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£PSYCHIATRY
@A human rights perspective

Introduction

Psychiatrists work to relieve patients of anxiety and suffering caused by mental illness[1] and stressful experiences. In doing this they are expected, like all doctors, to adhere to principles of medical ethics and to safeguard the rights of their patients. However, psychiatry has the potential to impinge on fundamental individual rights and personal liberty in a way which is distinctively different from other areas of medicine. This is so because (i) it focuses on individual thought and behaviour to a far greater extent than occurs in other clinical disciplines; and (ii) it is an area of medicine in which significantly more powers are granted to medical professionals to deprive individuals of their liberty or over-ride their expressed will on medical grounds.

Amnesty International has had a long-standing interest in certain aspects of the interplay of psychiatry and human rights as they relate to the organization's own work[2]. This reflects the practical and theoretical linkage between individual rights and what psychiatrists and other mental health professionals do to restrict those rights through legal or extra-legal measures. It also results from other important issues such as the severity of mental suffering caused by human rights violations which leads many of those affected to seek professional psychiatric help, and from the increasing role of psychiatrists in the death penalty.

The purpose of this paper is to set out those concerns of Amnesty International which are of particular relevance to psychiatrists and, indeed, other mental health professionals. It will present a case for a greater involvement of psychiatrists in the protection of human rights through their professional work and through the activities of professional associations.

Amnesty International's mandate

Since its creation in 1961, Amnesty International has worked for the defence of certain basic human rights. It has amended its statute slightly over the last three decades to take account of changing patterns of human rights violations but its focus continues to be on absolute opposition to torture and the death penalty, to extrajudicial political killings, to "disappearances", to imprisonment for non-violent expressions of political, social or religious belief or sexual orientation and promotion of the rights to fair trial[3]. Since 1991, Amnesty International campaigns more actively against human rights abuses carried out by armed opposition groups.

Amnesty International's concerns in the field of psychiatry and mental health stem in general from the organization's mandate and therefore are not primarily the direct product of an ethical analysis of psychiatry. While there are many aspects of psychiatric ethics which are of major importance to the profession and to the public at large, many are outside the capacity of a human rights organization such as Amnesty International which has a limited focus as set out below.

Abuse of psychiatry for political reasons

1This paper does not address the definition of mental illness nor the debate between orthodox psychiatrists and "anti-psychiatrists". Its starting point is that of the existing mental health structures and internationally applicable laws.

2See *The abuse of human rights and the psychiatric profession*. AI Index: POL 03/01/83, May 1983. For a regional analysis of the rights of the mentally ill see: Wachenfeld MG. *The Human Rights of the Mentally Ill in Europe under the European Convention on Human Rights.* Copenhagen: Danish Center for Human Rights, 1992.

3The scope of human rights issues on which Amnesty International acts are known as the organization's mandate. The essential details of Amnesty International's statute on which the mandate is based are set out in the *Amnesty International Report*, which is published annually in the middle of the year.

Amnesty International opposes as a violation of human rights the compulsory admission and detention of people in mental hospitals solely because of non-violent political activities[4] or thoughts; it would view such detainees as victims of the abuse of psychiatry for political ends. The determining factor for AI in making this assessment would not be primarily the mental health of the person so treated but rather whether their detention was a direct consequence of their political behaviour and did not conform to national and international legal and ethical norms regulating the treatment of the mentally ill. Amnesty International has documented cases where, even if the detained political activist were mentally ill as alleged, the illness was not of such a nature as to justify compulsory committal.

Prisoners convicted after due process and sent to mental institutions as a result of their mental illness would not fall within Amnesty International's mandate unless they were subjected to gross and deliberate physical or mental abuse amounting to cruel, inhuman or degrading treatment or torture. Similarly, patients compulsorily committed and treated in error as a result of professional incompetence would not be the subject of AI action.

Where is political psychiatry practised?

While many countries probably have inadequacies in their mental health services the deliberate use of psychiatric services for dealing with political opponents is uncommon and appears to be restricted to countries having systems of government based on absolute state power[5]. The state in which psychiatric abuses were best documented is the former USSR. As Bloch and Reddaway show in their history of Soviet psychiatric abuse, the first recorded case of the labelling of dissent as mental illness occurred in 1836 when the philosopher Pyotr Chaadayev was declared by Czar Nicholas I to be suffering from "derangement and insanity" after he had published a letter critical of the Czar. However, psychiatric diagnosis was seldom used to deal with opposition until the late 1930s during the period of Stalin's rule, when the practice of interning dissenters in hospitals started to occur in a limited, state-directed way. Awareness of political abuse of psychiatry outside the USSR developed in the mid-1960s with the publication of an autobiographical novel detailing this abuse[6]. By 1970 the issue of psychiatric abuse received widespread publicity following accounts of the treatment of General Pyotr Grigorenko and Vladimir Bukovsky, as well as the compulsory hospitalization of the well-known biologist Zhores Medvedev. Mr Bukovsky later sent abroad dossiers on individual cases of psychiatric abuse. In 1971 the Canadian Psychiatric Association denounced the abuse of psychiatry in the USSR and for the next decade and a half there was an international campaign against Soviet psychiatric abuse led by individual psychiatrists and human rights activists (see below). Only reluctantly did the major professional associations associate themselves with the campaign. The motivation of psychiatrists participating in the abuses has been the subject of speculation with two broad views emerging. Bloch and Reddaway argue that psychiatrists involved in abuses were conscious of the political ends of such abuse[7], while Reich, on the other hand, suggests that the Soviet diagnostic framework was such as to tend to direct psychiatrists into making diagnoses which were abusive in effect - in other words, they believed their diagnoses[8].

4The reason for specifying “non-violent” acts is not because AI is necessarily opposed to violence but rather because the issue of violence can make it difficult or impossible to differentiate between the legitimate committal of an individual because they are a risk to themselves or others and the illegitimate assertion of state power because of the individual’s views. This is similar to AI’s policy regarding political prisoners held in prisons.

5This is not to say that individual cases of psychiatric incarceration for political views cannot happen in democratic states. Eisenberg cites the case of the British poet Siegfried Sassoon who made powerful anti-war statements in July 1917. The dilemma for the authorities was that he was “too visible to ignore and too heroic to court martial”. Their solution was to send him to a psychiatrist specialising in “shell shock” following which he returned to active duty. (Eisenberg L. Essay: Human rights, personal responsibility and the teaching of medicine. *International Journal of Law and Psychiatry*, 1993; 16:393-402.) The US poet, Ezra Pound, was incarcerated in a Washington DC psychiatric hospital after making war-time broadcasts from Italy (with whom the USA was at war). There was no evidence that he was psychotic but, in contradistinction to the USSR practice, Pound was arguably interned with benign motives (to prevent his conviction on the serious charge of treason) and was not ill-treated in detention. (Stover E, Nightingale EO (eds.). *The Breaking of Bodies and Minds*. New York: WH Freeman, 1985, p.228.

6Valery Tarsis, the author of the novel *Ward 7* (about a man forcibly interned in a mental institution), also submitted a report to Amnesty International about conditions in Kashchenko psychiatric hospital in which he had been held in the early 1960s.

7Bloch S, Reddaway P. *Russia's Political Hospitals: The Abuse of Psychiatry in the Soviet Union.* London: Gollancz, 1977.

8Reich W. The world of Soviet psychiatry. In: Stover E, Nightingale EO (eds). *The Breaking of Bodies and Minds*. New York: Norton, 1985; pp.206-22.)

Through this international campaigning pressure, as well as through the internal reform mechanisms brought to bear in the late 1980s, the practice now appears to have ceased[9]. The issues of reforming psychiatric training, consolidating legal reforms and developing stronger independent professional associations remain high priorities in the republics of the former USSR. There also remains much work to be done in improving professional standards in psychiatry.

In other states, examples of this kind of abuse of psychiatry were also reported. In Romania, reports suggested that individuals were interned in psychiatric institutions in the absence of grounds for such compulsory measures. This occurred particularly during the 1970s. In 1980 for example, Amnesty International reported on the cases of Mihai Moise, Eugen Onescu and others who were detained for political reasons in 1979 and 1980[10]. Mr Moise was detained and reported to have been subjected to forcible medication though he was apparently not mentally ill during a period of some years in exile in France. Mr Onescu was a member of an independent trade union and was forcibly medicated with anti-psychotic drugs during a three-week period of detention; he was then released. In the 1980s this practice appeared to decrease though cases still occurred. For example, in 1987 or 1988 Nestor Popescu was detained in a psychiatric hospital 200 miles from his home in Bucharest. It seems that the reason was connected with his religious beliefs and criticisms of the Romanian government[11]. Other cases were reported by Amnesty International during the 1980s but after the fall of the government of President Ceausescu in 1989 and the introduction of reforms no new cases came to the attention of AI. (Though, as will be evident below (p.6), poor practices still exist.) However, there appeared to have been no effective measures taken to compensate those affected by abuses and it was unclear whether individuals committed before 1989 remained in detention without justification.

In Yugoslavia, Hungary, and Czechoslovakia allegations of political psychiatry were made in the 1970s and 1980s though at a much lower frequency than in the USSR. In the former German Democratic Republic, information from Stasi files which came to light following unification with the Federal Republic of Germany suggested that significant human rights violations involving medical personnel would come to light. While allegations were made that psychiatric abuse was practised[12] it seems that there was not a problem with systematic abuses of the type reported in the USSR.

In South Africa, allegations surfaced in the 1970s that private psychiatric hospitals were incarcerating black patients without clinical justification and were doing so solely for profit[13]. The Royal College of Psychiatrists[14] and the American Psychiatric Association[15] investigated persistent reports of "psychiatric abuse" and found evidence of disturbing practices: discrimination in service provision based on race; segregation of facilities; suffering as a direct result of apartheid. However, neither organization found that an analogy could be made with the type of abuse that occurred in the USSR. Their methodology and conclusions were not without critics[16] although there was recognition that the debate on psychiatric practice in South Africa was not being carried out on the same terrain as

9A report from a World Psychiatric Association delegation reported in July 1991 that they had received no information concerning new cases of psychiatric abuse though there had been a signal failure of the profession and the authorities to address the issue of rehabilitation of those affected by past abuses. At the time of writing, Amnesty International is investigating an alleged case of psychiatric incarceration for political reasons in Turkmenistan though, whatever the outcome in this case, the conclusion that systematic abuses have ended appears valid.

10 *The political abuse of psychiatry in Romania.* AI Index: EUR 39/20/80, 11 November 1980.

11 Amnesty International. *Nestor Corneliu Popescu.* Case details, July 1988.

12 Tufts A. Investigation of psychiatric abuse. *Lancet,* 1990; **336**:1434-5.

13 See: Jewkes R. *The Case for South Africa's Expulsion from International Psychiatry.* New York: United Nations Centre Against Apartheid, May 1984.

14 Report of the Special (Political Abuse of Psychiatry) Committee on South Africa. *Bulletin of the Royal College of Psychiatrists*, 1983;7:115.

15 Report of the Committee to visit South Africa. *American Journal of Psychiatry,* 1979; 136: 1498-1506.

16 Sashidharan SP. Apartheid and psychiatry. *Lancet,* 1984; ii:1475.

that concerning Soviet psychiatry[17]. There does seem to have been agreement among critics that, under apartheid, mental health services were discriminatory and prejudicial to the health and well-being of the majority of South Africans.

Japan has also been the subject of allegations of excessive use of compulsory psychiatric incarceration for non-medical reasons[18] and the International Commission of Jurists carried out some investigations and made recommendations for reforms, some of which have been carried out[19].

In Cuba, there have been allegations in recent years that not only the criminally insane but also political prisoners have been sent to forensic wards of state psychiatric institutions where they are kept in unhygienic and dangerous conditions and where they are exposed to ill-treatment either at the hands of staff or fellow inmates. In 1988 Amnesty International visited the Havana Psychiatric (Mazorra) Hospital in Havana. The delegation was permitted to visit one of the forensic wards - the Sala Carbó Serviá. However, the existence of a second forensic ward, the Sala Castellanos, was denied by a hospital official. It was this ward which was alleged to present harsh conditions and to be used for the punishment of prisoners[20]. While there is sufficient evidence to suggest that there were cases of abuse of political prisoners in psychiatric hospitals up until the 1980s, the practice does not appear to have been systematic. Over the past few years, AI has continued to receive occasional reports that prisoners under investigation for political offences particularly relating to freedom of expression, such as "enemy propaganda" or "disrespect", have been transferred for short periods to psychiatric institutions for tests. Prisoners facing possible death sentences are also subjected to psychiatric tests. After testing, they are usually returned to police detention or prison to await trial. The test results may be taken into account during the trial. To AI's knowledge, there have been no recent cases of political prisoners held without trial for long periods or serving their sentence in a psychiatric institution.

In 1991, the US organizations, Freedom House and Of Human Rights, published a report giving case details which also suggested that forensic psychiatry in Cuba was practised in a way in which the rights of detainees were not respected and, in some cases, practices amounting to cruel, inhuman or degrading treatment were inflicted[21]. Less clearly established is evidence that political abuses of psychiatry of the type formerly practised in the USSR have occurred systematically in Cuba[22]. There nevertheless is a strong case for Cuban forensic psychiatry to be more open to external scrutiny and for the adoption of improved standards of practice within the forensic sector.

Recently, a small number of cases of the political use of psychiatry have surfaced in China where forcible confinement appears to have been used to silence vocal critics[23] and Amnesty International has sought assurances from the authorities that such individuals will be released unless they are to be charged with a recognisably criminal offence.

The line dividing political psychiatry from non-political abusive psychiatric practice is not always a simple one to draw. In the USSR, prisoners held in psychiatric institutions for political reasons were also subjected to physical ill-treatment or abusive medical practices such as insulin shocks or administration of sulphur injections. However, in

17 Sashidharan SP, Cox JL, Orley J et al. South Africa and the Royal College of Psychiatrists. *Lancet*, 1982; ii:497-8.

18 British Medical Association. *Medicine Betrayed*. London: Zed Books, 1992, pp.77-78.

19 International Commission of Jurists. *Human Rights and Mental Patients in Japan.* Geneva: ICJ, 1985; Harding TW. Japan's search for international guidelines on rights of mental patients. *Lancet*, 1987; i:676-9.

20 Amnesty International. *Cuba: Recent developments affecting the situation of political prisoners and the use of the death penalty*. AI Index: AMR 25/04/88, 1988.

21 Brown CJ, Lago A. *The Politics of Psychiatry in Revolutionary Cuba*. New York: Freedom House, 1991.

22 In a preface to the above book, the former Soviet political prisoner Vladimir Bukovsky, who himself spent time as a victim of political psychiatry, suggests that in Cuba there is "not yet a political use of psychiatry as we know it but rather a bad imitation of it". (Preface to *The Politics of Psychiatry in Revolutionary Cuba*, *ibid.* p.xii.)

23 Amnesty International: *Medical concern: [Three prisoners] People's Republic of China*. AI Index: ASA 17/44/93, 22 December 1993.

some cases in the USSR and elsewhere, in cases without a political motivation for psychiatric detention, abuses have occurred. Even here the picture can be complicated; some abuses occur for malicious or punitive reasons while others occur because of poor professional standards of practice or supervision. A report by Professor Jeffrey Geller of the University of Massachusetts Medical School, based on a visit made to Bucharest in October 1992, illustrates the caution needed in interpreting poor medical practice in terms of deliberate ill-treatment. Professor Geller notes that, in one hospital, patients receive electroconvulsive therapy (ECT) without any anaesthetic or medication.

Patients are administered ECT while awake; they're held down by 4 to 5 staff people. They receive a course of six treatments, three treatments per week....In some programs as many as 50 percent of those diagnosed with schizophrenia receive ECT, generally without pretreatment medication.[24]

There was no suggestion in Professor Geller's report that such procedures, which would be regarded as poor and unacceptable practice in orthodox psychiatry, were carried out with deliberate intent to cause suffering, nor that the recipients of such treatment were victims of politically-motivated treatment. However, such treatment cannot be defended and underlines the need for greater exchange of professional experiences and improvement of psychiatric medical and nursing standards in countries with a history of political abuse of psychiatry.

Changes and prospects

Not surprisingly, the rapid changes which have occurred in eastern Europe and the former USSR have introduced a period of review of human rights and legal protections and have led to an apparent end to the use of psychiatry as an alternative punishment to political imprisonment in these countries. However, protection of human rights in psychiatric hospitals remains an important issue. There has been a change in critical focus from politically-motivated abuse to improving standards of professional practice as well as seeking rehabilitation for those who were victims of political psychiatry under previous governments.

Abuses associated with psychiatry have surfaced in other countries though these have not been politically motivated. In the United Kingdom, an enquiry into allegations of abuses in Ashworth High Security Hospital near Liverpool was established after a television report of ill-treatment of patients and unprofessional practices. The commission of inquiry found that patients were subjected to inhuman and degrading treatment, that some staff held racist and uncaring views incompatible with their professional role, and that certain psychiatric staff had failed to exercise proper vigilance. The enquiry made a number of recommendations and conclusions including the observation that "[Ashworth] hospital must be a prime candidate to be included as one of the establishments to be visited in the near future by the [European] Committee for the Prevention of Torture..."[25].

While abuses of the kind outlined above should not be tolerated they are distinctively different from politically-motivated misuse of psychiatry and require action by professionals, human rights groups and mental health advocacy groups to ensure that humane and ethical standards are maintained in psychiatric establishments and prisons.

Role of the profession

The issue of political abuse of psychiatry was first raised internationally by professional associations in 1971 by the Canadian Psychiatric Association and subsequently by the World Federation for Mental Health. As the volume of documentation grew (and particularly the dossier sent out of the USSR by Vladimir Bukovsky), so the case became increasingly pressing on the

24Geller J. A glimpse of Romanian psychiatry. In: *Geneva Initiative on Psychiatry. Documents on the Abolition and Prevention of Political Abuse of Psychiatry*, no.59. October-November 1992, p.53.

25Report of the Committee of Inquiry into Complaints about Ashworth Hospital, Volume 1. London: HMSO, 1992, p.252; cited in: *People with Mental Health Problems and Learning Disability*, a report by MIND and the National Council for Civil Liberties, London: Liberty, 1993; p.13.

international psychiatric community. However, the Mexico Congress of the World Psychiatric Association in November 1971 failed to seriously address the issue[26]. Ad hoc groups of psychiatrists expressed their concern at developments though the issue was clearly controversial: some voices had suggested prior to the Mexico congress that the issue was political rather than professional and urged that the Soviet body sort out its own problems free of external interference[27]. Following the congress, few professional associations declared their strong opposition though by 1973 increasingly forthright condemnation was heard[28]. The growing clamour for some action by the psychiatric profession led to the establishment of various human rights groups focusing on psychiatric abuse as well as to an increase in the outspokenness of some professional associations. By the time of the World Psychiatric Congress in Honolulu in 1977, there was considerable pressure for the subject to be addressed though again there were significant efforts made to maintain the focus on principles of psychiatric ethics rather than to examine specific practices. An ethical declaration — the Declaration of Hawaii — was adopted, as was a proposal to establish an investigative committee to look into allegations of psychiatric abuse[29]. Neither the abuses nor the international campaign against them diminished and in January 1983 the Soviet member association resigned from the international professional organization, the World Psychiatric Association (WPA). The Czech, Bulgarian and Cuban associations also resigned citing the politicization of the WPA as a reason. The issue of expelling the Soviet association — the subject of a number of resolutions — was therefore not discussed[30].

Although the changes to Soviet government policy under Mikhail Gorbachev were regarded outside the country as liberalising and positive, in the sphere of psychiatry improvements were slow[31]. However, some reforms of the law were introduced and acknowledgement of past mistakes were made. In 1988 in an interview with *Novoye vremya*, Dr Aleksandr Churkin, the Chief Psychiatrist of the USSR Ministry of Health, admitted that two former inmates had been "mis-diagnosed". In June of the following year, the newspaper *Literaturnaya gazeta* reported that politics had perverted the psychiatric system for decades and said that the leaders of the profession were to blame. Medical commissions re-examined the cases of a large number of psychiatric inmates and thousands of people were re-classified[32]. Nevertheless individuals continued to be held in psychiatric institutions for political reasons. However, a WPA delegation which visited the Soviet Union in 1991 reported that no new cases of abuse were brought to its attention but that there was no apparent effort to fully acknowledge previous abuses and to compensate victims. Since the break-up of the USSR at the end of 1992, Amnesty International

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26 See: Bloch S, Reddaway P. *Russia's Psychiatric Prisons*. London: Gollancz, 1977, chapter 4.

27 Bloch and Reddaway, *ibid.*

28 Both the American Psychiatric Association and the British Royal College of Psychiatrists spoke out more forthrightly, the latter adopting a resolution "deplor[ing] the current use of psychiatry in the Soviet Union for the purpose of political repression". See Bloch and Reddaway, *ibid.* p.320 and chapter 10 *passim.*

29 Bloch and Reddaway, *ibid.*

30 Bloch S, Reddaway P. *The Shadow over World Psychiatry.* London: Gollancz, 1983. The All-Union Society returned to the WPA at the Athens Congress in 1989 on condition that it admitted the existence of abuses and that it would support a visit by a WPA delegation some time after the Congress.

31 van Voren R (ed.). *Soviet Psychiatric Abuse in the Gorbachev Era.* Amsterdam: IAPUP, 1989.

32 See: Amnesty International. *USSR: Human rights in a time of change*. AI Index: 46/22/89, October 1989. As many as 2 million outpatients were reported to have been taken off registers in the period from January 1988 to early 1989 when an AI delegation visited Moscow.

has not documented any new cases in the republics that emerged from the Soviet Union[33].

Torture: psychological sequelae and the role of psychiatrists

Impact of torture: physical and psychological sequelae

Torture can have a devastating impact on the mind and body of its victims. Apart from the physical injury caused by trauma such as beatings, electric shock, violent sexual assault and near drowning, the psychological and emotional suffering provoked by torture can be severe. Long-term solitary confinement and exposure to inhumane conditions of detention can also cause deep suffering. Numerous studies have documented the effects of torture[34]. Following torture, affected individuals can (but do not necessarily) manifest symptoms such as disturbed sleep, flashbacks, withdrawal, aggressivity, sexual dysfunction, etc. There is now a copious and growing literature on torture and its sequelae, management of torture-related trauma[35] and also on the more general subject of post-traumatic stress disorder[36].

Diagnosis

The after-effects of trauma have been known for a long time but made an impact in Europe and North America at the time of the 1914-1918 war where thousands of soldiers were disabled due to "shell shock". Over the subsequent 75 years, other descriptive terms have been applied to the signs and symptoms evident after large-scale traumas. They usually reflect the origin of the trauma: for example, KZ (concentration camp) syndrome[37]; the war sailor syndrome[38]; Stasi persecution syndrome[39]; and rape trauma syndrome[40]. In the 1970s there was some debate about whether there was a clinical entity meriting the name "torture syndrome". Concurrently, in the wake of the return to the USA of large numbers of seriously traumatized veterans of the Vietnam war[41], the diagnostic category of post-traumatic stress disorder (PTSD) was introduced and subsequently consolidated as a clinical entity. Apart from the obvious utility of an agreed diagnostic tool, important non-medical implications of such a diagnostic entity included the requirement by the state for a clinical marker to determine rights to compensation and pension benefits. Evidence of PTSD was also introduced in courts as mitigating evidence in cases of

33Though see note 9 above.

34See the following reviews: Allodi F. The diagnosis and treatment of torture: a critical review; Goldfeld A, Mollica R, Pesavento B, Faraone S. The physical and psychological sequelae of torture. *Journal of the American Medical Association*, 1986; **259**:2725-9; Rasmussen OV. Medical aspects of torture. *Danish Medical Bulletin*, 1991; **18** (supplement):1-88.

35Basoglu M (ed). *Torture and Its Consequences.* Cambridge: Cambridge University Press, 1992.

36Figley CR (ed.) *Trauma and Its Wake: Traumatic Stress Theory, Research and Intervention.* NY: Brunner/Mazel, 1985; Ochberg FM (ed). *Post-traumatic Therapy and Victims of* Violence. New York: Brunner/Mazel, 1988.

37Thygesen P. The concentration camp syndrome. *Danish Medical Bulletin*, 1980; **27**:224-8.

38Askevold F. The war sailor syndrome. *Danish Medical Bulletin*, 1980; **27**:220-3.

39Peters UH. Uber das Stasi-Verfolgten-Syndrom. [The Stasi persecution syndrome]. *Fortschr Neurol Psychiatr*, 1991, 59 (7) :251-65.

40Burgess AW, Holmstrom LL. Rape trauma syndrome. *American Journal of Psychiatry*, 1974; **131**:981-6.

41In Vietnam, a state with a different political, social and cultural system to that of the USA, the war led to massive deaths and psychological trauma similar to that seen in US soldiers. See, for example, the brief account of a visit to the Hanoi Centre for Psychiatric Treatment given by William Branigin in *The Guardian Weekly*, 31 October 1993, p.17. A literary account of post-traumatic sequelae is given in the acclaimed novel *The Sorrow of War*, by the former Vietnamese soldier Bao Ninh (English language translation published by Secker and Warburg, London, 1994.)

violent crime.

However, PTSD in its current definition has its critics, including some from among those who find the concept useful. Following prolonged discussions and debate, the definition was modified when the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) was published in 1994. Some critics, however, reject the diagnosis as lacking utility since it may be culturally specific and not applicable cross-culturally, and it does not address the situation where the individual must survive in *continuing* trauma and where profound fear can be a rational response to political terror. Some eschew diagnosis on the grounds that "any nosologic categorization that would place the problem in the domain of psychiatry and reduce it to merely psychopathology cannot be acceptable"[42].

Concrete assistance

As a response to the growing numbers of victims of human rights violations perpetrated during the 1970s and to the large numbers of refugees arriving in receiving countries with sequelae of torture, clinics were established to offer appropriate psychological and social assistance. These usually include some kind of psychiatric service. Their work is summarized in a number of publications including a survey of such services produced by Amnesty International[43]. While some centres offer general medical services, there appears to a general recognition that mental health is a priority in delivering health care and that social and legal help is also vitally important. In 1982 the UN voted to change the fund for victims of torture in Chile to a more general fund for victims of torture anywhere in the world. Since that time, funding has been given to more than 160 projects in all regions of the world, a significant proportion for relieving post-traumatic mental suffering[44].

"Disappearance"

The practice

A "disappearance" occurs when there are reasonable grounds to believe that a person has been taken into custody by the authorities or their agents, and the authorities deny that the victim is in custody, thus concealing his or her whereabouts and fate. They are often not seen or heard of again. However, the person who has "disappeared" has not literally vanished.

Living or dead, each is in a very real place as a result of a real series of decisions taken and implemented by real

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42 Kordon D, Edelman L, Lagos D, et al. Torture in Argentina. In: Basoglu M (ed). *Torture and Its Consequences*, p.433-51 (quote from p.451). From the same book see the discussion of PTSD and torture: Mollica RF, Caspi-Yavin Y. Overview: the assessment and diagnosis of torture events and symptoms (pp.253-74); and also a general outline of PTSD: McNally RJ. Psychopathology of post-traumatic stress disorder (PTSD): boundaries of the syndrome (pp.229-52).

43 van Willigen L. Organization of care and rehabilitation services for victims of torture and other forms of organized violence: a review of current issues. In: Basoglu M (ed.) *Torture and Its Consequences*, pp.277-98; Hannibal K, Gruschow J (eds). *Health Services for the Treatment of Torture and Trauma Survivors*. Washington DC: AAAS, 1990; Randall G, Lutz E. *Serving Survivors of Torture*. Washington DC: AAAS; Amnesty International. *Preliminary survey of medical and psychosocial services to victims of human rights violations.* London: AI Index: ACT 75/01/94, January 1994. See also *Medical and psychosocial services to victims of human rights violations.*London: AI Index: ACT 75/02/95 (forthcoming).

44 United Nations. *Consolidated Report on Ten Years (1982-1992) of the United Nations Voluntary Fund for Victims of Torture.* ECOSOC Report E/CN.4/1993/23, New York, 1993. See also *United Nations Voluntary Fund for Victims of Torture: Report of the Secretary General: Addendum* (E/CN.4/1995/Add.1) for a further list of projects assisted.

people. *Someone* does know and, more importantly, is responsible.[45]

As a political phenomenon "disappearances" came to public consciousness in the 1970s when Guatemalan newspapers started referring to those who had apparently vanished after abduction as *desaparecidos*. From the 1960s through to the present time, "disappearances" have been reported to have occurred in many countries with significant human rights problems[46]. In some cases, "disappearance" is synonymous with killing; in other countries, those who are abducted remain alive in secret detention. In some cases this is prolonged. In Morocco in 1991, more than 300 "disappeared" were released after having spent up to 18 years cut off from the outside world, often is solitary confinement and in terrible conditions[47]. They returned to their families but with evident effects of their ordeal. Other "disappeared" prisoners remain to be accounted for, more than 30 years after their arrest. In the absence of clear evidence of their survival or a detailed account and evidence of their death -- their most likely fate -- it is difficult for their loved ones to come to terms with the loss.

The fact that disappearances cause suffering to people other than the immediate victim was recognized by the Human Rights Committee established under the International Covenant on Civil and Political Rights (ICCPR). As a result of a case brought in 1981 by the mother of Elena Quinteros, a young Uruguayan woman who disappeared in the 1970s, the Committee ruled that the Uruguayan authorities breached articles 7 (prohibiting torture and ill-treatment) and 10(1) (guaranteeing the right to be treated with humanity) in the case of the daughter who had been tortured in a military camp, but also that the mother too was a victim of the violations of the Covenant suffered by her daughter[48].

This conclusion flowed from the Committee's understanding of 'the anguish and stress caused to the mother by the disappearance of her daughter and by the continuing uncertainty concerning her fate and whereabouts. The mother has the right to know what has happened to her daughter' [and] 'is a victim of the violations...suffered by her daughter'.[49]

The Committee's decision gave formal recognition that the close family of the victim of a "disappearance" is also subjected to torture or other ill-treatment.

The effects

As suggested above, the effects of "disappearance" are devastating. Apart from the (usually) appalling suffering inflicted on the abducted person — if they are not immediately killed they may be brutally treated prior to release or murder — the loved ones of the "disappeared" person are put through immense stress and despair. Until the person is found, sometimes alive but more usually dead, the process of grieving for a personal loss is suspended. In many cases the

45 *"Disappearances": a Workbook*. Amnesty International USA, New York, 1981.

46 See the following Amnesty International reports: *Disappearances: A Workbook* (1991); *Disappearances* (1993); *"Disappearances" and Political Killings: Human Rights Crisis of the 1990s. A Manual for Action* (1994).

47 *Breaking the wall of silence: the "disappeared" in Morocco.* AI Index: MDE 29/01/93, April 1993.

48 Rodley N. *The Treatment of Prisoners Under International Law*. Oxford: Clarendon, 1987; pp.199-201.

49 Rodley *ibid.* citing *Quinteros v Uruguay* (107/1981), Report of the Human Rights Committee, *GAOR*, 38th session, Supplement no.40 (1983), Annex XXII, para.13,14.

"disappeared" relative is never found. Where the "disappeared" person *is* found they are likely to have physical and psychological problems requiring sympathetic and competent care. This may be given by family, friends or solidarity groups but professional expertise is also likely to be called upon. Those affected by the loss of a "disappeared" relative can suffer a number of psychological and emotional after-effects. Where they are unable to deal with these problems they may seek the assistance of counsellors and other mental health professionals.

The literature on the effects of "disappearance" on relatives is limited[50]. The most extensive has been published in Argentina where the phenomenon was widespread in the period of military rule (1976-83). The members of the Psychological Assistance Team of the Mothers of the Plaza de Mayo[51] have written extensively on their work with mothers of "disappeared" which was based on psychoanalytic theory and solidarity[52]. The profundity of the effects of "disappearance" can be gauged by the unceasing efforts of relatives of "disappeared" to determine the fate of their loved ones sometimes more than a decade after their "disappearance". Psychiatrists, who are well placed to understand the extent of the loss occasioned by a "disappearance", can contribute to therapeutic work with "disappeared" people who re-appear[53], relatives of victims, and to the campaign to end such abuses.

The death penalty

How psychiatrists are involved

Evidence of psychiatric involvement in capital punishment is poorly documented apart from in the USA. In that country, psychiatrists can be involved at various points during the legal process which starts with the arrest of the accused and ends with the carrying out of an execution, the successful appeal or the commutation of the sentence. In the early phase of a case, psychiatric expertise may be sought to evaluate the state of mind of the accused, at the time of the alleged crime and at the time of arrest. Information gained through interviews at this time may be used in evidence and therefore the psychiatrist concerned should make clear to the detainee that such information is not bound by the normal rules of confidentiality (unless a guarantee of confidentiality can be given) and that the interview is not primarily therapeutic in nature.

At trial, psychiatric evidence can be introduced concerning the likely state of mind of the defendant at the time of the crime and subsequently. Such evidence can contribute to an

50 See for example, Quirk GJ, Casco L (1994). Stress disorders of families of the disappeared: a controlled study in Honduras. *Social Science and Medicine*, 39:1675-9.

51 Members of this team later formed the *Equipo Argentino de Trabajo e Investigación Psicosocial* (EATIP).

52 Kordon DR et al. *Efectos psicológicos de la represión política.* Buenos Aires: Sudamericana-Planeta, 1986; Kordon et al. Torture in Argentina. In: Basoglu M (ed). *op.cit.* pp.433-51.

53 In Argentina, the re-appearance alive of "disappeared" people was rare. However, there were numerous cases of children born to women in secret detention who were adopted by families associated with the military. The mothers of these children are known or presumed to have been murdered in detention. These children have been the subject of intense efforts by their natural grandparents to trace them and reclaim them. The efforts of the *Grandmothers of the Plaza de Mayo* resulted in a number of children being identified and brought into contact with their surviving family members. Psychiatrists and other mental health professionals helped the families and young adolescents to come to terms with this experience. The dilemma of deciding the best interests of the child in such circumstances has yet to be adequately resolved and is beyond the competence of psychiatry alone to deal with.

assessment of the competence of the defendant to stand trial. While competence[54] is a legal and not a medical judgement, courts may press psychiatric witnesses to give their own assessment of the competence of the prisoner. There is widespread agreement that this is not the role of the psychiatrist though, in practice, lawyers on either side of the case can lead a witness to overtly or implicitly declare such a view.

In the USA, those states having the death penalty separate the sentencing phase from the trial of the case itself. During the sentencing hearing, mitigating evidence is presented by the defence, as well as evidence (such as aggravating factors) by the prosecution who, if they are seeking the death penalty, may try to establish that the convicted prisoner would constitute a continuing threat to society. This is one of the conditions in Texas on which the jury must be satisfied if they are to impose the death penalty. Psychiatrists regularly testify there on the probable "future dangerousness" of the convicted prisoner, a practice which was opposed in capital cases by the American Psychiatric Association which argued that psychiatrists were more frequently wrong than right in such predictions[55].

Ethical controversies

The ethical role of the psychiatrist in the death penalty has been the subject of debate in many countries, above all in the USA, where certain parts of the judicial process appear to risk involving mental health professionals to increasingly greater degrees as a result of the highly complex legal and evidential system. As noted above, the points at which psychiatric evidence can be introduced are: where a determination of competence to stand trial is made; where evidence of the psychiatric state of the accused at the time of the offence is relevant; at the sentencing stage where mitigating evidence is presented by the defence and contrary evidence can be presented by the prosecution; prior to execution where evidence of non-competence can be presented by the defence and countered by the prosecution. In the case of non-competence due to mental illness, the state may seek medical treatment for the prisoner in order to restore competence to allow execution.

Many psychiatrists have opposed the introduction of psychiatric evidence where it can reasonably be supposed to contribute directly to a prisoner's execution. Their argument is that it is unethical for a psychiatrist to assist the state in bringing a prisoner to the execution chamber. The main areas of professional practice where this opposition has been focused are: testimony of future dangerousness; assessing a prisoner's competence; restoring competence to be executed by giving psychiatric treatment.

Views of the profession

Although the debate over the involvement of medical professionals in capital punishment has

54"Competence" is a legal concept usually meaning capacity to understand right and wrong and to comprehend the reasons for arrest, trial and punishment. Those who are significantly mentally handicapped or whose capacity for understanding is affected by mental illness may be adjudged "incompetent".

55Amnesty International. *United States of America: The Death Penalty*. London: AI Publications, 1987, p.145. The APA submitted an *amicus curiae* on this subject before the Supreme Court in *Estelle v. Barefoot* but the court ruled that such predictions were admissible in court.

been raised by individual voices in the past[56], it was the discussion prompted by the introduction of lethal injection legislation in the USA which sharpened the debate. This debate involved all areas of the medical and mental health professions. The American Medical, Public Health, Psychiatric and Nurses Associations all introduced some form of declaration opposing medical involvement in carrying out executions.

The American Psychiatric Association (APA) declared that:

> The physician's serving the state as an executioner, either directly or indirectly, is a perversion of medical ethics and of his or her role as a healer and comforter. The APA strongly opposes any participation by psychiatrists in capital punishment...in activities leading directly or indirectly to the death of a condemned prisoner...[57].

The World Psychiatric Association, at its assembly in Athens in 1989, adopted a statement which concluded that "the participation of psychiatrists in any ... action [contributing to an execution] is a violation of professional ethics" (see appendix for text).

In 1992, the American Medical Association adopted a strong statement against the participation of doctors in executions. In the text of the resolution they touched on the role of the psychiatrist but invited the APA to contribute a section to the text on the role of the psychiatrist in the death penalty. The APA undertook an internal discussion which has not as yet been finalised. It is clear that the tension within the APA is between a restrictive position emphasising the Hippocratic traditions of medicine and proponents of a "truth-seeking" role for forensic psychiatrists which is less sensitive to the outcome flowing from forensic findings.

An authoritative review of the ethics of medical and psychiatric involvement in executions argued against psychiatric participation in activities such as certification of competence and giving treatment to restore competence solely to allow execution[58]. At the time of writing, the APA had not declared a position on the particularly contentious issues of certifying a prisoner fit for execution or medicating a non-competent prisoner in order to restore competence to allow execution.

Amnesty International's views on the death penalty and on psychiatric participation in the death penalty are set out in a number of publications[59]. Amnesty International regards the ethics of psychiatric participation in capital punishment as problematic in the extreme and believes that:

> psychiatrists have an important role not only in ensuring that individual psychiatrists don't contribute to executions through professional activities but also through pressing for a commitment to address the underlying problems in society rather than adopting fraudulent signs of action such as killing off a few convicted prisoners. They should contribute to the effort to instil in society a deep and unshakeable belief in the value of the human person. The psychiatrist's voice should be heard, speaking in defence of human rights and against the death penalty.[60]

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56 See, for example, West LJ. Psychiatric reflections on the death penalty. *Journal of Orthopsychiatry*, 1975; **45**:689-700.

57 American Psychiatric Association. *American Journal of Psychiatry*, 1980; 137: 1487.

58 See: Council of Delegates of the American Medical Association. *Journal of the American Medical Association*, 1993; **270**:365-8; *Breach of Trust: Physician Participation in Capital Punishment in the USA.* Report by Physicians for Human Rights, Human Rights Watch, National Coalition Against the Death Penalty, and the American College of Physicians. March 1994.

59 See for example, *When the State Kills...* London: Amnesty International Publications, 1989.

Imprisonment of psychiatrists

Psychiatrists are arrested and imprisoned for a variety of reasons including for criminal acts. However, of concern here are those arrests for reasons of political, professional or human rights activities. During the "dirty war" in Argentina in the period 1976-1983, psychiatrists were a professional group targeted during the early phase of repression. The Argentinian writer Jacobo Timerman suggested that the reason for this repression was the security forces' belief that "psychiatrists knew many behind-the-scenes details about subversive urban guerrilla activities, and that the mission of certain psychiatrists was to bolster the spirits of guerrillas"[61]. No evidence was produced to sustain such a charge and the lack of any due process rendered such a legal quibble irrelevant.

In other countries, repression has been more focused, singling out individual psychiatrists who are deemed to be politically active opponents of the government. Dr Mohamed Jaaidi is a psychiatrist who studied medicine at the University of Valencia, Spain, and specialized in psychiatry in Cordoba before returning to Morocco in 1974. At the time of his arrest in 1985 he was Director of Tetouan psychiatric hospital and Director of Sanitation for Northern Morocco. He was arrested at his home in Tetouan on 7 November 1985 at a time when a wave of arrests was taking place in the country. His wife, who is also a psychiatrist, remained without news of him for two weeks before learning that he had been sent to prison in Casablanca.

Dr Jaaidi and several others arrested in various parts of Morocco in the course of October and November were subsequently accused of the distribution of illegal pamphlets. He and 26 others were brought to trial in Casablanca in January 1986 on charges of having "participated in a clandestine organization, *Ila'l-Amam*, which aimed to overthrow the monarchy". He was sentenced to 12 years' imprisonment and sent to Tangier Civil Prison. He was one of 40 political prisoners released in mid-August 1991 under the terms of a royal amnesty.

The Soviet psychiatrists Semyon Gluzman in the 1970s and Anatoly Koryagin in the 1980s were sentenced to long periods in prison for their work in opposing and exposing the political abuse of psychiatry[62]. Dr Gluzman was arrested after writing an analysis of the wrongful diagnosis of General Piotr Grigorenko, who was a victim of the political use of psychiatry. He served 10 years in prison and exile. Dr Koryagin was charged with anti-Soviet agitation and propaganda around the time of the publication in *The Lancet* in 1981 of an article describing his findings with people found to be mentally ill by forensic psychiatrists in the USSR[63]. He was sentenced to 12 years of imprisonment and exile but was released in 1987. He subsequently left the country. Dr Gluzman is currently Head of the Association of Independent Psychiatrists in the Ukraine; Dr

60 *Psychiatrists and the death penalty.* AI Index: ACT 75/03/91, August 1991.

61 Timerman J. *Prisoner Without a Name, Cell Without a Number.* London: Weidenfeld and Nicolson, 1981, p.93. Timerman claims that in the first months after the seizure of power by the military, "no sector of the population suffered more from the wave of kidnappings and disappearances than psychiatrists" [p.93].

62 Bloch S, Reddaway P. *Russia's Political Hospitals. op. cit.*

63 Koryagin A. Unwilling patients. *Lancet*, 1981; **i**:821-4.

Koryagin remains in self-imposed exile.

It is likely that many appeals on behalf of detained psychiatrists are made by colleagues of the detainees and by their professional associations without this fact being made public. There have been individual appeals nevertheless published in medical journals and issued by medical associations. The most concerted campaigning has been conducted on behalf of Soviet psychiatrists imprisoned for opposing psychiatric abuse in the former Soviet Union. This perhaps reflects the professional as well as human rights interest in such cases. Particularly active in this field was the International Association on the Political Use of Psychiatry (IAPUP)[64] and national constituent associations such as the British Working Group on the Internment of Dissenters in Mental Hospitals. Other psychiatrists under threat must rely on individual and professional contacts as well as the activities of human rights organizations.

Role of psychiatrists in defending human rights

As the WPA's Declaration of Hawaii makes clear, the role of the psychiatrist should be guided by a fundamental sense of acting in the best interests of the patient and respecting their autonomy[65]

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> The psychiatrist must never use his professional possibilities to violate the dignity of human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment. The psychiatrist must on no account utilize the tool of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate. (Article 7)

The other international statement on human rights made by the WPA is the Declaration on psychiatrists and the death penalty though this, as indicated above, has not resolved issues relating to involvement of psychiatrists in specific aspects of capital punishment.

One issue which is not dealt with adequately in the current standards is the need for psychiatrists to speak out against abuses they witness or which are brought to their attention. A change in this direction through incorporation of an appropriate article in psychiatric ethical codes would bring such codes into line with other medical ethics standards which require doctors to refuse to tolerate torture or other cruel inhuman or degrading acts[66]. However, the effective exposure and disciplining of mental health professionals abusing their positions and skills requires more than criticism from the specialist professional association. The wider medical profession and, above all, the medical licensing and regulatory bodies, must act in such cases.

64IAPUP changed its name in the early 1990s to the Geneva Initiative on Psychiatry and placed increasing emphasis on practical assistance in the development of ethical and professional psychiatry in eastern Europe and elsewhere.

65While this declaration arose as a response to widespread concern about political psychiatry, it could be more widely applicable. For example, recent legislation in China aims at “improving the quality of the newborn population” and provides for restrictions to be placed on the marriage of partners deemed to have undesirable traits such as “relevant mental diseases”

66The World Medical Association's Declaration of Tokyo, for example, requires that the doctor not "countenance, condone or participate in" torture or other forms of cruel, inhuman or degrading procedures. While in practice this is apparently still not widely interpreted as a requirement to actively expose torture, it is certainly stronger than the injunctions of the Declaration of Hawaii.

Equally, there is a need for a commitment on the part of the profession to act in cases where colleagues are at risk or have been persecuted for actions compatible with medical ethics. Up to the present time, there has been a lack of a systematic approach to the defence of colleagues under threat. Such an approach has long been needed and should have a higher priority.

Conclusion

As this paper shows, there are many human rights issues which have direct relevance to psychiatry and psychiatrists. There is a powerful argument for psychiatric associations to strengthen their response to human rights abuses in general but particularly to those involving abuses based on the misuse of psychiatry (including the death penalty), persecution of mental health professionals, and the development of services for victims of human rights violations. Individual psychiatrists need both an example and support from professional bodies with the influence and authority to provide it — and they need it now.

Appendix 1

THE DECLARATION OF HAWAII
(World Psychiatric Association, 1977, 1983)

Ever since the dawn of culture, ethics has been an essential part of the healing art. It is the view of the World Psychiatric Association that due to conflicting loyalties and expectations of both physicians and patients in contemporary society and the delicate nature of the therapist-patient relationship, high ethical standards are especially important for those involved in the science and practice of psychiatry as a medical specialty. These guidelines have been delineated in order to promote close adherence to those standards and to prevent misuse of psychiatric concepts, knowledge and technology.
Since the psychiatrist is a member of society as well as a practitioner of medicine, he or she must consider the ethical implications specific to psychiatry as well as the ethical demands of all physicians and the social responsibility of every man and woman.
Even though ethical behaviour is based on the individual psychiatrist's conscience and personal judgement, written guidelines are needed to clarify the profession's ethical implications.
Therefore, the General Assembly of the World Psychiatric Association has approved these ethical guidelines for psychiatrists, having in mind the great differences in cultural backgrounds, and in legal, social and economic conditions which exist in the various countries in the world. It should be understood that the World Psychiatric Association views these guidelines to be minimal requirements for the ethical standards of the psychiatric profession.

1.The aim of psychiatry is to treat mental illness and to promote mental health. To the best of his or her ability, consistent with accepted scientific knowledge and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources. To fulfil these aims requires continuous research and continual education of health and care personnel, patients and public.

2.Every psychiatrist should offer to the patient the best available therapy to his knowledge and if accepted must treat him or her with the solicitude and respect due to the dignity of all human beings. When the psychiatrist is responsible for treatment given by others he owes them competent supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help of another colleague.

3.The psychiatrist aspires for a therapeutic relationship that is founded on mutual agreement. At its optimum it requires trust, confidentiality, co-operation and mutual responsibility. Such a relationship may not be possible to establish with some patients. In that case, contact should be established with a relative or other person close to the patient. If and when a relationship is established for purposes other than therapeutic such as forensic psychiatry, its nature must be thoroughly explained to the person concerned.

4.The psychiatrist should inform the patient of the nature of the condition, therapeutic procedures, including possible alternatives, and of the possible outcome. This information must be afforded in a considerate way and the patient must be given the opportunity to choose between appropriate and available methods.

5.No procedure shall be performed nor treatment given against or independent of a patient's own will, unless, because of mental illness, the patient cannot form a judgement as to what is in his or her best interests and without which treatment serious impairment is likely to occur to the patient or others.

6.As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from the compulsory nature of the treatment and if further therapy is necessary should obtain voluntary consent. The psychiatrist should inform the patient and/or relatives or meaningful others, of the existence of mechanisms of appeal for the detention and for any other complaints related to his or her well-being.

7.The psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment. The psychiatrist must on no account utilize the tool of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate.

8.Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient relieves the psychiatrist from this obligation, or to prevent serious harm to self or others makes disclosure necessary. In these cases, however, the patient should be informed of the breach of confidentiality.

9.To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when a case history is released for scientific publication, whereby all reasonable measures must be taken to preserve the dignity and anonymity of the patient and to safeguard the personal reputation of the subject. The patient's participation must be voluntary, after full information has been given for the aim, procedures, risks and inconveniences of a research project and there must always be a reasonable relationship between calculated risks or inconvenience and the benefit of the study. In clinical research every subject must retain and exert his rights as a patient. For children and other patients who cannot themselves give informed consent, this should be obtained from the legal next-of-kin. Every patient or research subject is free to withdraw for any reason at any time from any voluntary treatment and from any teaching or research program in which he or she participates. this withdrawal, as well as any refusal to enter a program, must never influence the psychiatrist's efforts to help the patient or subject.

10.The psychiatrist should stop all therapeutic, teaching or research programs that may evolve contrary to the principles of this Declaration.

Appendix 2

DECLARATION ON THE PARTICIPATION OF PSYCHIATRISTS IN THE DEATH PENALTY

(World Psychiatric Association 1989)

Psychiatrists are physicians and adhere to the Hippocratic Oath "to practice for the good of their patients and never to do harm".

The World Psychiatric Association is an international association with 77 Member Societies.

CONSIDERING that the United Nations' Principles of Medical Ethics enjoins physicians - and thus psychiatrists - to refuse to enter into any relationship with a prisoner other than one directed at evaluation, protecting or improving their physical and mental health, and further

CONSIDERING that the Declaration of Hawaii of the WPA resolves that the psychiatrist shall serve the best interests of the patient and treat every patient with the solicitude and respect due to the dignity of all human beings and that the psychiatrist must refuse to cooperate if some third party demands actions contrary to ethical principles,

CONSCIOUS that psychiatrists may be called on to participate in any action connection to executions,

DECLARES that the participation of psychiatrists in any such action is a violation of professional ethics.