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Attitudes and practices among Ethiopian health care professionals in psychiatry regarding compulsory treatment

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1. Introduction

Involuntary hospitalization and treatment of psychiatric patients represents a major ethical and legal challenge to psychiatry. The Declaration of Hawaii, approved by the General Assembly of the World Psychiatric Association in Vienna in 1983, presents guidelines for psychiatrists involved in compulsory treatment. The Declaration states that involuntary hospitalization or treatment is only acceptable in the context of mental illness resulting in the patient not being able to form a judgment as to what is in his or her own best interest and without treatment serious impairment is likely to occur.

In the present study, a questionnaire, similar to one used in a previous study in Spain (Desviat, Gonzáles, Gonzáles, et al., 1999), South African (Szabo, Kohn, Gordon, Levav, & Hart, 2000), Sweden (Kullgren, Jacobsson, Lynöe, Kohn, & Levav, 1996), and the United States (Kohn, Flaherty, & Levav, 1989), was distributed to Ethiopian psychiatrists and nurses. The specific objectives were to examine how issues of involuntary hospitalization, informed consent, restraint and seclusion, and confidentiality are perceived in Ethiopia by nurses and

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doctors. In addition, experiences of abuse of psychiatry and attitudes towards ethically controversial issues were explored. By examining these issues in different cultural settings with completely different legislation allows an understanding of international norms. Ethiopia, for example, lacks legislation in the field of compulsory care. In the Ethiopian society, individual human rights are seen in unison with the rights of the family. Ethiopia, therefore, provides an opportunity to address what is considered basic ethical clinical practice even in the context of no formal mental health legislation.

2. Material and methods

2.1. *The setting*

Until 1987, modern psychiatric services have been provided at the Amanuel Hospital (the only mental hospital in the country), the outpatient clinic at the Department of Psychiatry, University of Addis Ababa, and the psychiatric unit at a military hospital. All of these institutions are located in the capital Addis Ababa. Amanuel Hospital has 360 beds and the military hospital 30 beds for psychiatric patients. As of late 1986, there were only two indigenous psychiatrists in the country, one working at the university and the other one in the army. For many years, expatriate psychiatrists from Eastern Europe ran the mental hospital. As of 1999, there are 11 Ethiopian psychiatrists in the country all trained abroad; 10 of whom work in the above mentioned Ethiopian institutions and 1 in private practice. The psychiatrist/population ratio is 1:5.4 million, compared to roughly 1:5000 in Sweden. In 1987, psychiatric nurses were trained to provide mental health services to the general hospitals outside of Addis Ababa. Currently, there are 28 psychiatric units at regional hospitals each operated by two psychiatric nurses.

2.2. *The questionnaire*

In addition to basic demographic information inquiring into gender, age, and clinical work setting, the questionnaire was divided into three sections. The first section presented three brief case vignettes (see Appendix A) meant to illustrate a patient suffering from schizophrenia, a mood disorder, and no overt psychiatric disorder. The case vignettes were accompanied by multiple-choice questions focusing on actions that the respondent was ready to take with regard to the patient's behavior and psychiatric symptoms: (a) providing information to the patient on the diagnosis, discussing possible side effects from treatment, and imparting information to relatives; (b) utilizing involuntary admission; and (c) administering medications against the patient's will. The questions also contained modifications to explore if the subject's response would alter if the patient's risk for suicide or violence changed, or if a relative demanded admission or not.

The second section presented 20 ethical issues that the respondents rated from *ethical* to *unethical* on a five-point scale. The third section presented questions on experiences concerning abuse of psychiatry or psychiatric patients due to political, racial, religious, sexual, or

economical reasons. The questions focused on abuse heard of or encountered. The term *abuse* was not explained nor defined, and left to the respondent to interpret and judge.

2.3. Subjects

As Ethiopia has a small number of psychiatrists, psychiatric nurses have an expanded role. The working conditions and responsibility of the nurses at the regional hospitals representing the only psychiatric competence at their general hospitals are similar to those of the doctors. The nurses in the mental hospital also often make decisions regarding compulsory actions due to shortage of doctors at the hospital. As a result, to gain an understanding of clinical decision-making around ethical issues in mental health nurses as well as psychiatrists need to be included.

The questionnaire was distributed to most of the psychiatric nurses in the country during a continuing medical education course. All of the physicians and few of the nurses completed the questionnaire at their work setting. In all, 18 doctors, 9 psychiatrists and 9 residents in psychiatry, and 34 psychiatric nurses completed the questionnaire. Only two of the psychiatrists in Ethiopia did not participate in the study. Among the nurses, half worked at the mental hospital in Addis Ababa and the other half were psychiatric district nurses located at general hospitals throughout Ethiopia. There was one female psychiatrist and eight female nurses among the respondents. The mean age of the subjects was 38.8 years, ranging from 28 to 60 years. The mean ages of the doctors and nurses did not differ significantly (38.5 ± 5.9 and 39.6 ± 7.7 years, respectively). Anonymity was insured by data entry being conducted by a research assistant who had no contact with the respondents and all analyses were ran without identifiers.

2.4. Statistics

Responses of Ethiopian doctors and nurses were examined separately, and contrasted. Categorical data were analyzed by means of Fisher's Exact Test and McNemar's test for paired analyses for the Ethiopian sample. Results of statistical tests with $P < .07$ will be reported due to the small sample sizes. Comparisons of attitudes in the second section using the Likert five-point scale between Ethiopian professionals were analyzed using the Mann–Whitney test.

3. Results

Both the Ethiopian psychiatrists and psychiatric nurses reported being professionally satisfied. Among the doctors, the rate of professional satisfaction was 72% and among the nurses, it was 94.0%. The physicians and nurses had a differing view regarding the quality of psychiatric care in the country, only 33.3% of the psychiatrists saw it as average to excellent compared to 76.5% of the nurses (Mann–Whitney $U = 158$, $z = -3.22$, $P < .002$). Findings for the case vignettes are given in [Table 1](#).

Table 1

Responses of Ethiopian psychiatrists and psychiatric nurses to diagnostic and selected treatment aspects in the clinical vignettes (%)

	Vignette 1		Vignette 2		Vignette 3	
	Doctor	Nurse	Doctor	Nurse	Doctor	Nurse
Correct diagnosis	100	94.1	88.9	88.2	27.8	8.8
Confident of diagnosis	72.2	58.8	50.0	47.1	22.2	23.5
Inform about diagnosis						
Tell patient	61.1	32.4	88.9	67.6	72.2	35.3
Tell family only	27.8	50.0	5.6	11.8	16.7	41.2
Tell no one	11.1	17.6	5.6	20.6	11.1	23.5
When compliance is an issue						
Tell patient	44.4	41.2	72.2	52.9	66.7	35.3
Tell family only	38.9	41.2	22.2	29.4	22.2	41.2
Tell no one	16.7	17.6	5.6	17.6	11.1	23.5
Inform about side effects						
Before treatment	83.3	38.2	83.5	70.6	88.2	26.5
After treatment	5.6	26.5	11.1	17.6	11.8	44.1
On improvement	11.1	32.4	5.6	11.8	0	23.5
Do not inform	0	2.9	0	0	0	5.9
When compliance is an issue						
Before treatment	55.6	20.6	61.1	45.5	58.8	29.4
After treatment	27.8	38.2	27.8	36.4	29.4	32.4
On improvement	16.7	35.3	11.1	15.2	11.8	29.4
Do not inform	0	5.9	0	2.0	0	8.8
Disposition						
Inpatient	77.8	73.5	22.2	29.4	38.9	50.0
Outpatient/day hospital	22.2	23.5	72.3	70.6	44.4	38.3
No treatment	0	2.9	5.6	0	16.7	11.8
Involuntary hospitalization	72.2	56.3	27.8	48.5	27.8	68.8
Family demands it	72.2	48.5	27.8	45.5	44.4	48.5
Inform spouse against patient's wishes						
On admission	72.2	81.8	72.2	82.4	72.2	81.8
If telephones	82.4	66.7	83.3	72.7	82.4	66.7
If it facilitates care	94.1	100	94.4	90.0	94.1	100
If patient is disruptive ^a						
Limit setting	50.0	42.2	50.0	48.5	50.0	42.4
Pharmacological	100	97.1	94.4	94.1	100	97.1
Restraint	88.9	87.9	55.6	75.8	88.9	87.9
Discharge	0	0	0	3.9	0	0

^a Vignette 1 — threatening to others; Vignette 2 — assaultiveness to staff; Vignette 3 — loud and slamming doors.

3.1. Vignette 1: Schizophrenia

Nearly all the Ethiopian respondents recognized the case description as having schizophrenia or being someone with psychosis (96%). Sixty-three percent of the respondents were very confident in their diagnosis. Half of the physicians and only a third of the nurses would have told the patient their diagnosis. Nearly all the physicians (83.3%) would tell a patient

about side effects of medications prior to treatment. For nurses, this was true in only 38.2% (Fisher's Exact Test=0.014). A similar difference was noted between the physicians and the nurses when compliance was an issue (Fisher's Exact Test=0.067). Among the physicians, when compliance became a question they were less likely to discuss side effects prior to treatment initiation (McNemar's $\chi^2=0.063$); the nurses had a similar finding (McNemar's $\chi^2=0.07$).

Over 70% of both groups felt this patient belonged in a hospital, with the majority believing the patient should be involuntarily admitted if need be. If the patient became more violent, the physicians were more likely to agree with compulsory treatment compared to the nurses, such as when the patient threatened the family (Fisher's Exact Test=0.018, doctors 94.4%, nurses 62.5%) or the patient was violent and the family demanded hospitalization (Fisher's Exact Test=0.42, doctors 100%, nurses 78.8%). Nurses did become more likely to agree with committal when the patient's behavior became threatening (McNemar's $\chi^2=0.016$). Family pressure to commit the patient to the hospital did not alter the recommendations of either the physicians or nurses. Involuntary administration of medication, if this was an asymptomatic patient, was recommended by 41.2% of physicians and 27.3% of nurses. This number rose to 94.1% of physicians (McNemar's $\chi^2=0.004$) and 69.7% of nurses (McNemar's $\chi^2=0.001$) if the patient were hallucinating, and 94.4% of physicians and 84.4% of nurses if the patient was violent (McNemar's $\chi^2=0.035$ threatening versus violence among nurses). Physicians were more likely than nurses to recommend use of involuntary medication when the patient was potentially threatening (Fisher's Exact Test=0.052). The nurses were more likely to recommend medicating an asymptomatic patient when other nurses requested (McNemar $\chi^2=0.031$). The physicians did not alter their behavior regarding use of medications when demands by nursing staff were placed on them.

No differences between physicians and nurses were noted with regard to breaking confidentiality by informing the spouse, or with management of disruptive behavior. Over 80% of both groups would have employed use of restraints.

3.2. *Vignette 2: Mood disorder*

Most of the Ethiopian respondents identified the case as having a mood disorder with depression (88.5%). Slightly less than half (48.1%) however were very confident about the diagnosis. Both groups (75.0%) would tell the patient their diagnosis. This was significantly different than with the patient with schizophrenia (McNemar's $\chi^2=0.063$ doctors, McNemar's $\chi^2=0.008$ nurses). Similarly, both doctors and nurses would tell the patient about side effects of medications before initiating treatment. The nurses, however, became less likely to discuss side effects if compliance became an issue (McNemar's $\chi^2=0.012$). There no significant differences between the actions suggested by the psychiatrists or the psychiatric nurses.

Outpatient treatment was recommended by 71.2% of both groups. Both physicians and nurses would be more likely to hospitalize the patient involuntarily the more suicidal they became. If the patient had suicidal ideations but contracted for safety 50.0% of the doctors and 54.5% of nurses would recommend involuntary treatment. If the patient could not contract for safety this rose to 83.3% and 78.8%, respectively (McNemar's test=0.031 doctors,

McNemar's test = 0.012 nurses). If the patient had attempted suicide, 88.9% of the psychiatrists and 93.9% of nurses would recommend committal. The behavior of neither group was altered by pressure placed on them by family members.

Involuntary ECT was suggested by 27.8% of the psychiatrists and 36.4% of the nurses. If the patient developed continuous suicidal ideations, 77.8% of doctors (McNemar's $\chi^2 = 0.022$) and 82.4% of nurses (McNemar's $\chi^2 = 0.0001$) would recommend ECT against the patient's wishes. All respondents would have recommended the procedure despite the patient's refusal if there were repeated suicide attempts.

3.3. Vignette 3: No disorder

In this vignette, only 15.8% of the respondents recognized that the patient might not have a diagnosis. Most, however, were not very confident about their diagnostic decision. The physicians were more likely to agree with telling the patient their diagnosis (Fisher's Exact Test = 0.019). Compliance did not significantly decrease physicians or nurses telling patients about their diagnosis. Physicians were also more likely to discuss side effects with the patient prior to initiating treatment than the nurses (Fisher's Exact Test = 0.0001). The physicians became more reluctant to do so if compliance were to be an issue (McNemar's $\chi^2 = 0.063$). Most respondents, 75.0% of the doctors and 59.4% of nurses, agreed that not refusing to take medications did not imply that the patient had provided consent. If the patient's judgment was impaired, 41.2% of the doctors and 73.5% of the nurses felt that informing the patient about the medication was not necessary (Fisher's Exact Test = 0.034).

The physicians and nurses differed on the need for involuntary hospitalization if the patient refused recommended inpatient treatment (Fisher's Exact Test = 0.008). Physicians were no more inclined to commit the patient if they were assaulted (27.8%), but would do so more readily if the patient struck a family member (55.6%) (McNemar's $\chi^2 = 0.063$). The nurses would have been more inclined (84.8%) to recommend involuntary treatment if the patient had laid hands on the psychiatrist (McNemar's $\chi^2 = 0.039$), but not if they struck a family member (69.7%). In addition, the physicians were more likely to involuntarily hospitalize at the family's request if the patient was aggressive toward the psychiatrist (McNemar's $\chi^2 = 0.063$). The nurses would have responded accordingly to the family's demands (McNemar's $\chi^2 = 0.039$), but also would have taken action upon the family's request based on the case description (McNemar's $\chi^2 = 0.039$). As in the other vignettes, most respondents would have informed the spouse despite the patient's wishes and restrained the patient if aggressive behavior was displayed.

3.4. Attitudes inventory

The results of the 20 controversial statements, scored by the Ethiopian respondents on a five-point scale ranging from *ethical* (1) to *unethical* (5), are presented in Table 2, collapsed into three categories where scores 1–2 represented an *ethical*, 3 a *neutral*, and 4–5 an *unethical* view. The psychiatrists and the nurses differed in their attitudes on a number of issues. The physicians viewed the use of ECT in someone who consented as more ethical than

Table 2

Responses of Ethiopian psychiatrists and psychiatric nurses on the attitude inventory (%)

	Psychiatrists			Nurses		
	E	N	U	E	N	U
Giving ECT to any patient who could benefit from it and consents	83.3	5.6	11.1	39.4	27.3	33.3
Notifying relatives without the patient's permission	44.4	27.8	27.8	58.8	14.7	26.5
Not telling a psychotic patient about the side effects of medications	16.7	16.7	66.7	24.2	24.2	51.5
Physically restraining someone who is out of control	72.2	16.7	11.1	64.7	11.8	23.5
Recommending psychotically ill patients for sterilization	5.6	27.8	66.7	18.8	9.4	71.9
Using depot neuroleptics in chronic psychotic patient who refuses medications who is voluntarily hospitalized	94.4	0.0	5.6	84.8	3.0	12.1
Using depot neuroleptics in chronic psychotic patient who refuses medications who is involuntarily hospitalized	88.9	0.0	11.1	84.8	3.0	12.1
Giving ECT to a patient who could benefit from it and refuses who is voluntarily hospitalized	61.1	22.2	16.7	57.6	15.2	27.3
Giving ECT to a patient who could benefit from it and refuses who is involuntarily hospitalized	83.3	5.6	11.1	66.7	6.1	27.3
Physically restraining someone who is a little disruptive	16.7	22.2	61.1	12.1	12.1	75.8
Hospitalizing someone against their will who is not a danger to themselves or others	27.8	16.7	55.6	33.3	0.0	66.7
Not telling a nonpsychotic patient about the side effects of medication	11.1	5.6	83.3	18.2	18.2	63.6
Hospitalizing someone against their will who is a danger to themselves or others	88.9	5.6	5.6	85.3	0.0	14.7
Recommending abortions for psychotic patients	44.4	33.3	22.2	72.7	12.1	15.2
Having sexual relations with an adult patient who consents to it	0.0	0.0	100	0.0	12.9	87.1
Hospitalizing someone against their will only because the authorities demand it	5.6	11.1	83.3	36.4	9.1	54.5
Hospitalizing a psychotic patient against his will because of family pressure	50.0	33.3	16.7	23.5	23.5	52.9
Having sexual relations with your former patient	0.0	27.8	72.2	3.0	6.1	90.9
Reading a patient's mail	0.0	5.6	94.4	18.2	6.1	75.8
Notifying a patient's employer of the diagnosis	22.2	33.3	44.4	30.3	24.2	45.5

E = ethical; N = neutral; U = unethical.

the nurses (Mann–Whitney $U = 149.5$, $z = -3.08$, $P < .003$). The psychiatrists found recommending an abortion to a psychotic patient more unethical compared to the nurses (Mann–Whitney $U = 192.5$, $z = -2.14$, $P < .04$). The nurses viewed hospitalizing a psychotic patient

against their will because of family pressure as more unethical than the physicians (Mann–Whitney $U=188.5$, $z=-2.32$, $P<.03$).

The respondents were also asked their views on a number of procedures that historically have been used in psychiatry including use of ECT, neuroleptics, psychotherapy, frontal lobotomy, psychosurgery, and hypnotherapy. The psychiatrists viewed the following procedures as always unacceptable in the following proportion: psychotherapy (5.9%), frontal lobotomy (50.0%), psychosurgery (33.3%), and hypnotherapy (6.8%). As for the nurses, the following were always unacceptable: ECT (3.3%), neuroleptics (3.0%), frontal lobotomy (63.0%), psychosurgery (23.1%), and hypnotherapy (10.0%). Significant differences between nurses and psychiatrists were found with regard to the use of ECT (Mann–Whitney $U=193.5$, $z=-1.85$, $P<.07$), neuroleptics (Mann–Whitney $U=212.5$, $z=-2.19$, $z<.03$), and hypnotherapy (Mann–Whitney $U=101.5$, $z=-3.15$, $P<.002$).

A minority of respondents reported abuses in Ethiopian psychiatry. Only a small number reported political abuses in psychiatry (13.7%) and of those who did most stated that this had occurred over 10 years ago. No respondent reported current political abuses in Ethiopian psychiatry. No psychiatrist but 7.8% of the nurses claimed there were racial abuses in psychiatry, and similarly, for religious abuses, 12.1% of the nurses. Sexual abuse of patients was documented by 22.2% of the psychiatrists and 6.1% of the nurses. Half of those who reported this claimed that an incident had occurred in the past year. Economic abuses were reported by 18.0% of the respondents. All the reports of economic abuse were at least 4 years old. Only 11.1% of the physicians and 25.0% of the nurses agreed with the statement that patients' rights were safeguarded in the country; 22.2% of the physicians and 31.3% of the nurses gave a neutral response, while the remainder disagreed.

4. Discussion

We examined to what extent Ethiopian psychiatrists and psychiatric nurses recommended actions against the patient's will, the extent to which they would provide informed consent, and how strongly they protected confidentiality. In addition, we examined their responses to ethically controversial issues, and asked them to report on abuse of psychiatry or psychiatric patients. Although nearly all the mental health providers participated, the small number of respondents is a limitation that needs to be taken into account in interpreting the results. Although anonymity was insured, one cannot dismiss the influence of social desirability. Although case vignettes are an efficient procedure to examine attitudes and potential clinical practice, it remains unclear how closely they approximate actual behavior. The vignettes do not offer all the information one normally uses in making clinical decisions. Despite these limitations most previous reports in the literature on ethical issues in psychiatry focus on only a single dimension, such as compulsory hospitalization (Blank, Vingiano, & Schwartz, 1989), involuntary medication (Schwartz, Vigiano, & Perez, 1988), or restraint and seclusion (Klinge, 1994).

The most consistent difference we found between the physicians and nurses was that the latter was less willing to discuss the diagnosis or side effects of treatment with the patient. As

the nurses, due to the shortage of psychiatrists, have to work and treat patients with little or no supervision, these differences in attitudes about informed consent is an area that should be addressed. Both groups were less likely to inform patients upon initiating treatment of side effects or of their diagnosis depending on issues of compliance and behavior. For example, there was more reluctance to tell a patient with schizophrenia about their diagnosis. The rate of involuntary hospitalization and other forms of treatment rose as the patient became more dangerous to self or others, or was more symptomatic. The use of restraints in nearly all cases where behavior was disruptive may be a reflection of the lack of availability of staff and resources to provide a safe milieu in such situations. Similarly, the high rate of involuntary use of ECT among suicidal patients might be a result of the inconsistent availability of pharmacological agents to address potentially lethal situations.

Compared to the other countries where similar studies have been carried out (Desviat et al., 1999; Kohn et al., 1989; Kullgren et al., 1996; Szabo et al., 2000), the Ethiopian psychiatrists and nurses were more likely to recommend involuntary hospitalization, inform the spouse against the patient's wishes, and apply restraints. Interestingly, unlike in the other countries studied, in Ethiopia the decision to admit was not influenced by family demands. The lack of family pressure influencing decision-making and the willingness to provide information to the spouse despite the patients' wishes may be a reflection that the patient could not have presented for treatment without the family, and that families rights cannot be separated from that of the patient. Due to the lack of mental health services in Ethiopia, almost all admissions are of individuals who in practice would meet criteria for involuntary treatment. There are other factors influencing the decisions made by Ethiopian caregivers; often the patient's family has transported the individual long distances and not to admit him would be inappropriate and nearly impossible. It is therefore unlikely that involuntary care is used inappropriately in Ethiopia.

The fact that only 27.8% of doctors and 8.8% of nurses correctly suggested that Vignette 3 represented an individual with no obvious sign of mental disorder might seem alarming. However, given the circumstances in Ethiopia where only a severely disrupted person with a long-standing history of illness is likely to be admitted to hospital, it is not very surprising that they expect the case to have some kind of diagnoses. In most cases, the respondents also reported that they were less confident in their diagnosis. It is also reassuring that doctors with their more advanced training were more likely to respond that the cases suffered from no mental disorder.

In comparing the Ethiopian psychiatrists in their response to the controversial ethical issues, a number of differences were noted compared to psychiatrists in other countries. The Ethiopians were more likely to view involuntary procedures such as use of depot neuroleptics, use of ECT, physically restraining someone, and hospitalizing someone against their will who is not a danger to self or others as more ethical than other psychiatrists. In addition, they had less ethical concerns about recommending abortions to psychotic patients. Interestingly, although in the vignettes they were less likely to do so than other psychiatrists, they did not view family pressure influencing the decision to hospitalize someone as unethical.

Few respondents reported that they thought that abuse of psychiatry or psychiatric patients was a general problem and few have encountered such problems. The most frequently re-

ported type of abuse was economic. The abuse probably refers to situations where an inpatient's property is stolen or where the patients are fooled into unfavorable economical transactions. In the crowded mental hospital, this is not uncommon. Political abuse as a general problem was reported by four respondents, six had encountered this form of abuse, but in three cases, it occurred more than 10 years ago. In Ethiopia during the Mengisto period (1974–1991), political repression was strong and the mental health services were dominated by psychiatrists from the Soviet Union and other communist countries. It is generally acknowledged, however, that psychiatry was not under the same political pressures as it appeared to be in the former Soviet Union (Adler & Gluzman, 1993; Koryagin, 1989; Lavretsky, 1998). Race problems are said to be relatively small in Ethiopia despite the existence of over 80 different ethnic groups. Abuse of psychiatry based on racism was reported to be a general problem by two respondents and whether this is an unacceptably high figure or a low figure is difficult to say. In Ethiopia, the dominating religions are various forms of Christianity and Islam and in most contexts Christians and Muslims live and work peacefully together in contrast to the situation in other countries in Africa. This fact might be the reason why abuse of psychiatry for religious reasons was the least frequently reported type of abuse. Three respondents reported sexual abuse of patients as a general problem, and five had encountered cases of sexual abuse. Only doctors reported that this was a general problem although equal numbers of nurses and doctors had encountered the problem. It is unclear if these reports are of professionals assaulting patients or of acts between patients. Nevertheless, this is recognized as a problem worldwide (Gartrell, Herman, Olarte, Feldstein, & Localio, 1986; Herman, Gartrell, Olarte, Fedlstein, & Localio, 1987). For various reasons, we chose not to define abuse in this study. The concept is very complex and little is known about its nature. We preferred to explore in general terms to what extent the respondents identified this problem without narrowing or otherwise reframing their own concepts of what they perceived as abuse. Perhaps most disturbing was that only a small number of respondents agreed that patient's rights were safeguarded in Ethiopia.

Overall, there was awareness among Ethiopian psychiatrists and nurses as to the need to protect patient's rights. This study did raise a number of issues that merit further discussion within Ethiopian psychiatry with regard to involuntary treatment and informed consent. It is unclear how formal mental health legislation would alter attitudes and practices, but a forum where such issues can be raised and addressed is needed.

Appendix A

A.1. Vignette 1

A 40-year-old is brought to the psychiatrist. He is dressed in a ragged overcoat, bedroom slippers, and an old hat. The patient is extremely angry and talking in a child-like manner. He is hearing voices, and believes that the government and the police are out to get him. At times, the patient is incoherent and bursts into short speeches on how the government wants

him locked up. He believes his thoughts are being transmitted through the radio to government officials. Even prior to this episode the patient has been socially inappropriate.

A.2. *Vignette 2*

A 40-year-old is brought to the psychiatrist. The patient is a well-known political activist in the union and regarded as a troublemaker by the authorities. Two months earlier, he led a group of workers in a demonstration in order to protest the visit of a radical politician. His family reports that over the past 4 weeks he has not seemed like himself. He is more isolated, has difficulty sleeping, has early awakening, has been eating poorly, and has been tearful. He has also missed many days of work during the past weeks. There has been no evidence of suicidal ideation's nor of a formal thought disorder. The patient states that he will not see a psychiatrist because management will use that to end his employment.

A.3. *Vignette 3*

A 40-year-old is brought to the psychiatrist. Over the last 2 months, he has been making speeches against government policy, claiming that the country has to become racially and ethnically pure. The patient is enraged, talking loudly, without evidence of pressured speech. He is uncooperative during the exam stating that he is not insane and that he is being harassed without any justification by being brought to the psychiatrist against his will. His family had difficulty calming him down in the psychiatrist's office, and reported that they had never seen him this upset previously. They stated that he has held these views all his life. The family denied any previous history of mental disorders nor any current change in mood or behavior at home.

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