increase in the isthmus region. Echocardiography of the supra-aortic trunks and echography of the neck revealed diffuse goitre of the thyroid. The head CAT scan and magnetic resonance imaging (MRI) were normal. The EEG showed slightly slowed background activity. In a small proportion, there were low amplitude slow waves associated with sharp waves in the central temporal parietal (predominantly right central temporal) region with a tendency towards diffusion with different stimuli.

Etiological treatment was set with antithyroid (5 mg of carbimazole) and corticoid drugs (5 boluses of methylprednisolone iv and a schedule of oral corticoids), as well as symptomatic treatment with antipsychotics (9 ml of risperidone and 1.5 mg of clonazepam). Complete remission of the psychotic symptoms was achieved with this treatment.

We consider it important to emphasise that somatic disorders can begin with a neuropsychiatric clinical picture. Multiple psychiatric symptoms have been described as part of the prodromal symptoms of several physical diseases.[9,10] That is why, when faced with an acute psychotic episode without psychiatric antecedents or known somatic illness, a detailed organic screening is essential. We can conclude by indicating that the disorders related to the thyroid gland produce neuropsychiatric symptoms; the accompanying psychotic clinical picture has been recognised for years, but has rarely been studied from the psychiatric point of view. The diagnosis of acute psychosis caused by a medical illness makes etiological treatment and a cure for the disorder possible.

References

1. Brain L, Jellinek EH, Ball K. Hashimoto's disease and encephalopathy. Lancet. 1966;2:512–4.
2. Zamora Elson M, Labarta Monzón L, Mallor Bonet T, Villacampa Clavér V, Avellanas Chavala M, Seron Arbeloa C. Encefalitis de Hashimoto, a propósito de un caso. Med Intensiv. 2014;38:522–3.
3. Mocellin R, Walterfang M, Velakoulis D. Hashimoto's encephalopathy: epidemiology, pathogenesis and management. CNS Drugs. 2007;21:799–811.
4. Brownlie BEW, Rae AM, Walshe WB, Wells JE. Psychoses associated with thyrotoxicosis – ''thyrotoxic psychosis''. A report of 18 cases, with statistical analysis of incidence. Eur J Endocrinol. 2000;142:438–44.
5. Tamagno G, Federspil G, Murialdo G. Clinical and diagnostic aspects of encephalopathy associated with autoimmune thyroid disease (or Hashimoto's encephalopathy). Intern Emerg Med. 2006;1:15–23.
6. Mijajlovic M, Mirkovic M, Dackovic J, Zidverc-Trajkovic J, Sternic N. Clinical manifestations diagnostic criteria and teraphy of Hashimoto's encephalopathy: report of two cases. J Neurol Sci. 2010;288:194–6.
7. Sporis D, Habek M, Mubrin Z, Poljakoviæ Z, Hajnsek S, Bence-Zigman Z. Psychosis and EEG abnormalities as manifestations of Hashimoto encephalopathy. Cogn Behav Neurol. 2007;20:138–40.
8. Grommes C, Griffin C, Downes KA, Lerner AJ. Steroid-responsive encephalopathy associated with autoimmune thyroiditis presenting with diffusion MR imaging changes. Am J Neuroradiol. 2008;29:1550–1.
9. Ferraci F, Carnevale A. The neurological disorder associated with thyroid autoimmunity. J Neurol. 2006;253:975.
10. Galdeano Mondragón A, Oliván Roldán C, Barbadillo izquierdo L. Clínica psiquiátrica en la encefalitis de Hashimoto. Archiv Psiquiatr. 2010;73:7.

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Advance directives in mental health: Facts and values[☆,☆☆]

Las voluntades anticipadas en salud mental: hechos y valores

Dear Editor,

We often appeal to bioethical principles in ethical conflicts. Respect for autonomy is exemplified by informed consent and advance directive (AD) documents. In mental health we have to start from what the patients want and that they can participate in health decisions.[1,2] Patients sometimes refuse effective treatments because they are not well informed. In that case, the professionals have the moral obligation to ''make them autonomous and competent'' by informing them. In cases of incompetence, the representative has to engage in a dialogue with the professionals so that the patient is respected, as far as possible.

In this dialogue, non-maleficence (the obligation to do no intentional harm) is also confirmed. We have to avoid violent behaviour through containment (pharmacological, mechanical, etc.). However, depriving someone, unjustifiably, from the right to autonomy also represents moral harm, as the individual is kept from carrying out his/her interests. In addition, harm is inflicted by unjustified paternalism that infantilises the patients, stigmatising them and discriminating against them. It is essential to seek their best interest. The AD brings positive repercussions in their recovery.[3–7] Lastly, *fair* decisions can make it possible to save in health care expenses if the patients request that their lives not be

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prolonged beyond what is reasonable. Patients with dementia may fit this profile.

These principles are exemplified in the content and usefulness of the AD.

Wilder et al.[8] and Srebnik et al.[9] show that individuals with mental disorders accept neuromodulators and atypical antipsychotics better, refusing classic antipsychotics and lithium more frequently. Many professionals believe that the patients will reject *all drugs*; in fact, this does not generally occur.[8] The reasons for drug refusal are: negative effects, feeling drugged and being incapable of carrying out activities of daily living.[9]

At any rate, freedom of choice in treatment and knowing its contraindications and the importance of continuing with it improve drug adherence; this in turn reduces the number of recurrences, because it represents a motivation for following the treatment.[9] It is also a reason for choosing or refusing decisions about hospitalisation or contact persons for the patients while they are hospitalised.[10]

The use of an AD reduces coercive measures, as the medical team and the patient trust each other. In addition, establishing a proxy increases the possibilities of respecting the patient's desires and the individual will feel *empowered* by this.

Through all of this, we achieve respect for the individual (autonomy), we seek greater benefits (better drug compliance, etc.) and we avoid future harm (recurrences, coercive measures and so on). Freedom of choice in treatment can help to reduce the application of undesired treatments, and it is only fair that this should happen.

References

1. El-Wakeel, Taylor G, Tate J. What do patients really want to know in an informed consent procedure? A questionnaire-based survey of patients in the Bath Area, UK. J Med Ethics. 2006;32:121–8.
2. Hamann J, Cohen R, Diplich S. Why do some patients with schizophrenia want to be engaged in medical making and others do not? J Clin Psychiatry. 2011;72:1636–43.
3. La Fond J, Srebnik D. The impact of mental health advance directives on patient perceptions of coercion in civil commitment and treatment decisions. Int J Law Psychiatry. 2002;25:537–55.
4. Srebnik D, Rutherford L, Peto T, Russo J, Zick E, Jaffe C, et al. The content and clinical utility of psychiatric advance directives. Psychiatr Serv. 2005;56:592–8.
5. Rittmannsberger H, Pachinger T, Keppelmüller P, Wancata J. Medication adherence among psychotic patients before admission to inpatient treatment. Psychiatr Serv. 2004;55:174–9.
6. Hamann J, Cohen R, Leucht S, Busch R, Kissling R. Do patients with schizophrenia wish to be involved in decisions about their medical treatment? Am J Psychiatry. 2005;162:2382–4.
7. Swanson J, Swartz M, Elbogen E, van Dorn R, Ferron J, Wagner H, et al. Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. Am J Psychiatry. 2006;163:1943–51.
8. Wilder Ch, Elbogen E, Moser L, Swanson J, Swartz M. Medication preferences and adherence among individuals with severe mental illness and psychiatric advance directives. Psychiatr Serv. 2010;61:380–5.
9. Srebnik DS, Rutherford LT, Peto T, Russo J, Zick E, Jaffe C, et al. The content and clinical utility of psychiatric advance directives. Psychiatr Serv. 2005;56:592–8.
10. Srebnik D, la Fond J. Advance directives for mental health treatment. Psychiatr Serv. 1999;50:919–25.

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A new assessment method of posttraumatic psychiatric pathology☆

Un nuevo método de valoración de la enfermedad psiquiátrica postraumática

Dear Editor,

In 2011 there were 94,920 petty offences for lesions, 136,907 crimes against people's life, integrity and liberty,[1] 11,347 seriously wounded individuals and 104,280 individuals with serious injuries caused by traffic accidents.[2] Consequently, 347,454 individuals presented physical and/or mental lesions. Posttraumatic mental disorder (PTMD) is a disorder triggered by an external agent (of physical or mental nature) that can involve legal and economic repercussions. For legal assessment of PTMD, you need to know the type of lesion, its seriousness, the treatments received, its progression, time periods required for recovery and, principally, the individual's functionality once ''lesion stability'' is achieved; that is, the situation in which there is no possibility of improvement because all the scientifically accepted treatments have been applied. This implies that the both the expert and psychiatric reports have to focus on the diagnosis, on the seriousness and on the repercussion that the disability causes in the individual's life. There are some unique characteristics in PTMD[3]: (1) it can be produced with or without brain injury; (2) experiencing the trauma can trigger or worsen symptoms, and (3) there can be disproportion among trauma, symptoms and functionality.

To unify the parameters used to assess injuries, the use of required scales has been spreading. Although these scales may be imperfect and incomplete for quantifying personal injuries,[4] they have approached functionality, attempting to make a separation from the symptoms.[5] Among European Union members, until 1995 only Belgium, Spain, Greece and Portugal applied official scales for classifying or quantifying personal injury from road accidents.[6] The other countries

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