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# Differential ethics in global mental health

## ABSTRACT

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Advancing the opinion that global mental health supersedes public and international levels and deals with an integrative approach, this paper elaborates some of the implications of a differential ethics theory as outlined by H.M. Sass. Rejecting the extremes of moralizing generalizations and narrow scientific stances, it considers the need for cultural competence and praxis-relevant thinking in ethical evaluation. This does not only apply to the relationships between experts and lay people but also to the pluralistic constitution of ethics committees, in which different epistemic and value cultures must be integrated along a continuum of decision making processes including deontological and teleological stages.

**Key Words:** Differential ethics, global mental health, epistemic cultures

## Introduction

This paper aims at placing the contribution of Hans-Martin Sass in the context of global mental health research. The usual treatment of this topic is generally confined to psychiatry as a medical specialty (1). Although wider presentations have been made, including the special problems and priorities in low-income countries (e.g. 2), an adequate conceptualization of ethical dilemmas globally needs a careful reappraisal of concepts and definitions appropriate for an ethical analysis of population health and cultural diversity. The main obstacle for an analysis at this level requires an understanding of medicine and public health as scholarly fields (3).

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This presupposes an analysis both of individual cases and of population dynamics. Topics such as cultural validity of diagnostic labels, provision of services, and revision of current practices need a fresh insight into the particular challenges present in diverse environments (4). The very notion of a differential ethics is a useful insight into some of the problems we deal with.

## **Mental health: public, international, global**

The definition of mental health is still uncharted territory. It may well be an oxymoron perpetuated by language usage, since it tacitly establishes a distinction. If there is a mental health, then it is possible to think of a type of health that is non mental. This distinction finds no support in advocates of “biopsychosocial”, “holistic” or “integrative” models. They are language constructs based on a juxtaposition of discourses that may sound theoretically reasonable in view of the practical dualism that pervades medical thinking. But in practice, no somatic complaint exists without being at the same time a problem of the person who experiences it. The mere fact of communicating it is already a mental state or mental event. Recently, Galderisi et al. (1) have proposed a new definition of mental health that moves away from the eudemonistic notion that only positive feelings characterize mental health and that wellbeing and happiness are the cornerstones of good mental health. This deeply valoric underpinning is reinforced by the fact that current definitions and suggestions for intervention in case of illness stem from one particular tradition- Western thinking- and does not do justice to the many variants and differences to be found in other cultural contexts. The definition proposed states: “mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize. Express and modulate one’s own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium” (1, p.232)

This definition represents an advance with respect to others and it explicitly incorporates something resembling a transcultural concept. When it comes to its application to societal affairs, however, it may need some refinement and expansion. For instance, it needs to consider issues at the population level, in the field of public mental health (2). In this area, despite the importance of individual feelings and ability, it is the community effort that matters in order to prevent illness and promote wellbeing and health. Inequities in access, hardships due to forced

migration, conflict and natural disaster need to be conceptualized and approached from a social point of view. Economic and cultural determinants of health cannot be treated as dependent upon individual skills. Quality of life depends on factors beyond the competence of a single individual. These factors are preconditions for personal health. Even the healthiest individual may, under different forms of social stress, experience breakdown or illness.

There is also a field of international health, characterized by the development of standards derived from professional expertise and proposed by international agencies such as the World Health Organization with the intention of closing the 90/10 gap, the fact that 10 per cent of the world population receive more than 90 percent of research effort and has access to the goods of the civilizatory process.

Global mental health, in our view, goes beyond these levels. It is global not only for trying to be universally applicable in terms of geography or nationality. It is also global in the sense of covering all aspects of human life. The main consideration is the fact that human life is quite different in different contexts. Cultural and socioeconomic factors contribute to diversity both in the motivations and in the ways people get sick. The pathoplastic influence of culture, economy, tradition and education shapes the ways illness is manifested, conceptualized and dealt with. It is also possible to argue that, in a given context, the possibilities for expression are finite. The repertoire of symptoms and demands for help is limited.

### **Ethical analysis: the contribution of differential ethics**

Sass (3) argues convincingly that at least three levels of ethical analysis can be discerned in social discourse. The first, and most general, resembles the raw products that enter the industrial process. They are linguistic constructs of such character that anything can be derived from them. The usual moralizing discourse of many people, sometimes without awareness on the part of those who use it, employs words such as dignity, autonomy, beneficence and others at such a level that covers all situations and it is useless for decision making.

The second level is that of the intermediate principles. They include professional rules of conduct, normative propositions and other linguistic constructions amenable to a more restricted interpretation and which can be backed up with common sense experience.

These two levels, important as they are in a deep analysis, are insufficient for a differential consideration of concrete actions and local practices. Here, technical expertise and direct experience are needed to rightly evaluate appropriateness and

ethical perspectives. At this level, the specifics of context and situation must be incorporated to the analysis.

It is clear that such an insight demands that only persons in possession of skills and expertise should be granted the possibility to participate in ethical evaluation or consultation processes, an opinion also shared by Zaner (4) in an insightful critical analysis of the role of professional philosophers and ethicists in health care and research.

The field of global mental health, characterized by both technical skills and cultural competence on the part of its practitioners, is particularly in need of a clear demarcation between moralizing generalizations and precise ethical analysis. The differential ethics advocated by Sass in a comparison with the differential diagnosis of medical practice is a powerful tool for identifying and avoiding the typical extremes now pervading the field. This is either conceived simply from the perspective of the so called basic biological sciences (neurosciences in particular), disregarding the cultural-emotional component of health-related encounters, or is plagued with sentimental considerations regarding the need for equity and respect for human dignity. Between these extremes, one scientific and the other political, a paradigm might be constructed that recognizes the value of basic research and at the same time considers empathic understanding of different living conditions and cultural traditions. This does not simply mean to change the paradigm of psychiatry as it pertains to global issues (5). It demands a truly humanistic reflection on human life under different conditions and a consideration of both fact and belief in the architecture of practices and social mores.

### **Basic considerations: moralizing versus ethical analysis, deontology versus teleology, primacy of praxis**

The differential ethics approach demands recognition of some fundamental issues.

There is always a complex relationship between actors in a dialogue. Moralizing is a tendency towards hegemonic discourses. It presupposes a superior position on the part of the speaker who dictates the rules and norms. This applies both to instrumental values and to fundamental or intrinsic human values. The field of mental health, as portrayed in the discourse of international organizations and technical psychiatric jargon, assumes that definitions of illness or sickness, the meaning of outcomes in interventions, and the prognosis are to be rooted in the hegemonic discourse of Western biomedical science. Other voices are repressed or treated as mere belief without practical implications. Thus, the contribution of a differential ethics approach

might consist in the recognition of essential pluralisms and the acceptance of different moral universes in different communities. Principles and norms are necessary when diversity prevails. Virtues, considered as acquired human qualities, can be demanded when overall consensus is present. Upstream determinants of health- such as income, gender, and culture- must be considered along with downstream implications of the results of scientific inquiry and political regulation of practice.

There are always different stages in ethical reasoning. Some of them are deontological, that is, guided by conviction and belief and related to duties. Others are teleological and consider the consequences of actions. The final end-result is a mixture of belief and responsibility and those who hold administrative or political positions must be held accountable for the consequences of their decisions. These consequences, however, are to be weighed against the acceptance or rejection of those who are affected by actions and interventions.

Relevant is also the fact the many experts might agree on actions but disagree on the reasons behind them. The practical level is the crucial one. Theories and reflections supporting actions might be quite different. The “good Samaritan” might act on altruistic, utilitarian, Kantian or other philosophical grounds. The end result, however, matters more than the reasons leading to it or supporting it theoretically. This does not mean that philosophical analysis is unnecessary. But it should follow, not precede, actual behavior. The very idea of ethics in global mental health as “applied ethics” is nonsense. The importance of true practice and the necessary foundations of ethical reasoning in practical life render meaningless the very idea of a “pure” ethics that is monologically developed by someone and then “applied” to a certain field. It is precisely this idea that leads to the generalizing moralization that hinders and not stimulates useful research, acceptable outcomes, and sound public policies.

## **Working teams and institutions: differential ethics in professional behavior**

In the epistemology of moral discourse the distinction should be made on what appears as universal as given and what is imposed by the hegemonic paradigm. Different people inhabit different moral universes but at the same time everyone is an “epistemic stranger” to others. This means that the significance of even technical terms must first be ascertained before proceeding to establish teams or working groups. If different experts are brought together and agree in principle about the task ahead, we have a multidisciplinary team. If, in addition, those experts agree on basic definitions and principles, the team may be called interdisciplinary. But, if a step forward is required and those experts agree on the way each epistemic culture is

going to be considered, the group can be termed transdisciplinary. The stages of competition, cooperation and integration can be discerned in the constitution of these working teams, especially when they are designed to deal with difficult valoric issues in research and health care.

These considerations are in general disregarded when constituting committees and consulting teams. It is tacitly assumed that bringing together experts from different disciplines and moral persuasion will produce agreement on essential issues. Dynamics of the group depends on the process of its constitution and on clear rules of functioning. This is relevant for instrumental and essential values alike. In current practice of research and healthcare the role of institutions is crucial. The classical dyadic conception (patient-doctor, researcher-subject, client-professional) is no longer the only valid one. Institutions shape their own cultural environments by tradition, leadership, and economic considerations. To work for non-governmental organization is entirely different from being part of the state social system of care and research. The differential approach to value judgments and intervention design should be applied also to person aggregates and their internal relationships, because institutions do constitute an added layer of complexity to moral dilemmas. Differential ethics is also a needed concept when dealing with diverse professional backgrounds and life experiences. When long held assumptions and convictions are threatened by innovative ideas or proposals, emotions come to the foreground. Self-respect on the part of professionals involved, struggles for power, hidden leaderships or undisclosed political agendas may render all theorizing about the goods of group discussion useless. Differential ethics should also deal with moral emotivism and moral prescription in the working group (6). The naïve assumption of shared moral world is there as dangerous as it is when dealing with client or patient populations or with group problems.

The complexities of the situation and the need for a careful analysis of the decision making group can be illustrated by the example provided by the notion of outcome. Outcome, the result of interventions, is not a single, well agreed upon notion. As Thornicroft and Slade (7) point out, there is a wide taxonomy of the decisions researchers, clinicians (and ethics consultants, we might add) may take. The degree of satisfaction with the outcome depends on whose definition it fits. They propose eight components for evaluating outcomes, framed as decisions: Whose outcome will be considered? Which scientific stage is being investigated? What outcome domain(s) matter? What level of assessment will be used? Will clinical and/or recovery outcomes be assessed? Whose perspective will be considered? Will deficits and/or strengths be the focus? Will invariant or individualized measures be preferred?

These eight components may be considered, *mutatis mutandis*, for ethical decision making by a committee or an expert group. When a decision has been reached, the

question is not how good it is but whose values it exemplifies, and with which level of generalizability are the results of the deliberation to be considered. A research project that is considered unethical or in need of revision demands a decision based on opinion and fact. Or the decision is based on tradition and precedent. The decision might depend upon the assessment of a risk/benefit ratio. A “good” decision for a lawyer may not satisfy a priest. A researcher has different interests from a philosopher who does not practice empirical science.

The differential ethics approach, then, must also be applied within the expert group and take into consideration the stages of the deliberation process. There are times when deontological reasoning predominates and times when teleological considerations prevail

## Concluding remarks

In pluralistic societies, the problem of understanding differences comes to the foreground. The field of global mental health includes not only translational science, which is, converting scientific fact into accepted practice, but also analysis of moral universes and discourses using the tools of differential analysis. The proposals of Hans Martin Sass are relevant not only for the relationships between persons. They encompass also the institutional and societal levels. And, as we suggest, the institutional level, as exemplified by the ethics committee, whose composition should reflect the diversity of the society and at the same time accommodate different worldviews in a flexible and tolerant manner. When a decision has been reached, it can be supported along eight different dimensions that explicitly take into account the different epistemic and value cultures represented within.

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## Diferencijalna etika u globalnom mentalnom zdravlju

### SAŽETAK

Ovaj rad elaborira neke od implikacija Sassove teorije diferencijalne etike tako da unaprijeđuje mišljenja da globalno mentalno zdravlje nadilazi javne i međunarodne razine i bavi se integrativnim pristupom. Odbacujući krajnosti moraliziranja generalizacija i uske znanstvene stavove, ističe se potreba za kulturnim kompetencijama i etičkim vrednovanjem utemeljenim na relevantnoj praksi. To se ne odnosi samo na relaciju između stručnjaka i laika, već i na pluralističku konstituciju etičkih povjerenstava, gdje različite spoznajne i vrijednosne kulture moraju biti integrirane tijekom procesa donošenja odluka, uključujući deontološku i teleološku fazu.

**Ključne riječi:** diferencijalna etika, globalno mentalno zdravlje, spoznajna kultura