

Navigating the Libido Dominandi: Intricate Realities of Forensic Psychiatry Research Ethics in Zimbabwe

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Abstract

The purpose of this report is to present the inherent ethical issues experienced in conducting forensic psychiatry research in special institutions Zimbabwe. The inertia of the habitus of forensic psychiatry research ethics has consistently been acknowledged as a rather complex conundrum in literature. Zimbabwe is no exception. In Zimbabwe, the precarious double bind exposure of the objectified and disempowered forensic psychiatric patients creates a hysteretic research ethical terrain or platform for the researcher. The platform is such that the Ethical Review Board in medical research gives the researcher ethical approval to carry out a research study on forensic psychiatric patients. The reality on the field is that these potential participants (patients) are gagged by the environment in which they are being cared for. The environment is such that the researcher can only congregate with a forensic psychiatric patient for interview provided the researcher has violated all the provisions of the Belmont Report of 1979. This labyrinthine ethical excursion is a result of symbolic assertion of power and struggle for legitimating between the prison system, the judiciary and the medical system. This scenario then calls for collaboration as academia, practice, professional organizations and regulatory bodies to untangle this intricate ethical web.

Keywords: Forensic psychiatry; Zimbabwe Mental Health Act; Zimbabwe Prison Act; Zimbabwe Prison Service Standing Orders; Forensic psychiatric patients; Special institution; judiciary; Medical system; Medical Research Council of Zimbabwe; Prison system

Introduction

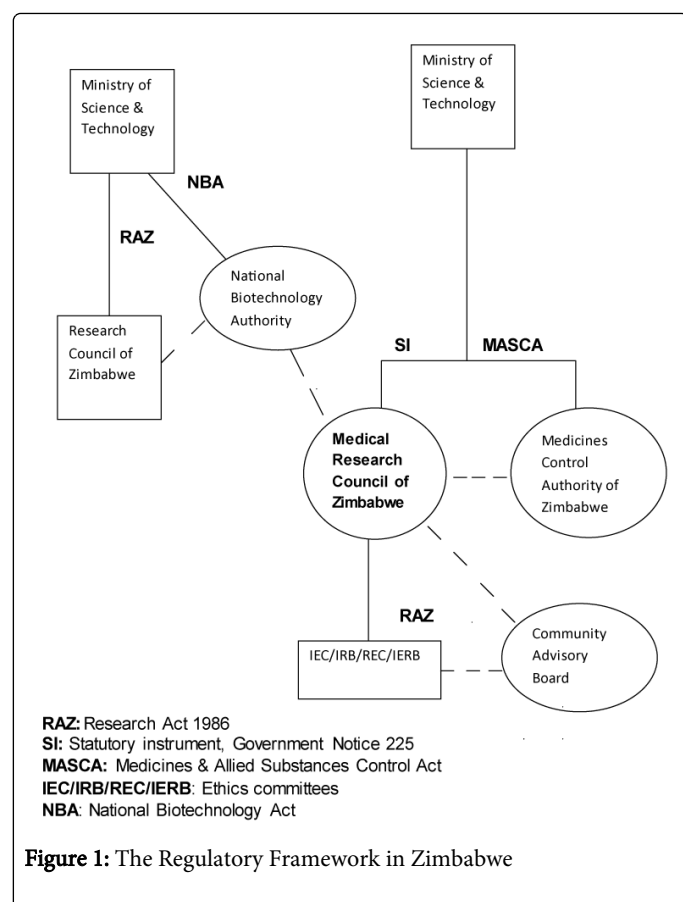
Little attention has been given to ethical dilemmas that are specific to forensic psychiatry in view of mainstream bioethics. This has called for an interdisciplinary research that explicates the link between the criminal justice system and forensic psychiatry [1-3]. It is also unfortunate that if researches are done at all in the area of forensic psychiatry, they are not published [4]. Ethics that are specific to forensic psychiatry are limited to assessment and treatment procedures. Research ethics seem to be ignored [5]. Specifically points out that the energy on forensic psychiatry ethics is biased towards clinical practice and consultancy. This then contributes to the obscurity of forensic psychiatry research and its attendant ethical issues. The bone of contention is that there are inherent competing interests between the health systems and the judicial systems which render forensic psychiatry a 'moral minefield'. The complexity of the issue is compounded by the fact that forensic psychiatric settings are viewed by society as places that should have custody of unlawful, untrustworthy people who are risk to others. This could be the reason forensic psychiatric settings are located in maximum security prisons where they exist as bastard 'orphans' that neither the prison system nor the health system wants to claim as their heirs [4]. In line with this forensic psychiatry research predicament [5]. Points out to the need for ethical guidance that is pertinent to prohibitive circumstances encountered in forensic and correctional research.

In this report, the author sought to present the inherent ethical issues experienced in conducting forensic psychiatry research in

special institutions. The report also borrows from and uses the language from the conceptual canon of Pierre Bourdieu, a French philosopher [7]. His concepts of dominance, field, capital, symbolic violence and symbolic suffering seem to speak directly to the ethical realities in forensic psychiatric research in Zimbabwe. The actual research study that was the basis of the described ethical conundrum sought to develop a constructivist interpretive based medico-judicial framework for rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe. This report focused on the ethics that applied to forensic psychiatric patients as participants in that particular research study. The following is the background that highlights medical bioethics against which the ethical challenges in forensic psychiatry research are discussed (Figure 1).

The Regulatory Framework related to medical research in Zimbabwe

The regulatory framework below shows the position of the Medical Research council of Zimbabwe and how it is related to other organs and statutes which control research activities in Zimbabwe. Medical research Council of Zimbabwe is central in the ethics discussed by this report.



Courtesy of Ethics Guidelines for Health Research Involving Human Participants in Zimbabwe Version 1.4 (2011)

The Medical Research Council of Zimbabwe

The setting of the special institution breeds a complex ethical terrain for the researcher. Before the researcher can reach the special institution, he or she has to be given ethical approval by the country's National ethics committee. This committee is called the Medical Research Council of Zimbabwe established in 1974 in terms of the Research Act of 1959 and the Government notice number 225 of 1974 to provide researchers in health issues with autonomous advice on the researches that one might want to conduct (Ethics guidelines for health research involving human participants in Zimbabwe 2011).

Basically, research ethics in Zimbabwe is informed by both national and international codes like the Belmont Report of 1973, the Nuremberg Code of 1949 and the Declaration of Helsinki of October 2000. The Universal Declaration of Human Rights of 1948 functions as an adjunct to these key texts. Of these the Declaration of Helsinki is biased towards clinical trials in Zimbabwe and the other two instruments run across all types of research in Zimbabwe (Ethical guidelines for health research involving human participants in Zimbabwe 2011:35-36). This report, however, refers to the latest versions of the Belmont Report (1979) and the Declaration of Helsinki adopted in 1964, revised and clarified in 2013.

Zimbabwe is also currently guided by a national policy document that was tailor made to suit the specific needs for ethical practice in research in Zimbabwe. The policy document is called Ethical

Guidelines for Health Research Involving Human Participants in Zimbabwe (Version 1.4 of 2011). Medical Research Council of Zimbabwe which is the National Ethics Committee directs the Institutional Review Boards in Zimbabwe by promoting accrediting and monitoring that these Institutional Review Boards are functioning within such relevant legislation, regulations and ethical guidelines and standards.

In a typical forensic psychiatry research which includes forensic psychiatric patients, the Council demands to be informed on how the participants will meet the inclusion and exclusion criteria and how the patients are to be ethically protected. In the study encapsulated in this ethical discussion, the researcher was asked, after submitting the proposal, to be more specific on the criteria of a mentally stable male forensic psychiatric patient. On this aspect, the final agreement was that the attending psychiatrist assessed the patients' mental state (e.g. mental stability). Those patients for whom the psychiatrist had made a written report to the Special Board as well as those whose reports had been sent to the Mental Health Tribunal by the Special Board to the effect that they were now mentally stable would be included.

The Medical Research Council of Zimbabwe also prescribed what course to follow in case of serious adverse events, modifications of the Protocol and conditions of termination of the study. The approval for the study discussed in this report was granted subject to completing and meeting the requirements for the Medical Research Council form 101, study protocol and informed consent form. This specification by Medical Research Council was the same as that required by Principle 22 of the 2013 revised Declaration of Helsinki.

The genesis of the ethical conundrum

To contextualize the ethical terrain specific to forensic psychiatry research ethics in Zimbabwe, a brief introductory account of the evolvement of forensic psychiatry in Zimbabwe will be discussed.

Evolvement of forensic psychiatry in Zimbabwe

Before 1908, In Zimbabwe, the then Southern Rhodesia, no psychiatric hospital existed. Gaols (prisons) served as detention institutions for psychiatric patients. Psychiatry evolved through the guidance of the Lunacy Ordinance Regulations of 1908, the British Mental Health Act of 1930 and Mental Health Act of 1976. All these legislative instruments repealed each other [8]. Currently, both general psychiatry and forensic psychiatry are driven by the Zimbabwe Mental Health Act, (Statutory Instruments15) of 1996, Zimbabwe Mental Health Regulations (Statutory Instrument 62) of 1999 and the Zimbabwe Mental Health Policy of 2004. Part 3 of the Act addresses forensic psychiatric patients. The provisions of part 3 of the Act provide a port of entry for the rehabilitation of forensic psychiatric patients as functional members of society. These forensic psychiatric patients are admitted in what are called Special Institutions in Zimbabwe. These institutions are hospitals located within a maximum security prison setting. This is the setting where forensic psychiatry research ethics discussed in this paper is situated.

Zimbabwe has two special institutions one in the northern region and the other in the southern region. The special institution in the northern region was gazetted in Parliament as a special institution on 18 February 2000 by the then Minister of Health and Child Welfare in terms of Part 14 Subsection 1 of Section 107 of the Zimbabwe Mental Health Act of 1996 and with the approval of the Minister of Justice, Legal and Parliamentary affairs. The gazette of the institution was

specific to its use for detention of forensic psychiatric patients in terms of the Act. The southern region special institution had been gazette earlier for the same purposes in 1978 [10].

It is also important to note that while the patients are admitted in the special institution, instruments other than the Zimbabwe Mental Health Act of 1996 and the Zimbabwe Mental Health Regulations of 1999 also apply to the same patients. These are the Zimbabwe Prison Act and the Zimbabwe Prison (General) Regulations of 1996 (1996:24). These two instruments are operationalised by what is known as the Zimbabwe Prison Service Standing Orders or the Commissioner's Standing Orders of 1992. Section 21 subsections 1 of the Zimbabwe Prison Act Chapter 7:11 empower the Commissioner of Prisons in consultation with the relevant Minister of Justice, Legal and Parliamentary Affairs to make Standing Orders without necessarily going through publication in the gazette. So the Commissioner of Prisons has the power to incorporate Standing Orders that may have been made previously for the smooth administration of the prison. In fact, this arrangement seems to be the source of the challenges encountered in forensic psychiatric research processes in special institutions in Zimbabwe [10].

The ethical bailiwick related to Zimbabwe Prison Services

The Zimbabwe Prison Services which at the time of the study was changing its name to Zimbabwe Prisons and Correctional Service was established under the Constitution of Zimbabwe. At the time of the study, the Prisons and Correctional Service were under the Commissioner-General. The special institutions where forensic psychiatric patients are being rehabilitated were housed under the Prison and Correctional Service. This means that permission to conduct the forensic psychiatry research on rehabilitation of forensic psychiatric patients is sought from the office of the Commissioner for Prisons and Correctional Service. This permission was granted from a department called Research and Development which functioned as the Ethics Review Board for prison services research from the Commissioner's office. This permission implied that the researcher could interview forensic psychiatric patients who met the criteria for the research study as stated in the proposal.

The height of the legislative ethical conundrum

The realities of forensic psychiatry research ethics were embodied in objectification and disempowerment of forensic psychiatric patients (and indirectly the researcher) and the classification system of the patients in special institutions.

Objectification and disempowerment of forensic psychiatric patients

Forensic psychiatric patients are expected to be empowered by the Zimbabwe Mental Health Act of 1996 as specified at the gazette of the special institutions. The implementation of that specification gets mixed up as soon as the patient reaches the special institution. Patients experience dynamics of objectification and disempowerment that directly spill into the research process. Objectification and disempowerment are embodied in the prison system's power to attach meaning and value and power to manipulate the business within the prison system setting. In this case that of research activities within the special institution. That symbolic power dynamic seems to emit symbolic violence in the form of domination of the application of the Zimbabwe Prison Act of 1996 that nullifies the interests of research

endeavours. The nullification interferes in the long run with efforts towards patient recovery [11,12].

The prison system does this by assigning forensic psychiatric patients prison numbers and classifying them according to crimes they have committed. The classification is derived from the Zimbabwe Prison Service Standing Orders Part IX Section 164 subsection 4. Most patients in special institutions or all forensic psychiatric patients who participated in the study had committed murder and were therefore classified as D-class. This part of the Zimbabwe Prison Service Standing Orders also applied to forensic psychiatric patients and the instrument derives from and operationalises the Zimbabwe Prison Act 1996 Part X section 63 subsections 2 paragraphs.

The classification system discourse

The classification system is brought to the fore by specifications of Part II Section 73 of the Zimbabwe Prison Service Standing Orders of 1992 [13]. This section spells out that no D-Class prisoner shall ever be sent outside the prison buildings without the authority of an officer of the rank of Chief Superintendent and above. A D-class prisoner is cared for in a Grade 4 prison according to Part VI Section 130. A Grade 4 prison's administration is completely secure as specified in Part II Section 20 (d) just as a Grade 3 Prison according to Part II Section 20(c) (i). In the study conducted, the special institution in the southern region was a Grade 3 prison while the special institution in the northern region was a Grade 4 prison. The classification system and its attendant security requirements concur with Holmes & Murray [14] who expressed that in forensic psychiatric settings, patients are held captive and penal sanctions applied to them. As a result forensic psychiatric patients exist in limbo between irreconcilable exigencies of rendering care while ensuring custodial tucking 'away' of patients to protect both sanitary and political interests of society [5]. suggested the need for interdisciplinary coalitions that should clarify how various legal decisions applied to forensic psychiatric patients can be harmonized especially with regards to judicial security and important ethical standards.

The implication of the classification system to research and research ethics

As specified in the Zimbabwe Prison Service Standing Orders, Part VI Section 129 Subsection 5 which applies to Grade 3 prisons, 'all interviews (including research interviews) shall be in sight and hearing of a prison officer who understands the language spoken The interview shall take place in a room or some form of enclosure. At least a table should separate the parties'. This was the experience in the southern region special institution. Subsection 6 of the same instrument which applies to a Grade 4 prison, in this case the special institution in the northern region specifies that 'all interviews shall be conducted in sight and hearing of a prison officer understanding the language spoken. The interview is to take place in the visiting room, the parties being separated and battery screening used'.

Part VII, Section 138 subsection 5 of the same instrument specifies that 'Class D prisoners (in the study were the ones who met the inclusion criteria) will see one visitor per visit and the duration shall not exceed 15 minutes. Each visit will be in the presence and hearing of the prison officer who understands the language. The parties will be separated by two sections of battery screening 1 metre apart. The area between the parties will be supervised by a prison officer and the prisoner will be under escort'. All these legal requirements technically

violated the provisions of the Belmont Report of 1979. This disjunction between the research ethical requirements and the provisions of the Zimbabwe Prison Service Standing Orders was supported by the notion that in Africa, ethical controversies present themselves against the use and application of conflictual legal and policy frameworks [4].

Weistock highlighted that ethical problems in forensic psychiatry are tied to the manner in which interviews are conducted and how the solicited information is processed. Although the author was referring to interview related to assessment and diagnoses, the problems can also be applied to forensic psychiatry research especially to the research study to which ethics discussed in this report are related. The picture painted by the processes explained above is underscored by Munthe, Radovic & Anckarsater (2010:35) who points out that the dual role conflict that underlines forensic psychiatry research is 'more complicated than acknowledged' [5].

The ethical antithesis

Part 13 of the Belmont Report of 1979 specifies that basic ethical principles are to be observed in the protection of human subjects of biomedical and behavioural research. The Belmont Report in this quest is supported by the Declaration of Helsinki of 1964 that has been revised in October 2013 at the 64th WMA General Assembly in Fortaleza Brazil. The Medical Research Council of Zimbabwe generally derives its ethical requirements from these two instruments. The principles basically include respect of persons, beneficence and justice. These provisions are breached by the power differential emanating from the double bind position of the forensic psychiatric patients [15].

Respect of persons (embodiment of misrecognition)

Respect for persons is embodied in treating participants as autonomous agents and protecting those with diminished autonomy (Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe Version 1.4 of 2011:4). In this particular research study, the researcher met the requirement for respect of persons by involving forensic psychiatric patients who met the inclusion criteria as follows:

Male patients admitted at the two special institutions at the time of the study.

Patients were above the age of 18 years.

Mentally stable patients: The attending psychiatrist of the patient assessed the patients' mental state (e.g. mental stability) and only those for whom the psychiatrist had made a written report for the Special Board or the Special Board had made written report to the Mental Health Review Tribunal to the effect that they were now mentally stable were included.

Patients must have been able to express themselves in Shona, IsiNdebele or English.

This criterion was approved by the Medical Research Council of Zimbabwe and an approval letter written to that effect. During the study forensic psychiatric patients who met the inclusion criteria were able to independently sign the consent forms. The Zimbabwe Prison Service, deriving from the Zimbabwe Prison Service Standing orders breached the autonomy of forensic psychiatric patients during interviews by demanding the presence of a chaperon in form of a guard during the interview. Respect for persons also points out that even prisoners should not be deprived an opportunity to participate in

research and that competing claims on respect of persons should be balanced, in this particular study, balancing the prisoner/patient phenomenon (Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe Version 1.4 of:4). By being present at interview, the prison system seemed to be denying the forensic psychiatric patients an opportunity to freely participate in the study. The hegemonic forces represented by the violation of respect for persons within the prison system results in what Bourdieu refers to as misrecognition. The misrecognition is specifically directed at the researchers who are supposed to be championing the observance of forensic psychiatric research ethics. Misrecognition culminates in dominance and reproduction of the interests of the prison system. This dominance and its reproduction underlines the established order of current intricate realities in the of forensic psychiatric research ethics in special institutions. This is all viewed by forensic psychiatry research ethics as symbolic violence in the sense that it deprives the forensic psychiatric patients of meaningfully contributing to issues involving their care [16].

Beneficence (embodiment of symbolic violence and symbolic suffering) Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe Version 1.4 of (2011:5) specify that beneficence is about "making efforts to secure their (participants) wellbeing." For this study, the permission from Medical Research Council of Zimbabwe was meant to allow for a research that would improve the quality of life for forensic psychiatric patients through development of a therapeutic jurisprudent medico-judicial framework. In forensic psychiatry research under discussion, it would seem like the reverse is true. Forensic psychiatric research in special institutions seems to depart from the Hippocratic principle of *primum non nocere*. This means that the presence of the guards during a research interview is meant to protect the interviewer from the forensic psychiatric patient instead of the other way round.

In line with this occurrence, Ward and Willis contends that researchers who wish to utilize interview based approaches in research in forensic psychiatric settings are faced by a situation where mistrust and fear prevail and this tends to override the interests and needs of forensic psychiatric patients. The guards' audience also could have caused emotional and psychological harm to the participants in that they wouldn't be free to express what they wanted to say, envisaged as a form of exploitation or symbolic violence as it were.

Justice (the complete oeuvre of ethical hysteresis)

In the research study under discussion forensic psychiatric patients were selected on the basis of meeting the selection criteria for the variable of interest (their rehabilitation) and not because they were in a vulnerable position (Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe Version 1.4 of 2011:5). Forensic psychiatric patients also were likely to benefit from the exploits of the research in question in the form of a therapeutic jurisprudence to which they would have contributed.

In the relevant research study the specifications of the Zimbabwe Prison Service Standing Orders directly violated or departed from provisions for privacy and confidentiality by demanding presence of guards during interviews. Presence of guards also violated distributive justice because if forensic psychiatric patients were not free to discuss issues affecting them with the researcher, they were unlikely to benefit from the advances of the research because it would have been intruded and therefore censored and un exhaustive. Forensic psychiatric patients as participants and the researcher were caught up in a double

bind or hysteretic situation where they were expected to align to both of the contradictory functions of the bioethical requirements of the Belmont Report ideal and the statutes regulating prison system where the research was being conducted. The result of this double bind or hysteretic scenario bred some kind of research ethical schizophrenia whereby the context in which forensic psychiatric patients were cared for and expected to participate in research from was at a punitive tangent. As such, participant patients and the researcher experienced symbolic suffering. This means that as a consequence of exigencies of a prohibitive research environment, the researcher and participant forensic psychiatric patients lived the experience of enduring to abjection, domination and repression of autonomy and agency in which there were accompanying feelings of humiliation and despair [18,19].

The role of capital in the navigation

The researcher had to negotiate or navigate this libido dominandi by using the cultural capital that she possessed.

The cultural capital

Bourdieu explained that cultural, social and symbolic resources are tapped from by individuals and groups so that they can fit into certain positional requirements in the social order in which they find themselves in. The label attached to these resources is capital. The amount of capital an individual possessed then determined their leverage in that social order. Grenfell points out “capital has the value derived from the field as recognised, acknowledged and attributed currency of exchange for the field so that it is able to organize itself and position those within it according to its defining principles.”[18].

In the prison system field which was the dominant field imposing prohibitions with regards to research processes, the researcher possessed cultural capital that was recognised and acknowledged by the prison system so that the possessed capital was able to ‘buy’ some semblance of understanding between the researcher and the powers that be. The primary cultural capital was embodied in letters of approval from the office of the Commissioner of Zimbabwe Prison and correctional Services. The letters became valued capital especially considering that the researcher did not expect that at any one point during the study, they would have to revoke the latent clauses in the approval from the Commissioner that had inherent authorization to conduct interviews with forensic psychiatric patients. In other words by granting permission for the research to be undertaken, the implication was that every aspect of the research proposal, including the methodology that applied to data collection procedures and ethical specifications, applied.

The secondary cultural capital was that the researcher was already familiar with players in the then prison system related to forensic psychiatric care and practice. The researcher was already involved in the system of both general and forensic psychiatry. This made the researcher aware of how the system worked. Also, at the time of the study the researcher was a senior government official at the National Referral Psychiatric Civil hospital where special institutions referred the forensic psychiatric patients as the end point or pending their discharge into the community. This situatedness of the researcher therefore seemed to have influenced how the prison system staff reacted to issues of security. The researcher was at least able to successfully negotiate the removal of guards during interviews but

physical barriers remained for forensic psychiatric patient participants [20-28].

Conclusion

Forensic psychiatric patients as participants in forensic psychiatric research in special institutions in Zimbabwe are almost ethically inaccessible. This ethical conundrum therefore calls for collaboration as academia, practice, professional organisations and regulatory bodies to untangle this intricate ethical web. This will then foster a therapeutic jurisprudence as the patients participating in research would be in a position to articulate realities of their current ineffective rehabilitation processes and co-construct a preferred future rehabilitation discourse.

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