

that this diagnosis is not generally applicable to *Falun Gong* practitioners, who are instead alleged to be suffering from a separate and more serious condition (albeit one not recognised in the official Chinese *Classification of Mental Disorders*) for which the term 'evil cult-related mental disorder' has conveniently been coined (Shen & Gong, 2000).

More worryingly, Dr Lee makes no reference in his letter to the reality that the *Falun Gong* practitioners concerned were first arrested by the police, in most cases to prevent them from staging peaceful demonstrations against the Chinese Government's continuing suppression of their spiritual movement nationwide. To our knowledge, the articles from the Chinese psychiatric literature concerning *qigong*-related mental disorder that Dr Lee refers to in rebuttal of the claims of political psychiatric abuse in China do not address the cases of patients detained by the police – they were all apparently voluntary patients. On both the above key counts, therefore, the *Falun Gong* cases (all of whom were reportedly arrested and then forcibly committed) evidently fall into a different category from that with which Dr Lee is personally familiar.

The recently compiled evidence of the state abuse of psychiatry against political dissidents over the past decades (Munro, 2000, 2002), most of which comes from the official Chinese psychiatric literature, is overwhelming in quantity and specificity. Given this past track record, the burden of proof now clearly falls upon the Chinese authorities to convince their own citizens and the outside world that the several hundred reported cases of arrested *Falun Gong* practitioners sent to involuntary psychiatric treatment (see <http://hrreports.faluninfo.net/book4/CategoryIndex.htm>) are, as Dr Lee seems to believe, valid and suitable cases for treatment. The simplest way to do this would be for the Chinese authorities to allow suitably qualified outside observers free access to the *Falun Gong* psychiatric detainees so that their mental conditions can be independently evaluated. Thus far they have shown no such willingness, and several Chinese nationals who tried to document such cases have been jailed.

We acknowledge that Chinese psychiatry as a whole is not generally complicit in these politically motivated distortions of ethical psychiatry and that they are largely (though by no means entirely) confined to

the domain of forensic psychiatry. This was also true, however, in the case of the former Soviet Union and certain Eastern European countries, where political dissidents, religious nonconformists and others formed but a small minority of the overall psychiatric inmate population. Then as now, the key issue is that the numbers of those affected is none the less substantial, and that any psychiatric diagnosis based on politics – whatever the scale – poses a potentially wider ethical threat to the profession. This is why the World Psychiatric Association, through its Madrid Declaration on Ethical Standards (see <http://www.wpanet.org/home.html>), has specifically banned member societies from engaging in politically based diagnosis of any kind.

Finally, the most pressing point to note is that, whereas the incidence of such practices in China had apparently been steadily declining since the late 1980s, the Government's crackdown on *Falun Gong* since July 1999 has resulted in a sharp renewal of politically abusive psychiatry. Failure by the international psychiatric community to speak out clearly against this disturbing trend now could well give the green light to a further expansion of these measures by the Chinese authorities in their ongoing fight against domestic dissent of all kinds.

Declaration of interest

D.L. is a member of Amnesty International and an academic patron of the Friends of Falun Gong UK. R.M. was China researcher for Amnesty International (1986–1989) and principal China researcher for Human Rights Watch (1989–1998).

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Cognitive impairment v. dementia

The February 2002 issue of the *Journal* contained a number of useful reviews of the major disorders that lead to dementia. In his paper on vascular dementia, Stewart (2002) suggested that we need to be 'identifying cognitive decline at a much earlier stage than dementia'. It occurred to me some time ago that the term 'dementia' has outlived its usefulness. It derives from a time when mental health workers were few and only gross changes in mental state were noted and dealt with. It still carries with it the therapeutic nihilism of those times and even the anticholinesterase inhibitors do little to dispel this, as they work for only a minority and for a short period of time. The term suggests a black-and-white distinction ('demented' or 'not demented'). In fact there are infinite variety of shades of grey. I have had a number of experiences of patients being referred as 'demented' largely for 'disposal' and have found that when we have taken them off toxic medication, treated their chronic chest infections, improved their diabetes and hypertension care, reduced the severity of their heart failure, got rid of their anaemia and managed their depression, anxiety or psychosis etc. we have been able to discharge them home or to relatively inexpensive long-term care. I see the person as cognitively impaired, and work to reduce the severity of that impairment – not simply by prescribing anti-dementia drugs. The widespread use of standardised ratings, such as the Mini-Mental State Examination (Folstein *et al*, 1975) and more advanced variations such as Cambridge Examination for Mental Disorder of the Elderly (CAM-DEX; now revised, Roth *et al*, 1999) have greatly improved doctors' ability to screen cognitive function, and while National Institute for Clinical Excellence guidelines encourage us to think of a specific score that delineates those with dementia from those without dementia, we are all aware that this is driven by accountancy rather than by medicine. At a practical level it is possible to get through the working week without using the term dementia and more accurately convey the person's mental state by speaking of cognitive impairment and elaborating on which areas are intact and which are dysfunctional.

Having written the above I feel some reluctance to post it as I think it is likely to raise more hackles than nods of agreement. It is as if I have suggested putting down a

much loved but ancient family dog just because it is no longer able to deter burglars and chase cats. I hope that in my lifetime we will have developed drugs that will prevent the onset of disorders that lead to dementia. When an effective cocktail of cleaving agents, anti-oxidants, free-radical scavengers and neurochemical enhancers is available we will all be having our cognitive

functioning tested by primary care on an annual basis much as we do now with our blood pressure. The ageing pooch will then die quietly in its bed.

Folstein, M. F., Folstein, S. E. & McHugh, P. R. (1975) 'Mini-Mental State': a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**, 189–198.

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One hundred years ago

Insanity and the death penalty

SIRS: – I have read with interest Sir W. T. Gairdner's letter in your issue of July 26th, p. 242, but I cannot agree with him that any idea of vengeance is present in the punishment meted out to the criminal by the State. Vengeance is entirely a personal emotion but the State knows no such passions, being impersonal, and in a strictly impartial manner enforces by suitable punishments the laws it has enacted. If the punishments do not have the desired deterrent effect they may be useless, but I submit that they cannot be regarded as State vengeance

on the criminal. It is true that the poet speaks of "the wild justice of revenge", because the act of the vengeful man and that of the State may equally deter from crime, but the motives of the act in the two cases are altogether different. With regard to verdicts, "Guilty, but insane", they would be contradictory under the present law. If a criminal is insane in the legal sense he cannot be guilty in the eyes of the law. That the legal definition of insanity in McNaughton's case is by no means in accordance with our present knowledge of mental disease may be readily admitted, but none the less I am one of those who do not think

that the public safety will gain by modern views of mental pathology being permitted further to diminish criminal responsibility.

I am, Sirs, yours faithfully,

Hackney-road, N.E., July 26th, 1902.
M. GREENWOOD

REFERENCE

Lancet, 2 August 1902, p. 313.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigendum

Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *BJP*, **180**, 234–247. The sixth author's name should read: D. Glaser.