

Table 1 Association between population density, elevated depressive symptoms, and suicidal thoughts (n=60,202)

	Elevated depressive symptoms	Suicidal thoughts
Continuous		
Model 1		
Whole sample	1.0006 (0.9999-1.0012)	1.0004 (0.9996-1.0012)
Men	1.0004 (0.9996-1.0012)	1.0010 (1.0003-1.0017)
Women	1.0005 (0.9998-1.0012)	1.0002 (0.9992-1.0011)
Model 2		
Whole sample	1.0005 (0.9998-1.0012)	1.0005 (0.9997-1.0014)
Men	1.0004 (0.9996-1.0011)	1.0010 (1.0003-1.0017)
Women	1.0005 (0.9998-1.0012)	1.0003 (0.9994-1.0013)
Highest population density (Highest tertile)		
Model 1		
Whole sample	1.22 (1.06-1.40)	1.15 (0.96-1.38)
Men	1.16 (0.98-1.37)	1.23 (1.03-1.48)
Women	1.21 (1.04-1.39)	1.10 (0.90-1.35)
Model 2		
Whole sample	1.20 (1.04-1.38)	1.15 (0.97-1.38)
Men	1.13 (0.96-1.33)	1.21 (1.02-1.44)
Women	1.21 (1.05-1.40)	1.12 (0.92-1.38)
Lowest population density (Lowest tertile)		
Model 1		
Whole sample	0.82 (0.72-0.95)	0.83 (0.70-0.98)
Men	0.86 (0.72-1.01)	0.84 (0.69-1.02)
Women	0.83 (0.72-0.95)	0.84 (0.69-1.01)
Model 2		
Whole sample	0.84 (0.73-0.96)	0.81 (0.69-0.95)
Men	0.87 (0.74-1.03)	0.85 (0.70-1.02)
Women	0.83 (0.72-0.96)	0.80 (0.67-0.97)

Data presented as odds ratio (95% confidence interval).

Model 1: crude model; model 2: adjusted for sex (whole sample), race, chronological age, educational status, employment status, intake of sugary foods, physical activity, TV-watching, and tobacco smoking.

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Sexual stigma, attachment difficulties, and emotional dysregulation among patients with severe mental illness

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Sexual behavior is directly affected by mental illness sexual stigma (MISS). Previous studies have shown high rates of MISS¹ and a correlation with high-risk sexual behavior.² However, those studies enrolled predominantly psychiatric outpatients. So far, little is known about the relationship between stigmatization, love life, and sex life in highly dysfunctional psychiatric patients. This pilot study, conducted with full Ethics Committee approval, described the sexual behavior and romantic relationships as well as investigated the correlation among depression, anxiety, type of attachment, and MISS in patients referred to treatment for severe mental illness (SMI) at the day hospital of a tertiary care center in São Paulo, Brazil.

The inclusion criteria were a diagnosis of SMI, age 18 years or older, literacy, cognitive ability to complete the

Table 1 Correlation matrix of depression, anxiety, adult attachment, sexual experience, and mental illness stigma

Scale	BDI	BAI	AAS Anxious	AAS Dependent	AAS Secure	ASES	MISS-Q Individual	MISS-Q Social	MISS-Q Structural	MISS-Q Total
BDI	1									
BAI	0.57*	1								
AAS Anxious	0.28	0.56 [†]	1							
AAS Dependent	-0.27	-0.30	-0.07	1						
AAS Secure	-0.43 [‡]	-0.05	-0.21	0.25	1					
ASES	0.32	0.03	-0.03	0.05	-0.23	1				
MISS-Q Individual	-0.63*	-0.55 [†]	-0.2	0.24	0.40 [†]	-0.05	1			
MISS-Q Social	-0.23	-0.43	-0.3	0.58 [†]	0.34 [‡]	0.16	0.51 [†]	1		
MISS-Q Structural	0.10 [‡]	-0.34 [‡]	0.06	0.16	-0.11	0.24	0.25	0.32	1	
MISS-Q Total	-0.37 [‡]	-0.57 [†]	-0.23	0.5 [†]	0.33 [‡]	0.14	0.78*	0.89*	0.57 [†]	1

AAS = Adult Attachment Scale (Secure, Dependent, and Anxious are domains of the AAS); ASES = Arizona Sexual Experience Scale; BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; MISS-Q = Mental Illness Sexual Stigma Scale (Individual, Social, and Structural are the MISS-Q domains; their sum score corresponds to the total MISS-Q score).

* $p < 0.001$, [†] $p < 0.05$, [‡] $p < 0.10$.

study instruments, and absence of organic neurologic conditions, current schizophrenic crisis, or current manic episode. Overall, 27 outpatients met these criteria and provided written informed consent for participation.

The sample was composed of 18 men and 9 women. On the Structured Clinical Interview for DSM (SCID), 18 (66.7%) met criteria for schizophrenia, seven (25.9%) for mood disorder, and two (7.4%) for schizoaffective disorder. The age of the participants ranged between 21 and 59 years (mean, 37; SD, 11.7). Fourteen participants (51.8%) reported a secondary education or less, while 13 (48.2%) reported at least some higher education. Sixteen (59.3%) were Caucasian, five (18%) reported current employment, and only one (3.7%) was married. Regarding lifetime romantic and sexual relationships, 20 (74.1%) participants reported at least one romantic relationship in the past, and 15 (57.7%) reported having had sexual intercourse at least once. On the other hand, only one (3.9%) reported a current romantic partner, five (18.6%) reported engaging in sexual intercourse in the preceding 6 months, and 11 (42.3%) reported masturbation.

Table 1 shows the correlation matrix of the measures. The Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and Mental Illness Sexual Stigma Questionnaire (MISS-Q) individual domain presented strong, statistically significant correlations between them, as did the anxious adult attachment style and BAI score. These findings are probably related to the internalization of MISS and diminished self-esteem, and suggest that patients with low self-esteem would also be more likely to feel socially inadequate, resulting in anxious symptoms.³ The MISS-Q social domain exhibited a high correlation

with the Adult Attachment Scale (AAS) dependent score, while the BDI score presented a negative correlation with the AAS secure score. These findings suggest possible emotional dysregulation among the patients, which may be related to dysfunctional attachment.^{4,5}

This study sheds light on the connections among negative emotion states, insecure attachment, and MISS among highly dysfunctional patients with SMI, who reported low rates of romantic and sexual experiences. However, a new study with a larger sample is necessary to confirm the internal validity and increase external validity. Subsequently, interventions focused on diminishing MISS and anxious attachment may have a positive impact on emotional status and increase opportunities for affectionate and sexual relationships in this population.

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

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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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