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crying out for help from under the rubble and of their utter helplessness to do anything. However, their stories were also of courage and fortitude, of their amazing faith in their religion and God, of their acceptance of the event as an act of God, and of their refusal to apportion blame or show anger towards anyone.

We listened to all the stories. Some people were more vocal and expressive than others. Some wept openly, others sobbed silently. However, everyone we met had a story they wanted to share. Wherever we went people wanted to keep on talking and wanted someone to listen to them. We listened as much as we could. We listened until there were no more stories to tell and no more tears to shed. We listened until we were completely drained emotionally. It was one of the most humbling experiences of my life.

From Castlewood to Kashmir

As I sat there in the camp in Ghari Habibullah, surrounded by the mountains and the stunning scenery, listening to the incredible experiences of these brave people, I could not help but think of my time in group psychotherapy at Castlewood Day Hospital all those years ago. All the processes experienced then could be witnessed here as well, but these were groups beyond training, beyond experiential learning and beyond role-playing.

On the long drive back to Abbottabad a thousand questions crossed my mind. How can so much tragedy befall so many innocent people, so suddenly? What justification is there for so many young innocent children to die? How do you erase the trauma of what your eyes saw, what your ears heard, what your hands felt and what your mind experienced? How does one pick up the pieces of one's life after a calamity of this proportion? Where does one get the strength to carry on after losing one's loved ones, one's house and one's community? Can a people ever recover from a tragedy of this magnitude? Listening to the accounts of these brave people of Kashmir, there is every reason to believe this too can be overcome.

Declaration of interest

None.

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Murad M. Khan Department of Psychiatry, Aga Khan University, Stadium Road, PO Box 3500, Karachi 74800, Pakistan, email: murad.khan@aku.edu

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DENNIS OUGRIN, SEMYON GLUZMAN AND LUIZ DRATCU

Psychiatry in post-communist Ukraine: dismantling the past, paving the way for the future

Ukraine, a nation of 48 million, became independent in 1991 following the collapse of the USSR. Ukraine still lags far behind many European countries in absolute income per capita and indices of transparency and corruption in public life, but its economy, grounded on robust industrial and agricultural resources, has grown 10% annually in the past 4 years. The extraordinary developments associated with the 2004 presidential elections and the Orange Revolution mean that democracy is now at the core of the state-building process and that Ukrainians are ready for radical changes. These changes are bound to include the principles and methods that have long prevailed in Ukrainian psychiatry.

Ukrainian psychiatry has embraced the tenets that guide contemporary psychiatry worldwide, but its roots lie in the psychiatric tradition of the USSR, where the mental health needs of the population were not always seen as a priority. Whether or not Soviet psychiatry can claim any achievement, it did play an inglorious part in the repressive policies of the Soviet state. The collapse of communism brought this chapter to an end, but the legacy of psychiatric practices of the communist period still haunts the countries of the former Soviet bloc. Addressing the lingering consequences of this not-so-distant past plays a major part in the task of developing newer models of mental healthcare in post-communist Ukraine.

Political abuse of psychiatry in the USSR

In the first decades after the 1917 revolution, the newly established Russian Association of Psychiatrists, chaired by Professor Vladimir Serbsky, was instrumental in the establishment of Soviet psychiatry (Fry, 1969). Psychiatric services in the USSR were meant to be grounded on humanistic principles, Pavlovian biological paradigms, the universality of access and, like other Soviet endeavours, administrative-command central planning. Psychiatric care

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should also be free to all those who needed it. Over the years, psychiatric services were centred on hospital care and large in-patient units while psychoneurological dispensaries offered out-patient care. By 1987 there were 335 200 hospital beds in the USSR and 10 million people registered at psychoneurological dispensaries (Zharikov & Kiselev, 1990). Most patients that were seen by these services were genuinely ill and in need of mental health-care, the standards of which could vary across a large territory spanning over 11 time zones. However, despite the altruistic ideals it had espoused at the outset, no historical account of Soviet psychiatry can ignore its association with the suppression of political dissent.

The origins of Soviet abuse of psychiatry date back to the non-medical use of psychiatry in Tzarist Russia (Bloch & Reddaway, 1984). There were reports of single cases of abuse throughout the 19th century, but these became far more frequent after the Bolshevik Revolution. Definite evidence of experimentation with psychiatry for specific political purposes comes from the late 1930s, at the peak of Stalin's atrocities. This involved initially a group of dissenters detained at the Kazan Special Psychiatric Hospital (forensic hospital or 'psycho-prison'), under the jurisdiction of the Ministry of Internal Affairs, and at the Gorky and Chistopol Open Psychiatric Hospitals. Testimonies of people without mental illness imprisoned at Kazan Specialist Psychiatric Hospital during the Stalin years described the influence of the NKVD (People's Commissariat of Internal Affairs), the predecessor of the KGB (*Komitet Gosudarstvennoi Bezopasnosti*), on psychiatrists' decisions regarding admission, diagnosis and treatment of political dissidents.

Forensic psychiatry acquired an important role in these procedures (Gordon & Meux, 2000). Political dissenters were commonly charged under article 70 (agitation and propaganda against the Soviet State) and 190-1 (discrediting the Soviet System) of the Criminal Code (Bloch & Reddaway, 1984). Forensic psychiatrists would be asked to assess those offenders whose mental state the investigating officers had deemed abnormal. Should the psychiatrists fail to agree on a diagnosis or the case prove to be politically sensitive, offenders could be referred to the Serbsky Institute of Forensic Psychiatry in Moscow. The accused had no right of appeal. Although their relatives or other interested citizens could appeal on their behalf, they were not entitled to nominate psychiatrists to participate in the process, given that all psychiatrists were regarded as fully independent and equally credible before the law.

As the system evolved, by the end of the 1950s psychiatric imprisonment became the single most commonly used method of punishing leaders of the political opposition. The subversion of psychiatric intervention for political purposes continued until the 1980s and resulted in long-term psychological dysfunction and social hardship in those who survived it (Adler & Gluzman, 1993). Hospitalised dissidents were routinely submitted to physical, pharmacological and psychological abuse, and the only realistic way out of their predicament was to publicly abandon their anti-Soviet views, and hence be declared 'cured'. Upon their release, dissenters were registered at, and remained under the supervision of, local specialist clinics, whereby KGB officers could persuade psychiatrists to compulsorily readmit them to hospital should they 'relapse'.

> 'Discharge did not bring release from continued threats – and the eroded social networks to which the inmates returned subjected them to a new set of stressors . . .Wives left, people died, friends deserted, jobs evaporated, and often there was not even a home to accept them. Social agencies were either hostile or indifferent to their plight' (Adler & Gluzman, 1993).

International repercussions

As the rate of political hospitalisations in the USSR increased over the years, the rate of incarceration of dissidents via the more politically sensitive judicial process slowed down, a feat which at first was portrayed by the authorities as proof of Soviet democratisation. Information about psychiatric abuse in the USSR only reached the West in the late 1960s (Bloch & Reddaway, 1984). In response to mounting international pressure, a few hospital prisoners were released and some were expelled from the USSR, but the Soviet authorities were reluctant to release sane inmates from the special psychiatric hospitals. Most of those who were released and expelled from the country were either genuinely mentally ill (D.O. met one of these in a UK hospital) or psychologically broken after years of inhumane suffering. Those few whose sanity was confirmed by independent psychiatrists, and who were able to provide a narrative of their experiences, added dramatically to the evidence about the political crimes of the Soviet regime. Their testimonies were widely publicised abroad and broadcast by radio to the USSR.

During the World Psychiatric Association (WPA) conferences in Mexico City (1971), Hawaii (1977), Vienna (1983) and Athens (1989), political abuse of psychiatry in the USSR was repeatedly denounced (http://www.geneva-initiative.org). This prompted the WPA to create a committee of ethics in 1973, followed by a committee to review abuse of psychiatry, in 1979. The Geneva Initiative on Psychiatry was originally the International Association on Political Use of Psychiatry, which was set up in 1980 to combat the political abuse of psychiatry. However, not a single Soviet psychiatrist has ever been brought to account for these practices, nor did the international psychiatric community ever manage to expel the Soviet All-Union Society of Psychiatrists and Neuropathologists from the WPA. Instead the Soviet Society suspended its membership rather than risk expulsion. Some Eastern European psychiatric associations followed suit (e.g. Czechoslovakian and Bulgarian) whereas others preferred to follow the developments.

Meanwhile psychiatric abuse persisted in the USSR throughout the years of the Gorbachev government but now on a reduced scale (van Voren, 1989). In 1988, the Presidium of the Supreme Soviet transferred the jurisdiction over the special psychiatric hospitals from the Ministry of Internal Affairs to the Ministry of Health. This

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included the Dnipropetrovsk Hospital, the only special psychiatric hospital in the Ukraine.

Further changes in legislation were made after delegations from both the Bureau of Human Rights of the US Department of State and the WPA were allowed to visit the USSR in 1989 and 1991 respectively. Imprisonment of political dissenters was curtailed and many political prisoners were released after amendments were made to article 70 and 190-1 of the Criminal Code (Polubinskaya & Bonnie, 1996).

Soviet psychiatric theory

The duration and scale of political abuse of psychiatry in the USSR required the sanction of a formal conceptual framework. Professor A. Snezhnevsky (1968), director of the Institute of Psychiatry of the Soviet Academy of Medical Sciences and the most prominent theorist of Soviet psychiatry, developed a novel classification of mental disorders that postulated an original set of diagnostic criteria. Schizophrenia, for example, was divided in two groups: progressive and continuous. Progressive schizophrenia was further divided into severe, moderate and mild, or sluggish forms. Along with paranoia, sluggish schizophrenia was the most frequently used diagnosis for the psychiatric incarceration of dissidents.

According to Snezhnevsky, patients with sluggish schizophrenia could present as ostensibly sane yet show minimal but clinically relevant personality changes that could pass unnoticed to the untrained eye. Psychotic features were non-essential for the diagnosis, but a carefully crafted description of sluggish schizophrenia established that symptoms of anxiety, depersonalisation, hypochondria or psychopathy were central to it. Symptoms referred to as part of the 'negative axis' included conflict with authorities, poor social adaptation and pessimism, and were themselves sufficient for a formal diagnosis of 'sluggish schizophrenia with scanty symptoms'. Thus patients with non-psychotic mental disorders, or even individuals who were not mentally ill, could be easily labelled with a diagnosis of sluggish schizophrenia. Snezhnevsky's classification failed to encompass the deviancy of all who questioned the ideological values of the state, but the orthodox alternative of being sentenced to a labour camp or to 'internal exile' in Siberia always remained available.

Mental healthcare in post-communist Ukraine

The USSR may have collapsed but old habits – and systems – die hard. Mental healthcare in Ukraine remains essentially state funded and hospital based. Its 87 psychiatric hospitals provide 47 000 beds (9.8 per 10 000 population) and employ most of the 4000 Ukrainian psychiatrists (8.4 per 100 000 population), many of whom trained under the Soviet syllabus (http://www.euro.who.int/mentalhealth/ctryinfo/HFAExtracts?COUNTRY=UKR&CtryName=Ukraine). Pharmacological treatments predominate using older and cheaper drugs, unless patients or their relatives are prepared to pay for costlier options. Some polyclinics offer out-patient care but few non-pharmacological treatments are available and community care is virtually non-existent. An administrative-command system still operates in most post-communist psychiatric hospitals, where authoritarian and arbitrary styles of decision-making and the use of outdated and inhumane treatments are still common (Kosnar, 2003). In post-communist Ukraine, the state security systems have been reformed and there is no evidence of political abuse of psychiatry. However, several cases are reported each year to a specialist legal advisory unit, established by S.G. at the Ukrainian Psychiatric Association, of practising psychiatrists who misdiagnose and mistreat patients for purely financial gains (Korotenko & Alikina, 2002).

Following the dissolution of the USSR, most former Soviet countries gradually drafted their own new mental health legislation (Appelbaum, 1998). S.G. and his team were instrumental in the drafting of the Law on Psychiatric Assistance, which the Ukrainian Parliament approved in 2000. The Law is broadly in line with similar legislation elsewhere in Europe, but there are significant difficulties in translating its principles into everyday psychiatric practice. However, the Ukraine is accessing the European Committee for the Prevention of Torture and Inhumane and Degrading Treatment or Punishment (CPT), which enables monitoring of all facilities in which prisoners or patients are in custody or detained. The CPT has undertaken such visits to the Ukraine and its reports are in the public domain (http://www.cpt.coe.int/en/states/ukr.htm).

Newer policies, priorities and training programmes in mental healthcare will have to account for the unmet needs of the population. The end of communism was followed by profound social changes, but the impact that these changes are likely to have had on those in need of mental healthcare has yet to be fully ascertained (McKee & Fister, 2004). A recent survey of 14 countries, conducted over a 12-month period by the World Health Organization World Mental Health Survey Consortium (2004), indicated an overall 20.4% prevalence of mental disorders in the Ukrainian population, with a 4.8% prevalence of serious mental disorders. Compared with the other countries, the Ukraine had the highest prevalence of mood disorders (9.1%) and the second highest prevalence of substance misuse disorders (6.4%). Only a small proportion (4.9%) of those with any mental disorder had received any treatment during the preceding 12 months, including 19.7% of those who had a serious mental disorder.

A time of transition: joining European psychiatry

Despite chronic underfunding of services and the persistence of obsolete practices (Rupprecht & Hegerl, 2000), Ukrainian psychiatry is striving to catch up with Europe academically, organisationally and in terms of professional

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training and standards of clinical care. The ICD–10 classification of mental disorders (World Health Organization, 1992) has officially replaced Snezhnevsky's nosography, although it has not yet been universally adopted. The transition from centralised control to a social health insurance system, adopting principles of managed care, is under scrutiny (Lekhan, 2004). Training of psychiatric nurses, social workers and community mental health teams has begun in Kiev. Ukrainian psychiatrists are developing new models of delivering services (Mikhailov *et al*, 2001) and devising new strategies for mental healthcare (Lekhan, 2004). To undertake this momentous task, they welcome cooperation with their colleagues from other countries.

As part of this effort, the Ukrainian Psychiatric Association organised the First Anglo-Ukrainian Conference on Psychiatry in June 2004, at the First Kiev City Pavlov Psycho-Neurological Hospital, to promote exchange of information between Ukrainian and UK psychiatrists. Owing to financial constraints only delegates from Kiev City and Kiev Region were able to attend, yet all participants deemed the conference a success and its proceedings are now being used for educational purposes across the country. The topics of the conference included the organisation of mental health services and psychiatric training in the UK and Ukraine, evidence-based principles of clinical management of psychiatric disorders and advances in clinical psychopharmacology. The sessions were followed by debates that highlighted the major challenges involved in reforming mental health services in the Ukraine. This, multidisciplinary teamwork and training, models of community care, and the development of publicly and privately funded mental health services will form the agenda of the next conference.

To prepare for the future, psychiatrists in the Ukraine and elsewhere have the duty to learn from the past. Probably the best option to overcome the legacy of Soviet psychiatry and curtail psychiatric malpractice in post-communist Ukraine lies in the radical reform of psychiatric services and reconfiguration of psychiatric training (Lekhan, 2004). As in other European countries, a new generation of Ukrainian psychiatrists is determined to ensure that the patients they treat receive the best standards of care. In Russia, the success of partnership projects involving UK and Russian mental health professionals has demonstrated the evolving benefits of exchanging experience on good clinical practice and models of service provision between these two countries in a range of specialties (Gordon & Meux, 2003; Bakanov *et al*, 2005). By promoting face-to-face discussion of alternative models of clinical practice and mental healthcare, initiatives such as these can offer Ukrainian and other former Soviet psychiatrists additional tools that may prove instrumental to the reforms that they are so eager to implement.

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S.G. is also a founding member of the International Medical Rehabilitation Centre for Victims of Wars and Totalitarian Regimes.

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Dennis Ougrin Senior House Officer in Psychiatry, York Clinic, Guy's Hospital, South London and Maudsley NHS Trust, London SE1 3RR, **Semyon Gluzman** Executive Secretary, Ukrainian Psychiatric Association, 103A Frunze Street, Kiev, Ukraine, ***Luiz Dratcu** Consultant and Senior Lecturer in Psychiatry, York Clinic, Guy's Hospital, South London and Maudsley NHS Trust, London SE1 3RR, email: luiz.dratcu@slam.nhs.uk

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