, has no access to artistic and cultural activities, necessary to guarantee a growth environment that promotes psychic development and relational skills. "Despite the growing evidence on the impact of culture on wellbeing [46,52,53] there is a recurrent argument that is raised in debates involving cultural practitioners and professionals: insisting on the role of culture in promoting wellbeing may be counterproductive in that it characterizes culture as an instrumental activity to promote other goals, however in the public interest. This argument, however, stems from a specific, and totally legitimate, vision of culture as a human activity that finds its justification in itself and has to be appreciated merely for what it is. Therefore, whereas one should avoid an over-simplification of cultural creation and participation processes as instrumental to wellbeing goals, it is equally fair to acknowledge that there may be cultural and artistic practice that may pursue such goals as part of a legitimate, historically founded vision of the role of arts and culture in contemporary societies" [54] (p. 21). Argolab2 Potential Space provides cultural and relational experiences that YA can meet and choose according to their interest and curiosity. This environment has increased confidence in the care pathway and fostered social skills, as evidenced by the data.

The academic literature underlined the terrible impact of the COVID-19 pandemic on this population and showed a correlation between the increase in suicide attempts and psychiatric disorders on the one hand and disruption to education, online teaching, and social isolation on the other hand [55–58]. This study demonstrated the efficacy of specific interventions targeting the young population and recommends that such interventions are implemented and supported by appropriate resources and facilities within DSMs. Further studies could, through statistical analysis and other qualitative data, assess the stability of the process also in relation to organizational variables.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/ijerph192215252/s1, Table S1. Diagnostic groups; Table S2. Prevalent YA patients—Distribution by Gender and Diagnosis; Table S3. Prevalent YA patients—Distribution by Nationality; Table S4. Incident YA patients—Distribution by Diagnostic Group; Table S5. Incident patients—Comparison between total population and YA population; Table S6. "*Argolab2 Potential Space*"—Population.

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Review

Performing Arts in Suicide Prevention Strategies: A Scoping Review

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Abstract: Suicide is a leading cause of death all over the world. Suicide prevention is possible and should be pursued through a variety of strategies. The importance of the arts for positive health outcomes has been increasingly evidenced. This scoping review aimed to identify the possible role of the performing arts—defined as a type of art performed through actions such as music, dance, or drama executed alive by an artist or other participant in the presence of an audience,—in suicide prevention programs. PubMed, Embase, PsycINFO, CINAHL, ProQuest Psychology Database, Scopus, and Web of Science were searched using terms in English for publications of original studies that included performing arts in suicide prevention programs. Thirty-five studies conducted between 1981 and 2021 were identified, of which only five were randomized clinical trials and four quasi-randomized studies. Interventions used different performing arts to improve awareness, self-efficacy, and soft skills relevant to suicide prevention. Studies were addressed mainly to gatekeepers but also directly to at-risk populations. While the study designs do not allow inferences to be drawn about the effectiveness of performing arts in preventing suicide, the review found that performing arts have been successfully implemented in suicide prevention programs. Research to evaluate the possible therapeutic benefit is warranted.

Keywords: suicide; prevention; performing arts; theater; role playing; gatekeepers

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1. Introduction

1.1. Suicide and Its Prevention

Suicide is a leading cause of death all over the world, with an estimated death toll of about 700,000 per year. Globally, for all ages, the suicide rate is greater in males than females. More than half of suicides occur under 50 years of age. Between 15 and 29 years, suicide represents the top third cause of death for females and the top fourth for males [1]. Recent findings reveal that the incidence of suicide is rapidly increasing throughout adolescence [2,3]. Because suicide is a public health priority, the WHO member States are working to achieve the goal of reducing the global suicide rate by one-third by 2030.

Suicidal behavior has multiple causes that are broadly divided into proximal stressors or triggers and predispositions [4,5]. In our experience, suicide prevention must be seen as a set of actions that can, in various cases, reduce the risk of suicide, although it is never completely nullified precisely because of the multifactorial nature of suicide. Psychiatric illness is a major contributing factor, and mood disorders, especially major depressive disorder and bipolar disorder, are associated with about 60% of suicides [6]. It is known, however, that factors such as chronic pain or illness, legal, criminal, or financial problems, impulsive or aggressive tendencies, substance abuse, adverse childhood experiences, loss, discrimination, bullying or violence, social isolation, and stigma are all linked to an increased risk of attempting suicide [7].

Suicide prevention is possible [8,9] and should be pursued through different strategies. WHO recognizes that evidence-based interventions for suicide prevention should be organized in a framework that distinguishes between universal, selective, and indicated interventions in order to modify health systems, societies, communities, and individual relationships with a "comprehensive, multisectoral approach" [10,11].

Since no single method is clearly superior to others [12], suicide prevention should involve public health strategies at a national level by promoting public education campaigns to reduce stigmatization, limiting access to lethal methods, such as firearms, dangerous medicines, or pesticides, and educating the media for a responsible report of suicide news [13]. It is crucial to improve the awareness of suicide risk factors and depression management by primary care physicians and non-psychiatrist medical specialists.

At the same time, it is also very important to enhance soft skills and education in recognizing the warning signs in college and high schools among teachers, students, and gatekeepers in general. Contact with potentially vulnerable populations provides an opportunity to identify individuals with risk factors, suicidal ideation, or previous suicide attempts and to guide them in a facilitated way toward the appropriate assessment and treatment [9]. Gatekeeper training programs are needed for as many individuals as possible who have suicidal ideation but do not seek help and need to be "helped in seeking help" since suicide risk factors are recognizable and thus identifiable [14].

Gatekeepers are defined as "individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine" and, therefore, who may be trained to identify at-risk persons and refer them to the appropriate support services [15]. The category includes clergy, first responders, pharmacists, geriatric caregivers, staff, and those employed in institutional settings, such as schools, prisons, and the military.

At the same time, educating youths about mental health, in terms of awareness, coping skills, and self-referral, is another key element in the complex scenario of suicide prevention strategies [11,16–18].

Although one of the main goals of suicide prevention is to reduce mental illness stigmatization, it is important to consider that raising public awareness of suicide may have the unintended consequence of adversely affecting vulnerable individuals by suggesting that suicidal behaviors are somewhat widespread and can be an acceptable way to cope with difficulties. Thus, suicide prevention strategies must take into account both the potential benefits and possible risks of the interventions [19].

1.2. Performing Arts and Mental Health

Art is broadly defined as any means of expressing individual and social values through concrete and creative activities and processes [20]. According to Dewey's conceptualization of art, artistic interventions can communicate a moral or educational purpose or explain experiences of the everyday emotional and rational inner world [21]. Art is a specific praxis focused on giving light and enabling the relationship between human beings and the world in which they live [22].

Although boundaries are sometimes difficult to define, the arts can roughly be divided into performing arts, visual arts, literature, culture, and digital arts. In recent years, there has been an increasing interest in research into the effects of the arts on health. The arts, in fact, strengthen a relationship with cultural identity, and their use can have positive effects on mental and physical well-being by promoting self-understanding, expression, confidence, self-esteem, and both verbal and nonverbal communication [23–26].

The arts can also contribute to the management and treatment of illness across a lifespan, as underlined by a recent scoping review by the WHO [27]. Performing arts provide imaginative experiences for both the art producer and the audience and provoke an emotional response and cognitive stimulation as well as stress reduction; the creative process of art production, in fact, requires novelty, creativity, and originality together with specialized and technical skills [27].

Since the mid-20th century, especially in Western countries, there has been a great deal of interest in evaluating the effect of the arts on health. In particular, the use of performing arts, defined as types of art performed through actions executed live by the artist or other participants for a present audience, such as music, dance, or drama, is becoming widely used as a tool for physical and especially mental health prevention, as well as promotion and treatment in care settings, as recently reviewed by Gaiha and colleagues [28]. In Italy, for example, one area of new theatrical engagement has been in psychiatric residential settings, just at the time when mental health policy reforms mandated by the 1978 Basaglia law led to the deinstitutionalization of psychiatric patients [29].

In recent years, there has been an increasing use of the arts to counter the stigma that still exists against mental illness. Interactive theater, for example, has been often recognized as a tool for promoting prosocial behavior and addressing deeply held stigmas [30]. This kind of prejudice is also being challenged by demonstrating the role of performing arts in promoting reintegration into employment, facilitating skill development, and the ability to engage in learned behaviors and breaking down barriers between people with and without mental illness [27,31–33].

In many cases, the experiences based on performing arts are developed for groups of people sharing the same conditions—such as youth or ill and vulnerable people—or the same cultural background—in particular, people living in rural areas, immigrants, or people affected by conflicts— [27,34–36]. An interactive performance model, in which students actively engaged in their own learning through dialogue, experimentation, and movement, seemed to be more effective than a traditional classroom approach in increasing students' willingness to comfort victims of sexual violence in distress [37]. People participate in the creation of artwork under the guidance of specialists: for this reason, it is crucial for these people to be trained to administer this type of intervention. It is also important for trainers to be aware of the possible dangers of these activities [38,39] in terms of being engaged in "demanding" activities that could have psychological negative effects on patients [40].

Performing art forms have demonstrated improvements in physiological parameters, such as blood pressure, heart rate, and immune status in patients with cancer, respiratory or cardiac disease, or diabetes, and, in the case of cancer patients, there was a reduction in anxiety and depression [27]. Dance and movements offered patients with mental illnesses a good way to communicate and increase physical activity, and in patients with Parkinson's disease, they reduced the sense of isolation [27,41]. According to some studies, involvement in performing arts reduced the risk of developing depression in adolescence or later in life, as active participation helped improve self-confidence. Children and adolescents who participated in art programs reported increased communication skills, anger management, and higher levels of well-being, socialization, and resilience than at the beginning of the experience [42,43]. Other studies indicated an improvement in life skills, coping skills, prosocial attitudes and behaviors, an increase in school performance, and the confidence to help their peers in ways not sufficiently supported by traditional programs [44–46]. Art classes involving creative writing, dancing, or listening to music strengthened the sense of mutual support among health care workers and improved the work environment by decreasing conflicts. Art programs were also found to facilitate caregiver–care interaction and intensify emotional responses, thus making treatments more effective [27,47].

Different art forms can also be helpful for the caregivers themselves, who can, thus, listen to their own needs, reduce stressors, increasingly improve empathy, enjoy moments of catharsis, and build a positive image of themselves and their effectiveness [27].

Much attention has also been given to the inclusion of performing arts, for example through role-playing, in the education and training of mental health workers, especially when considering the potential effects of these interventions on communication skills, empathy, and understanding of the needs of patients. In most cases, health care workers receiving this type of education understood how to respond more humanely to medical, ethical, and social needs and reported greater satisfaction with their jobs [48]. Participants could either be exposed to the arts (e.g., as active observers) or create their own arts (e.g., actors or writing dramaturgy). In both situations, they are active and involved in neuronal cognitive interactions with the play [49] and in dynamic present interactions with the trainers through, for example, the application of role-playing skills in a variety of hypothetical contexts and situations [27,50].

These approaches appear to be superior to passive techniques; the use of passive training methods, in fact, has been shown to have diminutive effects on both skill acquisition and subsequent behavior, in large parts, due to the limited opportunity to practice and receive constructive feedback on skill usage [51,52]. With active methods, it is easier to implement new skills, and participants can control their skill development (e.g., by practicing learned skills, asking questions, and receiving feedback appropriate to their performance) through dynamic interactions with trainers [31,33,53].

Performing arts that exploit these modalities can offer truly active cultural participation by involving participants in the creative process at any level through the assignment of active roles, such as that of actors, authors, organizers, or members of an active audience. It is also worth noting how the "real-time" dimension of the performing arts requires a specific social and physical encounter between participants, both in the creation of the product and in its fruition.

For the purposes of this review, performing arts include participatory theater, dramatic improvisation, role-playing, and in person attendance of a theater performance.

1.3. Performing Arts in Suicide Prevention

The creative expression that accompanies the art process is an engaging emotional experience that can powerfully contrast with the implicit destructiveness of suicide behaviors [29,54]. As mentioned above, there is clear evidence that art interventions can support mental health [27,55–58] since they facilitate dialogue, reduce stigma, and enhance expression, coping skills, empathy, and personal and cultural resonance, all of which address risk factors for suicide [27,59,60]. They can also facilitate the expression of emotions such as entrapment, loneliness, and burdensomeness [61], enhance belonging [57], and protect against suicidal ideation [62]. As with alcohol prevention and other public health topics, research on suicide prevention shows that didactic education and awareness-raising alone will not reduce the risk [63,64]. Instead, more direct and personal forms of involvement are needed [34,65].

Indeed, a major limitation of suicide prevention programs is the reliance on passive training techniques, such as listening to in-person lectures and self-study (e.g., online readings and watching videos) [66]. Hence, active learning techniques should be implemented, as they can help facilitate skill development and the ability to engage in learned behaviors [31–33,53]. As mentioned above, active learning techniques consist of dynamic interactions between the participants and the trainer through the application of skills in role-playing in a variety of contexts and hypothetical situations. These approaches appear to be superior to passive approaches in that participants can take control of their own activity.

Using theater programs as a suicide-prevention tool is not new. In 1974, Jackson and Potkay [67] reported favorable reactions from college-aged audiences to an educational play regarding suicide. More generally, the participatory theater has long been recognized as a tool for promoting prosocial behavior and addressing deeply held stigmas [34,37,68].

Seeing coping skills modeled through performance or direct interpersonal contact may give students the confidence needed to help their peers in ways not sufficiently supported by the traditional curricula [46]. As reported by Wasserman et al. [65], interactive role-playing with students can influence both suicide attempts and help-seeking behaviors.

1.4. Aims of This Review

Despite the potential value that the performing arts can have for suicide prevention, little systematic assessment of their utilization and therapeutic effects has been reported. We conducted a scoping review with the aim of evaluating the currently available evidence of the possible applications of performing arts to suicide prevention. Since we expected to find a very heterogeneous set of publications, we chose the format of the scoping review in order to provide a wide overview of what is currently known on the topic. More specifically, the review aimed at addressing the following main questions: (1) *Study design*: Which study designs have been used to assess the feasibility, benefit, and possible adverse effects? On which populations? In which settings? (2) *Purpose and outcomes*: Were there any attempts to estimate effectiveness? Which outcomes have been examined? What is the evidence for feasibility and effectiveness? (3) *Art Forms*: What types of performing arts have been used in suicide prevention?

2. Materials and Methods

The Joanna Briggs Institute (JBI) methodology for scoping reviews, described in the online JBI Reviewer's Manual [69], was employed for this review. The results are presented following the preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews (PRISMA-ScR) checklist [70]. No a priori protocol was registered. Further information on the process can be obtained from the corresponding author upon request.

Search Strategy

The review covers data published between 1981 and 2021. Selected keywords were combined to create search strategies which were adjusted for each screened database. Articles were searched in the following databases: PubMed, Embase, CINAHL, PsycINFO, Scopus ProQuest Psychology Database, and Web of Science on 25 May 2022. We searched for articles reporting the use of performing arts (theat* OR drama* OR recit* OR "performing-art*" OR "participatory-art*" OR psychodram* OR "role-play" OR "role-plays" OR "role-playing" OR "role-player*" OR roleplay* OR impersonat* OR storytell* OR "story-tell*") as a suicide prevention strategy.

The complete search string is available in Table 1. Hand-searching of the gray literature sources was also conducted, and additional references identified through other sources with a title and abstract (Google Scholar, Cochrane Library) were included for consideration.

Table 1. Complete search string.

Database	Search String
PubMed	("Suicide"[Mesh] OR suicid*[tiab]) AND ("Drama"[Mesh] OR theat*[tiab] OR drama*[tiab] OR recit*[tiab] OR "performing-art*"[tiab] OR "participatory-art*"[tiab] OR "Psychodrama"[Mesh] OR psychodram*[tiab] OR "role-play"[tiab] OR "role-plays"[tiab] OR "role-playing"[tiab] OR "role-player*"[tiab] OR roleplay*[tiab] OR impersonat*[tiab] OR storytell*[tiab] OR "story-tell*"[tiab])
Embase	(('suicidal behavior'/exp OR suicid*:ti,ab,kw) AND ('drama therapy'/exp OR theat*:ti,ab,kw OR drama*:ti,ab,kw OR recit*:ti,ab,kw OR 'performing arts'/exp OR 'performing-art*':ti,ab,kw OR 'participatory-art*':ti,ab,kw OR 'psychodrama'/exp OR 'role playing'/exp OR psychodram*:ti,ab,kw OR 'role-play':ti,ab,kw OR 'role-plays':ti,ab,kw OR 'role-playing':ti,ab,kw OR 'role-player*':ti,ab,kw OR roleplay*:ti,ab,kw OR impersonat*:ti,ab,kw OR 'storytelling'/exp OR storytell*:ti,ab,kw OR 'story-tell*':ti,ab,kw)) NOT 'conference abstract'/it

Table 1. *Cont.*

Database	**Search String**
CINAHL	(MH “Suicide+” OR TI suicid* OR AB suicid*) AND (MH “Drama” OR TI theat* OR AB theat* OR TI drama* OR AB drama* OR TI recit* OR AB recit* OR MH “Performing Arts” OR TI “performing-art*” OR AB “performing-art*” OR TI “participatory-art*” OR AB “participatory-art*” OR MH “Psychodrama+” OR TI psychodram* OR AB psychodram* OR TI “role-play” OR AB “role-play” OR TI “role-plays” OR AB “role-plays” OR TI “role-playing” OR AB “role-playing” OR TI “role-player*” OR AB “role-player*” OR TI roleplay* OR AB roleplay* OR TI impersonat* OR AB impersonat* OR MH “Storytelling+” OR TI storytell* OR AB storytell* OR TI “story-tell*” OR AB “story-tell*”)
PsycINFO	(DE “Suicidal Behavior” OR DE “Attempted Suicide” OR DE “Suicidal Ideation” OR DE “Suicide” OR DE “Suicidality” OR DE “Suicide Prevention” OR TI suicid* OR AB suicid*) AND (DE “Theatre” OR DE “Drama” OR TI theat* OR AB theat* OR TI drama* OR AB drama* OR TI recit* OR AB recit* OR MH “Performing Arts” OR TI “performing-art*” OR AB “performing-art*” OR TI “participatory-art*” OR AB “participatory-art*” OR DE “Psychodrama” OR DE “Role Playing” OR TI psychodram* OR AB psychodram* OR TI “role-play” OR AB “role-play” OR TI “role-plays” OR AB “role-plays” OR TI “role-playing” OR AB “role-playing” OR TI “role-player*” OR AB “role-player*” OR TI roleplay* OR AB roleplay* OR TI impersonat* OR AB impersonat* OR DE “Storytelling” OR TI storytell* OR AB storytell* OR TI “story-tell*” OR AB “story-tell*”)
ProQuest Psychology Database	(MAINSUBJECT.EXACT(“Suicides & suicide attempts”) OR ti(suicid*) OR ab(suicid*)) MAINSUBJECT.EXACT(“Drama”) OR MAINSUBJECT.EXACT(“Acting”) OR MAINSUBJECT.EXACT(“Performing arts”) OR MAINSUBJECT. EXACT(“Role playing”) OR MAINSUBJECT.EXACT(“Storytelling”) ti(theat* OR drama* OR recit* OR “performing-art*” OR “participatory-art*” OR psychodram* OR “role-play” OR “role-plays” OR “role-playing” OR “role-player*” OR roleplay* OR impersonat* OR storytell* OR “story-tell*”) ab(theat* OR drama* OR recit* OR “performing-art*” OR “participatory-art*” OR psychodram* OR “role-play” OR “role-plays” OR “role-playing” OR “role-player*” OR roleplay* OR impersonat* OR storytell* OR “story-tell*”) 2 OR 3 OR 4 1 AND 5
Scopus	((TITLE-ABS-KEY (suicid*)) AND (TITLE-ABS-KEY (theat* OR drama* OR recit* OR “performing-art*” OR “participatory-art*” OR psychodram* OR “role-play” OR “role-plays” OR “role-playing” OR “roleplayer*” OR roleplay* OR impersonat* OR storytell* OR “story-tell*”))) AND NOT ((INDEX (medline OR embase)) OR (PMID (1* OR 2* OR 3* OR 4* OR 5* OR 6* OR 7* OR 8* OR 9* OR 0*)))
Web of Science	TS = (suicid*) AND TS = (theat* OR drama* OR recit* OR “performing-art*” OR “participatory-art*” OR psychodram* OR “role-play” OR “role-plays” OR “role-playing” OR “role-player*” OR roleplay* OR impersonat* OR storytell* OR “story-tell*”)

2.1. Inclusion and Exclusion Criteria

The inclusion criteria to select the articles for this review were based on the population, concept, and context (PCC) elements reported below.

Population: Interventions could directly target specific at-high-risk populations or indirectly target gatekeepers. As regards the age range, we included articles considering both adults and youth.

Concept: We searched for original articles reporting about interventions using the performing arts as a suicide prevention strategy. We included participatory theater, dramatic improvisation, role-playing, role-playing online simulation, the vision of theater performance, and education-like applied theater as types of performing arts. Drama therapy has been excluded from this review since it is a specific treatment approach with a clear-cut therapeutic goal. We also excluded cinema and, in general, watching movies or participating in a cinema club because these imply a passive attitude, while theater performances involve audience participation in a more direct way since the performers and audience interact in a constant cyclic interchange. Moreover, each play or performance is an experience that exists in a finite space and time and has a sort of uniqueness, being much more linked to the relationship between that particular performer and the attending audience. We excluded book chapters or sections, reviews, thesis, conference proceedings or conference papers, and poster contributions to scientific congresses. We excluded all original papers that were not in English and all articles we were not able to find.

Context: The approach was inclusive, and no cultural, geographical, race, or gender-specific limits were set.

2.2. Screening and Selection of Articles

Articles were initially screened based on their titles and abstracts according to the criteria previously described. Duplicates were removed. Full-text papers published in English in peer-reviewed journals since 1981 were selected. The first 50 articles were examined together by two authors (EL and FDF); then, 10% of all the articles were independently screened for eligibility by the two authors, and a consensus was reached through discussion between the two authors and consultation with a third author (CD); finally, all the remaining articles were evaluated for their eligibility independently by the two reviewers and, in case of discordant opinion, consensus was reached with input from the third reviewer (CD).

2.3. Extraction and Presentation of Results

All the data relevant to inform the scoping review objectives and questions were extracted from the articles meeting the inclusion criteria. The strength of the evidence for each article was assessed according to the levels of evidence developed by the JBI [69].

The results were grouped according to the year, country, study design, main art forms (theater performance, role-playing), purpose, sample size, study population, and period of intervention. The study design has been classified according to the JBI levels of evidence [71].

3. Results

3.1. Selected Publications

The search yielded a total of 5737 records (Figure 1). After electronically eliminating duplicates, the titles and abstracts of the remaining 3086 records were manually screened for suitability based on the stated inclusion and exclusion criteria. Based on this review, another 36 duplicate publications were identified and, therefore, discarded. Among the remaining records, 3015 were excluded since they did not meet the criteria. A total of 35 publications were eventually included in the scoping review (Table 2).

3.2. Study Design—Which Study Designs Have Been Used to Assess Feasibility, Benefit, and Possible Adverse Effects? on Which Populations and Settings? What Is the Evidence for Feasibility and Effectiveness?

The selected studies are characterized by their extreme heterogeneity in terms of study design, type and size of populations studied, their purpose, and outcomes. Of the 35 included studies, most of them were observational studies without a control group ($n = 22$) [30,50,72–91], four were quasi-experimental prospective controlled studies [92–95], four were cross-sectional studies [96–99] and five were randomized control trials (RCTs) [18,100–103].

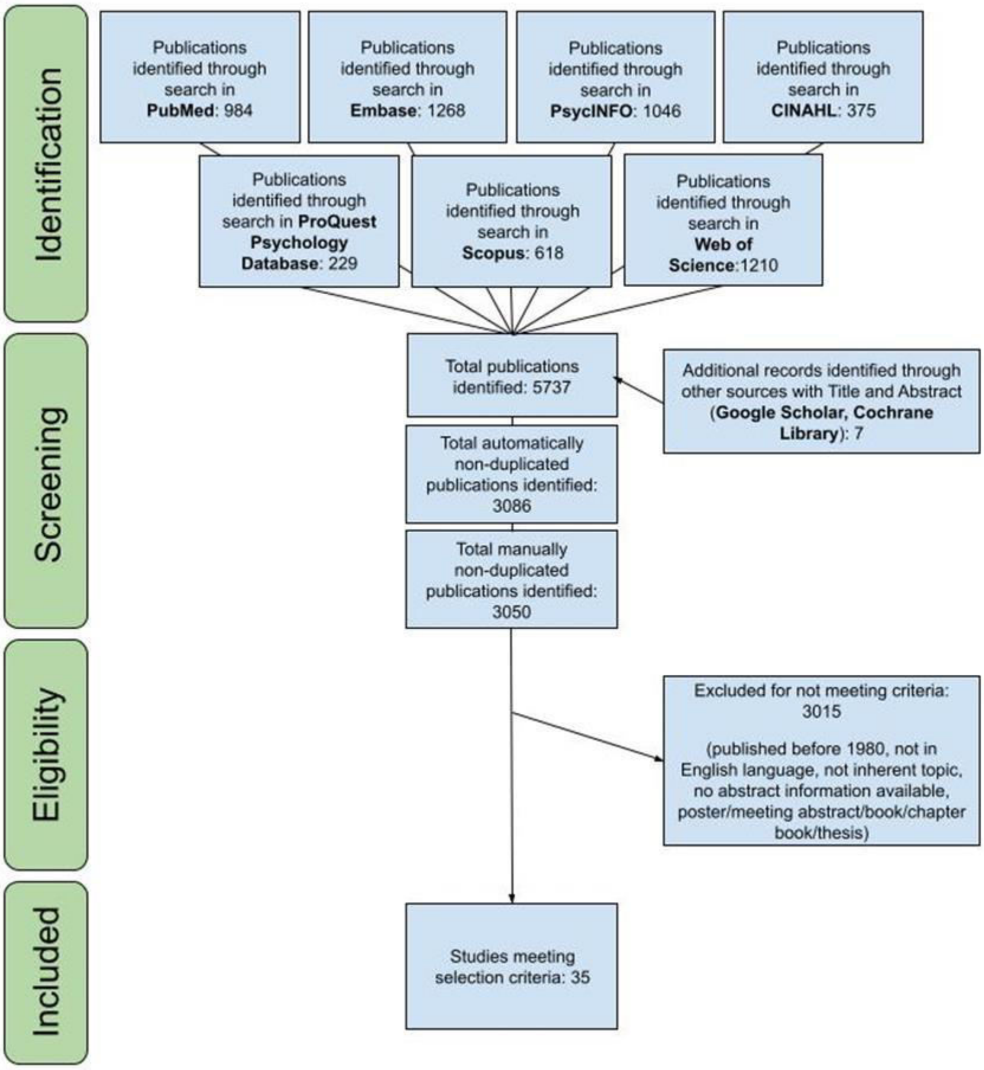

Figure 1. Study selection flow chart.

Table 2. Articles meeting the inclusion criteria.

Reference	Country	Study Design	Main Art Form Used	Purpose	Sample Size and Population	Period of Intervention
Bartgis et al., 2016 [82]	USA	Observational study without a control group	Role-play online	To examine the outcomes for American Indian and Alaska Native students, teachers, and faculty completing online role-play gatekeeper training simulations.	Gatekeepers-9000: university professors, college students, high school, and middle school educators	From April 2011 to December 2013
Birrane et al., 2015 [79]	Ireland	Observational study without a control group	Role play	To describe the development and evaluation of an educational intervention on youth mental health and substance misuse for primary care professionals.	Gatekeepers-30 general practitioners and other primary care professionals	Session: 2 h
Carpenter et al., 2021 [88]	USA	Observational study without a control group	Role play	To identify how to adapt the online Veteran Administration's suicide prevention gatekeeper training program (SAVE) for community pharmacy staff.	Gatekeepers-17 community pharmacy staff members	Session: 20 min and 1 h semi-structured interview.

Table 2. *Cont.*

Reference	Country	Study Design	Main Art Form Used	Purpose	Sample Size and Population	Period of Intervention
Coleman et al., 2015 [94]	USA	Quasi-experimental prospectively controlled study	Role play	To test hypotheses about two brief suicide prevention gatekeeper trainings (question, persuade, refer [QPR] and RESPONSE) and one longer suicide intervention skills training (Applied Suicide Intervention Skills Training [ASIST]).	Gatekeepers-126 (clinician, teachers, church leaders, coaches, corrections staff)	Session: 1 h 25 min. Period of intervention: 6 months.
Cross et al., 2007 [74]	USA	Observational study without a control group	Role play	To evaluate outcomes of a gatekeeper training for suicide prevention in a sample of non-clinicians.	Gatekeepers-76 nonclinical employees in a university hospital	Session: 1 h. Period of intervention: 6 weeks.
Cross et al., 2010 [76]	USA	Observational study without a control group	Role play	To assess and predict the impact of brief, gatekeeper training on community members' observed skills.	Gatekeeper-50 employees at US universities	Session: 6 h. Period of intervention: 4 months.
Cross et al., 2011 [100]	USA	RCT	Role play	To compare gatekeeper training as usual with training plus brief behavioral rehearsal for school staff and parents in a school community.	Gatekeepers-114	Session: 1 h 25 min. Period of intervention: 17 months.
Fanian et al., 2015 [80]	Canada	Observational study without a control group	Multiple art forms—spoken word, sound production and design, film, photography, multimedia arts, jewellery making and visual arts.	To evaluate a creative arts workshop for Tłı̨chǫ youth to explore critical community issues and find solutions together using the arts.	9 youth per day-ages ranged from 13 to 22	Session: 5 days
Fenwick et al., 2004 [92]	UK	Quasi-experimental prospectively controlled study	Role play	To evaluate the impact of two types of training courses: full day workshops with actors role-playing patients; and a half-day lecture.	Gatekeepers-107 from different disciplines	Session: 1 h 45 min. Period of intervention: 2 months.
Godoy Garraza et al., 2021 [103]	USA	RCT	Role play	To examine the impact of two training enhancements (role-play and booster) on intermediate gatekeepers training outcomes.	Gatekeepers-661 (287 QPR + Role-play; 374 QPR Alone)	Session: 1–2 h. Period of intervention: 6 months.
Goldberg et al., 2012 [97]	Russia	Observational study without a control group	Role play	To improve the education of existing primary care staff on the management of mental health disorders.	Gatekeepers-37 general practitioners, feldshers, practice nurses, psychologists, and teacher	Session: 5 days. Period of intervention: 3 months.
Gryglewicz et al., 2020 [50]	USA	Observational study without a control group	Role play	To examine the effect of role-play training on mental health practitioners' attitudes, subjective norms, and perceived behavioral control surrounding suicide risk assessment behaviors.	Gatekeepers-137 mental health workers	Session: 4.5 h. Period of intervention: 3 years.
Høifødt et al., 2007 [73]	Norway	Observational study without a control group	Role play	To describe the experience of newly educated physicians lived experience learning processes related to treating suicidal patients.	Gatekeepers-13 medical candidates	Session: 2 days

Table 2. *Cont.*

Reference	Country	Study Design	Main Art Form Used	Purpose	Sample Size and Population	Period of Intervention
Hutson et al., 2021 [89]	USA	Observational study without a control group	Role play-simulation	To describe objective structured clinical examinations (OSCEs) for nurse practitioner students aimed at building skills for managing a pediatric patient with acute suicidal ideation.	Gatekeepers-18 nurse practitioners, pediatric nurse practitioner and psychiatric-mental health nurse practitioners	Session: 20 min and 24 h to complete evaluation.
Kaur, 2021 [95]	India	Quasi-experimental prospectively controlled study	Role play	To investigate the effect of life skills training on the suicidal behavior of adolescents.	970 adolescents (485 experimental group; 485 control group)	Session: 40 min
Keller et al. J Soc Mark. 2017 [83]	USA	Observational study without a control group	Theater	To examine whether a community-based suicide prevention project could increase willingness to seek professional help for suicidal ideation among eastern Montana youth.	224 high school students	Session: the performance lasted 20 min, followed by a moderated 40 min Q and A session. Period of intervention: 6 months.
Keller et al., 2017 [30]	USA	Observational study without a control group	Theater	To evaluate a community-based, narrative theater project designed to increase awareness and use of suicide prevention resources among eastern Montana youth.	27 high school students and college students	Session: 12 weeks. Period of intervention: 3 years.
Keller et al., 2019 [99]	USA	Cross-sectional study	Theater	To analyze differences in Eastern Montana Caucasian and Native American youths' experiences with stigma about mental illness that affect help-seeking for suicidal experiences.	33 high school students and college students	10 weeks
Kratz et al., 2020 [87]	USA	Observational study without a control group	Role play	To evaluate the outcomes of an educational pilot study integrating didactic instruction, readings, role-plays, and simulation for teaching suicide intervention skills.	Gatekeepers-58 Master of Social Work's students	Session: 50 min. Period of intervention: 16 weeks.
Long et al., 2018 [101]	USA	RCT	Role-play online	To evaluate the impact of the At-Risk for Elementary School Educators online mental health role-play simulation for elementary school teachers on changes in teachers' helping attitudes and behaviors in students experiencing psychological distress.	Gatekeepers-18,896 schoolteachers, mental health professionals	Session: 45–90 min. Period of intervention: 3 months.
Morriss et al., 1999 [72]	UK	Observational study without a control group	Role play	To devise and evaluate the retention of a new brief training package for non-psychiatrically trained multidisciplinary staff to assess suicide risk and manage suicidal patients.	Gatekeepers-33 health and voluntary workers	8 h of interview skills training (2 h sessions).

Table 2. *Cont.*

Reference	Country	Study Design	Main Art Form Used	Purpose	Sample Size and Population	Period of Intervention
Nakagami et al., 2018 [85]	Japan	Observational study without a control group	Role play	To evaluate a suicide intervention program among medical staff.	Gatekeepers-74 medical staff members	Session: 2 h. Period of intervention: 1 month.
Nash et al., 2021 [91]	Australia	Observational study without a control group	Theater	To evaluate a workshop for health care students that used filmed vignettes from a verbatim theater play.	Gatekeepers-65 nursing, medical and allied health students and medical students only.	Session: 90 min
O'Reilly et al., 2019 [102]	Australia	RCT	Role play	To use a novel mental health first aid assessment approach involving simulated role-plays enacted by people with a lived experience of mental illness and explore participants' and simulated patients' views of participating in simulated role-plays of mental health crises.	Gatekeepers-22 pharmacy students	Mean duration of 28.8 min
Owen et al., 2018 [84]	USA	Observational study without a control group	Role play	To create a symposium curriculum to provide a structured, safe environment where mental health trainees and practitioners of various specialties cab obtain collegial support and education to reduce the stigma and potential isolation surrounding patient suicide.	35 mental health practitioners and trainees	Session: 4 h
Pasco et al., 2012 [93]	USA	Quasi experimental control study	Role play	To evaluate the efficacy of an experiential-based gatekeeper training, which included an emphasis on enhancing communication skills and relational connections in addition to the didactic foci of standard gatekeeper training.	Gatekeepers-65 college resident advisors	Session: 3 h
Robinson et al., 2016 [81]	Australia	Observational study without a control group	Role play	To examine the impact of delivering an evidence-based gatekeeper training package for suicide prevention (STORM®) in an Australian setting.	Gatekeepers-84 staff members from schools	Training package duration (2 days) and FU 8 weeks later.
Ross et al., 2021 [90]	USA	Observational study without a control group	Role play	To evaluate the Suicide Prevention for College Student Gatekeepers training program, designed to provide college students with information about the warning signs of suicide, as well as how to intervene when indicated.	Gatekeepers-65 college students	Session: 90 min. Period of intervention: 12 weeks.

Table 2. *Cont.*

Reference	Country	Study Design	Main Art Form Used	Purpose	Sample Size and Population	Period of Intervention
Silverman et al., 2013 [77]	Canada	Observational study without a control group	Multiple art forms—performing arts (drama, music, artmaking, and writing)—arts-based approach.	To describe a two-day arts-based symposium that brought together members from diverse cultural communities.	18 members from different cultural communities including the Inuit, Mohawk, Jewish, Christian, Baha'i, South-Asian Canadian, Senior and LGBTQ communities.	Session: 2 days
Stewart et al., 2009 [75]	USA	Observational study without a control group	Multiple art forms—classes encompassing the visual, performing, musical, media, and theatre arts.	To examine the effects of the Prodigy Cultural Arts Program on at-risk and adjudicated youth in a rural and an urban locale.	350 adolescents and their parents	Session: 2 months
Thomas et al., 2006 [96]	UK (Scotland)	Cross-sectional study	Theatre	To evaluate STIGMA play and workshops, with the aim of addressing sensitive issues close to young people, such as suicide or self-harm, and to improve seeking help attitudes.	950 secondary school children	Session: 1 h and 10 min
Timmons-Mitchell et al., 2019 [86]	USA	Observational study without a control group	Role-play online	To examine the impact of a virtual training program, Kognito At-Risk role-play simulation, on the mental health and suicide prevention gatekeeping skills of middle school educators.	Gatekeepers-33,703 middle school educators	Session: 45–90 min. Period of intervention: 3 months.
Vallance et al., 2014 [78]	UK	Observational study without a control group	Role play	To develop and evaluate a novel teaching session on clinical assessment using role play simulation.	Gatekeepers-10 medical students	Session: 90 min
Wasserman et al., 2018 [98]	Estonia, Italy, Romania and Spain	Cross-sectional study	Role play	To discuss mental health in terms relevant to youth (peer support, stress, crisis, depression, suicide, and help-seeking), after their participation in the Youth Aware of Mental Health Program.	32 adolescents	Session: a five-hour program spanning three weeks.
Wasserman et al., 2015 [18]	Europe (Austria, Estonia, France, Germany, Hungary, Ireland, Italy, Romania, Slovenia, and Spain).	RCT	Role play	To report the results of the Saving and Empowering Young Lives in Europe (SEYLE) study, a largescale, multi-country, European randomized controlled trial of the school-based prevention of suicidal behavior in adolescents.	11,110 adolescents	Session: 5 h in 4 weeks. Period of intervention: 12 months.

Most of the studies were published from 2010 onward (29, 83%) [18,30,50,64,76–83,85–91,93–95,97–103]. Regarding geographical provenience, 54% of the studies were conducted in the US (19) [30,50,74–76,82–84,86–90,93,94,99–101,103], four in the UK [72,78,92,96], three in Australia [81,91,102] and two in Canada [77,80]. The remaining studies were from Norway (one) [73], Russia (one) [97], Ireland (one) [79], Japan (one) [85], and India (one) [95]. Two studies reported a European experience (the Saving and Empowering Young Lives in Europe–SEYLE- and Youth Aware of Mental Health Program–YAM-study) and had a mixed population, respectively, from the Austrian, Estonia, France, Germany, Hungary, Ireland, Italy, Romania, Slovenia, and Spain–SEYLE study [18], and from the Estonian, Italy, Romanian and Spain–YAM study [98].

Most of the studies (22) [18,50,74–76,79,82–87,90–96,100,101,103] used quantitative methods to assess their outcomes, while a smaller portion used a qualitative approach (7) [30,73,77,88,98,99,102] and six studies used mixed methods, with both qualitative and quantitative data collection or analysis techniques [72,78,80,81,89,97].

The studies were heterogeneous as to the sample size: fourteen studies (40%) had a very small sample size (from 10 to 50 participants), eight studies had a sample size from 51 to 100, five studies had a medium sample size (ranging from 101 to 349 subjects), and eight studies had a very large sample size of up to 33,703 participants [86]. The studies with the largest sample sizes (9000, 11,110, 18,896, and 33,703 participants [18,82,86,101], used online role-playing simulator techniques, except for the SEYLE study [18].

Regarding the participants, most of the studies were addressed to gatekeepers as school staff members, educators, university professors, college or high school students, social workers, and nonclinical employers in hospitals (twelve studies, 31.4%) [74,76,81,82,86,87,90,92–94,100,103]; nine studies were addressed to youth, adolescents, college or high school students as vulnerable and high-risk populations [18,30,75,80,83,95,96,98,99], ten to health professionals in training [50,72,73,78,79,84,85,88,89,102], such as medical school students, nurse practitioners, residents, physicians, and pharmacy staff members. Two studies were addressed to the adult population [77,91], and finally, three had mixed recipients (i.e., schoolteachers and mental health professionals or gatekeepers and adolescents, as in the SEYLE study) [18,97,101].

3.3. Purpose and Outcomes—Was There Any Attempt to Estimate Effectiveness? Which Outcomes Have Been Examined? What Is the Evidence for Feasibility and Effectiveness?

Four studies reported on the outcomes of online gatekeeper training programs, with positive outcomes in terms of preparedness, likelihood, and self-efficacy [82,86,101]. In Vallance's study, attitudes towards a novel application of learning technology were also evaluated in terms of usability, utility, and improvements in psychiatric skills/knowledge. Users also expressed less anxiety and more enjoyment than when role-playing face-to-face [78].

Fourteen studies reported on the outcomes of different gatekeeper training programs in which role-playing was used [50,72,74,76,79,81,85,87–90,93,97,102]. The studies were mainly focused on evaluating pre-post knowledge and perceived skills (attitudes), but some studies also analyzed the diffusion of knowledge, satisfaction, behavior, and the acceptability of the program. Some studies also planned a follow-up evaluation of the post-intervention evaluated competencies [81,85,90].

Four studies, two RCTs [100,103] and two quasi-experimental prospective controlled studies [92,94], compared different gatekeeper training programs. In particular, Coleman tested hypotheses about two types of brief suicide prevention gatekeeper training (question, persuade, refer [QPR] and RESPONSE) and one longer suicide intervention skills training (Applied Suicide Intervention Skills Training [ASIST]), finding that all three types of training showed large changes in prevention attitudes and self-efficacy that was largely maintained at follow-up. ASIST trainees showed large increases in asking at-risk youth about suicide at follow-up [94]. Cross et al. compared gatekeeper training as usual with training plus brief behavioral rehearsal (i.e., role-playing). They found that both training conditions resulted in enhanced knowledge and attitudes, but interestingly, behavioral rehearsal with role-playing practice resulted in higher total gatekeeper skill scores both immediately after training and at follow-up [100]. Godoy and colleagues aimed to examine the impact of two training enhancements (role-playing and booster training) to QPR gatekeeper training programs and found that at the six-month follow-up, among the participants assigned to role-playing, a significantly larger proportion of those were assigned booster performed identifications and referrals of high-risk subjects [103]. Finally, Fenwick et al. compared the impact of two types of training courses: full-day workshops with actors using role-playing with patients and a half-day lecture and found that both types, of course, led to improvements in skills and confidence, which were sustained at a two-month follow up [92].

Two other studies were focused on reducing the stigma and isolation surrounding a patient's suicide [84] and described the experience of dealing with suicidal patients [73] with a qualitative approach, providing additional information about this delicate theme.

A description of interactive approaches which increased awareness of mental health issues was provided both by Wasserman, who interviewed youths who participated in the YAM program, a universal mental health promotion program [98] and by Fanian, who described art model interventions for youths in North-West Territories in Canada, where they explored critical community issues and found solutions together using the performing arts [80]. Different studies focused on increasing awareness of mental health and suicide problems or an increase in the willingness to seek help or to struggle against stigma [30,83,91,96], for example, with positive outcomes in terms of self-efficacy for communicating about suicidal thoughts or seeking help [30,83]. Keller and colleagues analyzed differences in Eastern Montana Caucasian and Native American adolescents and young adults' experiences with stigma about mental illness that affected help-seeking for suicidal experiences. Using textual analysis, they found that for both ethnic groups, stigma is a barrier to expressing emotional vulnerability, seeking help, and acknowledging mental illness [99].

Two studies were aimed at reducing suicidal behaviors among adolescents. An Indian quasi-experimental prospective controlled study [95] tested the effect of life skills training on suicidal behavior in 950 adolescents in the ninth grade. They measured the frequency of suicidal behavior pre-and post-intervention with a self-report psychometric test and found a significant effect of life skills training in reducing suicidal behavior. The training also improved decision-making, problem-solving, goal-setting, conflict resolution, advocacy, coping, and mindfulness skills for students. The SEYLE study was a multicenter, cluster-randomized controlled trial. Participating schools were randomly assigned to receive one of three interventions or as a control group. QPR is a gatekeeper training module targeting teachers and other school personnel, the YAM targeting pupils, and screening by professionals (ProfScreen) with the referral of at-risk pupils. The primary outcome measure was the number of suicide attempt(s) made by a 3-month and 12-month follow-up. No significant differences between the intervention and control group were recorded at the 3-month follow-up however, at the 12-month follow-up, YAM was associated with a statistically significant reduction in incident suicide attempts and severe suicidal ideation compared with the control group [18].

Stewart and Colleagues examined the effect of the Prodigy Cultural Arts Program on at-risk and adjudicated youths in a rural and an urban locale, with specific outcomes on mental health symptoms, delinquency, and family functioning. The results suggest a significant improvement in family functioning overall as well as statistically significant changes in mental health symptoms, including depression/anxiety, somatic, and suicidal symptoms for both males and females and in both urban and rural settings. The authors also underlined that females appeared to especially benefit from the program [75]. A two-day art-based symposium that brought together members from diverse cultural communities has been described in a qualitative way by Silverman et al., with the objective of gathering information on the participants' experiences of exploring the issue of suicide within an art-based approach and of determining if cross-cultural themes would emerge. They found that using the arts helped to facilitate dialogue and communication, and that specific cross-cultural themes did emerge [77].

Only two studies reported detailed information on costs and feasibility: SAVE [88] was chosen over six other online gatekeeper programs because it was available free of charge and is relatively short. Owen's study reports detailed each item's costs (venue, food, support for statistical analysis, faculty members' time). All the other studies did not report cost details or other information on the feasibility of their interventions [84]

Twenty-five interventions are specific to suicide [18,30,50,72–74,76–78,81,83–85,87–90,92–95,99,100,102,103], and the remaining 10 include suicide but also broaden to include mental health [75,80,86,91,97,98,101], stigma [96], psychological distress [82], and substance abuse [79].

3.4. Art Forms—Which Type of Performing Arts Have Been Used on Suicide Prevention?

The art forms used in the studies and included in the review were grouped into three forms: theater, role-playing, and multiple art forms.

Twenty-seven studies used primarily role-playing [18,50,72–74,76,78,79,81,82,84–90,92–95,97,98,100–103], five studies involved mainly theater [30,83,91,96,99], three studies involved multiple art forms [75,77,80], as speech, sound production, and design, film, photography, multimedia arts, jewelry making, visual and performing arts, music and theater, artistic creation and writing).

The components of the art forms used in the studies were articulated as follows.

3.4.1. Theater

Keller and Wilkinson [83] and Keller et al. [30] focused on *Let us Talk*, a community-based suicide prevention performance that was created by community and university theater directors in collaboration with a health research team and student performers. Keller et al. [99] analyzed performances that originated from five theater workshops led by professional theater directors and groups of volunteers. During the playwriting process, the student-actors shared memories, songs, and poems with writer-actors to develop a creative script based on their own experiences of depression, suicidal ideation, suicide attempts, and grief over the suicide of a friend or family member in meetings of 2–3 h per week for 10 weeks. Nash's study [91] evaluated a workshop for health students that used filmed vignettes of a verbatim theater. The STIGMA program [96], provided to students in the Scottish Highlands, consisted of a play with professional actors, a workshop, and evaluation forms to address sensitive issues close to young people, such as suicide or self-harm, and to identify individuals who were struggling or discouraged from seeking help. The duration of the intervention (the play and workshop) was one hour and ten minutes, and information booklets were distributed at the end.

3.4.2. Role Playing

The suicide prevention gatekeeper training program QPR (question, persuade, refer) [104] was used in six studies [18,74,76,94,100,103]. It consisted of a lecture, a 10 min introductory video, the distribution of summary handouts and reference cards, and a question-and-answer discussion period. The participants were given an additional opportunity to use role-playing in small groups. Each group was given a scenario that included a precipitating problem, multiple suicide warning signs, and indications of the need for intervention where they had to play the roles of the suicidal student and the adult caretaker.

The YAM program was developed for the SEYLE study [18] as a coded intervention aimed at all students to promote a greater understanding of mental health, involving 3 h of role-playing sessions with interactive workshops. YAM aimed to increase mental health awareness of the risks and protective factors associated with suicide, including knowledge of depression and anxiety, and to improve skills for coping with adverse life events, stress, and suicidal behavior. YAM was also examined in Wasserman's study [98], in which researchers investigated youth's levels of motivation, their ease with engaging in dialogue with mental health professionals, and comfort with the format and content of YAM through interviews in a qualitative way.

The Campus Connect Gatekeeper course applied in Pasco's study [93] is part of the standard orientation for resident advisors at Syracuse University. During their training, participants are provided with information on suicide prevalence rates among college students, suicide warning signs, and strategies for asking students if they are thinking about suicide. Additionally, participants are instructed on active listening skills and are guided through multiple experiential exercises designed to provide practice, ask questions about suicide, and practice active listening skills. All training courses conclude with role-playing.

Kratz's study [87] explored the educational outcomes of a four-week course on suicidology. The course was characterized by a multimodal structure, which also included role-playing, in which each student spent 50 min with a standardized client presenting a moderate to a severe suicidal crisis.

Some authors organized day-long workshops [85,92] with actors playing depressed patients. A similar strategy was provided in a training course for mental health practitioners [50] in which, after the use of role-playing, trainers and participants discussed how to formulate risks and develop a safety net for the client at risk in the exemplary case. A specific type of high-fidelity simulation was the objective structured clinical examination (OSCE) [89], a high-quality, standardized experience designed to enable nursing students to master skills in the clinical setting. Students encountered a patient who was presented to a mental health clinic experiencing specific psychiatric symptoms in order to build the clinical skills needed to provide pediatric psychiatric care.

Nine other studies [72,73,79,81,84,90,95,97,102] used role-playing in suicide prevention interventions and training programs for gatekeepers, but no detailed information on role-playing was given in the text.

Different studies included in this review used online role-playing. The *At-Risk for Elementary School Educators* simulation is an online digital experience developed by Kognito and used in two studies [86,101]. It is a self-directed online simulation that takes 45 to 90 min. The simulation platform offers role-playing experiences with a virtual student and parent who have similar emotions, personalities, memories, and reactions to students experiencing psychological distress and their parents.

Other online simulations have been used [82], in which the participant interacts with computer-guided avatars or virtual humans rather than another person in highly replicable virtual role-playing games. Users interact with avatars of intelligent, fully animated, and emotionally responsive students who are experiencing psychological distress, such as suicidal thoughts. Additionally, in the study of Vallance [78], users interacted only through their avatars, communicating via audio-microphone headsets. The role-playing phase involved students using their avatars to interact with the teacher, playing the avatar of a "depressed teenager".

The online adaptation of the Veteran Administration's suicide prevention gatekeeper training program (SAVE) was developed for community pharmacy staff [88]. It is a relatively short online gatekeeper program that models telephone and in-person interactions with at-risk patients using semi-structured interviews.

3.5. Multiple Art Forms

The Kǫts'ìıhtła ('Let us light the fire') project was a five-day arts and music workshop for young people that took place in the community of Behchokǫ, North-West Territories, Canada, with the aim of empowering young people to explore critical issues facing their community and their lives and to find solutions together using the arts [80].

Silverman [77] led a two-day art-based symposium in which, through drama, music, artmaking and writing, a group of members from diverse cultural communities was able to share complex feelings and share their thoughts in a creative way through drama, music, artmaking, and writing in order to explore the topic of suicide from their own cultural perspectives. Mixed arts, such as visual, performing, musical, media, and theatrical arts, have also been used in the Prodigy Cultural Arts Program [75] addressed to young people who had been adjudicated in the juvenile justice system and at-risk non-offending youth in the community.

The classes (requiring three hours per week for eight weeks) were taught by master artists from the community who deliberately developed positive and supportive relationships with the young people.

4. Discussion

This scoping review found indications supporting the use of performing arts in suicide prevention interventions: performing arts are useful to improve awareness, self-efficacy, and soft skills relevant to suicide prevention, both in gatekeeper training programs and in interventions with high-risk populations. However, given the extreme heterogeneity in terms of the study design, type and size of populations studied, purpose and outcomes, with a few RCTs and mainly observational studies without control groups and small sample sizes, no firm conclusions about effectiveness can be drawn. For most studies, the main goal was to describe a specific kind of intervention, mostly gatekeeper training programs, with a simple pre- and post-intervention evaluation, very often without any control group. A few studies reported evaluation at follow-up. Moreover, many studies presented a sample bias because of self-selection in that participants volunteered to participate, so generalization may be limited. Skills retention over time was evaluated only in a few studies.

The strongest results obtained from four of the five RCTs included in this review underlined the utility and advantage of role-playing techniques in gatekeeper training programs [18,94,100,103]. Coleman, Cross, and Godoy analyzed immediate outcomes, i.e., trainee attitudes and knowledge of the gatekeepers with superior results for the prevention programs, including role-playing. The SEYLE study demonstrated a significant reduction in incident suicide attempts and severe suicidal ideation (which is an ultimate goal of the gatekeeper training program as described by Coleman et al. [94]) at the 12-month follow-up for the YAM program, which involves role-playing sessions with interactive workshops for students [18], compared to the control.

Despite the methodological limitations, the identified studies reported that, overall, performing art techniques had a positive impact on suicide prevention programs. In fact, no studies reported negative outcomes or unintended harm. Thus, performing arts can be tentatively considered to be a useful tool to enhance the effects of suicide prevention programs. This was mainly shown by the studies of gatekeepers' training. Fewer studies directly involved high-risk populations, probably because their inclusion in research is more challenging for logistic and ethical issues.

Data on the feasibility of implementation in community settings are rather limited. Very few studies [84,88] reported details on costs or other practical information. This is a significant limitation that should be addressed in future studies. When choosing to adopt a specific intervention program, public health policymakers must consider not only the effectiveness but also cost-effectiveness. Another point is that all the studies except one [95] were conducted in economically developed countries, underlining the need to also implement research on performing arts interventions for suicide prevention in disadvantaged settings and especially in those contexts where low-cost interventions, such as the performing arts, are needed to reduce stigma and enhance mental health awareness [35].

Keeping in mind that raising public awareness of suicide may adversely affect vulnerable individuals [19], we searched the identified studies for possible unintended harm from the preventive interventions, but none reported negative outcomes. A possible publication bias, with only positive outcomes studies being published, could be involved in this finding.

When planning this review, we expected to find more studies of theater, drama, or plays in suicide prevention programs. However, we found that most of the studies used role-playing as an active learning method for training gatekeepers. In many programs, role-playing provided the opportunity to conduct quasi-realistic encounters with "patients" in a controlled learning environment to improve competence in managing patients at risk of suicide. Indeed, role-playing allows learners to participate in realistic situations that might be stressful in real life, allowing them to make mistakes and learn in a stress-free environment that has been shown to facilitate skill acquisition [101].

Gatekeeper training was effective in all the studies in changing attitudes and building knowledge, but there are still little data on how it increases prevention behavior, that is, about the effect on a real-life context. Indeed, many interventions report mainly educational benefits and self-perceived behavioral changes rather than actual changes in clinical practice [97].

As mentioned before, research by Cross and colleagues [76,100] showed that adding role-playing to QPR achieved promising results. Cross et al. [100] found that the addition of role-playing led to an increase in almost half of the standard deviation in prevention behavior compared to standard QPR. Their role-playing is a 25 min addition to the QPR that begins with modeling desired prevention behaviors, including the suicide question, followed by practicing these behaviors in small groups: this seems to be a feasible and effective addition to the QPR or other short gatekeeper training courses.

As expected, theater-based narrative engagement approaches can support comprehensive suicide prevention programs by helping to identify and address entrenched beliefs and stigmas and empowering participants to learn about and access resources in their community [83]. The narrative format of the *Let us Talk* approach allows actors and audiences to acknowledge each other’s vulnerabilities and fears and collectively empower themselves [68]. Overall, in all the groups, participants’ perceptions of efficacy increased after the *Let us Talk* performances. The open discussion of loss, ideation, and suicide attempts presented in the live theater performance reduced audience members’ fears of contacting professional adults regarding suicide risk and was helpful in increasing students’ perceptions of their efficacy in contacting teachers or professionals regarding suicide risk.

Since we found very few studies using pure theater techniques, we hypothesized that, even though it is a very widespread method of psychosocial intervention, it remains too little studied and described in biomedical research, while more of the literature is available from a social sciences perspective, thus pointing to the need of trans-disciplinary research projects.

5. Limitations

The results of this review are limited by the small number of studies that used rigorous methodology to assess effectiveness.

Another limitation is the considerable heterogeneity of the studies with respect to design, population, and purpose. Moreover, the review included both studies using theater techniques and studies using role-playing in a more didactic way, which are at quite different ends of the “performing arts” concept, even though both require active participation. Even more distant from the participatory theater is online role-playing, which is anyhow included in this review since it requires interaction with participants and is an interesting and promising way to engage trainees in suicide prevention programs.

A more general limitation is that publication biases could not be assessed given the nature of the study outcome measures, so it is possible that studies reporting more favorable experiences with performing arts were more likely to be published.

6. Conclusions

The studies included in this scoping review provide overall support for the inclusion of performing arts in suicide prevention programs, both when these are used to train gatekeepers and when they are addressed directly to adolescents or high-risk populations. The more rigorous studies, with a randomized controlled design, demonstrated the clear effectiveness of these programs, including role-playing techniques, while other studies mostly indicated good responses in terms of increased knowledge, self-efficacy, and awareness, without strong evidence of efficacy. In role-playing, the component directly involving the trainee in actual performance seems to be a key factor in enhancing the learning process, while in the theater-based intervention, it is the emotional involvement that increases awareness and eventually facilitates help-seeking behaviors by reducing suicide-related stigma. However, the specific elements of performing arts that significantly contribute to the effectiveness of these interventions need to be further evaluated in future studies.

The small number of studies on the effects of performing arts, and especially theater techniques, on suicide prevention, is in marked contrast with the real-world diffusion of these forms of psychosocial interventions in schools, health care settings, residential psychiatric programs, and prisons. There is a need for closer collaboration between researchers in the medical field and those in art institutions. Further studies are warranted to explore the possible therapeutic benefit of performing arts in suicide prevention strategies.

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Review

Psychoanalytic Interventions with Abusive Parents: An Opportunity for Children's Mental Health

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Abstract: Research has extensively shown that most people who experience maltreatment in their childhood develop mental disorders, psychosocial adjustment problems, and, in many cases, become maltreating adults themselves. Preventing child maltreatment and treating abused children and abusive parents are, therefore, pressing public health issues. As established by the UK Children Act in 1989, child development is enhanced by remaining in the family whenever the child's safety is assured. Thus, developing prevention and intervention programs for the purpose of repairing, whenever possible, the child–parent relationship should be a social priority. This narrative review focuses on the psychoanalytic studies related to intrapsychic dynamics and therapeutic intervention for physically abusive parents. The role of the transgenerational transmission of abuse and parents' narcissistic fragility is crucial. Psychoanalytic interventions focus on helping the parent work through their past painful experiences and narcissistic vulnerability. Parent–child psychotherapy and mentalization-based treatment have been found to be prevalent, while there is scarce literature regarding intensive individual psychoanalytic treatment. Within the framework of attachment theory, brief interventions were developed; however, they did not prove effective for those parents who suffered experiences of maltreatment or severe neglect in childhood and for whom long-term parent–child psychotherapy resulted, which proved to be the most effective.

Keywords: physical child abuse; psychoanalytic intervention; transgenerational transmission of abuse; child–parent psychotherapy

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1. Introduction

A considerable body of research has profusely demonstrated that the long-term effects of child maltreatment are devastating: many people who have been abused in their childhood develop later mental disorders, manifest psychosocial adjustment problems, and, in many cases, become abusive adults themselves [1,2]. Preventing child maltreatment and treating abused children and abusive parents are, therefore, pressing public health issues.

When a child is at risk of abuse in a family or when abuse has already occurred, assessing whether the child should be removed from the family or whether intervention in the family can prevent future abuse is of the utmost importance. Even in cases where the child is initially removed from the family for his or her own protection, it is necessary to assess whether an intervention with the parents will suffice to allow the child to return to the family later. It is, therefore, a matter of assessing how motivated the parents are to engage in a path of change and which intervention is most appropriate in each specific situation.

In my experience, when intervention programs are not available for abusive parents or those parents at risk of abuse, it unfortunately often happens that the child is removed from the family to be placed in residential facilities or foster families, without careful consideration being given to the potential long-term harmful effects following the disruption of the relationship with his or her family, although these effects are extensively highlighted in the literature [3–5]. Indeed, while removal from the family protects the child from the risk of maltreatment, it also exposes him/her to permanently undermining the possibility of repairing the relationship with his/her parents, understood both as real persons and as his/her internal representations. As psychoanalysis has taught us extensively, living with bad internal objects implies constant struggle and suffering along with a greatly increased risk of developing psychopathological disorders and maladjustment in interpersonal relationships. Moreover, as Novick and Novick [6] stated, parents, when the relationship with them is good enough, are a lifelong resource. Whenever possible, therefore, interventions should be aimed at repairing the relationship [3,5], and social workers should avoid being tempted by the impulsive, action-oriented style of the families they work with by choosing quick and drastic solutions that may be harmful to the child in the long run [7].

As also established by the Children Act in 1989 [8], child development is enhanced by remaining in the family whenever the child's safety is assured, and social services should strike a balance between protecting children and ensuring that they can remain with their families [9]. Developing prevention and intervention programs in public health services for the purpose of repairing, whenever possible, the child–parent relationship should be a social priority.

Psychoanalytic studies have aimed at understanding the internal world of abusive parents and identifying what interventions might help them become more competent. Studying and comprehending the inner world of parents who are prone to physically abusing their children can be helpful in understanding the deeper motivations for their behavior as well and, thus, in devising interventions not only aimed at modifying their behavior but also directed at intervening in the unconscious dynamics that lead them to the abusive behavior.

Since the pioneering work of Selma Fraiberg [10] at the Child Development Project, University of Michigan, in the 1970s, other psychoanalysts have worked to develop intervention models based on a psychoanalytic understanding of the mental functioning of parents who abuse their children or are at risk of doing so. It was the groundbreaking work of psychoanalysts such as Richard Galdston [11], Brandt Steele [12], and Selma Fraiberg herself [10,13] who highlighted the extent to which child abuse can be considered a treatable syndrome and the outcome of a breakdown in the parent–child relationship, which enabled the development of intervention programs aimed at repairing the relationship.

The goal of this article is to present a narrative review of psychoanalytic studies in this field, specifically focusing on the intrapsychic dynamics of parents who physically abuse their children, and the therapeutic interventions developed by psychoanalysts to treat maltreating parents.

The article focuses specifically on physical abuse, following the recommendation [14] not to group together different types of abuse, since it has long been known that, for example, sexual abuse is an issue completely apart from physical maltreatment [3]. As it is only directed at studies that have addressed intrapsychic dynamics and the treatment of physically abusive parents from an exclusively psychoanalytic perspective, the review does not examine other types of treatments, even though they have proven effective.

2. Methods

For the purposes of conducting a narrative review to present an overview of studies published to date, highlight emerging themes, and identify future research directions, the terms "child abuse or neglect or maltreatment or mistreatment" and "psychoanalysis or psychoanalytic or psychodynamic" or "infant–parent psychotherapy" and "parent*"were searched in titles, abstracts, and main texts using the Psycarticles, Psychinfo, Psychology and Behavioral Sciences Collection, Medline, and Pep-web databases. Inclusion criteria comprised original articles published in the English language in peer-reviewed journals before June 2022. According to the exclusion criteria, dissertations and chapters in books were not taken into account. After applying the exclusion criteria, 386 potentially relevant articles were found, and, finally, after examining the abstracts and bibliographies of each article, 23 papers were selected for the present review. Rather surprisingly, only about 5% of the reviewed abstracts showed that the studies focused on parents who had abused their children. Articles were excluded from the review for the following reasons: 41 addressed the topic of parents committing sexual abuse; 10 referred to the historical and/or sociological aspects of parenting; 23 were about other types of maltreatment (neglect, emotional abuse, Munchausen syndrome by proxy); 2 were about mentally ill mothers who had killed their children; 1 was about parental noncompliance in pediatric treatment; in 2 cases, the articles could not be found; and in the remaining cases, the articles either mentioned only psychoanalytic or psychodynamic interventions without addressing it or were about the psychoanalytic treatment of people who had been abused by their parents.

3. Results

3.1. The Intrapsychic Dynamics of Parents Who Physically Abuse Their Children

3.1.1. The Transgenerational Transmission of Abuse

Rather surprisingly, it was not until the 1960s that child abuse became the focus of attention in social policy and psychological studies [15]. Steele [12] highlighted the extent to which the abusive parent, closely identified with a harsh and rejecting mother and a negative self-image dating back to childhood, subjected their child to similar experiences suffered in childhood. In his clinical experience, he observed that these parents often predominantly resorted to the defense mechanisms of denial, projection, identification with the abuser, and role reversal. Green [15] conducted the first empirical study of a group of 60 abusive mothers using a comparison group of 30 neglectful mothers and a control group of 30 nonabusive parents. He found corroboration for Steele's clinical experience and emphasized how crucial it was for abusive mothers to resort to role reversal in the expectation that their children should fulfill unmet needs for dependence and the confirmation of their goodness. The child is most likely to be abused when he/she is not gratifying to the mother, thus, when he/she is most demanding, needy, and irritated. Probably for this reason, Green [15] surmises, abuse is more frequent in the child's first two years of life and when the child has physical defects or atypical development. The child who cries often and does not gratify the mother with affectionate and compliant behavior is experienced by abusive mothers as confirmation of their inadequacy and evokes in them the rejection perceived by their parents during childhood.

Recent studies [2,16] have confirmed that having been abused in childhood is an important risk factor; however, studies on the transgenerational transmission of abuse have actually shown that not all abused children become abusive parents, and they have highlighted some protective factors that break the cycle of abuse: having received emotional and social support from significant adults, having received psychotherapy, and being able to acknowledge one's feelings of anger about the abuse suffered [17]. In addition, it must be kept in mind that abuse is the result of the interaction between individual, family, social, and cultural factors [18] and that having been abused in childhood is, therefore, only one of the individual factors that may be involved. Wilkes [19] found in a group of abused parents who did not become abusers that they clearly recognized how wrong their parents' behavior had been and attributed no blame to themselves for what had happened, and he hypothesized that these were two crucial resilience factors. Already Selma Fraiberg [13] had observed that the possibility of experiencing pain from one's childhood history is a crucial deterrent against repeating abuse toward one's children, and a recent study [20] showed that maintaining good memories of childhood moderates the transgenerational transmission of abuse. A recent meta-analysis [21] confirmed that sensitive, stable, and secure relationships can break the cycle of abuse. When the child does not have the opportunity to rely on other sensitive and caring adults, he/she is mostly forced to deny the malevolence of the abusive parent to protect his/her internal parental image. He/she often blames him/herself for the parent's abusive behavior, and this seems to exert a dual function: on the one hand, seeing him/herself as bad saves the parent's image, and on the other hand, it makes the child feel active and in control of the situation. This may lead the child to enact disturbing behaviors [22].

Moreover, as Galdston [23] states, the abusive parent–child relationship is characterized by intense ambivalence and deep attachment. The strength of this attachment makes clinical management more complicated than in cases where parents are indifferent to the child. “Parents and children who have been largely indifferent to each other may take leave with little regret. They have suffered the cold of indifference rather than the heat of anger” [23] (p. 392). Furthermore, the abused child who has taken upon him/herself the malevolence of the parent in order to maintain a good internal image of him/herself will suffer from low self-esteem, may have little autonomy, and will lack the ability to differentiate self from other [22].

Steele and Pollock [24] interviewed 60 abusive families and found that few among them had been physically abused by their parents; rather, all of the abusive parents interviewed had felt very criticized by their parents, unwanted, and unloved.

The mechanisms by which the transgenerational transmission of abuse occurs have been more clearly highlighted recently by observational studies of the parent–child relationship and empirical studies in the area of attachment theory and mentalization.

Seligman [25] reports a particularly telling observation of the interaction between a father who was repeatedly abused as a child, and his son, a three-day-old boy.

“In this brief episode, he holds his baby very awkwardly, just below his neck, and forcefully brings the neonate’s face close to his own with a look that seems to convey some tenderness along with much anxiety. Next, the father tries to force Daniel to drink from a bottle while the baby desperately shows that he is satiated, first by not sucking and keeping his mouth closed and then by tensing up and finally going limp; during this sequence, the father rebuffs efforts by his wife and a therapist-observer to get him to notice Daniel’s resistance to his brutal ministrations, remaining oblivious to his son’s repeated signals. The father again brings his face intrusively close to his son’s, calls him ‘Chump!’ and says in a pugilistic manner, ‘Do you want to tell me about it?’ He hoists the baby high up in the air, as if he were roughhousing with a much older boy. Finally, as the baby seems to collapse into a droopy, withdrawn state, the father exclaims, ‘That’s enough of your garbage!’” [25] (p. 138).

Seligman [25] observes that, no matter how characteristic this type of interaction may become in his interpersonal experience, this child, who has experienced a very distressing sense in his bodily experience of being prodded, jostled, and deprived of any comfort and control of his body, will feel that being helpless and incapacitated are fundamental modes of the experience of the self.

The observation of this interaction also provides insight into the concept of pathological projective identification. The father disregards his son’s signals, treating him with hostility while feeling that he loves him (hostility is perceived by observers). In this way, he externalizes his “bad,” powerless, hostile self by attributing it to his son, enacting this without any reflective thought. Under these conditions, Daniel can not only do nothing but identify with these emotional and relational states, including the sense of powerlessness, which the father keeps out of his awareness by pouring it onto his own son, but he can also internalize a pattern, in that the way to deal with his own feeling of powerlessness is to make the other person feel powerless.

This example also shows how it may be precisely the feeling of fragility evoked by the very young child that stimulates abusive behavior in parents who have not felt that their own fragility has been respected and have, thus, been unable to develop feelings of acceptance and tenderness for their own and others’ fragility.

Empirical studies conducted within the framework of attachment theory have fully demonstrated that the Internal Working Models (IWM) of self and other are transmitted from one generation to the next along with defensive strategies for coping with distress in the face of perceived danger. Mothers with secure attachment patterns help their children develop good emotional regulation strategies, while mothers with distancing attachment patterns emphasize autonomy and minimize distress, and mothers with preoccupied attachment patterns are unpredictable. They, alternating responsive responses with neglectful or inappropriate responses, promote emotional dysregulation, as do mothers who have developed disorganized patterns [26,27]. Interestingly, these studies highlighted the crucial role of mentalization, operationalized as reflective functioning, in the transmission of attachment security: the children of mothers who experienced negative childhood experiences but were able to come to terms with them by acknowledging their own suffering and trying to understand their behaviors and those of their parents, as motivated by mental states, more frequently developed attachment security. These studies provided important empirical support for what had been previously tested in clinical work [27].

A number of studies have specifically investigated the quality of attachment patterns and reflective function in abusive parents [28–31], highlighting the prevalence of dismissive and disorganized mind states in abusive parents. Ammaniti and colleagues [28] found that 87.5% of abusive parents evinced an insecure state of mind regarding attachment and that 47% of these insecure parents specifically exhibited unintegrated states of mind, such as Unresolved or Cannot Classify states of mind, as a consequence of dissociative states that developed following early traumatic experiences of loss and/or abuse. Rosso [30] found that, in her sample, maltreating parents had not experienced poverty, poor education, lack of social support, or physical illness in their childhood, but they had suffered high degrees of family conflicts associated with significant neglect experiences, especially with their mothers, findings already reported in previous studies [32,33].

In Rosso's study [30], more than 90% of the abusive parents showed an insecure state of mind regarding attachment with a prevalence (66.7%) of dismissing classification. Compared with the control group of nonabusive parents, they showed high reliance on the defensive strategies of idealizing their childhood experiences, derogating their attachment needs, lacking memories in addition to passivity in thought processes, and disorganized states of mind regarding grief and/or abuse experiences. Rosso argues that the marked tendency to derogation that these parents exhibit may specifically explain how the devaluation of relationships and attachment needs—probably acquired in their childhood history to defend themselves through exclusion from awareness of emotional pain and their experiences of fragility and helplessness—makes it very difficult for them to take care of their children's emotional needs. In this study, the dismissive and derogatory state of mind was found to be associated with severe mentalizing deficits, often with a particular type of deficit called Negative Reflective Functioning, which involves the tendency to avoid and refuse to take a reflective stance. The study found that parents who inflicted the most severe maltreatment on their children showed this specific mentalization deficit. As Fraiberg [10] already observed in her clinical work, these parents were not able to process their painful childhood experiences and were not aware of either their own emotional pain or that inflicted on their children. The results of this research stimulated the development of specific interventions centered on attachment and mentalization, as discussed below.

3.1.2. Narcissistic Fragility

Many authors emphasize how parents who abuse their children suffer from significant narcissistic fragility. Eldridge and Finnican [34] pointed out that parents who abuse their children unknowingly wished to become parents for the purpose of finally having someone to maintain their narcissistic balance; in other words, to support their psychic integrity by supporting their fragile self-esteem.

Early experiences of good caregiving allow the child to feel safe and idealize caregivers, perceiving them as very powerful and eager to share and bestow their strength. This basic trust allows the child to later tolerate inevitable frustrations provided they are progressively and appropriately dosed to the child's coping capacities. The early relationship with an empathetic parent, who is able to understand how much frustration the child can tolerate, enables the child to develop a cohesive nuclear self [35], which implies possessing an internal sense of importance and value that is stable over time and helps to comfort oneself in difficult times, as well as to set balanced ambitions and ideals.

In Eldridge and Finnican's view, the personality of the abusive parent exhibits a particular form of developmental disorder in which the child, despite him/herself, is called upon to play the role of one who must support the narcissistically fragile parent by helping him or her maintain a sense of self. In addition, the narcissistically fragile parent experiences particularly intense difficulties when coping with parenting because his or her unmet child needs are stimulated by the task of taking care of the child's needs. The young child demands that his own needs be met and does not gratify the parent's needs, especially when he/she cries and when he/she is demanding. The narcissistically fragile parent, when his/her needs are frustrated, may have angry outbursts and mistreat his/her child.

Narcissistic deficits were further observed by Blumberg [3], Crivillé [36], Rosen [37], and Purcell [38]. The latter, during his decade-long work at Children's Charter with abused children, observed that these families are often described as "upside-down", in that they are characterized by role reversal, projection, and disturbed attachment: parents re-enact the unmet needs of their own childhood while forcing their children to assume the role of those who must support their self-esteem. When children fail to meet their parents' needs, they become the object of their anger. Purcell [38], in agreement with Eldridge and Finnican [34], surmises that the reaction of abusive parents stems from failures and reversals in the early developmental stage of grandiosity because of the parent's inability to engender in the child an initial feeling of omnipotence and gradual disillusions suitable for bearing the frustrations and limitations imposed by reality.

Steele [39] reports that his extensive clinical experience with abusive parents enabled him to find that they, even when they were not physically abused in their childhood, suffered from a lack of adequate emotional support and, in general, from profound neglect of their emotional needs. As Steele states, "neglect is harder (than abuse) to define, to tell how much love is not there-something like trying to describe the contents of a vacuum" [39] (p. 1006). He points out, in particular, how devastating the absence of maternal validation responses is for the child, an absence that does not allow him/her to develop the basic trust that is essential to sustain and maintain narcissistic balance. The parent who lacks the ability to be empathetic is unable to recognize and validate the child's emotional experience [40].

Galdston [23] pointed out that it is precisely the parent's narcissistic fragility that does not allow him or her to deal adequately with the child's emancipatory behaviors, first and foremost during the early separation–individuation phase, when the child, through assertive behaviors, displays his or her need for individuation. The abusive parent confuses assertiveness with an aggressive attack aimed at his/her fragile self and may have uncontrolled angry reactions. The parent thus communicates to the child that he/she does not tolerate aggression and perceives it as violence. Aggression, here understood as a vital drive aimed at individuation, cannot be tolerated and is punished. At the same time, Galdston [23] observed in his work with 75 abusive families that the abusive parent finds it very difficult to prohibit the child's improper actions because he/she fears that the prohibition will be followed by the child's (intolerable) violence. The mother cannot bear the threat of her child's aggression. In his extensive experience, Galdston found that outbursts of anger and abuse alternate with an inability to put appropriate limits on children's behavior. He reports, for example, of one mother who constantly moved objects around the living room in a vain attempt to keep the objects out of her 3-year-old daughter's reach, without ever being able to tell the child directly that she did not want her to touch them. Another mother complained about how difficult it was for her to enter a store with her daughter because she felt obligated to buy the child everything she wanted, because of fear that if she refused, the child would make a scene and embarrass her. Another mother reported being afraid to meet other children for fear that her daughter would see their toys and want them for herself and that she would be unable to say "no." Among the youngest children, who were just beginning to walk, Galdston observed that the interaction with their mothers was characterized by a description of their aggression completely out of proportion to the facts. The mothers spoke of their children as if they were threatened by their mobility. "Wild", "uncontrollable", "destructive", and "attacking" were among the terms most often used to describe children barely able to take their first steps. Usually, these adjectives were used to modify the term "monster," which was the epithet most often used to label children.

Mothers responded to their children's first expressions of aggression either by avoiding them through denial or by violent physical abuse. Both of these patterns of response left children with the same impression, namely, that they were carrying dangerous aggression, unmanageable by others and themselves because of its potential for violence.

3.2. Therapeutic Intervention

The first question that arises is how to intervene in cases of abuse while ensuring the child's safety and, at the same time, not compromising the therapeutic alliance with parents. Tuohy [22] observes that sometimes the removal of the child can have an ego-supportive effect if the social worker does not have a punitive attitude, but, on the contrary, this effect can be achieved if he/she shows a genuinely protective attitude by communicating to the parent that he/she cannot allow him/her to harm him/herself and/or the child and that he/she intends to protect his/her family from such danger by taking care of all its members, parents and child. In any case, it is widely suggested to avoid the removal of the child whenever it is possible to provide treatment to the parents [41].

A pioneering intervention is described by Galdston [11] who established The Parents' Center Project in Massachusetts in 1969 for the dual purpose of protecting children from further abuse and strengthening the integrity of their families. In its first 7 years, the Center treated 46 families with 73 children, being able to care for 15 families at a time. The treatment, which consisted of a therapeutic daycare unit for children and a therapeutic group for parents on a weekly basis for a period ranging from four weeks to five years, proved to be very effective for children, who showed good developmental recovery and was helpful in preventing further abuse, which occurred in only two mild cases for a short period. Galdston noted that the changes in the parents (mostly the mothers were the abusive parents) were not profound; however, caring for the parents and children at the same time allowed for the establishment of a good therapeutic alliance and thus willing acceptance of the care provided to the children. Galdston does not go into the difficulties encountered with the parents; he merely describes their mental functioning dominated by deep ambivalence toward themselves and their children, feelings of profound dissatisfaction in their relationships with their parents and partners, and a pervasive inability to desire and achieve a satisfying life undergirded by intense feelings of guilt and a poor self-image.

Blumberg [42] reports that, in his experience, he has encountered predominantly abusive mothers of often very young children (less than one-year old) and, in any case, usually no older than three years, and he attributes this to the fact that mothers are usually the caregivers of the young child for most of the day and, therefore, the ones most frequently exposed to the child's demands. Regarding treatment, he suggests not only considering the abusive parent but also the other parent since abuse is a family problem and signals a crisis in the family unit. He also recommends trying not to separate mothers from their children and to house both in residential facilities where trained professionals can take care of both the parent and the child. This intervention, in Blumberg's opinion, should precede long-term psychotherapy of the parent. Regarding this, he stresses that the therapist should first deal with his or her negative countertransference toward the abusive parent and focus on the parent's intrapsychic conflicts rather than on the parent–child relationship in order to prevent the narcissistically fragile parent from feeling neglected by the therapist and thus developing hostile feelings toward the treatment. Psychoanalytic psychotherapy would be the best form of therapy for the abusive parent, who usually has a negative self-image and suffers from ego weakness, along with treating the other parent, who, at best, has been unable to offer the necessary support to the abusive parent. When parental hostility is too high and does not allow for a sufficient therapeutic alliance, it can be very helpful to offer parents the opportunity to participate in help–help groups where they can confront other abusive parents without feeling judged and without fear of punishment. Blumberg also finds it very useful that twenty-four-hour "hotlines" run by trained staff are available to accommodate requests from parents in crisis.

Concerning couple dynamics, a very interesting contribution is made by Freedman [41], who stresses how necessary it is to consider abuse a couple issue, while avoiding placing sole responsibility on the abusive parent. She points out that, in her experience, very frequently projective identification considerably characterizes the couple relationship and that this implies that the abusive parent is often the repository of the nonabusive parent's projections and that it is precisely these projections that are decisive in triggering the abusive behavior. Freedman's recommendation should be taken seriously, given how widespread the practice of removing the abusive parent from the household without considering the contribution of the nonabusive parent is. Freedman advises against colluding with the couple's tendency to attribute difficulties to one parent alone, a tendency that is very often supported by the nonabusive parent's need not to address his or her intrapsychic conflicts in order to avoid intolerable emotional pain. Freedman proposes a multifaceted model of assessment that includes couple interviews, individual interviews, and couple interviews in the presence of the child for the purpose of achieving a psychodynamic understanding of the parental couple that allows for a focus on the deep dynamics that contributed to the abusive behavior and for assessing the possibility of the couple's involvement in therapeutic work to address the difficulties.

From the study of the articles included in this review, three main types of psychotherapy treatment based on psychoanalysis emerged: parent–child psychotherapy, classical individual psychoanalytic treatment, and mentalization-based treatment.

3.2.1. Parent–Child Psychotherapy

The pioneer of parent–child psychotherapy in family situations of abuse or high risk of abuse was Selma Fraiberg [10,13]. Many of these families at assessment turn out to be multiproblem, hard-to-reach families that are clearly unmotivated to undertake treatment. Selma Fraiberg [10] developed a specific program at the Child Development Project, University of Michigan, where two psychoanalysts, three clinical psychologists, two social workers, and a pediatrician worked, all of whom were part-time, thus representing the full-time equivalent of 3.5 staff members. The team was able to care for more than 140 families per year. In reporting on their first 50 cases, Fraiberg points out that their method combined psychoanalytic principles and techniques with traditional social service practices and theoretical knowledge of developmental psychology.

First, Fraiberg stresses the need to understand the transference dynamics and defensive apparatuses of these parents. She points out that transference, understood as the unconscious repetition of the past in the present in which people from the present are perceived with the qualities of significant figures from the unremembered past, is not only elicited by the psychoanalytic situation but is present in everyday life and manifests itself, especially in emotionally conflicting situations; thus, social workers, who usually meet their patients at times in life when they experience severe emotional conflicts, can be helped to understand their patients if they pay attention to transference dynamics. Fraiberg, for example, describes a young mother who, after being referred to the hospital, did not respond to summonses and did not show up until a month later as a woman who was presumably very frightened about meeting the social worker, imagining her to be a dangerous woman. When the girl showed up, she appeared angry, demanding, oppositional, and kept repeating that no one was helping her and no one understood her. The therapist decided to immediately interpret the negative transference by telling the patient that she well understood her anger toward those who were trying to help her if she did not feel understood; she wished to understand her, but if the patient did not feel understood, she would have reason to be angry with her and could tell her so. In another example, a mother showed up for appointments but would not speak. The therapist assumed that the patient's silence was a defense against painful affects and, after long silences, she told the patient that she thought she was very angry with her, coming to appointments to be helped without getting any help! No wonder she did not trust her; why should she?

In both cases, the interpretation of negative transference was crucial in fostering the therapeutic alliance. Later, it became clear that both patients were transferring the internal image of their past parents onto the therapist from the very beginning. The risk in such cases is that the patient's negative transference triggers negative countertransference in the therapist, compromising the treatment outcome. Fraiberg emphasizes how necessary it is for the therapist to ask what motivates the parents' abusive behavior and to avoid merely using labels. She writes: "Label is not a diagnosis. It is a mailing address" [10] (p. 96), meaning that if the therapist merely labels a mother, for example, as refusing, and the mother does not become nonrefusing, the next address will be the court, and after the court, the mother and child may have different addresses. On the other hand, understanding what leads a mother to reject her child can enable the treatment of the mother and the mother–child relationship by fostering the psychological development of both. In this regard, Fraiberg reports how enlightening it was, in the case of a mother who was evidently rejecting her four-month-old daughter, to understand that the woman had such an unconscious fear of hurting her daughter that rejection was the best way she had found to protect her daughter from herself. In this case, psychotherapy conducted during home visits once–twice a week enabled the mother to be able to acknowledge her own pain experienced in her abusive childhood experiences and to have less fear of being identified with the aggressor and acting against her daughter.

Identification with the abuser is a defense frequently used by abusive parents who were themselves abused in their childhoods: It is the defense that allowed them to defend themselves against distress and ego disintegration through a kind of unconscious psychological fusion with their abuser. If the therapist stands by the patient and allows him or her to experience, within the safety of their therapeutic relationship, the pain that he or she was unable to experience at the time, the risk of acting out abusive behaviors toward the child decreases considerably, while the patient gradually manages to disidentify from the abusive object.

Fraiberg's working model has continued over time to guide the organization of public services caring for parents or high-risk children. Lieberman and Pawl [7] report a clinical example of the treatment of an abusive mother and her child that shows how effective integration of developmental guidance, infant–parent psychotherapy, emotional support, and practical assistance can be. They emphasize how, in cases referred by the court for treatment, it is necessary to conduct an assessment intervention, including home and office visits, for a few weeks in order to assess the possibility of building the therapeutic alliance with the parent and to avoid imposing psychotherapeutic treatment out of the blue. Lieberman and Pawl also recommend interpreting negative transference from the earliest sessions, and they present a reflection regarding the appropriateness of including the child in sessions with the mother: On the one hand, participating in sessions with the mother exposes the child to highly charged material; on the other hand, if the child has been abused, he or she can be greatly helped by joint sessions with the mother to deal with these situations in a protected and safe context, in which the mother's disturbing behaviors can find acceptance and can be recognized for their deeper meaning. The therapist's interventions can help the child to better cope with the situations he or she experienced with the mother.

Selma Fraiberg went on to work at the Infant–Parent Program at San Francisco General Hospital—University of California, which was later directed by Seligman, who integrated infant–parent psychotherapy with nondidactic developmental guidance and concrete support. The Program was able to care for about 60 families per year with children up to three years of age [43]. The intervention usually began with a four-to-six-week assessment of the family in order to learn about the child's developmental level, the psychodynamics of the parent–child relationship, and the couple relationship, if any, as well as the family's psychosocial and economic issues. Many cases required cooperation with child protective agencies and courts. Videotaping parent–child interactions for later viewing with the family was also introduced in some cases. Treatment usually took place in a weekly visit lasting

60–90 min at the family's home. The focus was the infant–mother relationship; however, other family members were included in the treatment program when indicated. According to Seligman, home visiting allows the therapist to learn more about the relationship and makes the parent feel more understood about the demanding task he or she faces even on a practical level in raising the child. At the same time, the therapist has to deal with situations different from those he or she encounters in his or her office, including new transference and countertransference configurations, and sometimes it can be difficult to maintain the therapeutic frame, yet this is often the only way to reach families. Many of the therapist's efforts are aimed at establishing and maintaining the therapeutic alliance, which sometimes involves continuing to go to the home of patients who do not show up, thus continuing to maintain the trust and hope that the therapeutic relationship can begin and be maintained. Working with these families also involves providing them with direct support by helping them in their contact with other social agencies. The usual analytic interpretive work thus takes place in unconventional contexts. Building a supportive relationship provides the basis for interpretive analytic work that focuses on repetition in the transference to the therapist and to the baby to help parents realize how much they are reenacting their pasts. Within the therapeutic relationship, nondidactic development guidance is conveyed with nondirective techniques designed to help the parent understand the child's mental states while avoiding the bias of their own negative childhood experiences. Seligman emphasizes how often in these cases the therapist must deal with what he calls bureaucratic transference, meaning the expectations that the parent has developed from previous experiences with the social agencies with which he/she may have previously come into contact. Very often, in fact, abusive parents come to the therapist after having been referred to other social agencies and have sometimes already had contact with the court.

Seligman emphasizes how effective early infant–mother psychotherapy can be precisely because new parents are particularly prompted by their condition to recall their childhood experiences and reflect on their relationship with their parents. Their internal representations and defenses are very evident and much easier for the therapist to understand than during usual psychotherapy with an adult patient. Recent motherhood or fatherhood can be a valuable opportunity for change: While it can awaken old conflicts, it can also be an opportunity for deep processing and change. The therapist's help can foster good responses from the child that can disconfirm the parent's expectations and thus enable the child to experience a new beginning, discovering in him/herself unexpected resources and a new and happier possibility of a parent–child relationship, which can free him/her from the unconscious impact of his/her own negative childhood experiences. The therapeutic relationship, with containment and soothing, helps parents counteract the negative internal representations that had begun to deteriorate the relationship with the child and provides the basis for interpretive work. The quality of the therapeutic relationship and interpretive work gradually enables the development of greater self-confidence and disidentification from the bad internal and external objects.

Arons [44] believes that mother–child psychotherapy is organized around goals common to both psychoanalysis and attachment theory, namely, the possibility of recognizing, naming, and metabolizing feelings containing distress and fear. The therapist simultaneously considers the relationship between mother and child; between self and mother; between self and child; and between child, mother, and self. The child communicates through body language and affect with the therapist, whose job it is to be emotionally reached and, subsequently, to transform the affective communications by symbolizing them into words. The therapist tries to hear what the child is expressing, to name the child's affective communications to keep the child, the mother, and her relationship with both in mind, paying attention to what the child evokes in the mother and what the mother evokes in the child and what both evoke in the child. Arons notes that the therapist is caught between the child's developmental drives and the mother's conflict between repetition of the past and hope for a new and different future.

Ludwig-Korner [45] wonders whether infant–parent psychotherapy is a psychoanalytic method. There are many differences between the usual psychoanalytic treatment and mother–child psychotherapy. In the latter, the therapist has a bifocal approach, sometimes including other family members; the setting can change both in relation to the length of the sessions and to the location, taking place sometimes in the therapist's office and sometimes in the parent's home. In addition, the goal is to reduce symptoms as quickly as possible; sometimes the therapist and parent may discuss concrete interactions and videotape some interactions in order to discuss them later. The therapist is very involved in the mother–child interaction; he/she tries to capture affective communications and provide them with containment, thus trying to help mother and child develop some specific ego functions, first and foremost, a greater capacity for emotional regulation. Ludwig-Korner questions whether this type of psychotherapy involves the constitutive aspects of psychoanalytic work, such as the analysis of unconscious fantasies, relational representations, and transference. The child has not developed symbolically represented relational fantasies but shows the therapist through his/her emotional reactions what his/her representations of relational experiences are, and sometimes he/she enacts the emotional state of the parent who is talking to the therapist. She concludes that not only is mother–child psychotherapy a psychoanalytic treatment but adds that psychoanalysis has benefited greatly from the empirical contributions of infant research studies and attachment theory, for example, coming to understand that nonverbal emotional exchanges are at least as important in analytic treatment as verbal exchange, that a crucial goal of treatment is to help the patient develop self-regulating ego functions, and that this is accomplished first and foremost through sensitive and responsive listening.

Amanda Jones [46] also points out that early mother–child psychotherapy can offer the mother a valuable opportunity to address deeper conflicts related to dependence, vulnerability, and experiences of helplessness precisely because these are so intensely evoked by the infant. Psychoanalytic foundations can be found in the task of making meaning of observed behavior, hypotheses about the influence of unconscious processes, and interpretive work performed to construct a narrative. The child "remembers" through his/her actions; the parent shows how he/she defends him/herself from emotional contact with intolerable emotions to which the child exposes him/her. Mother–child psychotherapy helps the parent to be able to afford to suffer emotional pain in the company of a reliable therapeutic relationship and helps the child not to identify with the defenses used by the parent. The therapist can observe how both mother and child defend themselves through the use of projective identification and how this can fuel destructive escalation. The therapist's ability to contain the distress felt by the child and parent helps both develop greater emotional regulation skills and decreases the need for both to resort to the defensive use of projective identification. The child's distress can find an adequate mirroring response from the parent if the parent succeeds in not being overwhelmed by the child's distress. If the parent fails in this, on the contrary, he or she will provide the child with an amplified version of his or her own distress by feeding it further and forcing the child to enact maladaptive defenses. The therapist's ability to contain the distress of both and put into words the emotional happenings experienced allows the parent to become more aware of his or her own distress and defenses [46]. Jones also makes use of videotaping to show the parent the defensive processes in action and to help the mother understand the child's mental states and translate them into words, thereby increasing her ability to mentalize. She videotapes a few minutes of interaction between the mother and the child to review them with the mother during the next session, inviting her to free associate with what she sees. Observing the videotape can allow one to see that the parent attributes mental states to the child that the child is not experiencing, helping the parent realize that the child makes them his or her own and that these are precisely mental states that the parent does not tolerate in himself or herself. For example, a parent may attribute hostile intentions to a child who wishes to approach playfully, and subsequently, the child becomes angry [46]. In the clinical example presented, Jones shows how a mother realizes, upon viewing the videotape, how frightened she appears to be of her son, realizing that it cannot really be such a small child who frightens her. Later, the mother realizes that she is emotionally confusing the experience with her child with the experience with her abuser in the past. Working in this way, it is possible to make sense of the observable behaviors by connecting them to the unconscious processes that cause them, thus freeing both mother and child from the compulsion to act out destructive behaviors that take the place of what cannot be endured and, thus, thought about. Jones, too, stresses the importance of accommodating negative transference because it is necessary for the therapeutic setting to first allow freedom to express negative feelings so that feelings of love can truly emerge [46].

3.2.2. Individual Psychoanalytic Treatment

The search for literature material has revealed a considerable paucity of contributions regarding the individual psychoanalytic treatment of parents who have abused their children. Only Steele [39] reported his clinical experience with middle-class parents treated in a private setting. Presumably, the paucity of contributions in this area also depends on the fact that child abuse is a public health issue and thus engages public health services in developing specific treatment programs, but public services cannot afford the expense of high-frequency psychoanalytic treatment. However, given instead the considerable production of articles regarding the intensive psychoanalytic treatment of abused patients, it is also plausible to wonder whether the abusive parent is unlikely to require psychoanalytic treatment and/or whether psychoanalysts may be reluctant to offer intensive psychoanalytic treatment to people who have abused their children.

Indeed, some articles point out how difficult it can be for the therapist to come to terms with negative transference and countertransference with these patients.

Tuohy [22] notes that working with abusive parents is narcissistically depleting for the therapist, given that these families have very profound needs, frequent crises, and intense negative transference reactions. Tuohy reports that Altshul [47] pointed out that, in these situations, the therapist may enact some defenses: denying his or her fatigue and, through reaction formation, duplicating efforts or overidentifying with the patient so that he or she may feel that he or she is receiving what he or she is giving the patient. The risk of burnout is very high in the treatment of these patients, and to combat it, Tuohy [22] suggests the constant presence of supervisor support, peer support through frequent case presentations, and the possibility of engaging in other professional activities, e.g., intervention planning, teaching, research, and training. The patient's anger can strain the therapist's ability to resist without retaliation; at the same time, to help the abusive parent, it is crucial to make it easier for him/her to tolerate ambivalent feelings in treatment by allowing him/her to have the experience of being able to express his/her anger without the threat of destruction or losing the therapist. Tuohy observes that the therapist runs the risk of denying the abusive part of the parent when he/she fails to address the feelings of anger that the patient communicates.

Green [15] notes that abusive parents are often defiant and masochistic because of their deep, unconscious need to turn the treatment situation into a repetition of their early experiences of rejection. The therapist should be prepared to deal with negative countertransference, which includes the natural tendency to be indignant about the abusive parent's callous and cruel behavior toward the child. In addition, the abusive parent, who often shows hostility toward the therapist and a lack of cooperation, misses appointments and arrives late, constituting an attack on the narcissistic balance of the therapist, who does not feel acknowledged in his or her efforts.

The analyst must prepare to step into the shoes of a controlling, critical, punishing object that is difficult to trust [39]. The unconscious roles of both victim and abuser are re-created in both intimate relationships and transference, and a paranoid worldview associated with the avoidance of emotional contact and defenses against feelings of helplessness and worthlessness dominates in the early stages of treatment, characterizing transference–countertransference exchanges dominated by feelings of hatred [48].

Some psychoanalysts who have approached the subject of the psychoanalytic treatment of abused patients have highlighted the difficulty of working with their hatred and the perverse structure they have developed by eroticizing hatred.

As Milton [49] states, identification with an abusive object that despises the frightened child's feelings and sadistically eroticizes pain and hatred is what makes it most difficult for the therapist to treat the patient, who must also deal with the depth of his or her corruption, hatred, and addiction to perverse arousal. At the same time, the perverse structure can provide stability and may be the best psychic compromise solution, fulfilling many functions: It transforms painful experiences into gratifying ones and stabilizes them by creating dependence on the arousal stimulated by cruelty and the accompanying feeling of omnipotence, and, in addition, when the perverse area of functioning is sufficiently circumscribed and split, it can allow tolerable degrees of normal functioning, protecting against psychotic breakdown [49].

Experience with abused patients also teaches that the analyst must be careful to show them both love and hate; the analyst must do this by being careful to show both in small doses: Hate makes the patient feel safe, but it destroys, while love makes the patient feel less persecuted, but only for a while; then, it can trigger persecution. It is a constant give and take. When the emotional temperature is too high, it can sometimes be helpful, even to the establishment of an "as if" dimension in the analytic couple, to observe the similar dynamics (of love and hate) that the patient experiences outside the analytic couple [50].

Winnicott [51] wrote that "whatever his love for his patients, he (the analyst) cannot prevent himself from hating and fearing them, and the more he realizes this the less he will let hate and fear determine what he does to his patients" (p. 235).

Gabbard [52] has dealt extensively with this issue, pointing out how patient hatred can induce in the analyst the temptation to counterattack (through actions or interpretations used as hostile actions), the desire to retreat into detached indifference, or the denial of the hatred itself. He warns that hatred becomes persecutory and destructive in treatment, particularly when it is hidden and denied, so the analyst who tries to offer love as an antidote to hatred only pushes hatred underground and intensifies its persecutory quality. It is necessary for the analyst to ask him/herself what defensive maneuvers he/she puts in place to avoid hating the patient, aware of the patient's need for an analyst to show him/her that he is capable of feeling hatred and also to tolerate feeling hatred. The patient will only be able to tolerate his/her own hatred if the analyst can also afford to hate him/her [52].

Another defensive tendency is the temptation to collude with the patient's splitting, focusing only on his good and loving aspects. Ferenczi [53,54] teaches a great deal about the analyst's difficulties in accommodating negative transference and how the attempt to meet the patient with infinite patience leads the analyst to acknowledge his own hatred of the patient. As Ferenczi already pointed out, it is a thorough personal analysis that can help the analyst to bear the negative transference, which involves first feeling and suffering it on one's own skin, before turning it into a thought and then into words for the patient.

Gabbard [55], in this regard, observes how analysts, unaware of their hatred, can make boundary violations at different levels, rationalized by considering the patient a person who has experienced severe deficits that require a real relationship with the analyst to improve, and warns us by helping us recognize that what provides a holding environment is more openly dealing with hatred than providing "love," considering that the abused patient is asking to come to terms with an attachment to an object of hatred and not love [55].

In contrast, Kohutian-trained psychoanalysts, who are much more optimistic about treatment with the abusive parent, emphasize the potential of the development of a self-object transference in the analytic relationship.

According to Green [15], when planning treatment, it is necessary to intervene at three levels: to decrease environmental stressors by providing the mother with support (e.g., through a home visit program and the availability of daycare facilities for the child) so that she can care for the child according to her own possibilities while waiting for these to increase, to help the child to be less distressed, and to offer support to the mother.

Green's idea is that it is important for the parent to have a corrective emotional experience with an accepting, noncritical, and rewarding adult. He also points out that some specific difficulties must be addressed when treating abusive parents: How can a therapeutic alliance be built if the therapist is involved in reporting to the court? How can a parent so fragile in self-esteem accept help without feeling criticized?

Green stresses that it is necessary to gratify the parent before making demands on him or her and that caution should be exercised in proposing psychotherapeutic treatment for the child because the parent, before a therapeutic alliance has been established with the treatment team, may experience the child's therapist as a rival and thus sabotage the treatment [15].

Given the narcissistic fragility usually suffered by parents who enact abusive behaviors, from a Kohutian perspective, the development of a self-object transference is crucial. Narcissistically vulnerable patients need their distress soothed to avoid turning it to the children. Eldridge and Finnican [34] recommend a noncritical attitude on the part of the therapist, together with an understanding that their abusive behavior indicates an attempt to maintain self-cohesion. This would promote the development of transference. They recommend giving the patient the time he/she needs to expose the split-off, painfully needy self, as well as the time he/she needs to heal the split and not to provide interpretations in the early stages of treatment because they might overwhelm the patient. They suggest strengthening self-object functions while avoiding, however, encouraging regression, providing interpretations of the patient's wishes and longings so that he/she can experience the parts of the self that have been walled off by the fear of rejection or punishment. According to Eldridge and Finnican, this way of proceeding in therapy by offering him/herself as a self-object allows the patient to feel whole and integrated, which leads him/her to decrease his/her abusive behaviors. Upon examination of the literature considered for this review, only one contribution was found that reports the individual psychoanalytic treatment of abusive mothers within a public service setting in detail [9]. In Brennan's experience, when children are subject to child protection service providers, rarely do the providers engage with parents to understand the origins of their parenting difficulties to really help them cope with them. According to Brennan, psychoanalytic therapy is the most appropriate treatment because it is the only one that addresses the deeply unconscious origins of the hostility parents act out against their children. However, some issues need to be kept in mind: Not all abusive parents accept the offer of psychoanalytic treatment; there are no empirical studies showing that psychoanalytic psychotherapy is effective in reducing the risk of abusive behavior, and even when it proves effective, it takes a long time for profound changes to occur in the parent; and, finally, it is possible that in the early stages of treatment, the risk of acting out of previously repressed feelings increases [9]. Despite these important issues, Brennan decided to organize a psychoanalytic psychotherapy service for abusive parents moved by a desire to help both parents and children. She observed that the parents who did not accept treatment or stopped it early were the ones who suffered from a deep sense of helplessness and seemed resigned to loss. She believes that these parents found that the best way to deal with their mental pain was to abandon all trust and hope in order to avoid the risk of yet another unbearable disappointment, a defensive maneuver described by Symington [56] as taking refuge in the cocoon.

Brennan presents some clinical exemplifications: with mothers who never showed up for appointments, with mothers who prematurely discontinued treatment, and with mothers who instead pursued it for several years. She highlights how often abusive parents' stubborn refusal to begin treatment can reveal their unconscious desire not to care for their children in order to protect them from their hostility and in the hope that they will be placed with more competent families. When patients succeed in starting and continuing long-term treatment, the early narcissistic damage suffered has not totally destroyed their hope, probably because of some good relationships they have experienced. Nevertheless, during therapy, Brennan experienced the patients' terror of becoming emotionally close and perceiving their dependence, also bringing the issue of negative transference and countertransference to the forefront [9]. In the course of psychoanalytic psychotherapy with abusive mothers, it became evident that the children were expected to be potential saviors but were soon experienced as persecutors; those who demonstrate the parent's wickedness, which, being intolerable, must be projected. Due to the effect of transference, the therapist in the therapeutic relationship takes on the role of the persecutor and, at the same time, feels intensely persecuted by the patient, suffering both the pain of feeling deprived and the pain of feeling deprived. This emotional experience, conveyed through projective identification, allows the therapist to "become the patient" who suffered deprivation in her childhood and who, in spite of herself, inflicted mistreatment on her children [9].

Brennan wonders how much these patients may frighten the therapist because of intense transference pressures and to what extent this leads therapists to avoid deepening transference. I would add, is it perhaps also because of this fear that intensive treatments are not offered but, at best, involve weekly treatments? Brennan still wonders whether many of the failures of psychoanalytic therapies with these patients are due precisely to the therapist's unconscious resistance to being in deep contact in the transference and countertransference relationship with such high and intense levels of destructiveness. Abusive parents often find themselves facing the impossible task of having to meet the deep needs of their children without being able to do so because no one has ever met their own deep needs, and the analyst, countertransferentially, Brennan observes, finds him/herself trapped in the position of someone who is trying to meet the opposite needs of two generations of dangerously deprived families. It is understandable that, in this emotional situation, the therapist does not feel like embarking on and pursuing a long-term therapeutic relationship that involves degrees of emotional pain that are difficult to bear [9]. The therapeutic relationship is effective if the deep needs of the patient are met, but in such cases, the struggle against destructive instances can be too hard.

Psychotherapeutic work in public service is further complicated by the fact that the patient experiences not only transference with the therapist but also with the institution, and the therapist cannot guarantee absolute confidentiality by having to, at the very least, report whether or not the patient shows up for sessions.

Brennan concludes her paper with a reflection regarding a very complex question: Is parenting therapy for the parents or for the children? How much does the therapist have his patient in mind and how much does he/she have in mind the protection of the patient's children? How can the patient feel that he/she is in his/her analyst's mind if he/she feels that the analyst has his/her children in mind first and foremost? How can the analyst manage relationships with other professionals involved in child protection? How can he/she use information about the patient that comes from other professionals and not from the patient him/herself?

Despite all of these important questions and all of these difficulties, Brennan concludes that in her experience the psychoanalytic psychotherapy service offered to abusive parents is unique for people who would otherwise never have the opportunity to be helped to come to terms with their grief, their anger, and their despair, often victims of an abusive past and ruthlessly exposed to the risk of becoming abusive parents themselves [9].

3.2.3. Mentalization-Based Treatment

Findings from the previously cited studies support the development of therapeutic mentalization-based interventions adequately suited to the specific needs of impaired parenting. Mentalization-based treatments, first developed by psychoanalyst Peter Fonagy's research group at University College London, can be considered extensions of Selma Fraiberg's pioneering work. Rosso [30] suggested that the prevention policies of welfare services should take into account mentalization deficit, especially if associated with a derogatory state of mind regarding attachment needs, as a major risk factor for failure in parenting. Berthelot and colleagues [32] suggested that focusing on mentalization may be crucial for the well-timed identification of individuals with a history of child maltreatment who are expecting a child, since intervening postpartum with parent–infant dyads may already be a step too late, as findings [57] show that an intergenerational impact of child maltreatment can be observed shortly after birth.

Some studies on mentalization-based treatments have focused specifically on intervention with abusive parents. Schechter and Willheim [58] believe that it is necessary for the therapist to allow the patient to experience what it means to safely consider another person's mind, showing him/herself that he/she can reflect on the patient's feelings without him/herself becoming dysregulated. In this way, the therapist provides the patient with external regulation and the support he/she needs to begin to consider the mind of his/her children. By keeping the therapist in mind, the patient gradually develops the ability to tolerate his/her own feelings when confronted with his/her children's distress. The mutative action does not depend on didactic directions, but on developing the ability to consider his/her children's minds, without withdrawing out of fear of experiencing negative affects again by feeling helpless and retraumatized. If the therapist has helped the parent develop a greater ability to tolerate and regulate his or her negative affects triggered by the children, the parent will be better able to regulate his or her emotions and thus be more willing to consider the mental states of his or her children [58].

Intervening on emotional regulation is crucial, as affective regulation deficits have been widely found in abusive parents [59], and a recent empirical study [60] confirmed that physically abusive mothers have a specific difficulty in recognizing negative emotions, particularly sadness. The parent's hypersensitivity and irritability indicate that the development of a normal barrier to stimuli has been compromised, presumably as a consequence of a primary relationship that did not protect against stimuli. In cases where the abusive parent was him/herself abused, not only did his/her mother fail to act as a supplementary stimulus barrier by protecting him/her from stimuli he/she was not yet able to tolerate but she subjected him/her to traumatic overstimulation that impaired the development of emotional regulation capacity [22]. Emotional regulation deficits are also transmitted from one generation to the next: If the mother does not protect her child from stimuli she is unable to tolerate, the child will not develop the normal integrative functions of the ego, will easily cry inconsolably, will suffer from sleep and feeding disorders, and will show general restlessness. He/she will thus be a hard-to-manage child who will further trigger the parent's anger, and thus, a vicious cycle will be fed [22].

Mentalization-based treatment originates from the observation that abusive parents who themselves were abused children develop ineffective defenses against mental pain related to the abusive experiences suffered in the past and that these defenses do not allow the development of the ability to mentalize and process their emotional pain. On the contrary, they defensively resort to identifying with the aggressor [26,27]. Ensink and colleagues [61] found that it is specifically the ability to mentalize one's traumatic experiences rather than the general ability to mentalize that impairs parenting.

Several mentalization-based programs for parents have been developed over the past 20 years [62,63], based on both individual and group interventions.

Sadler, Slade, and Mayes [64] developed a manualized home-visiting program for young primiparous mothers called Minding the Baby (MTB), conducted alternately by nurses and social workers once a week from the third trimester of pregnancy until the child's first year of age and every two weeks until the child's second year. The nurses were mainly concerned with prenatal care and health education while the social workers were mainly devoted to mental health and psychological issues regarding both the mothers and children; however, both used specific techniques to improve mentalization regarding their own and their child's mental states.

Baradon and colleagues [65] developed a short-term manualized group treatment called "New Beginnings" aimed at incarcerated mothers with children. Each group, led by an experienced psychodynamic psychotherapist, included up to six mothers and their infants and lasted four consecutive weeks, with two two-hour sessions weekly. In each session, a topic, chosen to activate the attachment system (e.g., pregnancy, one's own childhood experiences, experiences regarding motherhood), was addressed; time was devoted to playing with the children; and then, the mothers were invited to talk about their children, with particular reference to their mental states.

Suchman and colleagues [66–68] developed the Mother and Toddler Program (MTP), aimed at substance-abusing mothers of children up to 3 years of age. The goal of the program, consisting of 12 individual weekly sessions that also included the use of videotaping and guidance about the child's psychological development, was to help mothers become aware of which situations they experienced with their child that elicited difficulties in them and to more accurately understand their child's mental states.

None of these studies, however, specifically addressed the treatment of abusive parents. Only two recent articles [69,70] report on individual, couple, and group treatments focused on mentalization with abusive parents. Hoffman and Prout [69] emphasize the importance of an individual or group-focused parenting intervention in helping parents master negative emotions toward their children by taking a reflective, non-judgmental stance toward the parent, focusing on which feelings lead the parent to maltreat their children and which painful emotions trigger the child's disruptive behavior. Spanking the child is thought of as the result of feelings of helplessness and vulnerability against which the parent defends himself for acting inadequately powerful by physically punishing the child. Thus, spanking is conceptualized as a manifest behavior resulting from the parent's need to avoid painful emotions, so it could be avoided if the parent is helped to understand which mental states of his or her own and the child's cause the misbehavior to thus move from an automatic reactive stance to a reflective stance [69].

The therapist's curiosity about the motivations for the child's and parent's behaviors helps the parent be, in turn, curious to understand what mental states underlie these behaviors. This intervention, based on psychoanalytic principles, diverges from cognitive behavioral interventions, in that the therapist does not simply instruct the parent on how to act, but first and foremost strives to understand the parent's pain and to make sense of it, including through the careful consideration of transference and countertransference dynamics. Embracing and containing the parent's negative emotions by giving them meaning helps the parent himself develop the tools to master the emotions by which he was previously overwhelmed [69].

A recent study [70] describes a group intervention called Group Attachment-Based Intervention (GABI ©) aimed at very socially isolated and at-risk parents of children up to age 5. Parents may attend three groups per week, but may also choose to attend less frequently. Each group session lasts two hours: In the first hour, each parent is helped by a therapist to observe, tune in to, and reflect on their own and their child's mental states in the play interaction, while in the second hour, the children remain in a playroom with the therapists, and the parents participate in a parent group led by a therapist. The parent group is focused on reflecting on one's own mental states, one's childhood history, and the mental states of the children. Parents and children come together in the last 15 min. Reflective functioning is considered the hallmark of this intervention, which, in some cases, is integrated with intensive individual long-term psychotherapy and other supportive interventions [70].

3.2.4. Evaluation of the Effectiveness of Interventions

In a review regarding interventions with abusive parents aimed at improving the parent–child relationship by promoting attachment security, Valentino [71] distinguishes between short-term (5–16 weeks) and long-term (20 weeks–1 year) interventions with weekly visits and the involvement of the mother–child dyad. Short-term interventions aimed at improving maternal sensitivity were rated positively by parents, but no data are available regarding the actual reinvolvement of these parents in the child welfare system.

With regard to long-term interventions, a Randomized Controlled Trial (RCT) [72] found that child–parent psychotherapy was more effective than both Psychoeducational Parenting Intervention (PPI) and the community standard interventions typically available through the Department of Social Services in fostering child attachment security. In addition, child–parent psychotherapy was more effective in maintaining it one year after the end of the intervention. As highlighted earlier, child–parent psychotherapy is a non-directive intervention aimed at establishing a strong therapeutic alliance with the parent who, in the context of a secure relationship with the therapist, can process past experiences so that they no longer iterate negatively on his or her current relationship with the child. PPI, on the other hand, is an educational intervention aimed at teaching parents how to engage in more positive interactions with their children and specific skills designed to reduce negative behaviors.

In organizing interventions provided by public social and health services, however, costs must inevitably be taken into account. Abusive parents often need multiple interventions, psychological intervention being only one among many. They often live in poverty and need financial support to provide for their basic needs; in addition, they need practical help in managing and caring for their children until their psychological resources grant them a greater ability to care for their children for a longer time. The shrinking affordability of social and health services leads to the development of short-term and less expensive interventions, including in terms of training professionals. At the same time, on a social policy level, it is necessary to consider what can be the devastating consequences of a lack of early intervention focused on the parent–child dyad. Findings from studies in this field [73] indicate that the intervention typically provided to abusive parents based on case management is insufficient to avoid the negative sequelae of maltreatment involving conduct disorders, personality disorders, and social maladjustment, as well as perpetuating the cycle of abuse in subsequent generations.

Within the framework of attachment theory, several short-term intervention programs aimed at abusive parents or those at risk of abuse have recently been developed, which have proven effective, but only for those parents who have not suffered from traumatic childhood experiences and who are not particularly narcissistically vulnerable [74].

Moss and colleagues [73] report that an attachment-based intervention comprising eight weekly home visits was effective in improving sensitivity in a group of abusive parents; however, careful consideration of the study shows that 72% of parents were reported for neglecting and not for physical abuse, and a follow-up was conducted only 10 weeks later. Moran and colleagues [75] reported that short-term attachment-based interventions were not effective in fostering attachment security or maternal sensitivity for adolescent mothers who had disorganized states of mind regarding their childhood attachment experiences and/or who had suffered physical or sexual abuse in their childhoods. Steele and colleagues [76] also observed that having suffered negative childhood experiences moderates the effect of GABI ©, proving itself less effective in these cases. Van der Asdonk and colleagues [74] note that parents who have experienced childhood maltreatment represent a specific group of parents for whom it is more difficult to intervene effectively. The study also found that abusive parents who have undergone more traumatic experiences respond less well to brief intervention, and these findings indicate that it is necessary to identify these parents early in order to provide them with the most appropriate intervention aimed at processing their traumatic experiences as soon as possible.

Finally, it should be noted that this review highlights the absence of studies evaluating the effectiveness of specifically psychoanalytic treatments, and thus, the cited studies are not included among the evidence-based treatment programs for abusive parents.

4. Summary and Future Directions

Research has extensively highlighted that most people who have experienced maltreatment in their childhood develop mental disorders, manifest psychosocial adjustment problems, and, in many cases, become maltreating adults themselves [1,2]. Preventing child maltreatment and treating abused children and abusive parents are therefore pressing public health issues.

When a child is at risk of abuse in a family or when abuse has already occurred, a crucial question concerns assessing whether the child should be removed from the family or whether intervention in the family can prevent future abuse. As established by the Children Act in 1989 [8], child development is enhanced by remaining in the family whenever the child's safety is assured, and social services should strike a balance between protecting children and ensuring that they can remain with their families [9]. Developing prevention and intervention strategies in public health services for the purpose of repairing, whenever possible, the child–parent relationship should be a social priority.

Psychoanalytic studies have focused on understanding the internal world of abusive parents and identifying which interventions can help them become more competent parents. This article attempts to present a narrative review of psychoanalytic studies in this field specifically focusing on the intrapsychic dynamics of physically abusive parents and the treatments developed by psychoanalysts to treat them.

The article focuses specifically on physical abuse, following the recommendation [14] not to group together different types of abuse, since it has long been known that, for example, sexual abuse is an issue completely apart from physical maltreatment [3].

A narrative review was conducted for the purpose of presenting an overview of psychoanalytic studies in this field, focusing on the intrapsychic dynamics of parents who physically abuse their children and the therapeutic intervention.

Regarding intrapsychic dynamics, the review highlighted the predominant role of the transgenerational transmission of abuse and narcissistic fragility. Not all abused persons become abusers themselves, and this depends on how well the experience of abuse was processed and accepted without recourse to denigrating defenses or based on identification with the abuser. Not all abusive parents were physically abused in their childhoods, but even those who did not experience abuse suffered from a lack of recognition and validation from their parents, a lack that resulted in a deep narcissistic vulnerability that leads them, when they, in turn, become parents, to need their children to support their fragile narcissistic balance. They are thus truly psychically ill-equipped to support their children's needs and they cannot understand children's aggression as a life drive. Physical abuse, in these cases, follows feelings of helplessness and of vulnerability evoked by their children's demands that are intolerable to them.

Therapeutic treatments developed in the psychoanalytic clinic thus focus on helping the parent come to terms with past experiences and his or her narcissistic vulnerability. Interventions based on mother–child psychotherapy and mentalization have been found to be prevalent, while there is very little literature regarding intensive individual psychoanalytic treatment.

Research on treatment effectiveness has shown that while brief therapeutic interventions aimed at improving parental sensitivity are effective in many other cases, parents who have experienced traumatic childhood experiences need long-term intensive therapeutic interventions.

Psychoanalytic research has highlighted how psychoanalytic intervention in these cases is very difficult by presenting specific difficulties in managing negative transference and countertransference. No article focusing on the efficacy of long-term individual psychoanalytic treatment was found, and the review also showed that interventions are aimed in almost all cases at mothers, although the need to involve both parents was stressed by several authors.

This review also highlights another important limitation of psychoanalytic studies regarding the treatment of physically abusive parents, namely, the absence of controlled studies on their effectiveness. As mentioned above, the psychoanalytic studies cited herein are not included in the evidence-based treatments. It is believed that future research should first make up for this deficiency. As is well known, the issue of outcome research in psychoanalysis is very complex, yet efforts in this direction are necessary in order for the effectiveness of psychoanalytic interventions to be demonstrated.

Specifically, in the area of treatment for physically abusive parents, research can be further complicated by the fact that public health services often complain that they are not financially equipped to provide long-term treatment and that these parents, especially if they come from low-income households, cannot access treatment in private settings.

This review also pointed out that the identified studies were mostly dated. This leads one to wonder why psychoanalysts have long been much less concerned with understanding physically abusive parents and their treatment, while there are plenty of recent studies regarding abused children and their treatment. From my point of view, it would be desirable for future research in this field to regain vigor and for psychoanalysts to be encouraged to write and publish their studies in this area, considering that, despite the absence of controlled studies, the contribution of psychoanalytic understanding can be useful and can contribute to the treatment of parents by fostering healthier growth in children.

5. Conclusions

This review focused on the contribution of psychoanalysis to understanding the intrapsychic dynamics of abusive parents and the development of specific therapeutic interventions. With regard to physical abuse, it was found that only about 5% of the studies deal with assessment and therapeutic intervention with parents, while most studies deal with abused children. Yet, there is ample evidence that early intervention with parents is necessary to avoid the devastating consequences and break the cycle of abuse.

The literature on the father–child relationship is entirely lacking, with almost all work on intervention being focused on the mother–child relationship. There are also very few studies focused on individual psychoanalytic treatment. The near absence of literature on individual psychoanalytic treatment and the paucity of contributions regarding the treatment of abusive parents leads one to wonder whether these people elicit serious negative countertransference reactions in therapists to such an extent that they avoid taking them into treatment. Indeed, the issue of negative transference and countertransference was addressed in most of the reviewed articles.

The review also highlights the absence of controlled studies designed to support the effectiveness of psychoanalytic interventions aimed at physically abusive parents. It is recommended that future research should move in this direction.

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Commentary

Protection of Prisoners with Mental Health Disorders in Italy: Lights and Shadows after the Abolition of Judicial Psychiatric Hospitals

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Abstract: In Italy, a person suffering from a mental disorder who commits a crime will be given a custodial security order and serve the period of admission at a *Residenza per la esecuzione delle misure di sicurezza (REMS)* (Residence for the Execution of Security Measures, hereinafter "REMS"). These institutions have been established recently and though equipped with the necessary safety measures, the focus is on psychiatric therapy. Despite being present on a national scale, access is very limited in terms of capacity. Immediate remedial measures are needed, so much so that the European Court of Human Rights recently condemned Italy for this very reason. This article, through a review of the constitutive principles of these institutions, shows how they have very positive aspects such as the attention to necessary psychotherapy in order to protect the right to health and the real taking charge of the fragility of the subjects; however, it is seen how there are many negative aspects linked above all to the scarce availability of places in these structures. The article provides suggestions on a more comprehensive strategy for facilities for detainees with mental disorders.

Keywords: health; prison; prison medicine; REMS; forensic psychiatric treatment; safety; ECHR

1. Introduction

In Italy, a person responsible for a crime but judged not guilty or guilty but with diminished criminal responsibility by reason of total or partial insanity will be given a custodial security order in the event the person poses "a threat to society", psychiatrically speaking. To arrive at this assessment, which significantly affects the treatment of the detainee, an accurate medical–legal and psychiatric analysis is necessary, psychiatry specialists will be able to evaluate in this sense whether the pathology is so serious as to constitute a total or partial mental insanity and whether their conduct and capacity for self-control is lost in such a serious way as to constitute a danger to others and to society. Today, such an order means that the person will be admitted to a *Residenza per la esecuzione delle misure di sicurezza* (Residence for the Execution of Security Measures, hereinafter "REMS") [1], whereas prior to 2015, the order would be executed in a judicial psychiatric hospital (*Ospedale Psichiatrico Giudiziario* (*OPG*), hereinafter "OPG") [2,3].

The transition from the OPG to the REMS system posed considerable difficulties. Decree-Law No. 211, dated 22 December 2011, ordered the closure of OPGs by 31 March

2013 on the basis of a parliamentary investigation, which confirmed the extreme degradation present in OPGs and the general inefficacy of the treatment interventions that had led to the involuntary commitment of the detainees [4,5].

On 30 July 2008, the Italian Senate set up a select committee [6] to investigate the efficacy and efficiency of the National Health Service, including the quality of life and care within OPGs. The committee's report on the quality of life and care within OPGs brought to light the deplorable conditions present in these institutions tasked with the custodial care of persons with mental disorders. This report proceeded to describe the "serious and unacceptable structural and hygiene-healthcare deficiencies" in addition to the overall inadequacy of the current system, which is "similar to a prison or mental asylum and completely different from the system used by the Italian mental health service".

The committee's report noted serious deficits in the staffing levels of medical and healthcare personnel as well as "clinical practices which are inadequate and, in some cases, harmful to the dignity of the person, as regards mechanical actions and at times the improper use of psychopharmological agents, contrary to their therapeutic purpose and to the regulations for safe use issued by the Italian Medicines Agency (*AIFA*)" [7]. Thus, the committee deemed legislative intervention necessary and urgent in order to take the management of such institutions away from the prison administration. The aim was to effect a "thorough cleansing" of facilities used for sectioning mentally ill offenders, the ultimate objective being the "complete abolition of this method of treating the guilty but mentally ill, i.e., the permanent closure of OPGs". The committee recommended legislative intervention to "abolish a situation of fact and of law which is, in many aspects, completely incompatible with the precepts of the Constitution". The senators who served on the select committee even furnished a draft bill to abolish OPGs and replace them with alternative facilities [8], which was in large part approved.

Before it was decided to convene the select committee, the Prime Minister had already issued a decree (1 April 2008), as part of a general reform of the prison healthcare system, setting out a three-stage program to abolish judicial psychiatric hospitals. The first stage consisted of transferring healthcare management to the regional government in which the facility was located and, at the same time, tasking the Mental Health Departments with jurisdiction over the territory in which the OPG is located to draw up an operating plan to discharge those who have completed their custodial security order. The objective of the second stage was to redistribute those who had been committed to the various OPGs throughout the national territory, thus creating treatment bases in order to return detainees to their home environments. In the third stage, the regional governments in Italy were to take charge of all those committed who originated from the territory of said regional government, resulting in region-based psychiatric care provided to mentally ill offenders.

Subsequently, the Minister of Health's decree of 1 October 2012 (Requirements for Residential Facilities for People Admitted to Judicial Psychiatric Hospitals and to Care and Custody Homes) specified the minimum structural, technological, and organizational requirements for new residential facilities to be able to receive people who have been given a custodial security order of admission to a judicial psychiatric hospital, i.e., a REMS. The sole scope of these internally managed facilities is healthcare, and the facilities fall under the direction of the regional health service, which is under obligation to ensure patient care and proper safety and supervision.

2. From OPGs to REMSs

Having described the gradual overhaul of the system to care for those with mental disorders, it is important to mention the relevant developments in legislation and treatment that have led to the progressive abolition of judicial psychiatric hospitals (OPGs) and the establishment of REMSs [9,10].

In the context of prison healthcare, the Prime Minister's Decree of 1 April 2008 [11] ordered the transfer of healthcare functions, work relationships, financial resources, equipment, and fixed assets from prison administrations to regional governments. This transfer also affected OPGs.

Law No. 9, dated 17 February 2012 [12], enacting Decree-Law No. 211, dated 22 December 2011, specifically Art. 3(3) of the above law, stipulates that beginning with the permanent closure of OPGs, custodial security orders of admission to judicial psychiatric hospitals or in custodial care homes must be carried out exclusively in designated REMS healthcare facilities, with the exception of those who no longer pose a threat to society, who must then be discharged without delay and assisted by the local Mental Health Department.

Only offenders affected by serious mental disorders can be admitted to REMSs, such as psychotic-spectrum disorders, major depression, or serious personality disorders [13], potentially in comorbidity with other disorders. Such disorders must have manifested in the commission of crimes that are commensurate with the symptoms and exhibit an actual need for high-intensity psychiatric treatment.

Art. 3(3) mentioned above detailed a specific allocation of funds to cover the costs incurred in the process of abolishing OPGs, including the recruitment of qualified personnel to deliver treatment–rehabilitation pathways designed to facilitate the recovery and social reintegration of patients transferred from OPGs. This represents an exception to national regulations regarding curtailing personnel expenditure.

At the time OPGs were operational, it was not uncommon to encounter patients who were sectioned with no appointed date for reintegration as a result of multiple extensions of the custodial security order. In that regard, Law No. 81, 9 May 2014 [14], provides that the time period of provisional or final custodial security orders, including admission to a REMS, cannot exceed the custodial period established by law for the crime committed, taking into consideration the maximum sentence available in law.

Ultimately, in addition to the closure of OPGs, the legislator's objective was to devise and implement a national treatment network for this type of user by consolidating the facilities at the Mental Health Department's disposal, enabling them to take charge of said offenders and provide treatment–rehabilitation pathways. In fact, personal treatment rehabilitation plans must be created for every user within 45 days of entering a REMS. Committing a person to a REMS to serve the custodial security order, on behalf of the Department of Prison Administration, is based on the principle of territoriality (usual residence/domicile); this aspect is also proof of the desire to maintain the concept of "community psychiatry", i.e., care given in the place in which the person lives and in which they have developed, to a greater or lesser extent, a social network.

The process of abolishing OPGs, which thus far has been achieved only in part for a number of reasons, which are beyond the remit of this article, has led to the establishment of 31 REMSs throughout Italy [15], resulting in a total of 760 beds (Table 1).

Table 1. Distribution of REMS beds in Italy.

Region	Province	No. of Beds
Abruzzo and Molise	Aquila	20
Basilicata	Matera	10
Calabria	Cosenza	20
Campania	Avellino	20
Campania	Caserta	20
Emilia Romagna	Bologna	14
Emilia Romagna	Parma	10
Emilia Romagna	Reggio Emilia	10
Friuli Venezia Giulia	Pordenone	2
Friuli Venezia Giulia	Trieste	2
Friuli Venezia Giulia	Udine	2

Table 1. *Cont.*

Region	Province	No. of Beds
Lazio	Frosinone	20
Lazio	Frosinone	11
Lazio	Roma	20
Lazio	Roma	20
Lazio	Roma	20
Lazio	Rieti	15
Liguria	Genova	20
Lombardia and Valle d'Aosta	Mantova	160
Marche	Pesaro Urbino	25
Piemonte	Cuneo	20
Piemonte	Torino	20
Puglia	Barletta Andria Trani	20
Puglia	Brindisi	18
Sardegna	Cagliari	16
Sicilia	Catania	20
Sicilia	Catania	18 (women)
Sicilia	Messina	20
Toscana and Umbria	Firenze	9
Toscana and Umbria	Pisa	30
Trentino Alto Adige	Trento	10
Veneto	Verona	40

3. Positive Aspects of REMS

The creation and implementation of the REMS system has fundamental implications on the management model employed by the Mental Health Department [16,17], including as regards detention, which can be summarized as follows:

1. The active role of users of psychiatric services. The associationism of family members and users, together with the third sector operating within the area of mental health, has been working towards an advocacy approach for some time with a slow but steady increase in representation. The objective of these parties should be to effect continuous improvement in quality that favors best practices that embody the therapeutic-care alliance between users and practitioners. The synergy that exists between these two parties when participating in social health projects is the result of the development of a "culture of the right to the most effective treatment", which is obtained by means of a shared approach to personalized care (it is no coincidence that these are termed personal treatment rehabilitation plans) [18].
2. Clinical activities focused on areas of vulnerability, risk factors, disabilities, and recovery, widening the scope of the traditional method focused solely on nosographic identification and diagnostic standardization; in other words, a progressive transition from "disease" to the areas of interest cited above, which enable a greater degree of realignment with existential values and legitimate reintegration in the person's home environment. As a result, interventions targeting treatment and rehabilitation assume greater value, as opposed to those designed solely for reparative purposes, thus resulting in a more comprehensive biopsychosocial approach to psychiatric disorders [19].

3. The enhancement of community care pathways [20]. Psychiatric interventions more acutely focused on territorial services serve to enhance the primary objective of community mental healthcare, to reinforce deinstitutionalization, and to advance a non-hospital centric vision. In this context, extending the health budget to include mentally ill offenders could (1) facilitate the creation of personalized treatment-rehabilitation pathways and (2) "free up" resources for other Mental Health Department activities. In the current historical, financial, and political climate, it cannot be denied that proper organizational analysis aimed at optimizing a community-based approach to psychiatry may well prove to be the springboard for promoting the effective and efficient use of resources required by the Recovery and Resilience Plan (RRP) issued by the European Union to all member nations.

4. Negative Aspects of REMS

In recent years, the creation and implementation of the REMS system has been met with considerable criticism, for example, Order No. 131, dated 24 June 2021, issued by the Italian Constitutional Court. In its ruling, the Constitutional Court (tasked with adjudicating the constitutional legitimacy of laws), in considering the difficulties and shortcomings of admissions to REMS facilities, requested the Ministry of Justice and the Ministry of Health to provide an explanatory report on the matter.

The case originated with the Court of Tivoli, Rome, when a preliminary investigations judge raised the question of constitutional legitimacy due to the fact that the provisions would oust the jurisdiction of the Ministry of Justice in executing custodial security orders by admitting offenders to REMS facilities. In that specific case, the judge had made a provisional custodial security order in a REMS facility in the case of a person, investigated for violence towards or threatening of a public official, who was affected by mental disorder and systematic alcohol abuse. Consequently, the accused was deemed a threat to society, and the judge made the custodial security order and provisionally ordered conditional release to a psychiatric facility until such time as transfer to a REMS became possible.

However, the offender systematically refused to be treated and to abide by the obligations set upon him. Nonetheless, despite the insistence of the public prosecutor, the Department of Prison Administration confessed that nothing could be done about the repeated rejection of transfer requests due to the lack of available REMS beds because they are managed exclusively by the regional health service.

The Court ruled that, since the matter did not concern mandatory healthcare treatment but custodial security orders, made on the basis of a two-fold assessment in terms of the commission of a crime and posing a threat to society, the order must come under the Ministry of Justice's jurisdiction as the prison administration's supervisory body.

For that reason, the Court ordered the appropriate authorities to prepare a report outlining the number of REMS, the number of patients admitted, the number of patients on the waiting list and the average waiting time, the number of people given an alternative order, such as conditional release, while waiting to be transferred to one of these facilities, and the form of any coordination between the Ministry of Justice and local health authorities.

A subsequent, but by no means less important, judicial ruling on the topic of REMS facilities was given by the European Court of Human Rights, dated 24 January 2022, which granted the appeal of a young psychiatric patient who had been detained for a long time in Rebibbia Prison (Rome) despite the fact that in January 2019, the Supervisory Magistrate had ordered him to be admitted to a REMS facility under a custodial security order. The order had not been carried out due to the chronic lack of available beds.

In March 2020, the patient appealed to the European Court of Human Rights, simultaneously filing a request for interim measures. On 7 April 2020, the European Court of Human Rights indicated an interim measure under Art. 39 of the Regulations, ordering the Italian Government to arrange for the immediate transfer of the appellant to an appropriate facility and ensure he received treatment congruent with his condition. That measure was only carried out on 12 May 2020.

In its 24 January 2022 judgment, the European Court held that subjecting the appellant to the ordinary prison regime, which continued for almost two years despite the opposition of the psychiatrists treating him, prevented him from receiving the necessary healthcare treatment for his psychopathological condition. This constituted a violation of the prohibition of inhuman and degrading treatment and punishment set out in Art. 3 of the European Convention on Human Rights (ECHR).

The Court also held that the detention of the appellant was unlawful, ruling that his being held in seriously degrading conditions in an ordinary penitentiary institution, combined with the failure to provide personalized treatment and to transfer the patient to a REMS facility, constituted a violation of the right to liberty and security of person under Art. 5 of the ECHR.

Furthermore, the Court held that the Italian legal system was in violation of Art. 5 of the ECHR due to the lack of an appropriate provision to ensure fair compensation for the unlawful deprivation of liberty, as well as of Art. 6 of the ECHR due to the national authorities' failure to execute the trial court's ruling to release the appellant.

Finally, the Court held that the considerable delay on the part of the Italian government to implement the interim measure issued by the Court in April 2020 was in violation of the right to individual applications under Art. 34 of the ECHR. In fact, the Italian government took more than one month to transfer the appellant to an appropriate facility. The Court also held that "it is incumbent on [every] government to organize its penitentiary system in such a way as to ensure respect for the dignity of detainees, regardless of financial or logistical difficulties".

Furthermore, the judgment awarded the appellant compensation for non-patrimonial damages due to the violations of Articles 3 and 5 of the ECHR.

The issue that came before the European Court transcends that appellant's specific case in that the root problem goes to the essence of the Italian legal system, as highlighted numerous times by the prison administration itself: the chronic lack of available REMS beds. According to the latest statistics published by the National Guarantor for the Rights of Persons Detained or Deprived of Liberty [21], as of February 2021, 770 people who received a custodial security order were waiting to be admitted to a REMS facility, 98 of whom were being unlawfully detained in prison facilities, whereas the remaining 672 were free.

5. Conclusions

At the time of the reform, i.e., when Decree-Law No. 211, dated 22 December 2011, was enacted by Law No. 9, dated 17 February 2012, the number of REMS facilities and beds required throughout Italy was set using quantitative parameters, which necessitate reevaluation over time to ensure they continue to meet the actual needs. In fact, the number of persons who have received a custodial security order is significantly greater than the number of available REMS beds, posing an immediate turnover problem to facilities that are unable to ensure sufficient rotation of beds in time to take charge of new patients given similar orders by the Judiciary [22,23]. The inability to accommodate the actual demand has led to the phenomenon of the ever-expanding waiting list. Many factors have contributed to this dilemma, not least the elevated number of provisional custodial security orders. As a result, a proportion of mentally ill offenders either stay at home on license under the responsibility of their families with mandatory Mental Health Center monitoring, while others are provisionally put into Therapeutic Communities or remain in custody in Italian prisons *sine titulo*.

The first few years of post-reform experience have highlighted the need for the Mental Health Department to devise an appropriate mental health treatment program and provide training for practitioners in the sector. It is not simply a case of a lack of availability in terms of numbers, but along with the obvious need to expand the number of facilities, it is essential that the complex dynamics (crime, mental disorder, threat to society, etc.) be evaluated and accommodated in a sequence of activities designed to foster involvement, participation, and exchange. Ideally, this approach should encourage participants of

REMS treatment–rehabilitation plans to share the thinking, needs, and expectations of their community-creating, in a word, a "pathway" from antisocial to social and, if possible, even pro-social behavior [24].

The human capital element is essential to the success of this approach, i.e., the practitioners operating within the various environments. The specific activities that REMS workers are called upon to perform entail close and prolonged contact with mental and behavioral disorders that render professional continuity problematic due to the risk of burnout and trauma [25]. For this reason, it is essential for practitioners to develop a good awareness of that contact, supported by training and professional development courses and by a shared view of transversality. The collective opinions of the various mental health professionals–psychiatrists, psychologists, nurses [26–29], social care workers, professional educators, rehabilitation therapists, etc.—can have the advantage, when needed, of providing innovative solutions within a sector that is always at risk of chronicization and automatization.

Ultimately, interventions to expand and sustain REMS activities—through financial, organizational, and professional resources—not only benefit individual patients but also the wider community, enabling the respect of rights and liberties provided for by the Italian Constitution and the European Convention on Human Rights. For that reason, an emergency plan to expand these facilities is now more important than ever, as it is not simply a case of increasing the number and availability of beds but, above all, of creating a capable system of professionals who put their resources to use in these specific activities, remembering that they also need attention, training, and assistance.

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Article

A Qualitative Exploration of the Functional, Social, and Emotional Impacts of the COVID-19 Pandemic on People Who Use Drugs

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Abstract: Since 2020, people who use drugs (PWUD) experienced heightened risks related to drug supply disruptions, contamination, overdose, social isolation, and increased stress. This study explored how the lives of PWUD changed in Philadelphia over a one-year period. Using semi-structured interviews with 20 participants in a Housing First, low-barrier medication for opioid use (MOUD) program in Philadelphia, the effects of the first year of the COVID-19 pandemic on the daily lives, resources, functioning, substance use, and treatment of PWUD were explored. Interviews were analyzed using a combination of directed and conventional content analysis. Six overarching themes emerged during data analysis: (1) response to the pandemic; (2) access to MOUD and support services; (3) substance use; (4) impacts on mental health, physical health, and daily functioning; (5) social network impacts; and (6) fulfillment of basic needs. Participants reported disruptions in every domain of life, challenges meeting their basic needs, and elevated risk for adverse events. MOUD service providers offset some risks and provided material supports, treatment, social interaction, and emotional support. These results highlight how there were significant disruptions to the lives of PWUD during the first year of the COVID-19 pandemic and identified critical areas for future intervention and policies.

Keywords: substance use; medication for opioid use disorder; COVID-19; social networks; social isolation; vaccine hesitancy

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1. Introduction

People who use drugs (PWUD), such as opioids, are at elevated risk for severe COVID-19 and mortality, as they have high rates of underlying health conditions [1,2], high rates of homelessness, incarceration, provider-related stigma, and lack of access to health resources [3]. PWUD were also particularly vulnerable to other adverse experiences during COVID-19 due to criminalization of substance use, poverty, unemployment, homelessness, contamination of the drug supply, and risk of overdose [4,5]. During the first year of the pandemic, rates of overdose and medication for opioid use (MOUD) service use changed over time, but ultimately increased, resulting in over 100,000 drug overdose deaths in the US in the 12 month period ending April 2021 [6–10]. Thus far, there is limited literature on the effects for PWUD beyond their rates of infection with COVID-19, use of services, substance use, and rates of overdose. The few qualitative studies that explored the daily experiences, social, and mental health effects of PWUD were conducted in Canada and the United Kingdom [11–16], and it is unclear how well these experiences reflect those in the United States.

In addition to national efforts to promote safety during the pandemic—such as mask wearing policies and social distancing guidelines—federal, state, and local policy changes were rapidly enacted during the pandemic to adapt care for PWUD to mitigate disruptions in MOUD services and to preserve housing for vulnerable persons [17]. The effectiveness of these policy changes has largely been positive. Several studies have reported on how adaptations during the pandemic—such as mobile vans with extended release MOUD [18], expanded methadone take-homes [19,20], and telehealth [21]—helped to minimize disruptions to those previously engaged in services. However, many individuals struggled with MOUD adherence during the pandemic and some forms of support were disrupted, such as group therapy visits [22] and harm reduction services (necessitating reuse of injection equipment, which increased risk for COVID-19 and other infections) [23,24]. In addition, PWUD have low vaccination rates for all diseases [25]. Understanding vaccine perspectives specific to PWUD can better support these communities with education and outreach campaigns. Lastly, it is also less clear how well PWUD were able to rally individual-level (e.g., coping ability) and community-level resources for harm reduction practices (e.g., MOUD services, fentanyl testing strips) to mitigate their risk of substance use, social isolation, and safety concerns. Understanding the cumulative effects of the pandemic on all these domains is critical to identifying areas for future interventions as substance use experts anticipated many increased risks for harmful outcomes related to substance use for this population [26].

For the present study, we explored how individuals with opioid use disorders (OUD) in an integrated primary and behavioral healthcare, MOUD, and supportive housing program perceived the pandemic's effects on their lives during the first year of COVID-19 as well as their attitudes towards vaccination, social distancing, and other COVID-19 prevention measures. We sought insight into how policy changes designed to preserve MOUD access and social distancing operated and how social, economic, housing, and community-level stressors contributed to individuals' ability to engage in harm reduction, engage in MOUD services, and affected their mental health, social connections, resources, and substance use.

2. Materials and Methods

2.1. Setting and Study Sample

The structure of the overall low-barrier, integrated MOUD program at the Project HOME Health Services (PHHS) federally qualified health center (FQHC) was described previously [27]. The Integrated Care Clinic (ICC) where this project took place is a partnership between the PHHS FQHC and Pathways to Housing PA (PTHPA), a Housing First program that provides supportive housing to people with serious mental illnesses and substance use disorders [27,28]. The ICC is unique in that the primary care and MOUD services are embedded and integrated with the PTHPA permanent supportive housing services including care coordination, nurse care management, on-site psychiatric services, peer support, and an array of additional services.

From April 2020 to March 2021, PTHPA served 235 clients with MOUD services, which were predominantly male (59%) and non-Hispanic White (54%). The mean age of those served was 42.3 years old (*SD* = 9.5; range: 24–66). A convenience sample of 20 participants in the ICC MOUD program were recruited by staff at PTHPA. The sample did not significantly differ in the proportion that were male ($z = -0.51$, $p = 0.61$) or non-Hispanic White ($z = -0.51$, $p = 0.61$) of the total population served. Twenty of 23 clients who were approached agreed to participate. Inclusion criteria required participants to be at least 18 years old, English-speaking, currently receiving MOUD services through PTHPA, and able to consent. Study personnel explained the study to interested participants and obtained verbal consent. Verbal consent was obtained to minimize risk of infection during interviews and to protect the anonymity of the participants.

2.2. Procedures

Two female PhD interviewers with extensive qualitative interview experience with PWUD (ELK, MKR) conducted in-depth semi-structured qualitative interviews with participants over the phone or through Zoom from January to April 2021 (see Supplementary Materials for interview guide). The research team collaboratively developed a set of open-ended questions that asked participants about the impacts of COVID-19 on their lives with a focus on social determinants (e.g., food, income, housing, safety, transportation), services, and social impacts. Interviews lasted 10–45 min and participants were compensated with USD 20 cash and two transportation passes for their time. A pseudonym is used when participants are directly quoted. The study was approved by the Thomas Jefferson University Institutional Review Board under protocol no. 20G.344.

2.3. Analysis

A professional transcription service transcribed audio-recorded interviews verbatim. An initial codebook was created by the coding team through line-by-line analysis of three randomly selected interviews and revised according to team consensus. Once a codebook was developed, transcripts were analyzed in Nvivo 12 through directed and conventional content analysis [29]. Interviews were independently coded by four female coders with extensive field experience with PWUD and graduate training in psychology (Ph.D.) and public health (Ph.D. and MPH) as well as undergraduate training in anthropology (BA). Codes with a Cohen's Kappa (k) below 0.70 were individually reviewed and reconciled. Once intercoder agreement was consistent, alternating pairs of primary and secondary coders independently coded the interviews and any remaining coding discrepancies were resolved via consensus agreement. After completing coding, six authors (ELK, MPH, KMS, KSJ, SH, and KS) composed thematic memos and the group iteratively examined the relationships between the codes to arrive at the central themes.

3. Results

The majority of participants were non-Hispanic White (60%) and male (65%; $n = 20$). The average age was 44.2 years old ($SD = 8.1$; range: 31 to 59 years old) with participants reporting an average of 27 months in MOUD treatment at PTHPA (range: 0.5 to 132 months; see Table 1). Knowledge of personal infection with COVID-19 was rare, with only two participants reporting possible infection. Eight participants discussed knowing others who were infected, and 25% knew someone who died from COVID-19. Six main themes related to COVID-19 were identified during analysis: responses to the pandemic; access to MOUD and support services; substance use; impacts on mental health, physical health and functioning; impacts on social networks; and fulfillment of basic needs.

Table 1. Sample demographic and clinical characteristics ($n = 20$).

		n	%
Gender			
	Cisgender man	13	65%
	Cisgender woman	7	35%
Race/Ethnicity			
	White	12	60%
	Black	4	20%
	Latinx	3	15%
	Other	1	5%
		M	*SD*
Age		44.2	8.1
Number of Months in MOUD Treatment		27.3	29.6

3.1. Responses to the COVID-19 Pandemic

3.1.1. COVID-19 Attitudes and Behaviors

Attitudes about COVID-19 ($n = 13$) ranged widely, with some indicating a great of skepticism about how dangerous it was, some reporting apathy, and some a great deal of fear. Of those who were skeptical, two cited conspiracy theories around population control, government sources of COVID-19, or a belief that fentanyl exposure was protective against COVID-19. Among those expressing fear, concerns were wide ranging. These included a general sense of fear from others around them, concern about where they might be at high risk to become infected by COVID-19 (jail or public transit), general fear of what the future held, difficulty getting healthcare from hospitals due to fear of infection, and fears of COVID-19 generally. However, fear of COVID-19 was far from the main stressor for many, as illustrated by Jerry, who said, "I'm more worried about getting shot around here than I am about COVID".

Personal infection with COVID-19 was relatively rare, as only two assumed they were infected with COVID-19 at one point. However, eight participants discussed knowing others who were infected, and a quarter knew someone who died from COVID-19 infection. Despite varying attitudes about COVID-19, 18 of 20 participants reported wearing a mask at least some of the time and 16 described practicing social distancing. About a third indicated taking COVID-19 precautions very seriously in terms of handwashing, social distancing, and consistent mask use. Vigilance about preventing COVID-19 infection was difficult and took a social and mental toll on people. The majority of participants reported getting tested for COVID-19 at some point, often multiple times through PTHPA, in jail, at the hospital, or at church. Some discussed how they had changed their behaviors to reduce their likelihood of arrest and exposure to COVID-19 because they were afraid of how vulnerable they would be while sharing a cell, as noted by one older male participant (Walter):

> Yeah, because jail is even worse, they got people piled up on each other and it takes two weeks to get the results back so you could be bunking with someone who has COVID.

People also perceived a great deal of tension and fear from others when in the community, which exacerbated some of their own negative feelings. A few expressed extreme frustration when others did not comply with COVID-19 prevention measures. Conversely, a small number expressed a great deal of discomfort while wearing a mask or frustration that masks interfered with their ability to read others' social cues or to make connections to new people or clinical staff. People who disliked masks discussed how it affected them physically and mentally. Mentally, they felt more irritable or felt that others around them were irritated by wearing masks and physically it was hot, uncomfortable, and hard to breathe. Ben noted how COVID-19 guidelines had major personal costs as they interfered with his access to critical resources.

> I've got it on now. I wear a mask. I stay the distance. I practice the distancing. And mostly now, I stay inside now. But a lot of places I wasn't able to go. Because of COVID, you can't get in a lot of places. Even some shelters were limited because of the COVID. A lot of things were limited due to the COVID and the amount of people allowed into these places. So a few places I couldn't get into and I just had to suffer, I guess, or get used to it.

3.1.2. Vaccination

Among the 19 participants who responded about vaccination, 11 were vaccine-willing, 5 were not vaccine-willing, and 3 were vaccine hesitant. Two participants among the 11 vaccine-willing had already received vaccinations at the time of the interview. The 11 people who were vaccine-willing expressed motivations such as not wanting to be infected with COVID-19 and fears of serious illness or death from COVID-19. When asked if they would hypothetically be willing to be vaccinated that same day, most immediately replied in the affirmative. Some expressed concerns about vaccine side effects; however, these worries did not impact vaccination intent. Gabby said:

> Because I want to avoid the virus. I'll have it protect me against it . . . but I would still wear my mask and everything, just to be on the safe side.

Others reported previous vaccine hesitancy but ultimately decided in favor of vaccination. Walter said:

> I wasn't going to get it, but I think I'm going to get it now because I just don't want to take the opportunity of having a third breakout or a big boom, back into red being a high risk.

Three participants were vaccine-hesitant. While two were unsure whether they would ultimately be vaccinated, one believed she would likely get vaccinated after she was able to "see how it's going" with others. These participants cited deeper concerns about side effects and believed the precautions they were already taking (e.g., handwashing, social distancing) were adequate. Five participants were unwilling to receive a vaccine at the time of the interview. Reasons for refusal included: not wanting to introduce the vaccine substance into their body, previous adverse experience with influenza vaccination, government distrust, and beliefs that their body's immune system response was adequate. Two noted a belief in conspiracy theories related to the COVID-19 vaccine, fertility, and population control. Bob was adamant about his decision to remain unvaccinated:

> You've got it or you don't. You're going to get it or you won't. You got it, not being around people that have it, period. That's all there is to it.

3.2. Connection to MOUD Services

One year into the COVID-19 pandemic, PTHPA was a main service provider for all participants, though only five exclusively received services there. Participants described receiving telehealth services, home visits, as well as regular clinic visits throughout the pandemic, albeit less frequently for some (n = 5). Participants largely reported core MOUD services were accessible during COVID-19 with six individuals stating directly that there was no change in their service access or quality. One participant noted that despite a decrease in the number of staff, all the normally scheduled home visits, transportation, clinic visits, and money distribution did not change in function. "Anything I need help with, they are there for me", said one participant (Ben) and another commented that PTHPA was his lifeline. A few participants had concerns about PTHPA staff turnover as interfering with rapport and one client expressed concern that PTHPA was trying to help too many high-need people simultaneously, which limited their capacity to help her. Five interviewees noted the loss of MOUD group structure as an important place for social interaction, an activity replacement for substance use, and a reason to come into the office more routinely for services. The loss of these groups increased their sense of isolation and anxiety.

The majority of participants (n = 13) also described receiving services from other specialty substance use treatment centers including outreach, harm reduction, housing, inpatient rehabilitation, methadone treatment, and abstinence-based treatment groups (e.g., Narcotics Anonymous). Many reported some disruptions or adaptations by these providers during the pandemic, such as reduced bed capacity, online groups, and lower capacity for in-person treatment groups. All participants receiving outside methadone treatment (n = 4) reported that clinic resources were operating at full capacity with some modifications (such as conversion of Narcotics Anonymous meetings from in-person to Zoom).

3.3. Substance Use, Harm Reduction, and Overdose

3.3.1. Substance Use

We did not ask people for a comprehensive substance use history, only about the frequency and quantity of their use in the prior year. Among those reporting a decrease, they attributed it to social-distancing and staying home alone, fear of incarceration and subsequent infection, and loss of income. Tag outlined how access to his MOUD helped to facilitate his staying home, as it decreased his need to seek out drugs.

> It's been affected. I don't go out as much, so I just use my Suboxone. It is helpful in a way because I won't go out as much to gets drugs. I'll use my Suboxone. So in a way it's helpful.

Six others described decreased use over the prior year due to personal motivation, positive buprenorphine/methadone experiences, and changes in behavior following adverse experiences and increased access to mobile services. Those who said COVID-19 directly increased their substance use (n = 2) explained that being forced to stay home caused boredom that increased their cravings and use.

Of the 16 participants that discussed the local drug supply, the majority reported it had worsened during COVID-19 (n = 11) and several reported contamination of all substances. Participants described heroin suspected as adulterated with fentanyl, xylazine (a veterinary tranquilizer), or amphetamines and of powder or crack cocaine adulterated with fentanyl or unknown substances. These participants expressed a lack of confidence in the identity and purity of their substances of choice and fears of unexpected, adverse physical reactions of vomiting, bacterial infections, and overdose. ClaireBear expressed her deep frustration with the changes to the drug supply and its impact on her health.

> They cut it with crap. It's not like heroin...Yeah, it's tranquilizer, which affects your whole GI system. It's not even for human consumption, and then your GI system doesn't work for a couple days so that anything you eat goes putrid in your stomach. It comes up either through your mouth or out the other way, and it's horrible.

Three participants explicitly expressed that their frequency/quantity of substance use was directly impacted by the contaminated drug supply. Five individuals reported no change in the cost, availability, nor quality of the drug supply during COVID-19, which they attributed to their long-standing relationships with their suppliers. While they did not express personal fear of contamination of their drugs, they acknowledged that the purity of the general supply fluctuated throughout the city.

3.3.2. Harm Reduction

All participants named at least one method of harm reduction that they employed while using substances during the pandemic, namely MOUD services (n = 19). For the 16 who still used drugs at some point in the prior year, most still used in the presence of another person or asked someone to check in on them (n = 10), and some utilized fentanyl test strips (n = 6) and naloxone (n = 5). Eight participants described partaking in actions that increased their agency over the frequency of their use and methods of consumption (i.e., not selling their buprenorphine, spacing out doses, sniffing/snorting instead of injecting, avoiding triggering spaces/people, not sharing syringes). Access to naloxone was seen as plentiful during the pandemic, as Bob described, "I got more Narcan than the whole world, and I've got neighbors". Several participants also remarked that their consistent access to naloxone was critical to reversing witnessed overdoses.

3.3.3. Overdose

Four participants discussed personal overdose or extreme withdrawal that occurred during the pandemic. Participants recalled their experiences within the context of other complex vulnerabilities, including the transition in and out of incarceration, mental health crises, social isolation, and termination of methadone treatment. Almost half of the participants reported knowing people who overdosed in the prior year, such as a friend's overdose described by Elisha.

> My one friend, he had went down and, and he got his drugs and he went to use in the usual place that he does where they're all other people and the cops, they come and told everyone they, they couldn't be in groups anymore. So they made everyone disperse, which caused him to, you know, get on the train and use on the train and then he used too much. And you know, overdose.

3.4. Impacts on Mental Health, Physical Health, and Functioning

The mental health effects of the pandemic were highly individualized. Several participants expressed a great deal of fear about the pandemic, but others reported skepticism and apathy. Of those who were skeptical, two cited conspiracy theories around population control, government sources of COVID-19, or a belief that fentanyl exposure was protective against COVID-19. COVID-19-specific fears broadly fell into three categories: (1) a general sense of fear from being around others; (2) concern about high risk of infection COVID-19 in jail, public transit and hospital settings; and (3) fear for the future. Vigilance about preventing infection was difficult and took a social and mental toll on participants.

When directly asked about their mental health, almost half initially reported no adverse effects and two reported improvement. Importantly, most participants who had mental health struggles reported that they could turn to PTHPA for support. However, later in the interview, eight said that they have felt more lonely, isolated, irritable, or anxious. These impacts were largely attributed to non-pandemic issues, such as housing quality, deaths, and substance use. The pressures of the pandemic also raised some existential questions and many participants described a complex, evolving reaction over time, which was best described by Miss B:

> Being under these conditions I would say, and I'm speaking in general but I'm also speaking for other people, it kind of forces you to look at your life. It forces you to face reality and figure out what you want to do and what it's going to be like because the COVID came on so strong and fast and for all those people who died, it's caused me to feel depressed a lot. It's caused me to realize how little of a life I have. How empty and it's just the reality of it. It's what it is. It's just crazy. It brings fear for the future. You never know what's going to happen and you feel like... I feel like I've had to cherish every little thing. I've also felt offended a lot. There's nothing I can do about it. It's going to be what it's going to be.

The majority of participants ($n = 11$) stated their physical health was "okay" or "good", though several described complex histories of hospitalizations for overdose, injuries, and other health conditions and six reported their health was adversely affected by COVID-19. Those who reported their health as "bad" or "not good" typically reported mobility issues, such as back or leg pain, that interfered with daily tasks. Almost half reported receiving assistance with their physical health from PHHS and PTHPA during the pandemic and there was little note of disruptions to access to primary care services.

Most individuals ($n = 12$) reported COVID-19 impacted their daily routines. Of those limiting their daily activities by staying at home, most reported feelings of isolation, irritability, anxiety, or loneliness related to their restricted activities. For example, Savannah described how shut downs due to the pandemic closed off many of her routines

> Let's see. It's hard to, let's see. It's a lot harder shopping and getting everything that I need because a lot of places aren't even open. You can't really go out and eat anywhere. You know how you go out and you have conversations? You know what I mean? You can't do all that, so yeah. It's a big blocker, also.

However, three continued their daily activities normally, enjoying a mix of indoor and outdoor activities. Some reported going to PTHPA as a reason to leave their homes and for needed social interaction.

3.5. Impact on Social Connections

Several participants reported missing social activities (e.g., family gatherings, going to groups) as the vast majority (*n* = 16) reported social distancing efforts. Throughout the interviews participants described impacts on their relationships and all were asked to identify the three people closest to them in their social networks (SNs). The majority (*n* = 12) identified three people that they were close to, primarily family members, and half reported daily contact with someone. Many reported less frequent contact with family, particularly in-person contact due to distance, infection concerns, or transportation issues. This was particularly difficult for the loss of contact with children, as described by Elijah,

> It's not like it was before where we're seeing each other every day and, or like every week, especially with the kids and in COVID, you know, it's we don't want to have them on the bus or like on the train or whatever, any type of transportation we get over here and vice versa. So, we've kind of just been doing it over the phone . . . but it's just not the same as being there in person.

A few described still seeing their closest friends and family on a daily basis and feeling closer to them as the pandemic meant they spent more quality time together. For two people, their only contacts were with a service provider and another two were only seeing their social network members via the phone and they reported feeling lonely, anxious, and depressed. A quarter described the importance of social connections with service providers and other patients while they lacked access to their closest friends and family.

Loss was a significant theme. Almost half of participants reported a loss during the pandemic, and the majority of those deaths were due to COVID-19 (5 out of 9). One interviewee spoke around the abrupt loss of her friend, who went into the hospital after feeling unwell and passed away of COVID-19 shortly after, stating " . . . and my heart is broken to the core". Participants also lost friends, spouses, or family members to other causes, including drug use.

3.6. Attendance to Basic Needs

At the time of interview, 17 participants were housed and three did not have stable housing (in a shelter, in a hotel, and homeless/"couch surfing"). Only two interviewees discussed housing changes during COVID-19. Savannah said she took an undesirable apartment out of fear that there would not be any options available in the future due to COVID-19 and Walter explained that couch-surfing was more difficult now due to social distancing. While the majority were satisfied with their living conditions, some reported wanting a change due to noisy neighbors, bug infestation, and community violence (*n* = 5).

Access to food varied and even among those who said they had enough food (*n* = 11) four indicated that they would run out at the end of the month. This required individuals to be vigilant for community-level resources, which Ben found to be plentiful if a person knew where to look.

> There's people who will pull up from anywhere at any time with food. I'm going to tell you something nice. There's so many people that give away food, cook food and come down there and give it out, I swear to God. I'm not kidding you. They do have food services down there. And they have Prevention Point, the community center, even though I said you can't stay in there during COVID, they still have coffee in the morning and they'll have donations from Wawa.

> They'll hook you up. And then also, on the other side of Huntingdon, they have St. Francis. And St. Francis has a meal every night for you.

For some, their circumstances improved, as they noted their benefits increased during the pandemic (n = 6). There was a near even split in access to increased formal benefits (n = 11 receiving), such as supplemental security income and stimulus checks, though two reported difficulty accessing these funds. Informal means of income, such as odd jobs or panhandling, diminished during the pandemic due to social distancing (n = 8) and several stated that they could not meet their daily needs (n = 7) or lacked basic supplies at the end of the month (n = 13), described succinctly by Scott as "I don't even have toilet paper for my ass, or food". Several participants described new barriers to transportation during the pandemic, as they reported fewer buses and trains in operation with decreased hours and three described witnessing increased violence on public transit. Several participants (n = 6) decreased travel due to anxiety about COVID-19, having less places to go, and a lack of funds for transportation. Over half of participants reported that their access to transportation did not change during COVID-19 or increased, largely due to PTHPA still picking them up for their healthcare appointments.

4. Discussion

The present study explored the intersection of the ongoing opioid overdose crisis and the first year of the COVID-19 pandemic on PWUD in a supportive housing setting and resulted in six identified themes: response to the COVID-19 pandemic, access to MOUD and support services, substance use, impacts on mental health, physical health and functioning, impacts on social networks, and fulfillment of basic needs. Remarkably, participants in the present study reported little MOUD service disruption almost one year into the pandemic, which suggests that the policy changes regarding MOUD (e.g., easier access to telehealth, allowance of telephone services, allotment of greater take-home doses) and other supports (e.g., stimulus payments, increased benefits) supported access to and continuity of MOUD. However, some important services, such as group meetings, decreased during the pandemic, and were keenly missed. Across states, MOUD services connections varied highly during a comparable timeframe. A Pennsylvania study analyzing claims from January to October in both 2019 and 2020 found that the onset of the COVID-19 pandemic was associated with a reduction in both the number of new patients initiating MOUD treatment and the number of patients filling buprenorphine prescriptions [30]. In contrast, a Texas study utilizing the Prescription Drug Monitoring Program (PDMP) found a marked increase in new buprenorphine patients in the first 90 days of the pandemic [31]. It is possible that the low-barrier program model in the present study allowed for easier retention and future research should explore what specific mechanisms were critical to MOUD retention and should be perpetuated.

Global and local disruptions to the unregulated drug market during this time were associated with elevated risk of harm, such as overdose. Accordingly, several studies noted increased drug use by some PWUD [11,13], as well as changes to MOUD service capacity [12]. In our sample, changes to the drug supply meant that participants often felt that there were higher rates of adulterants, such as fentanyl or xylazine, which made drugs more dangerous overall. Only two participants reported increased drug use, perhaps reflecting the ongoing connection to MOUD services by participants. Despite personal use being stable or reduced, participants still contended with several adverse events related to drug use, including personal or witnessed overdose, impaired health, decreased access to inpatient rehabilitation services, and impaired relationships. Some harm reduction strategies, such as using with others, were more difficult but not absent among participants. The strategies that were less disrupted included access to their MOUD medication, having naloxone on hand, and fentanyl test strips, which suggest that local policies were effective at providing resources and tools among participants connected to care.

As has been found previously among PWUD [32], some participants reported increased feelings of sadness, boredom, irritability, anxiety, and loneliness during the pandemic. Participants described how they were negatively affected by their compliance with social distancing and restricted activities in the general community and the changes to their social environment were often directly referenced as causing their mental health distress. While there were relatively low rates of personal infection among our participants, several had lost a friend or family member to COVID-19, exacting a significant emotional toll. The majority of individuals were able to maintain some contact with friends and family in-person, albeit decreased due to poor phone access and lost abilities to travel to see family (due to insufficient funds or social distancing). Few participants described total social isolation but the frustrations of their social constrictions within the broader community and beyond their network were a pervasive challenge. Nationally, reports of mental health symptoms and poor access to mental health services increased over the course of the pandemic [33–35] and future research should explore the impacts on those in public services in order to determine where additional resources are most urgently required. Many credited their service providers as providing essential emotional and instrumental social supports, particularly among those who lacked any contact or had especially reduced access to their closest friends and family during COVID-19. Encouragingly, many participants described retaining their access to physical health services, as they received their MOUD through a specialized primary care designed for PWUD, which highlights the value of integrated care programs to address the needs of highly vulnerable populations.

Participants in this study were mixed in their intentions to receive the COVID-19 vaccine, though most intended to be vaccinated or had already received their COVID-19 vaccination by the start of the interview. These findings complement those of an Australian survey with PWUD where most indicated they would be vaccinated, but 15% said they would definitely not [36]. Further survey research with this cohort confirmed that vaccine rates for PWUD lagged behind those of the general population [37]. Concerns among participants were like those of other Americans with varying levels of medical mistrust. General medical mistrust and beliefs regarding COVID-19 include concerns that the government cannot be trusted to tell the truth about COVID-19, information is being held back by the government, and anxieties about the safety and efficacy of the COVID-19 vaccine [38]. In many ways, this suggests that while PWUD should receive tailored risk communication about the COVID vaccine, the content can remain similar to that delivered to other groups with some additional considerations. For example, PWUD may have suppressed immune systems due to HIV infection [39] and inadequate nutrition and hydration, especially during periods of heavier drug use [40]. This increased susceptibility to morbidity from COVID-19 should be communicated in a non-judgmental manner. The rewards of vaccination should be emphasized, as many participants indicated their mental health had worsened during the COVID-19 pandemic. Vaccination would allow PWUD the opportunity to reconnect with family and friends and to feel less nervous when in crowded places or among others. Overall, these findings highlight the need for increased public mental health efforts to help rebuild social connections in communities particularly affected by opioid use and COVID-19, as they experienced significant upheaval and urgently need intervention.

Participants in this supportive scattered site housing program maintained housing throughout the first year of the pandemic, which may reflect both the effectiveness of the housing model as well as federal policies that prevented eviction. Certain segments of PWUD communities are at increased risk of COVID-19 infection due to congregate living situations such as recovery houses and homeless shelters [3]. Emerging research indicates that messages focused on altruistic appeals are effective at convincing vaccine-hesitant people to accept the COVID-19 vaccine [41]. This approach may translate well with PWUD.

PWUD often have limited access or interrupted access to cellphones and the internet [42], which means that education about vaccines needs to occur where PWUD spend time. Community-based organizations already providing services to this population are natural partners for vaccination programs. PWUD are open to discussions about COVID-19 vaccination and have similar motivations and concerns about vaccinations as people who do not use drugs. Like other marginalized populations, messages—and vaccinations—should be brought to locations where PWUD frequently visit. These include harm reduction services such as syringe exchange programs, programs where people receive MOUD, housing programs, transit hubs, food banks and related food-access services, libraries, and mutual aid programs such as 12-step programs.

Similar to other studies with PWUD [12], many participants in the present study lacked necessary resources, such as enough food or basic necessities. Encouragingly, almost half reported accessing their primary care services and had access to mental health support services. Participants described multiple concurrent stressors related to housing or neighborhood issues, lost or reduced opportunities for employment, food scarcity, boredom, loneliness, sadness, irritability, and anxiety. However, they often did not directly attribute their personal issues to the pandemic, perhaps reflecting the chronic distress present in their lives. In particular, increasing neighborhood gun violence was a significant source of stress for these participants, as rates of gunshot deaths in Philadelphia increased dramatically in 2020 and in 2021 [43].

Strengths and Limitations

Among the strengths of this study was the comprehensive assessment of how the social determinants of health were affected for this population, the use of social network mapping interviewing, access to resources and supports across agencies and systems, attitudes and experiences with COVID-19, as well as probing about the local drug supply. Despite these strengths, the study is limited by the small sample size that was drawn from one program in one city. However, our participants reflected the experiences of people at a range of different points in their recovery, did not differ in terms of gender or race/ethnicity from those receiving services from the clinic during that period, and were drawn from Philadelphia, a major center for the opioid crisis, meaning that concerns about their representativeness should be somewhat mitigated. Most participants were housed and many engaged in at least some social distancing practices within their living spaces, which may not reflect the experiences of many PWUD. Participants were already accessing services from one organization, which may contribute to the high use we found of other services and high access to harm reduction tools. Similarly, participants expressed relatively stable access to services and satisfaction with services they received. This may be somewhat unique to the low threshold services received and the COVID-19 responses of those agencies. Finally, interviews were subject to social desirability bias. Future studies might expand on these findings with a larger sample in a broader range of contexts and service providers to establish their generalizability.

5. Conclusions

MOUD service access and retention were critical goals during the pandemic to protect highly vulnerable PWUD. For those with access, Housing First services played a crucial role in maintaining engagement in MOUD services and avoidance of harm and expansion of these services could help PWUD who remain vulnerable. Contrary to national trends, the majority of our sample were stable or able to reduce their use of substances, which highlights the critical role of low-barrier MOUD services during the first year of the pandemic. The relaxation of the restrictions related to the prescription of buprenorphine and methadone helped to preserve the continuity of care for PWUD and policy makers should consider making these changes permanent to improve treatment access in the future.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/ijerph19159751/s1, Questionnaire S1: Interview Guide.

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Article

Motherhood in Alternative Detention Conditions: A Preliminary Case-Control Study

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Abstract: Many women in detention are mothers and often the sole caregivers of their children. Italy, as most European countries, allows mothers to keep their children with them in detention, with the aim of preserving the fundamental bond between mother and child. Since prison does not seem to provide a good environment for the child's growth, there are different alternative residential solutions, such as Group Homes. The aim of this preliminary study was to explore the differences between mothers living in detention through alternative measures with their children and mothers who are not detained regarding parenting stress, child behavior from the parent's perspective, and maternal attachment. Twelve mothers were enrolled in this study, divided equally between the detained and the control groups. Both groups' participants completed a three-questionnaire battery in order to assess parenting stress, child's behavior, and maternal attachment. The analyses of variance showed significant differences between the two groups, with the detained group reporting higher scores than the control group in almost all the subscales of parenting stress. The results highlighted that imprisoned mothers might experience more stress than the general population. There is a need to design intervention programs to support parenting in detention.

Keywords: imprisoned mothers with children; alternative detention conditions; Group Homes; parenting stress; child behavior; maternal attachment

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1. Introduction

Although, as of today, the female population represents a small portion of the total number of incarcerated people in Europe and across the world, this is increasing every year [1]. Many women in detention are mothers and find themselves as the sole caregiver of their children. In most European countries, it is possible for young children to spend the first years of their lives with their mothers, either in prison or in alternative places of detention [2,3].

In Italy, as in most European countries, Law No. 354 of 26 July 1975 allows incarcerated mothers to keep their children with them, under special circumstances, until the age of three. The aim is to preserve the dyadic mother-child fundamental bond from birth [4,5] as both child psychiatrists and other specialists in the international scientific community agree that mothers and children should not be separated in the early years of the children's lives [1,6,7]. However, despite the efforts to make prison nursery sections livable for children, these remain environments that do not match the needs for socialization and psycho-physical development that growth requires [8].

Given these opinions, there are data resulting from different studies to consider.

First, it seems reasonable to expect mothers in detention to feel powerless, to experience distress regarding their role, and stress related to deprived conditions [9–11].

Second, the negative outcomes for children associated with parental imprisonment have been well documented by researchers [1,12]. Children whose parents are involved in the criminal justice system in the UK, USA, and Canada, are at increased risk of (1) developing behavioral difficulties (e.g., engaging in delinquent behavior) and (2) reporting higher levels of externalizing problems, which can result in aggressive and antisocial behaviors [12–15]. Moreover, in Italy, it has been reported that children who live in detention with their mothers frequently suffer from sleep disorders, inappetence, apathy, and restlessness [8].

In addition, multiple studies conducted in the US have found that the reduced contact between mother and child during imprisonment may exacerbate attachment disorders and damage the developing attachment bond [7,16,17]. According to Borelli and colleagues [18], it is possible that, compared to preoccupied attachment, both secure and dismissing attachment are more suitable for mothers in detention, but only in terms of perception of social support, parenting competency, depressive symptoms, and substance abuse history [18]. Finally, there is a significant gap in the literature on mothers' attachment to their children during cohabitation in detention, especially in Italy.

All consequences and effects cited above led the Italian Legislative system to reconsider accommodations for imprisoned mothers. Thus, in 2001, Law n. 40 made it possible for imprisoned mothers to serve their sentences through three alternative measures of detention, allocated in appropriate facilities [19]. The first alternative measure is a prison reserved for mothers who reside with children and which in Italy is known as "Istituti a Custodia Attenuata per detenute Madri" (ICAM). This alternative measure is a prison for all intents and purposes except for the establishment of environmental modifications to prevent children from recognizing the prison setting in which they are housed in [20]. The second alternative measure is home detention, applied for minor crimes, which allows the women to spend the sentence at their own home with their children, under electronic and police monitoring. When home detention is not possible due to adverse housing conditions, a third alternative measure is applied, the protected Group Homes. This kind of accommodation consists of spacious houses where some dyads of mothers and children can have their own room and space. While there are several controls carried by the police [21], the living environment more closely resembles that of a domestic home. Unfortunately, in Italy, the availability of protected Group Homes is limited by the lack of funds provided by the State [22], and there are only two existing Group Homes: the "Casa C.I.A.O." in Milan and the "Casa di Leda Colombini" in Rome [23].

Although alternative solutions to prison exist, in the literature, there is a lack of data regarding their possible effects on the quality of mother–child relationships. It appears to be important to provide preliminary evidence about the impact of alternative measures of detention by comparing a group of women in detention through alternative measures with a group of mothers who are not detained. Therefore, the aim of this preliminary study was to explore the differences between mothers living in detention through alternative measures with their children and mothers who are not detained regarding parenting stress, child behavior from the parent's perspective, and maternal attachment. Our first hypothesis was that mothers currently detained through alternative measures would experience higher levels of stress compared to mothers not in detention. A second hypothesis was that children living with mothers detained in alternative measures facilities would report higher levels of difficult behavior because of the delicate living conditions. The third hypothesis was that maternal attachment would be higher in women detained in alternative measures facilities, presumably because of a greater protective instinct.

2. Materials and Methods

2.1. Participants

This study was approved by the Ethics Committee of the Department of Dynamic and Clinical Psychology, and Health Studies of the Sapienza University of Rome.

After reading and signing the Informed Consensus, 12 mothers ($M = 35.0$; $SD = 7.6$ years old) were recruited.

Participants belonged to two different groups: six in the detained and six in the control group.

The detained group's inclusion criteria were the mother's age of >18 years, a child living with her at least for the last 2 years, the child's age of 2–12 years, or occupancy in an alternative measure scenario, such as in a Group Home or home detention location. Group Homes are spacious houses, often confiscated from organized crime organizations, where mothers and children reside together in their own rooms. They have facilities that can be commonly found in a regular living environment, e.g., kitchen, bathroom, living room, and outside garden. Detention in Group Homes is applied when the mother's original home conditions are not in line with standard hygiene guidelines. Home detention is employed, instead, when the mother's home is considered a safe place for her and her child; therefore, she is offered the chance to serve her sentence there, together with her child, with a precise timeline of controls enforced by police officers. The control group's inclusion criteria were a lack of previous convictions or prison residency, the mother's age of >18 years, a child living with her, and the child's age of 2–12 years.

The exclusion criterion for both groups was an inability to speak and read Italian.

The recruitment of the women in Group Home detention facilities took place at the "Leda Colombini" Group Home in Rome. The recruitment of the women in home detention scenarios took place at the head office of the "A Roma, insieme Leda Colombini" Association and at the Roma camp of Castel Romano, which is a nomad camp located in Rome. Members of the Roma and Sinti communities are allowed to spend their house arrest inside the nomad camp.

The recruitment of the control group took place in their private homes.

2.2. Materials

Three different self-report questionnaires were administered to assess the variables of interest.

The first questionnaire administered was the Parenting Stress Index Short Form (PSI-SF) [24], a questionnaire consisting of 36 items and four main scales. Participants were asked to rate their responses on a five-point Likert scale (from strongly agree to strongly disagree) to the extent to which they would agree with each sentence. The Parental Distress Scale assesses the levels of personal distress associated with factors such as depression, couple conflict, or the necessity of the parents to adapt to the needs of a child. Subsequently, the Parent–Child Dysfunctional Interaction Scale assesses the level of dissatisfaction the parent feels about his or her interactions with the child and his or her disapproval of the child's behavior. Finally, the Difficult Child Scale assesses a parent's perception of a child's capability for emotional regulation. The PSI-SF also comprises a Defensive Responding Scale, which assesses the parents' tendency to deny or minimize the difficulties associated with parenting. Overall, the sum of the scores obtained in the PSI-SF scales allows for an estimation of the level of Total Stress.

The second questionnaire used was the Eyberg Child Behavior Inventory (ECBI) [25], a 36-item measure administered to parents that assesses child behavior from a parent's perspective. It includes an Intensity Scale, which measures the frequency of each behavioral issue and varies from 1 (never) to 7 (always), and a Problem Scale, that assesses how problematic a child's behavior is in their parent's opinion (for each item it is asked "Is this a problem for you?"). In the latter scale, each item allows to choose "Yes" or "No" as possible answers.

The third questionnaire used was the Maternal Attachment Inventory (MAI) [26], which is based on Attachment theory [27] and assesses maternal attachment towards the child. The MAI is composed of 26 items concerning actions or feelings associated with maternal affection towards the child that are rated on a scale from 1 (almost never) to 4 (almost always).

The questionnaires were of a self-report nature, but it is important to underline that some women of the detained group were unable to understand the meaning of some items fully, so it was necessary for the researcher to read and explain the questions to the participants. In the control group, women completed the surveys in a self-report form.

2.3. Data Analysis

In order to analyze the difference between the two parenting conditions (home detention and free living), analyses of variance (ANOVAs) were performed, with Group (detained vs. control) as the between-group factor, on the scores of parenting stress (PSI-SF), child behavior from the parent's perspective (ECBI), and maternal attachment (MAI).

Analyses were conducted using the "Statistica8" software (StatSoft, Inc., 2007, Tulsa, OK, USA).

3. Results

The descriptive statistics of the participants were reported in Table 1. ANOVAs were performed on 12 women, divided into two groups (six detained and six control), to assess the differences in parenting stress (PSI-SF), child behavior from the parent's perspective (ECBI), and maternal attachment (MAI). The main effects of the detention situation were reported on the PSI-SF score for total stress, dysfunctional mother–child interaction, difficult child, and defensive responding, with the detained group reporting higher scores than the control group. There were no significant differences between the two groups for ECBI and MAI scores. The results of the questionnaires are summarized in Table 2.

Table 1. Characteristics of participants.

	Detained Group (n = 6)	**Control Group (n = 6)**
Mother's age (m ± sd)	34.0 ± 8.7	36.0 ± 7.0
Child's age (m ± sd)	4.5 ± 2.2	4.5 ± 1.5
Nationality (*n*, %)	Bosnian (2, 33.2%); Italian (2, 33.2%); Croatian (1, 16.6%); Serbian (1, 16.6%)	Italian (6, 100%)
Level of education (*n*, %)	No education (1, 16.6%); Third grade level (1, 16.6%); Fifth grade level (1, 16.6%); Sixth grade level (2, 33.2%); High school (1, 16.6%)	High school (3, 50%); Bachelor's degree (3, 50%)
Detention placement (*n*, %)	Home detention without child (1, 16.6%); Group Home "Leda Colombini" (4, 66.6%); Roma Camp (1, 16.6%)	N.A.
Presence of a second parent (*n*, %)	No (1, 8.3%); Yes (5, 91.6%)	Yes (6, 100%)
Presence of a partner (*n*, %)	Yes (5, 83,4%), No (1, 16.6%)	Yes (5, 83.4%); No (1, 16.6%)

Table 2. ANOVA with the group factor (detained vs. controls) as the between-group factor on scores from the Parenting Stress Index (PSI), Eyberg Child Behavior Inventory (ECBI), Maternal Attachment Inventory (MAI).

	Detained (n = 6) m ± sd [1]	Control (n = 6) m ± sd	F (1, 10)	p	Post-Hoc
PSI total stress	60.5 ± 10.5	45.7 ± 5.2	9.6	0.011	detained > control
PSI parental distress	28 ± 5.7	20.8 ± 5.7	4.7	0.054	
PSI parent-child dysfunctional interaction	24.5 ± 5.3	16.8 ± 1.8	11.1	0.007	detained > control
PSI difficult child	26.3 ± 4.1	20.2 ± 1.8	10.9	0.007	detained > control
PSI defensive responding	18.3 ± 3.4	12.2 ± 4	8.1	0.017	detained > control
ECBI intensity	107.5 ± 16.6	80.7 ± 26.5	4.4	0.062	
ECBI problem	5.8 ± 5.5	1.8 ± 2.6	2.6	0.138	
MAI total score	103.5 ± 1.2	103.5 ± 0.8	0.0	1.00	

[1] Notes: m = mean; sd = standard deviation; p = p-value.

4. Discussion

The aim of this preliminary report was to explore the differences between mothers living in detention through alternative measures with their children and mothers who are not detained regarding parenting stress, child behavior from the parent's perspective, and maternal attachment.

As hypothesized, the main finding showed significant differences in the levels of parental distress between the detained mothers and the control ones. In particular, compared to the control mothers, mothers under alternative measures of detention reported higher levels of dissatisfaction concerning interactions with the child and higher disapproval of the child's behavior. Moreover, mothers detained through alternative measures reported higher negative perceptions of the child's capability for emotional regulation and a greater attitude toward denying or minimizing the difficulties associated with parenting. These findings suggest that mothers in alternative detention would experience higher levels of distress, as expected. Although the alternative measures of detention, such as Group Homes and home detention, are aimed at supporting parenting, in this preliminary report, the mothers in detention experienced a higher level of distress than those who are not in detention. This is in accordance with the current literature, as mothers in detention in other countries, such as in the US, were reported to display higher levels of stress compared to the general population [9–11,28]. Following the preliminary findings of the present report, it seems that the current measures of alternative detention in Italy do not sufficiently provide the parenting support necessary for protecting the well-being of both mother and child. Currently, there are no studies that compare motherhood in prison and motherhood in detention under alternative measures, such as in Group Homes and home detention. Through this comparison, it would be possible to fully understand if specific alternative measures could actually improve the quality of the relationships between detained mothers and children and their psychological well-being compared to conventional detention. Therefore, further studies should be planned to fill this important gap.

Despite the fact that children living in alternative measures facilities did not exhibit higher levels of dysfunctional behaviors compared to the control group, these results have likely been influenced by the limited sample size, and it might be possible to observe such differences when working with larger samples. This seems to be supported by a trend in the ECBI's numbers, suggesting higher levels of dysfunctional behaviors among the detained group in comparison to the control group. While there are no studies in the current literature that concern behavioral functioning in children living in alternative measures facilities, it is known that children who live in prison with their mothers in Italy frequently suffer from sleep disorders, inappetence, apathy, and restlessness [8]. More broadly, it has been reported that children whose parents are involved in the criminal justice system are at increased risk of developing behavioral difficulties, such as engaging in delinquent behavior and reporting higher levels of externalizing problems, which can result in aggressive and antisocial behaviors [12–15]. These studies, while relevant, were conducted in the UK, USA, and Canada, where the criminal justice systems differ from the Italian one. This further underlines the necessity of studies that assess the impact that living in alternative detention facilities, such as Group Homes and home detention in Italy, can have on children's behavioral functioning.

The analyses did not show any significant differences in maternal attachment between the two groups in the Maternal Attachment Inventory scores (MAI) [26] (Table 2). Nonetheless, it is possible that the results obtained by the detained group might have been slightly influenced by the mothers in order to obtain a juridical benefit regarding child custody or in the legal judgment of their detention by exhibiting a healthier functional pattern of maternal attachment. Supporting this, mothers living with or without their children while serving a sentence have been reported to experience a sense of inadequacy, failure, and shame concerning their parenting abilities [19]. Furthermore, the mother's perception of her ability to perform her role in a socially acceptable way may shape her view of herself as a mother [9]. In this regard, the experience of imprisonment could create confusion about the maternal role and threaten one's identity [9,29]. Therefore, it could be possible that mothers from the detained group may have slightly altered some scores in order to protect themselves and their image of themselves as mothers so that they could live with their child without disturbance or separation from any institution.

It is known that the adoption of the role and the identity of the mother starts with pregnancy and continues with early motherhood. This process could be affected by environmental precarity and personal adversity [30], suggesting that they might be impacted by incarceration. It is, therefore, possible that these multiple biasing factors have altered the test results.

Due to the lack of research concerning mother–child attachment in the context of detention through alternative measures, more studies are needed to comprehend how the imprisonment experience can affect maternal attachment and identity.

Overall, the study presented several limitations. Primarily, the size of the sample was small. Although 12 subjects can be sufficient to conduct an exploratory study on a topic that is scarcely investigated, data analyses are limited in generalizability, diversification, and impact. In addition, the age range of children (2–12 years) considered in the present study was quite broad and could potentially lead to discrepancies in the interpretation of the results, considering the specificity of the developmental stages that occur during these ten years. Further studies should monitor this variability to verify the effect of developmental stages on mother–child relationships in detained conditions.

Moreover, the questionnaires used to carry out this study were not adequate regarding the characteristics of the detained group of the present study, probably due to the gap concerning the language skill between the two groups. Indeed, in the detained sample, five out of six women were not able to complete the administration through the self-report mode because they did not fully understand the meaning of some items; therefore, the experimenter had to read and explain the questions to each one of them.

Previous studies suggested that the level of schooling and literacy is a very important factor affecting performance on tests in general, especially on cognitive tests [31]. However, as of today, there is a lack of translated and validated questionnaires for participants belonging to different ethnic and social minorities, such as those considered in the detained sample of the present study. Consequently, there is a strong need to adapt and validate specific questionnaires in order to obtain results comparable among different ethnicities and social minorities.

Another limitation of the present study was the social desirability bias that was presumably more present in the detained group.

The detained group can be defined as a niche within a niche since they were primarily incarcerated mothers, and secondly, five out of six women were of Roma ethnicity. As far as it has been possible to observe, detained women living with children in Italian prisons are mainly from the Roma community [32]. In Europe, the term "Roma" is often used to refer to a very wide range of different communities, such as the "Roma", the "Gypsies", the "Travellers", the "Manouches", the "Ashkali", the "Sinti", and the "Boyash" populations [33]. In Italy, people from Roma culture can no longer be described by the term "Gypsies", as the word has become associated with racially disparaging epithets [34]. The Roma community has faced a long global history of genocide, exile, discrimination, and rejection by occidental societies over the years [34]. Moreover, Roma individuals have faced years of slavery [35], and unfortunately, there are multiple prejudices and stereotypes related to Roma culture. They are often accused of being "filthy" nomads, of stealing, and of not wanting to integrate with the "host" society [36]. Indeed, in modern society, the Roma community is often subject to racial discrimination, and this fact may intensify the difficulties of the scientific community to reach this population and deepen variables of interest [34].

Regarding the practical developments of this preliminary study, it should be noted that there is a strong social need to raise awareness on the topic. In fact, many people are not aware of the existing conditions of detained mothers living with their children and, more broadly, of their relationship dynamics and of the related social implications.

The inexistence of research tools validated for ethnic and social minorities contributes to fueling social and ideological distancing towards those minorities in contemporary society that could be filled by the scientific community.

5. Conclusions

In conclusion, the findings of the present preliminary report show that mothers living in alternative measures detention facilities are more stressed than mothers not in detention. In particular, when compared to control mothers, mothers detained in alternative measures facilities reported higher levels of dissatisfaction concerning interactions with the child and higher disapproval of the child's behavior. Moreover, mothers detained in alternative measures facilities reported higher negative perceptions of the child's capability for emotional regulation and a greater attitude toward denying or minimizing the difficulties associated with parenting. These findings suggest that mothers in detention experience higher levels of distress in general.

These findings suggested planning studies to verify the psychological impact of alternative detention on the well-being of mothers and children. It seems necessary to design intervention programs to support parenting in prisons, ICAMs, residential homes, and protected Group Homes [7,19]. The goal would be to reduce the risk of recidivism, support healthy motherhood, and increase the development of a stable mother–child relationship [19,28,37,38].

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available on reasonable request from the corresponding author. The data are not publicly available due to privacy reasons.

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