Acknowledgements

To all participants and professionals involved in the project, especially to Julie C. Vieira, Osvaldo H. Takeda, Ana L. A. Alves, Karen M. G. Mattos and Michele S. Cruz.

Disclosure

The authors report no conflicts of interest.

How to cite this article: Scanavino MDT, Alves LC, Yamaguchi ER, Wainberg ML. Sexual stigma, attachment difficulties, and emotional dysregulation among patients with severe mental illness. Braz J Psychiatry. 2020;42: 106-108. http://dx.doi.org/10.1590/1516-4446-2019-0635

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Decision-making for involuntary commitment in Brazil: elucidating misunderstandings between reasons and justification

Braz J Psychiatry. 2020 Jan-Feb;42(1):108-109
doi:10.1590/1516-4446-2019-0554

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The decision of whether to commit a patient involuntarily is one of the most complex tasks in psychiatry, and arguably represents the pinnacle of responsibility in the profession. Nevertheless, despite the importance of the subject, there is a gap in the literature regarding how psychiatrists deal with the legal and ethical criteria for involuntary hospitalization in Brazil.[1-3]

According to Law 10216/01, supplemented by Ministry of Health Ordinance no. 2391/GM/2002, involuntary hospitalization is that which occurs "without consent of the individual and at the request of a third party."[1] This means that any patient who does not provide written consent for admission, regardless of reason, must have his or her potential hospitalization communicated to the judicial authority for evaluation.[4]

In practice, this is done by completing a *communication of involuntary psychiatric commitment* form, which must be sent within 72 hours to the judicial authority.[2] The form includes two major criteria in the evaluation of the patient: the *reason* for involuntary commitment and the *justification* for such commitment.

Given the overlapping complexity of assessing risk (which will be the *reason* for commitment) and evaluating a patient's decision-making capacity (which will be the *justification* for involuntary commitment), it is imperative that these concepts be clear and that any misunderstandings be resolved.

Accordingly, determining whether a patient's condition constitutes sufficient risk to effectively deprive them of freedom must be done on a case-by-case basis, taking into consideration not only a formal diagnosis, but also social support and the emotional conditions of family members to provide home care, or, alternatively, to advocate for involuntary commitment. This information is essential in the psychiatric decision-making process, since patient improvement is highly dependent on the involvement of family members in treatment.

Beyond simply evaluating whether a patient presents a risk to oneself, the psychiatrist must determine if the patient has ability to choose and bear responsibility for his or her actions, which will serve as the basis for *justification* of involuntary commitment when such ability is absent.

When a patient is brought to the psychiatrist by family members due to potentially self-injurious behavior, the psychiatrist should evaluate if that behavior is in fact a symptom of a mental disorder. In the absence of a diagnosed mental disorder, or if a mental disorder is present but does not deprive the patient of choice, involuntary hospitalization is not justified, because the patient's autonomy must be respected unless there is an imminent risk of death.[1-5]

In addition to being necessary for scientifically based decision-making and from an ethical-legal standpoint, clarifying these concepts will lead to more accurate completion of the involuntary hospitalization form mentioned above. Additionally, access to epidemiological data from this form will allow subsequent epidemiological analyses, free of ideological biases, which would permit consistent evaluation of the scenario of involuntary hospitalization in Brazil.

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This letter is part of the review performed by the first author's doctoral studies at USP, with input from the second author.

Submitted Feb 18 2019, accepted Nov 04 2019.

Disclosure

The authors report no conflicts of interest.

How to cite this article: Castellana GB, Shraiber LB, da Silva TF, Barros DM. Decision-making for involuntary commitment in Brazil: elucidating misunderstandings between reasons and justification. Braz J Psychiatry. 2020;42:108-109. http://dx.doi.org/10.1590/1516-4446-2019-0554

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Comment on "Transcranial magnetic stimulation of the medial prefrontal cortex for psychiatric disorders: a systematic review"

Braz J Psychiatry. 2020 Jan-Feb;42(1):109-110
doi:10.1590/1516-4446-2019-0707

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In a recent issue, the *Brazilian Journal of Psychiatry* published a systematic review on transcranial magnetic stimulation of the medial prefrontal cortex for psychiatric disorders conducted by two of the authors of this letter (RCM and AC).[1] It has since come to our attention that a multicenter clinical trial of great relevance to the topic was not included in the review. This unfortunate oversight was due to the trial's publication taking place after acceptance of the review. Nonetheless, the importance of this trial is such that it would have influenced our overall analysis of the literature on medial prefrontal cortex transcranial magnetic stimulation (mPFC TMS), which motivated this correspondence.

The study in question, conducted by Carmi et al.,[2] is the largest randomized controlled trial to date investigating the use of mPFC TMS in the treatment of a psychiatric disorder. In 11 centers across the United States, Canada, and Israel, the researchers tested the efficacy of 20 Hz mPFC TMS in 99 patients with obsessive-compulsive disorder (OCD). The main outcome measure was the Yale-Brown Obsessive Compulsive Scale (YBOCS). Repetitive TMS was performed with an H-coil, which produces deeper and larger stimulation volumes than those of regular coils. Before and during the TMS session, a personalized OCD symptom provocation technique was used to activate the relevant neural circuitry being targeted. The trial design and sample size were based on a pilot study previously completed by part of the same group.[3]

The intervention resulted in a significantly different decrease in YBOCS measures between the active and sham groups ($p = 0.01$), with an effect size of 0.69. The between-group difference was maintained at 1-month follow-up, with a response rate of 45.2% in the active treatment group vs. 17.8% in the sham group. Had it been included in the review, this trial would have a low risk of bias according to the quality assessment tool. It would also have changed the tone of our conclusions, since it figures as the first high-quality mPFC TMS trial with a relatively large sample, offering solid evidence for the clinical application of this intervention, expanding on findings from pilot trials and smaller studies.

Other than the clinical importance of this publication, the successful therapeutic use of mPFC TMS emphasizes the value of a circuit-based approach to mental illness, and how neuromodulation interventions such as TMS can be effectively used for this purpose.[4] Greater understanding of the neurobiology of mental illnesses has guided a recent shift in attention in TMS research from regions more closely associated with cognition and executive functions (e.g., the dorsolateral prefrontal cortex) to areas involved in limbic processes and emotional regulation (e.g., the mPFC).[5] The results obtained by Carmi et al. are an important example of how this different approach can aid the development of new effective treatments for psychiatric disorders.

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Submitted Sep 12 2019, accepted Dec 09 2019.

Disclosure

The authors report no conflicts of interest.

How to cite this article: Marques RC, Cantilino A, Zangen A. Comment on "Transcranial magnetic stimulation of the medial prefrontal cortex for psychiatric disorders: a systematic review". Braz J Psychiatry. 2020;42:109-110. http://dx.doi.org/10.1590/1516-4446-2019-0707