and alcohol consumption are in line with previous research and consistent with the idea that psychostimulant misuse may reflect a general tendency for greater substance use.[4] In addition, the association with the variable university is consistent with the notion that psychostimulant misuse patterns vary widely locally and regionally.[2] Overall, these results suggest it is reasonable to devise strategies to address psychostimulant misuse that take local factors (institutional or cultural, for example) into consideration, and following the same broad lines of strategies targeting other substances.[5]

Gelline M. **Haas**,[1] Ana Clara **Momo**,[2] Thaís M. **Dias**,[3] Tosin A. **Ayodele**,[2] Marcelo L. **Schwarzbold**[4]
[1]*Programa de Residência Médica em Psiquiatria, Instituto de Psiquiatria de Santa Catarina, São José, SC, Brazil.* [2]*Curso de Medicina, Universidade Federal de Santa Catarina (UFSC), Florianópolis, SC, Brazil.* [3]*Curso de Medicina, Universidade do Sul de Santa Catarina (UNISUL), Palhoça, SC, Brazil.* [4]*Programa de Pós-Graduação em Ciências Médicas, UFSC, Florianópolis, SC, Brazil.*

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Tourette's disorder and sexual offenses: psychiatric-forensic considerations

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A clinical condition characterized by multiple, persistent motor and/or vocal tics, present to a variable extent since childhood, was first described in the 19th century. First known as Gilles de la Tourette syndrome, it is now included in DSM-5 as Tourette's disorder. With a prevalence of 3 to 8 cases per 1,000 school-age children, it is more frequent in males; symptoms usually begin between 4 and 6 years of age, worsen in pre-adolescence, and may decline in adolescence.[1] Changes in the cortico-striatal-thalamic circuitry[2] promote executive dysfunctions, impaired impulse control, and impaired inhibition of undesirable behaviors.[3] Anxious factors exacerbate the symptomatology.[4] Obsessive-compulsive disorder (OCD) and attention deficit hyperactivity disorder (ADHD) are the most prevalent comorbidities and the most important differential diagnoses, along with tourettism (Tourette's-like symptoms secondary to brain injury).

Rarely does Tourette's disorder per se lead to criminal behavior, although comorbidities, anger episodes secondary to obsessive ruminations of intrusive thoughts, and motor (copropraxia, coprography) and verbal (coprolalia) inadequacies may increase this risk.[3] There is no lack of empathy as found in antisocial personality. The modest specialized literature concerning the clinical specificities of Tourette's disorder and associated legal issues demonstrates that these patients are frequently found guilty when charged with offenses.[3,5,6] We will share our considerations about a case evaluated at Instituto Psiquiátrico Forense Doutor Maurício Cardoso, in Porto Alegre, southern Brazil.

At age 35, the patient was indicted for statutory rape after he impulsively kissed the mouth and caressed the genitals of a neighbor's child in front of the child's mother. During childhood, the patient had exhibited restless and disruptive behavior secondary to impulsivity. From the age of 7, he developed checking and symmetry obsessive-compulsive symptoms and motor tics, which included touching feces; he ultimately received a diagnosis of Tourette's disorder with comorbid OCD. During adolescence, the patient's neuropsychiatric symptoms worsened. He became unable to manage his self-care, began pharmacotherapy (haloperidol), and was hospitalized for dosage adjustments at age 12. The patient had an impoverished relationship life, was somewhat infantilized and dependent on relatives. He denied paraphilias of any order, coprolalia, or psychotic experiences. Currently, he reported obsessive rituals as well as sensory phenomena related to touching: "like an intuition [...]. I usually can't control" (*sic*).

His involuntary movements, which appeared minimal during the evaluation, were exacerbated when the patient was observed indirectly. He had normal intelligence (IQ 74), had never used illegal substances, and denied any psychiatric or criminal family history.

The patient adequately modulated affect, and endorsed guilt and shame for the offense he had committed. The diagnoses of Tourette's disorder and OCD increased the manifestations of acts that were not necessarily subjugated to volition, making commission of the sexual offense more impulsive and disorganized (committed in the presence of others). This modus operandi is distinct from that of sexual aggressors, whose practices involve premeditation and dissimulation, absence of guilt, and high odds of recidivism. The judge accepted the expert's report, considered the patient not guilty by reason of insanity, and ordered regular outpatient treatment in the community. Identifying the clinical repercussions of Tourette's disorder, as well as understanding its forensic psychiatric implications, can improve referral and treatment and prevent double stigmatization.

Fernanda T. **Nunes**,[1,2] Lisieux E.B. **Telles**[1,2,3]
[1]*Hospital de Clínicas de Porto Alegre (HCPA), Porto Alegre, RS, Brazil.* [2]*Instituto Psiquiátrico Forense Doutor Maurício Cardoso, Porto Alegre, RS, Brazil.* [3]*Departamento de Psiquiatria, Universidade Federal do Rio Grande do Sul (UFRGS), Porto Alegre, RS, Brazil.*

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Prevention of suicide in older adults

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''People who don't cherish their elderly have forgotten whence they came and whither they go.'' (Ramsey Clark)

It is common for older adults to recall the point in their life when their thoughts naturally shifted from exclusive concerns about the future and what lies ahead to also contemplating the past and what was. This transformation does not take place in a day, but over the course of months and years. There is little published information to pinpoint when it occurs, but empirical data would suggest it happens in the seventh decade of life.[1] An individual commences the process of objectively and subjectively confronting the ''beginning of the end'' with mixed emotions, as they assess and take stock. What has one achieved or accomplished that is of significance? What opportunities remain in the decades ahead? How closely does one's real life match the life imagined decades ago? What goals are still left to attain? And, perhaps, the most daunting question of all: how will it all end?

In approaching older adulthood, one may assess their satisfaction with the past, and level of confidence – emotionally, physically, financially, and socially – in what the future entails. Unfortunately, for some older adults, this is an arduous process, and the satisfaction and confidence on which they are meant to draw is insufficient, or even nonexistent. They feel ill-equipped to confront what lies ahead, and faced with the perception of a tormented demise, some older adults take deliberate measures to bring their life to a premature end. Older adults (age 65 and up) comprise nearly 12% of the American population, but account for 18% of suicides, making suicide among the elderly one of the most uncontrolled public health issues in the United States.[2] Suicide rates are the highest in individuals aged 70 years or older among both men and women in almost all regions of the world.[3] These statistics alone are alarming enough to warrant attention by health care practitioners, but as dire as the problem may seem, its actual dimension is probably even worse. Published studies fail to account for the overlooked phenomenon of ''silent suicide,'' including death from intentional medication non-compliance, self-starvation or dehydration, or ''accidents'' that were not necessarily accidental.[4] Forensic pathologists and other investigators may be left with insufficient evidence to determine the intent of a deceased person. The stigma of suicide, the reputation of the deceased individual, and financial considerations such as life insurance payouts are among the reasons these deaths are misclassified. The elderly also have an inordinate rate of completed suicide by means of firearms, hanging, and drowning.[5] The incidence of double suicide, where spouses or partners choose to take their lives together, is also high among this demographic group.

As older adults are unlikely to seek treatment for mental health issues, the first line in defending against suicidality among the elderly is family, friends, and primary care providers.[5] They must be concerned when older adults make statements conveying hopelessness or worthlessness. They must draw suspicion when learning