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"Psychiatric oblivion": considerations on the hypothesis of a law

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Summary. The introduction of a law on psychiatric oblivion, similar to the recent one for oncological oblivion, presents numerous complexities due to the differences between the two areas of illness, especially in terms of recovery and clinical stability. While a definitive cure is often achievable in oncological diseases, in severe mental disorders, such as schizophrenia or bipolar disorder, complete remission in the absence of therapies is rare. Even in cases of effective treatment response, patients may exhibit subclinical symptoms or cognitive and functional deficits, making the concept of psychiatric oblivion particularly problematic. Some diagnostic categories, such as brief psychotic disorder or postpartum depression, could theoretically benefit from oblivion legislation, given the potentially limited course and frequent absence of relapses. However, for the majority of psychiatric conditions the requirement of a long period of remission without therapy appears difficult to achieve. An alternative could be the introduction of criteria based on the stabilization of maintenance therapy, but this would require a more complex and less easily standardized clinical judgment. Other limitations are the residual vulnerability to relapses, the difficulty in determining a precise medical history and the influence of persistent social stigmatization, which could undermine the effects of oblivion. Therefore, the creation of a law on psychiatric oblivion would require a restrictive and selective approach, focused on specific diagnoses and long-term clinical remission criteria, tailored to the clinical and adaptive peculiarities of mental illness.

Key words. Ethical issues, possible legislation, psychiatric oblivion, role of diagnosis, role of treatment.

"Oblio psichiatrico": considerazioni sull'ipotesi di una legge.

Riassunto. L'introduzione di una legge sull'oblio psichiatrico, analoga a quella recente sull'oblio oncologico, presenta numerose complessità legate alle differenze tra le due aree di malattia, specialmente in termini di guarigione e stabilità clinica. Mentre nelle malattie oncologiche una guarigione definitiva è spesso raggiungibile, nei disturbi mentali gravi, come schizofrenia o disturbo bipolare, la remissione completa in assenza di terapie è rara. Anche nei casi di risposta efficace ai trattamenti, i pazienti possono presentare sintomi subclinici o deficit cognitivi e funzionali, rendendo il concetto di oblio psichiatrico particolarmente problematico. Alcune categorie diagnostiche, come il disturbo psicotico breve o la depressione *post partum*, potrebbero teoricamente beneficiare di una normativa sull'oblio, dato il decorso potenzialmente limitato nel tempo e la frequente assenza di ricadute. Tuttavia, per la maggioranza delle patologie psichiatriche il requisito di un lungo periodo di remissione in assenza di terapia appare difficilmente realizzabile. Un'alternativa potrebbe essere l'introduzione di criteri basati sulla stabilizzazione della terapia di mantenimento, ma questo richiederebbe un giudizio clinico più complesso e difficilmente standardizzabile. Ulteriori limiti sono rappresentati dalla vulnerabilità residua a ricadute, dalla difficoltà nel determinare una precisa anamnesi e dall'influenza di stigmatizzazioni sociali persistenti, che potrebbero vanificare gli effetti dell'oblio. La creazione di una legge sull'oblio psichiatrico richiederebbe quindi un approccio restrittivo e selettivo, focalizzato su specifiche diagnosi e criteri di remissione clinica a lungo termine, adattandosi alle peculiarità cliniche e adattative della malattia mentale.

Parole chiave. Aspetti etici, oblio psichiatrico, possibile legge, ruolo della diagnosi, ruolo del trattamento.

The Law on oncological oblivion

In December 2023, the Italian Parliament approved the law on the so-called "oncological oblivion" ("Provisions for the prevention of discrimination and the protection of the rights of people who have been affected by oncological diseases").

It is initially specified by the law that «In order to exclude any form of prejudice or unequal treatment, this law contains provisions regarding equal treatment, non-discrimination and guarantee of the right to be forgotten of people recovered from oncological pathologies».

«The "right to the oncological oblivion" means the right of people who have recovered from an oncological disease not to provide information or undergo investigations regarding their previous pathological condition, in the cases referred to in this law».

The areas in which the law reiterates the right to be forgotten are: a) "Access to banking, financial, investment and insurance services" (economic-finan-

cial area); b) "... adoption matters" (family context); c) "Access to competitive and selective procedures, to work and professional training" (professional field), in each of these cases excluding the obligation to provide information on the previous state of health, with specific regard to any previous oncological pathologies.

A time limit is established for the operational application of the law in each individual case («more than ten years from the conclusion of the active treatment of the pathology, in the absence of relapses, or more than five years if the pathology arose before completion of the twenty-first year of age»).

The Law is innovative and, even without explicitly stating it, aims to reduce or eliminate the stigma (health, psychological, social, cultural) associated with oncological disease and the possible consequences deriving from it.

Medico-legal reflections on stigmatization and hypotheses of legal oblivion in mental disorders

Research indicates that the stigma of mental illness represents a substantial obstacle to effective treatment and rehabilitation, manifesting itself in forms of social exclusion and discrimination[1,2]. Different psychiatric disorders are stigmatized to varying degrees, from those perceived as dangerous or unpredictable, such as schizophrenia, which suffer higher levels of stigma[3], to anxiety disorders that, on the contrary, are so frequent in the population that they are socially accepted. Furthermore, psychiatric stigma competes with other types of stigma, such as those related to race and socioeconomic status, further complicating access to mental health services[4]. In fact, at a legal level, stigma is addressed by the legislator through the case-specific application of the right to privacy for certain situations such as, for example, practices related to pregnancy in subjects affected by mental illnesses, abortion[5], HIV and, more recently, Covid-19, which especially in the pandemic period[6], has been the subject of various legislative measures not only oriented towards risks[7] but aimed at avoiding social isolation even after recovery from the infection. The impact of stigma is profound and can affect the quality of the person's mental life by promoting reduced access to care, poor adherence to treatment, reducing the therapeutic efficacy of treatments, particularly in serious mental diseases[8,9]. Furthermore, if it is associated with psychiatric disorders, it profoundly affects various areas of life, including employment, adoption processes and financial transactions. This stigma extends significantly to adoption practices, where potential parents with previous psychiatric diagnoses are frequently subjected to more severe scrutiny and prejudice, negatively impacting their chances of approval[10,11].

People with mental disorders often face significant barriers to employment, as employers may have concerns about their productivity and reliability[12]. Such discrimination perpetuates a cycle of disadvantage, further marginalizing those with altered mental health conditions and hindering their full participation in social activities[13].

Furthermore, stigma affects not only individuals but also their families, causing social isolation and exacerbating psychosocial challenges[3].

Ethical considerations highlight the need to minimize harm and maximize benefits of diagnosis and treatment, taking into account the difficulty-to-measure symptoms and negative impacts on various aspects of life[14,15].

Psychiatric oblivion seen in this perspective could represent an initial step to fill a significant gap in overcoming the prejudices regarding psychiatric disorders and their course, which in some clinical manifestations can result in a complete remission of acute symptoms[16].

This is clearly a theme that underlines the usefulness of not only legal but also bioethical considerations in the field of mental disorders, applicable from time to time to different sensitive areas of psychopathology and behavior[17,18].

The hypothesis of "psychiatric oblivion"

Based on this last consideration, it is interesting and necessary to reflect on the possible extension of the theme of the right to "oblivion" in the clinical field in which the meaning of stigma has historically always been stronger and more felt, that is, that of mental illness.

The question is in itself very simple. Can the inspiring principles and operational rules provided by the law for "oncological oblivion" be exported from the oncological field to the psychiatric field? Is it foreseeable that, with the necessary diversifications relating to the substantial differences between the two areas of pathology, the criteria and scope of application of a "psychiatric oblivion" can be defined?

Beyond easy simplifications relating to the "inspiring principles", it is essential to recognize the complexity of the matter and the need for a reflection on it to adhere to objective criteria for evaluating the real clinical and legal spaces in which to formulate theses and hypotheses.

The current situation on the issue of the stigma of mental illness in Italy has reflected in recent decades, often even in many ways guiding it, the evolution that this issue has demonstrated in the medical and social culture of the Western world[19].

Today, in a theoretical cultural context, the complete denial of previous negative and marginalizing prejudicial attributions to having been in the past or being currently affected by some form of mental disorder appears absolutely implicit, especially in relation to the clinically most serious types of these. But this does not prevent that, in social reality, the presence of a full-blown mental disorder in progress or recently in the past, of significant clinical entity, may be an obstacle, practically and legally, to action in the three areas (economic, family, professional) in which the law on oncological oblivion instead affirms the intention to guarantee the operational freedom of the interested parties.

Naturally, the situation is different when the same considerations are applied to the case of a previous and long-regressed pathology, clinically no longer present even a long time after the suspension of therapies[20]. That is, to the case that can at least formally follow the model used to define the criteria necessary for the recognition of the right to be forgotten in oncology.

It is necessary to underline, however, that a law obviously recognizes its field of enunciation and application only in the legal context of the problem, that is, in the regulations aimed at safeguarding from the negative consequences of the persistence of the memory of previous mental pathologies, but naturally it can do nothing with respect to the persistence of such memory and its consequences in the family and general social contexts. Unlike what concerns oncological pathology, the delimitation between these two orders of fields appears extremely blurred and uncertain in the case of mental illness.

The purposes of a hypothetical law on "psychiatric oblivion" should consist both in a guarantee with respect to the same areas (financial, family, professional) indicated in the field of oncological diseases and in the consequent reduction of the residual dimension of stigma still associated with mental illness, even if in contexts, such as family and social ones, where the scope of the law is exhausted and that of general cultural influence persists.

Critical issues in defining the possibilities and scope of application of psychiatric oblivion

Delimitation of the clinical field with the need for legislation

It is clear, but not free from uncertainty, that the evaluation of the possible usefulness of oblivion and the consequent legislation must be restricted to those forms of mental disorder in which the risk of social stigma is more marked or in which the general operational consequences relating to the disorder itself are more serious.

For example, no social, cultural or health stigma actually accompanies the current presence or previous history of an anxiety disorder, nor are there real operational limitations in the social sphere for subjects affected by a disorder of this nature. Limitations in acting in the economic field or in the possibilities of professional development, etc., are never assessed for any subject affected by panic disorder. The enormous increase in diagnostic categories of psychiatric nosography makes it real that for the vast majority of possible diagnoses of mental disorder the need to legally reflect on a possible oblivion regulation should not even be taken into consideration, as these conditions are in themselves irrelevant, and as such recognized, on the operational capacities of subjects meeting the criteria of the different diagnoses.

On the contrary, for mental disorders characterized by definition by a greater severity of the clinical picture and with a corresponding potential limitation of the capacity for judgment[21] and to act rationally, such as of course psychotic disorders, the most severe forms of clinical severity of depressive disorders or bipolar disorders, the most serious cases of obsessive-compulsive disorder, mental disorders induced by substance use, etc., the need to reflect on the possibility or opportunity of an oblivion regulation relating to the past pathology appears absolutely well-founded.

A first indicative parameter should naturally be represented by the clinical severity of the previous disorders, even if inevitably subjected to extreme interpersonal variability and often difficult to be objectively reconstructed; but a second parameter, the temporal one, appears prevalent both in the consideration of the weight of the previous clinical severity and in the judgment on the possibilities or otherwise of access to oblivion.

Indefiniteness of the concept of absence of disease over time in the psychiatric field

The law on oncological oblivion provides for its individual applicability «…more than ten years from the conclusion of active treatment of the pathology, in the absence of relapses, or more than five years if the pathology arose before the twenty-first year of age».

Therefore, "recovery" is not mentioned, but this concept is implicit in the observation of a prolonged period of absence of oncological disease after the suspension of therapies.

Beyond the formal terminologies, this shifts the reflection on the concept of "recovery" applied to mental disorders, in particular in the most serious cases of these[22].

In the case of severe mental disorders, "recovery" represents a condition of more uncertain definition

than in disorders of lesser severity or, of course, in comparison with other disorders of a somatic nature.

Mood disorders

In a very common example, "recovery" or, better, "complete prolonged remission" can be indicated in the case of an episode of bipolar disorder, whether depression or excitement, rather than referring to the disorder itself, potentially recurring in subsequent phases even a long time after the remission of the single episode[23]. The area of mood disorders therefore represents, among those inherent to the most severe forms of a mental disorder, one of those in which the possibility of a regulation on oblivion can be more appropriately evaluated. But the temporal criterion of "complete remission" for at least 10 years must critically be associated with that of the start of this period from the suspension of therapies. A 10-year remission without therapies is very rare in bipolar or recurrent depressed patients. The severity of any "relapses" could be considered: simple affective oscillations that do not affect the quality of life of patients or real new clinical episodes. Furthermore, does compliance with the 10-year criterion guarantee against a new episode over time? In oncology, yes, at least with respect to the primary disease. In psychiatry, no. Clinical relapses can occur even after more than 10 years from remission, especially if in the absence of therapy. This represents another critical element for which it appears difficult to export the criteria provided for oncological oblivion. The vast majority of patients affected by severe mood disorders continue with the necessary maintenance therapies over time.

The case of prophylactic treatment with lithium in bipolar patients is emblematic, but even depressed patients often take prolonged maintenance treatments for long periods after remission, with antidepressant drugs or mood stabilizers.

Ten years of complete remission after the suspension of therapies really represent a very restrictive criterion with respect to the objective of oblivion of previous pathological manifestations. One could perhaps refer, in clear contrast to what is expected in the case of oncological oblivion, to complete remission associated with stable adherence to maintenance treatments; but it is clear that this would introduce extremely complex evaluative uncertainties. Only the case of mood disorders that by definition present a course tending towards complete remission even in the absence of therapy, as in the emblematic case of postpartum depression or other episodes related to specific and theoretically non-recurring life situations (even if in theory other episodes of depression associated with subsequent pregnancies or spontaneously occurring even after the remission of the puerperal episode cannot be excluded), could be different, even with an unavoidable wide degree of uncertainty.

Psychotic disorders

The considerations appear even more complex in the case of psychotic disorders, in the vast majority of cases characterized by a chronic course (and not phasic/recurrent as for mood disorders), with the possibility of symptomatic attenuation/remission almost always in relation to the treatments and with persistent risk of exacerbations both spontaneous and in relation to irregular intake of therapies[24].

In the specific case of a patient suffering from schizophrenia, i.e. already diagnosed as chronic, the possibility of a complete remission of over 10 years in the absence of therapies is evidently extremely unlikely, so much so as to suggest in the case a revision of the diagnosis itself.

As in the case of mood disorders, the long period of symptomatic remission associated with the stability of adherence to the prescribed treatments could be evaluated as a potential criterion for obtaining oblivion for patients with psychotic disorders, but with an even higher degree of uncertainty.

In chronic psychotic patients, in fact, an almost constant course is the persistence of subclinical symptomatic aspects even in cases with the most effective response to treatments, associated with dysfunctional cognitive profiles that almost always accompany the entire subsequent course of life, as well as of the disease, of these patients, potentially not irrelevant with respect to the areas of functional interest foreseen as the objective of oblivion.

The discussion could be different for those cases of psychotic disorders, such as Acute Psychotic Disorder or Schizophreniform Disorder, which in their own diagnostic criteria provide for a clear temporal circumscription of the psychopathological manifestations, potentially, and often actually, free from subsequent relapses even after suspension of the adequate pharmacological treatment carried out during the acute episode.

Substance-induced disorders

Mental disorders associated with substance use represent an extremely varied and complex clinical area, both with respect to the substances being taken and the mental disorders induced by them, characterized from time to time by prevalent aspects of a psychotic, affective, mixed, behavioral, etc. type, often of extreme clinical severity. The very sharp increase in the diffusion of substances capable of inducing such mental alterations, from cannabis to cocaine and the vast number of new psychostimulant and hallucinogenic substances, etc., makes it in-

creasingly relevant to reflect on their consequences over time and on the possibility of access to oblivion for previously affected subjects. In general, therefore, the only concrete way in order to identify the possibility of oblivion is the reference not just to the last date of intake of substances (objectively in the majority of cases very difficult or impossible to be verified in an objective anamnestic evidence), nor even to the persistence of their use over time, in the presence or absence of a condition of dependence and in the absence of specific consequent mental alterations, but rather to the date of the last intake of therapies aimed at treating the psychiatric symptoms induced by the substances themselves[25]. This means that in this heterogeneous clinical area, in order to evaluate the opportunities and possibilities of oblivion, both clinical and temporal parameters must be taken into consideration, similar to those already evaluated for mood disorders and psychotic disorders, with the additional difficulty of having to distinguish the intrinsic effects of the intake of substances from the primary psychiatric symptoms, on which to carry out the evaluations relating to the oblivion. Moreover, the clinical similarities between primary psychotic and affective disorders and similar substance-induced conditions supports the rationality of this standardization of judgment.

Obsessive-compulsive disorder

In the case of obsessive-compulsive disorder, reflection on the possibility of oblivion must naturally be limited to the minority of cases in which the psychopathological manifestations reach a level of such clinical severity at some points in the course, with the related dysfunctional consequences, as to make intensive therapeutic interventions necessary, more or less limited or prolonged over time. The chronicity of the course constitutes a central clinical characteristic of the disorder, which implicitly makes it very difficult to respond to the criterion of a long period of complete remission in the absence of therapies. It is necessary to observe, however, that, even if in a chronic setting, the clinical severity of the disorder can present variations over time, even of considerable importance, with the possibility of a large symptomatic reduction or of symptomatic aspects that can in fact simply interface with prevalent personality disorder traits. Considering such phases of remission in their aspects of expression of altered personality rather than persistence of ongoing disorder, periods of remission can in theory be described even of very long duration, such as to respond to the criterion of the duration of 10 years necessary to access oblivion of the previous pathology. Also in this case, however, the criterion of the absence of therapy in the long period of remission appears difficult to achieve, or at least achieved in a minority of cases, so much so as to propose again also for patients affected by obsessive-compulsive disorder the possibility of evaluating, instead of the absence of therapy, the stability of the regular assumption of the prescribed treatments under specialist supervision, with all the above mentioned uncertainties[26].

General considerations on the possibilities of psychiatric oblivion

Therefore, some reflections and prospective evaluations can be proposed.

Life expectancy vs. quality of life expectancy

Even if the law on oncological oblivion does not explicitly state this aspect, limiting itself to underlining the purpose «[...] to exclude any form of prejudice or unequal treatment [...]», the difference with the hypothetical institution of a psychiatric oblivion is implicit, where the same purpose would naturally be the guarantee of the person already affected by mental disorder with respect to the memory and the hypothetical recurrence of new potential mental and behavioral alterations.

The difference is substantial, because a "cured" oncological disease has very high probabilities of perpetuation of the state of health and of absence of risk to life, such as to fully justify the right of the interested party to the cancellation of the memory of the previous pathology. On the contrary, in the case of a serious mental disorder, the chances of maintaining the state of mental health in the long term and in the absence of treatment are certainly much lower, only partly increasable in relation to the continuation of prophylactic treatments against new situations that put at risk not so much physical health or life as social and behavioral health, more difficult to classify in the realm of oblivion.

Residual vulnerability

In determining the possibilities of access to psychiatric oblivion, the realistic situation of the persistence of a vulnerability towards relapses for a long period even after a hypothetical complete remission of the psychopathological picture, spontaneous or induced by treatments, must therefore be adequately considered, such as to constitute a risk factor for the recurrence of the pathology certainly greater than that of oncological relapses. This does not naturally constitute an absolute limit with respect to access to oblivion, but would perhaps in fact impose a diversification of judgment in relation to the individual clinical histories. Nor should the frequent persistence of

dysfunctional psychological and relational profiles that often accompany conditions of even complete clinical remission be overlooked, as possible intrinsic indicators of previous psychopathological manifestations, such as to outline all the possible pictures of "deficit recovery".

Uncertainty both of precise anamnesis on disorders still very often covered in the family environment and of objective determination of the duration of the period without therapy

It is evident that both in clinical practice and in the anamnestic information provided by the interested parties it is often very difficult to acquire information on the times of onset of mental disorders, on their real course, on their remission, on which to base the beginning of the period necessary for access to oblivion.

The very nature of psychopathological conditions and the cultural context partly still existing despite the evolutions of recent decades very often make the memory of the temporal aspects of the course of a mental disorder vague. It could perhaps be considered the reference to access to psychiatric assistance facilities from whose documentation the times of persistence and cessation of the symptomatic phases of the disorders or the dates of any hospitalizations or the documentation of the suspension of the prescription of therapies can be more precisely shown, but the complexity of this situation appears very evident and difficult to resolve in formal terms.

Persistence of memory/stigma even in unofficial forms and fragility of oblivion in the face of clinical recurrence (or just oblivion of the previous history)

However, it is impossible not to take into account the fact that the simple "memory" of a previous serious mental illness often accompanies the interested party in his or her living environment even well beyond the terms potentially indicated by the law. The scope of this would possess a value of formal efficacy, that is, of guarantee in the social functional areas already indicated for oncological oblivion, but naturally nothing could be done with respect to the memory of past disorders nor, unfortunately, with respect to the residual quota of potentially perpetuated family or social stigmatization.

On the other hand, in the case of a clinical recurrence of the disorder even after the terms prescribed for access to oblivion, it would likely be much more immediate than in the case of recurrent oncological pathology the re-actualization of the memory of previous mental pathologies and the identification of a logical and chronological thread, existing or not, between past and new psychopathological manifestations, such as to frustrate the objectives of oblivion previously achieved.

Considerations and perspectives

From all the above, it would seem very problematic to formulate a law on psychiatric oblivion formally superimposable to that provided for by the law on oncological oblivion, even if sharing the latter's aims.

The substantial diversity between the two areas of disease and above all the divergences relating to the concepts of recovery (or in any case of a prolonged period in the absence of symptoms following the suspension of therapies) and of absence of illness without therapies require, for any provision on psychiatric oblivion, fields and rules of application referred to the peculiarity of the pathology.

Generally, any law should necessarily be restrictive with respect to the clinical field of application, providing for possible access to oblivion for not all patients who have suffered from serious mental disorders in the past. Only some diagnostic categories could be included ex officio (e.g. acute psychotic disorder or postpartum depression), even if with due attention to the individual correctness of the diagnosis and the judgment on the course. For the remaining majority of cases, complete and persistent remission should be assessed according to adequately critical criteria, taking into account the clinical peculiarities of each case.

It is clear that the main factor limiting access to oblivion is represented by the temporal criterion of a defined number of years (10 in the case of oncological oblivion) of stable remission in the absence of therapy, a condition that is objectively uncommon for mental disorders with previous aspects of severity.

The hypothesis of replacing the requirement of the absence of therapy with that of the controlled stabilization of maintenance therapy would be closer to clinical reality but would introduce the need for evaluation criteria that are objectively very difficult to meet.

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References

1. Davis S, Kumari D, Kelkar P, Chaudhury S, Saldanha D. Stigma among patients suffering from psychiatric disorders. In: Saldanha D (ed). A Guide to Clinical Psychology: Psychopathology. Hauppauge, NY: Nova Science Publishers, 2023.
2. Catanesi R, Carabellese FF, Rinaldi R. La riabilitazione in psichiatria: alcune considerazioni in tema di responsabilità degli operatori delle strutture riabilitative. Zacchia 1998; 1: 37-58.

3. Świtaj P, Chrostek A, Grygiel P, Anczewska M. Exploring factors associated with the psychosocial impact of stigma among people with schizophrenia or affective disorders. Community Ment Health J 2016; 52: 370-8.
4. Dobransky KM. Reassessing mental illness stigma in mental health care: competing stigmas and risk containment. Soc Sci Med 2020; 249: 112861.
5. Cioffi A, Cecannecchia C, Cioffi F, Bolino G, Rinaldi R. Abortion in Europe: recent legislative changes and risk of inequality. Int J Risk Saf Med 2022; 33: 281-6.
6. Ricci P, Pallocci M, Treglia M, et al. The effect of physical exercise during COVID-19 lockdown. Healthcare 2023; 11: 1618.
7. Cioffi A, Rinaldi R. COVID-19 and healthcare-associated infections. Int J Risk Saf Med 2020; 31: 181-2.
8. Davis S, Gupta N, Samudra M, Saldanha D. Evaluation of stigma among patients reporting to a tertiary care psychiatric center. Medical Journal of Dr DY Patil Vidyapeeth 2023; 16 (Suppl 1): S32-S40.
9. Anastasia A, Colletti C, Cuoco V, et al. Demographic variables, clinical aspects, and medicolegal implications in a population of patients with adjustment disorder. Neuropsychiatr Dis Treat 2016; 12: 737-43.
10. van der Sanden RL, Bos AE, Stutterheim SE, Pryor JB, Kok G. Experiences of stigma by association among family members of people with mental illness. Rehabil Psychol 2013; 58: 73-80.
11. Ferrara R, Ricci P, Damato FM, et al. Pregnancy in autistic women and social medical considerations: scoping review and meta-synthesis. Front Psychiatry 2024; 14: 1222127.
12. Corrigan PW. How stigma interferes with mental health care. Am Psychol 2004; 59: 614-25.
13. Stuart H. Mental illness and employment discrimination. Curr Opin Psychiatry 2006; 19: 522-6.
14. Tolchin B, Tolchin DW, Stein MA. How should clinicians minimize harms and maximize benefits when diagnosing and treating disorders without biomarkers? AMA J Ethics 2021; 23: E530-536.
15. Rinaldi R. Health in the 21st Century: new rights come to the fore. La Clinica Terapeutica 2018; 169: e149e-e3150.
16. Vaishnav M, Javed A, Gupta S, Ashurov Z. Stigma towards mental illness in Asian nations and low-and-middle-income countries, and comparison with high-income countries: a literature review and practice implications. Indian J Psychiatry 2023; 65: 995-1011.
17. Bersani G, Rinaldi R, Iannitelli A. The assisted suicide of Italians in Switzerland and the silence of psychiatry. Riv Psichiatr 2018; 53: 173-6.
18. Vergallo G, Gulino M, Bersani G, Rinaldi R. Euthanasia and physician-assisted suicide for patients with depression: thought-provoking remarks. Riv Psichiatr 2020; 55: 119-28.
19. Cutroneo AS, Sangiorgi D, Lucchi F. Self-fulfilling prophecies in service design: strategies to address virtuous and vicious circles for mental healthcare transformation. In: Pfannstiel MA, Brehmer N, Rasche C (eds). Service design practices for healthcare innovation. Cham, CH: Springer, 2022.
20. Kok L, Soliman IW, Van Dijk D. Psychopathology after admission to the intensive care unit. Netherlands Journal of Critical Care 2019; 27: 186-9.
21. Di Fazio N, Morena D, Piras F, et al. Reliability of clinical judgment for evaluation of informed consent in mental health settings and the validation of the Evaluation of Informed Consent to Treatment (EICT) scale. Front Psychol 2024; 15: 1309909.
22. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62: 593-602.
23. Goldberg D, Fawcett J. The importance of anxiety in both major depression and bipolar disorder. Depression and Anxiety 2012; 29: 471-8.
24. Robinson D, Woerner MG, Alvir JM, et al. Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. Arch Gen Psychiatry1999; 56: 241-7.
25. Foulds JA, Simon J, Adamson JM, Boden JM, Williman J, Mulder RT. Depression in patients with alcohol use disorders: systematic review and meta-analysis of outcomes for independent and substance-induced disorders. J Affect Disord 2015; 185: 47-59.
26. Giridharan N, Smárason O, Provenza NR, et al. Psychotherapy for treatment-resistant obsessive-compulsive disorder. Adv Psychiatry Behav Health 2023; 3: 1-10.

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