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Through a glass, darkly: ethics of mental health practitioner-patient relationships in traditional societies

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ABSTRACT

Assumptions about the universality of ethics and the use of dominant ethical frameworks of mental health care may obscure the differences and contextual realities in traditional societies. The 'culture' of the encounter between the mental health practitioner and the patient can be viewed through three dominant perspectives; paternalism, autonomy and reciprocity. Culture strongly influences how persons construct and negotiate their autonomous identities and the concept of relational autonomy may be more relevant in traditional societies like India. In this article, research studies and practitioner viewpoints are brought together to highlight the debates related to patient-practitioner communication, confidentiality and disclosure, informed consent and decision-making capacity, involuntary admissions and discharge processes, use of covert medication, advance directives and cultural influences on the definition of professional boundaries. Understanding the complex interplay of cultural beliefs and processes, culturally embedded practitioner value systems, economics, social justice paradigms and existing mental health care systems in traditional and resource-poor societies can provide a deeper understanding of the ethics of mental health care. A view of reality as interpretative and contextual can enhance our understanding of the ethical playing field in mental health care in both traditional and modern societies.

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Introduction

The description of societies in dualities has its limitations, but looking at contexts as 'traditional' *vis-à-vis* 'modern' offers a way to understand whether the ethical frameworks in mental health care are global, local or 'glocal'. The belief in the universality of ethical codes has been described as a 'mirage' (Ahmed, 2000), with ethical signposts and interpretations likely to differ in traditional and eastern societies. Looking through a Western lens to interpret and evaluate the ethics of mental health practice in traditional societies like India could yield an obscure and imperfect view of reality. A more meaningful and nuanced understanding of the relationship between ethics, culture and context calls for an intentional, critical and introspective stance.

The 'culture' of the encounter between the mental health practitioner and the patient can be viewed through three dominant perspectives: *paternalism*, *autonomy* and *patient self-determination and reciprocity* or the involvement of patients in the planning or implementation of their care (Pelto-Piri, Engström, & Engström, 2013). The social structures and processes in traditional contexts can influence how these perspectives are viewed and valued. India has been described as a vertical, collectivist society (Triandis, 1995), with interdependent self-construals (Markus & Kitayama, 1991).

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The inherent power-distance hierarchies and the sense of duty (*dharma*) align closely with the paternalistic framework in mental health care, with relatively lower emphasis on patient autonomy and collaborative involvement in decisions related to mental health care. In the concept of *dharma*, the foremost responsibility is towards God and to the teacher/guru (Seetharam, 2013). With the doctor/therapist seen as the Guru in the Indian therapeutic paradigm, the patient may construct a relationship based on dependence and not on freedom of choice (Neki, 1973). Although there may be variations in the degree and forms of authority and surrender in this relationship, patients also sometimes view the therapist as akin to a divine figure.

Many traditional societies are in resource-poor countries where health care delivery systems are unevenly distributed, mental health legislation is inadequately monitored and regulated and user advocacy movements are in their infancy. In countries like India, with wide socioeconomic, cultural and linguistic disparities, patients and family members may have limited understanding of and access to the ethical frameworks of practice. Mental health practitioners are often schooled using textbooks and paradigms developed in more Westernised or modern societies and may struggle to reconcile this with the cultural realities of practice. This article debates on critical ethical issues in the practitioner-patient interaction, with a focus on the circumstances of the South-East Asian and Indian sub-continent regions.

Autonomy: relative and relational?

The dominant ethical frameworks are built on the foundation of a vulnerable individual's rights to autonomy, choice and self-determination during the process of interactions between mental health practitioners and patients.

Culture is a strong influence on how persons may construct and negotiate their autonomous identities. Individualistic societies and Western bioethics models emphasise the patients' right to make independent decisions about mental health care, including refusal of a treatment provider's recommendations. This approach of 'putting most of our ethical eggs in the autonomy basket' (Lepping & Raveesh, 2014, p. 1), and neglecting other important ethical principles of justice, beneficence and non-maleficence, has been criticised. In many South-Asian contexts, families may be closely involved in the decision-making process, sometimes even circumventing the patient's expressed wishes at the time (Chaturvedi, 2008). Both mental health practitioners and families may often value beneficence and health over patient autonomy (Wasan, Neufeld, & Jayaram, 2009).

Alternative philosophical positions, like feminist care ethics, speak to the concept of *relational autonomy* (Ho, 2008), and place empathy and relationships at the heart of decision making (Lepping & Raveesh, 2014). This position may be more culturally congruent for traditional societies, where family involvement is seen as a strength and one that may promote individual wellbeing and agency. Adopting the relational lens does not take away concerns that families may prioritise their own needs and values over those of the patient (Ho, 2008). Patriarchal systems in traditional societies can impair the personal autonomy of women and helpful or potentially harmful decisions may be taken by others on their behalf.

In this article, issues related to patient-practitioner communication, confidentiality and disclosure, informed consent in the context of assessment of decision-making capacity, involuntary admissions and discharge processes and covert medication will be discussed. Recent debates on advance directives and cultural influences on the definition of professional boundaries will also be addressed.

Communication and disclosure

The quality, safety and ethical standards of clinical care depend to some extent on the quality of clinical communication between the practitioner, the patient and the family. There are many interrelated dilemmas faced by mental health professionals regarding communication, which are influenced by the sociocultural context – *how* to provide information, *when* to provide information, *how much* information to provide and with *whom* to share information.

The amount and type of information about illness, treatment, outcome and quality of life are issues of debate. From a patient-centred viewpoint that respects autonomy, clear disclosure of the diagnosis is advocated. In traditional societies, there may be inadequate or incomplete disclosures due to a range of factors. A cross-cultural study that examined diagnostic disclosures among psychiatrists in Japan and North America (McDonald-Scott, Machizawa, & Satoh, 1992) revealed interesting distinctions. While there was relative uniformity in the approach to discussing the diagnosis of patients with affective or anxiety disorders, variations were prominent in diagnoses like schizophrenia, where 'prognosis is uncertain or the diagnosis is feared' (p. 147). Compared with 70% of North American psychiatrists, less than 30% of Japanese practitioners revealed the diagnosis to the patient, instead preferring to use more generic and acceptable terms like 'neurasthenia'. In traditional societies, the process of trying to develop a co-constructed illness narrative can also be challenging due to the range of explanatory models that include supernatural or religious attributions, like past sins or *karma*.

Psychiatrists across the globe may struggle with disclosure of 'difficult' diagnoses, like schizophrenia or borderline personality disorder (Shergill, Barker, & Greenberg, 1997). One can understand how factors like labelling, widespread societal stigma or inadequate insight among persons with schizophrenia can make it more challenging. In societies with low awareness and high social prejudice, the potential negative impact of complete disclosure of the diagnosis might be greater; for instance, lowering the changes of arranging a marriage for the patient or even for the well siblings.

Practitioners may often be guided by the desire to protect their patients from the negative consequences of disclosure and ensure beneficence and non-maleficence. There is little research that explores how much patients expect or want to know about their illness. In one study (Shergill et al., 1997), albeit in a Western context, most patients wanted to know their psychiatric diagnosis and perceived this as helpful in the treatment process. If patients do not know the name of the diagnosis, how can they participate actively and meaningfully in the treatment process? The inclusion of the patient perspective would help clarify whether non-disclosure may sometimes be a culturally sensitive approach, but at other times could reflect the assumptions, cultural misconceptions or biases of the practitioner.

There can be diverse beliefs and practices among practitioners who work in the same cultural context. A qualitative exploration revealed that while some Chinese-American practitioners viewed non-disclosure as disempowering and feeding into societal stigma, others saw it as culturally competent and sensitive (Hwang, 2008). Overall, more experienced psychiatrists in both American and Japanese cultural contexts (McDonald-Scott et al., 1992) had a higher likelihood of disclosure, suggesting that beliefs may change and skills may be learnt along the professional journey.

The other question pertains to *when* the mental health practitioner discusses the diagnosis – is it spontaneously or only when asked? A study among Japanese psychiatrists (McDonald-Scott et al., 1992) suggested that the 'don't ask-don't tell' policy was prominent. In traditional societies, the paternalistic stance and the power hierarchy between the practitioner and patient means that the onus of initiating communication may typically lie with the professional. In India, the practitioner-patient relationship has been construed as mirroring the '*Guru-Chela*' (Spiritual teacher-disciple) bond (Neki, 1973). With the practitioner seen as the benevolent guru, akin to a joint-family elder, the patient and family members may have questions that are not always voiced. Mental health practitioners are then faced with making the choice between waiting until asked and being proactive in disclosure. The other question that arises is whether information about disclosure should be withheld at the initial stages of the consultation. Chinese-American psychiatrists responded to this issue by suggesting an individualised approach, focusing on developing a relationship and waiting for an opportune time to make the disclosure (Hwang, 2008).

In a traditional and developing society, the family plays a significant role in each stage of the help-seeking and treatment trajectory. In Asian cultures, a responsible family member (patriarch) is the decision maker. Discussions about the diagnosis with family members may often exclude the patient and be initiated without his or her consent (McDonald-Scott et al., 1992).

The interpretations of confidentiality may differ across cultural contexts and this raises many ethical questions.

Negotiating confidentiality

The mental health practitioner is privy to sensitive information and is often viewed as the ‘keeper of secrets’. The term ‘breaking confidentiality’ is suggestive of the fragile aspects of the practitioner-patient relationship. Strong philosophical arguments have stressed that confidentiality increases the likelihood of honest disclosures from patients, supports their rights and is an important professional obligation (Beauchamp & Childress, 2009).

The sociodynamic context has been emphasised, while considering the concepts of confidentiality and privacy. The boundaries of confidentiality may be more fluid in traditional societies, and privacy may be seen as isolating people in an interdependent society (Neki, 1992). Naik, Menon and Ahmed (1998) asserted that it would be ‘culturally incongruent to exclude families from both ‘major or minor decisions that concern adult patients, *particularly women*’ (p. 425, emphasis added).’ The concept of confidentiality has been viewed as relatively irrelevant in the Indian context (Varma & Gupta, 2008), and as something that patients themselves may not want. Although, family involvement and support is a strength in traditional societies, and one that we should capitalise on, there is the danger of disclosing personal or sensitive information to family members without considering the ramifications. For instance, hasty revelations of diagnostic and/or other information about a woman patient to her in-laws or even the spouse, could have major negative interpersonal and even legal consequences. In a recent survey of clinical psychology trainee therapists (Bhola, Sinha, Sonkar, & Raguram, 2015), ethical dilemmas related to diagnostic disclosures to family members were a prominent concern. Another grey area involved disclosures to family members about revelations made by an adolescent client. Cultural beliefs about a parent’s right to know everything about their child’s problems make for a tenuous balance between protecting the integrity of the therapeutic space and ensuring family involvement and commitment (de Sousa, 2010). Abrahams and Salazar (2005) advise that rather than operating from an ‘either-or’ position, there is a need to use an ethical decision making process to reconcile cultural values in negotiating confidentiality with South Asian clients.

Patients in traditional societies may not understand that confidentiality is part of the process, and indeed it may be difficult to have private discussions in some treatment settings in resource-poor countries. The onus must be on the mental health practitioner to educate patients about their rights in this professional relationship at the outset.

The training of mental health practitioners emphasises the fiduciary nature of the relationship with patients, but this may be viewed differently by other segments of society. A recent case exemplifies these contesting views: a patient used the Right to Information Act to gain access to medical records of her treatment at a psychiatric hospital in India (Express News Service, 2012). While the hospital declined, citing the confidential nature of information gathered from various informants, the Central Information Commission ruled that the information must be released. This ruling in turn was stayed by the High Court. Such test cases demonstrate that professional views about confidentiality may sometimes be at odds with community beliefs and legal viewpoints. In another recent development in the state of Punjab in India, police officials have been pressuring doctors working in de-addiction programmes to submit personal and contact data on all patients registered with them in the past three years (Express News Service, 2015). The widespread problem of addiction in the state has apparently prompted this, but it also clearly demonstrates how confidentiality as an ethical and professional imperative is threatened.

Informed consent: competence and decision-making capacity

Ideally, personal consent for treatment and hospitalisation needs to be voluntary, informed and provided by a person with the capacity for reasoned decision-making. In Western contexts, the person’s right to self-determination is emphasised, and clear and convincing evidence of incompetence is required before a surrogate decision-maker or court-appointed guardian is involved. Conversely in Asian countries like India, practitioners, families and even the legal frameworks have tended to lean towards what is best for the patient, even if the decision impinges on personal autonomy. In most treatment contexts in India, evaluations of decision-making capacity are usually based on informal clinical judgments:

The inadequate awareness, alternate explanatory models (Kleinman, Eisenberg, & Good, 1978) and stigma linked with psychiatric illnesses can lead to both patient and family members refusing consent for medication, treatment or admission. Explanatory models held by mental health practitioners, and by psychiatrists in particular, are often biomedical (Bhui & Bhugra, 2002). These may exclude the diverse, complex and sometimes transient meanings that patients and caregivers bring to the encounter (Williams & Healy, 2001). These difficulties in reaching a shared understanding about the illness, its causation and treatment will necessarily impact the process of obtaining informed consent. An ethical and patient-centred approach would ensure that adequate information about the risks and benefits of different options is provided in a way that supports and facilitates autonomous decision making and in a language that is easily understood by the patient and/or the surrogate decision maker. Written consent may be sought for certain procedures, and factsheets could be useful for literate patients. However, attention to the principle of autonomous decision making should not be ‘reduced to a signature on a piece of paper’ (Jacob, 2014, p. 36). In addition, while patients may want the ‘right to know’, they could still want the onus for treatment decisions to be on the mental health professional (Jacob, 2014).

In an interview-based study on treatment-related decision making capacity (Gandhi & Vankar, 2007), 64% of inpatients diagnosed with psychosis demonstrated a lack of capacity. This lack of capacity was associated with low education, lack of employment and a high level of psychopathology and cognitive dysfunction. Among the patients who were involuntarily admitted, 23% had adequate decision-making capacity, while 41% of patients who were voluntarily admitted had a lack of capacity at the time of the interview. Discrepancies in the presence or absence of decision-making capacity and the type of admission suggest the need for a comprehensive assessment of capacity. Cohen and Batista (2010) pointed out that lower education level does not preclude decision making capacity, although adaptations in the method of assessment might be needed. Clinicians must guard against making assumptions about a patient’s ability to participate in the decision making process based on their education level or rural background, and spend the time to elicit what the patient desires.

The use of coercion

Coercion can take many forms and some are clear ethical violations. The use of physical force to get mentally ill individuals admitted to the hospital or to prevent them from leaving is difficult to justify on ethical grounds. The use of restraints and seclusion as a means of punishment, an alternative to adequate treatment or as a convenient option for staff are unequivocal human rights violations (Shah & Basu, 2010). The death of 24 chained patients at a faith-based mental asylum at Erwadi, India, in 2001 led to many recommendations by the National Human Rights Commission, including a strong directive against physical restraints (Nagaraja & Murthy, 2008).

‘The ends justify the means’ approach is often put forward as the argument for using a coercive approach for involuntary admissions, under certain circumstances and within the bounds of the law. This involves a risk-benefit analysis that considers the anticipated clinical and social outcomes and the patient’s perceptions and decision-making capacity and chooses the ‘least restrictive alternative’ (Shah & Basu, 2010, p. 206).

A review of qualitative studies (Sibitz et al., 2011) examined different aspects of the experience of coercion and highlighted several negative themes. These included a sense of violation or abuse of human rights associated with restricted autonomy and limited participation in decision making; a sense of not being cared for, respected or listened to; and strong negative emotional responses, leading people to feel devalued and stigmatised. Compulsory admission and treatment can also have a negative impact on the therapeutic relationship and contribute to a view of hospitalisation and treatment as prejudicial and unjust. However, some persons subjected to coercive treatment may come to view it as necessary and to regard hospital as a place of safety and protection (Srinivasan & Thara, 2002).

The 'involuntary patient': admissions and discharges

There are legal provisions for involuntary admissions in select situations, but gaps could exist between the intent and letter of the law and the processes followed in clinical practice in India. The negative effects of compulsory treatment can be greatly attenuated through respectful engagement with health professionals, not overextending coercive processes and maintaining usual routines, rituals and relationships while under involuntary care. The way people perceive the experience of coercion may profoundly affect their sense of self and identity, which are crucial aspects in the course of illness and recovery (Sibitz et al., 2011).

The use of coercive measures ought to be confined to acute crisis events and implementation should be improved substantially. Education and service development should focus on both how to prevent coercion and how to apply coercive measures in case of acute danger. Integrating the views of service users is crucial to making essential improvements. An involuntary admission can be helpful when done according to the letter of the law, but should not become the justification for other decisions taken by the mental health fraternity for the patient.

There is a worrying gap between legal provisions in the Mental Health Act, 1987 that support autonomy in the discharge process and the realities of practices in India. A Government of West Bengal report (Government of West Bengal, 2013), prepared by the State Mental Health Cell, discussed how large numbers of recovered patients in state mental hospitals desired discharge but their families could either not be traced or were unwilling to accept them. Despite clear processes under Section 40 for discharge by the Superintendent of the hospital, this was most often not followed. Concerns over the safety and protection of these persons 'specially of the female patients after release' (p. 4), inadequate rehabilitation facilities in the community and the prevalent custodial view have contributed to this definite violation of patient autonomy once the patient has regained capacity. The ripple effect of the problems with discharge is seen in the overcrowding at some state mental hospitals, further compromising patient rights.

Treatments: voluntary or involuntary?

Patients may be ambivalent or refuse to take treatment, particularly psychotropic drugs and electroconvulsive therapy (ECT), which is often viewed as potentially unsafe and a 'last-resort' treatment (Arshad et al., 2007). A range of ethical issues related to personal autonomy, right to information, competence, informed consent and consent by proxy gain importance in relation to specific treatments like ECT (Rajkumar, Saravanan, & Jacob, 2006). There are continuing debates on the ethical issues associated with the use of unmodified ECTs in India (Andrade, 2003) and ongoing efforts to ensure a basic minimum standard for obtaining informed consent.

Long acting injections of antipsychotic medications have effect for two to four weeks and can improve compliance and prevent any exacerbations and relapses. Infringement of personal autonomy can be minimised by involving the person in the care and treatment process, sharing information, being open to questions and attempting to obtain consent. In cases where the decision-making capacity is impaired, involvement of the caregiver as a surrogate (and temporary) decision-maker and documenting the process is recommended. The policy of taking 'blanket consent' from the patient and/or caregivers for interventions during an inpatient stay should be discouraged.

Other clinical encounters can involve decisions about investigations during admission; for instance, testing for sexually transmitted diseases or pregnancy for a woman with bipolar disorder who exhibited symptoms of sexual disinhibition prior to the admission. The processes for providing information and obtaining consent from the patient and/or caregiver in a range of such clinical situations need to be clearly defined.

The deception game: the use of covert medication

Currently, deception in treatment and giving hidden medicines to a mentally ill person who is uncooperative, suspicious or refusing to take medications is the subject of fierce ethical debate in India. On one hand, this is done to help the ill person recover, sleep or for symptom control and can function as a pathway to the restoration of autonomy; on the other hand, it can be questioned on ethical grounds as compromising individual freedom of choice. This practice may be followed in a 'climate of secrecy' in Western contexts, due to the fear of professional censure and litigation (Hung, McNiel, & Binder, 2012; Lewin, Montauk, Shalit, & Nobay, 2006). Research suggests that this practice is far more prevalent among psychiatrists in India than those working in the USA (Wasan et al., 2009). A report on management of medication noncompliance in outpatients with schizophrenia by families in India by the use of concealed medications (Srinivasan & Thara, 2002) stimulated dissenting opinions on the use of this subterfuge as culturally appropriate.

There has been a slew of professional options supporting the cautious use of these surreptitious practices, 'taking it out of the closet and using it selectively' (Kala, 2012, p. 257; Singh, 2008). Nuanced perspectives have discussed the advantages and disadvantages of covert treatment (Latha, 2010; Ramachandran & Thara, 2012; Sarin, 2012; Shah & Basu, 2010). Patient and caregiver perspectives on covert treatments are scarce. In the report by Srinivasan and Thara (2002), about a quarter of the patients with schizophrenia later became aware of this deception and had negative reactions towards family members. Overall, most of the patients who were treated with concealed medications later became compliant and such arguments are often offered as justification for these choices.

Srinivasan (2012) recounted the personal struggles as a parent caring for a non-compliant patient and invoked the suggestion to legalise covert medication. In India families shoulder much of the responsibility of care of mentally ill individuals and directly experience the consequences of poor medication compliance. These differences in patient and caregiver responses reflect the pulls between individual and family autonomy in decisions about the use of concealed medications (Wong, Poon, & Hui, 2005).

There is a shift away from debating the use of covert practices towards the documentation and development of clear guidelines for the management of non-adherence (Ramachandran & Thara, 2012). With the family, this includes education on pharmacotherapy and a range of strategies to deal with non-adherence. Individual and group modalities with patients are recommended to address the issues of lack of insight or acceptance of the disorder, dealing with perceived side-effects as well as a careful assessment of decision-making capacity. For patients who lack the capacity to make decisions on their own, the principle of autonomy is not violated, provided the treatment is in the patient's best interests (Hung et al., 2012).

Reasons for refusal of medication must be elicited: for instance, a woman may reveal that medication refusal is associated with the strong social pressures to have a child. The practitioner cannot choose the covert administration route in this situation. It is incumbent on the clinician to use all reasonable efforts at persuasion in the face of treatment refusal and not use covert practices as a shortcut. The implications and options need to be discussed with caregivers and any members of the team. Consultation and supervision, clarity about how long to continue this practice and documentation of the process are all methods of ensuring that practitioners walk the ethical line in this controversial and uncertain territory (Hung et al., 2012). Psychiatric training should offer the opportunity for nuanced debates that address the conflicts between ethical principles, using real-life case scenarios (Wong et al., 2005).

Advance directives: a new challenge

Advance directives, a tool to document preferences for care in advance of decisional incapacity, champion patient autonomy and have recently been incorporated into the India's proposed Mental Health Care Bill (Ratnam, Rudra, Chatterjee, & Das, 2015). Counterpoints have questioned whether this concept can be extrapolated from the Western context without accounting for a range of practical, social, economic, cultural and political considerations (Ratnam et al., 2015; Sarin, Murthy, & Chatterjee, 2012). In a few exploratory studies and reviews in India, psychiatrists have indicated concerns about their peripheral role and there have been expressions of both support and apprehension from carer stakeholders (Kumar et al., 2013; Ratnam et al., 2015; Shields et al., 2013). Positive experiences with the process of formulating advance directives were reported by a majority of a sample of patients from urban and rural settings in India (Shields et al., 2013).

Concerns about the implementation of advance directives have been raised and this contentious issue is likely to be debated fiercely in the Indian mental health scenario. These include the fragmented service delivery systems in the country, which include faith-healing and other alternative systems, the 'social-recalibration of patient autonomy' with family typically involved in decision-making, the potential for abuse and the lack of monitoring mechanisms, the typically hierarchical and paternalistic nature of the practitioner-patient relationship and the overall mismatch with local cultural frameworks (Sarin et al., 2012; Shields et al., 2013). An exploration of the service-user perspective in an outpatient setting in India (Pathare, Shields, Nardodkar, Narasimhan, & Bunders, 2015) revealed that most were comfortable with appointing a representative (usually a family member) to make decisions on their behalf during a period of decisional incapacity or relapse.

Frames of the relationship

The patient-practitioner relationship is meant to operate within a professional boundary. Creating and maintaining the frame of the therapeutic relationship is impacted by the strong power hierarchies in the societal structures, the fluidity in the timeframe and boundaries of the interaction and overall definition of the relationship in traditional societies like India. This may be reflected in patients and their caregivers referring to practitioners as a family member, asking personal questions or having an unquestioning belief in the practitioner's stance. The frames of the relationship may be defined differently in some social contexts and these do not necessarily have to conform rigidly to Western constructions or be viewed as boundary violations. However, there is a caution against ethical transgressions, with the personal role potentially blurring into the professional role. The power imbalance in the relationship should not preclude a collaborative interaction or one in which the patient can ask questions, debate and even disagree with the practitioner.

The issue of accepting gifts from patients is a contentious one, and particularly since most ethical codes offer no clear cut guidelines. One perspective presents the refusal to accept gifts like sweets or fruits from patients in South Asian cultures as culturally insensitive and damaging to the therapeutic relationship. Equally, there are cautions against a myopic view of gift giving (and taking) as culturally sanctioned and thereby always acceptable (Hoop, DiPasquale, Hernandez, & Roberts, 2008; Kurpad, Machado, & Galgali, 2010). There is little evidence that accepting such gifts improves treatment outcomes and Khan (2010) presents an eloquent argument against loosening the ethical framework and hiding behind the 'curtain of culture'. The initial stage of accepting smaller gifts could gradually lead to more serious boundary violations. Kurpad et al. (2010) discuss how taking a box of sweets from a patient may be acceptable. The riders include accepting this on behalf of the entire treating team, from a patient who can afford it, and on a specific occasion. Clinicians in traditional societies must consider these perspectives and develop a consistent well considered policy and one that is addressed at the outset of the clinical encounter.

More serious sexual boundary violations occur among the mental health fraternity across the world, as in India (Kurpad et al., 2010), but may be marked by a 'conspiracy of silence'. In traditional societies where mental health care is evolving, there is inadequate attention to boundary-related ethics in the training phase and an absence of clear and enforceable redressal mechanisms (Amin, Gadit, & Patel, 2008). Although Indian practitioners in the fields of psychiatry and clinical psychology are guided by the ethics codes of their professional organisations, the issue of accountability and regulation persists (Isaac, 2009).

Critical perspectives on ethics and the cultural context

In mental health practice, much is revealed about patients' private emotions, beliefs and experiences, and practitioners' personal values may also percolate into this professional interface. Values are culturally mediated and practitioners' responses in ethically challenging clinical situations are at least partially a product of their own personal cultural development (Hoop et al., 2008). Although ethical paradigms emphasise neutrality, this can be threatened in the face of clients' behaviours or disclosures that evoke strong negative feelings in the mental health practitioner. When practitioner values reflect the dominant discourse on masculinity and patriarchy, it is possible that there is less sensitivity to the rights and personal autonomy of female patients in the treatment process (Joshi, 2015). This may be at odds with ethical frameworks that emphasise autonomy and justice. Mental health practitioners must cast an inward gaze on their own assumptions and value positions, and recognise and work with any incongruence with professional ethical paradigms.

The multicultural and transitional nature of cultural contexts influence the perceptions, interpretations and the negotiation of ethical dilemmas. The use of an oversimplified cultural lens has the danger of assuming that all patients from South Asian or other traditional societies share the same world view about concepts such as autonomy or confidentiality (Abrahams & Salazar, 2005). Additionally, many traditional societies are in transition and the changing sociocultural contexts can give rise to uncertainties for mental health practitioners. The increasing ease of access to information in the digital and print media, even in traditional societies, may challenge paternalistic frameworks of practice. A shift to a mixture of individualistic and collectivist leanings has been noted in Turkey, a country situated at the cusp of Eastern and Western cultures, but this has also meant greater segmentation, with concepts of autonomy differing between tribal/rural and urban areas (Kara, 2007). A qualitative inquiry in Japan uncovered two co-existing patterns of a practitioner-patient relationship: the traditional *Omakase* (entrusting) model and an emerging active participatory model (Slingsby, 2004). These changes call for flexible modulation from practitioners based on their individualised evaluation of the patients' world view (Abrahams & Salazar, 2005).

There is a need to critically evaluate ethical codes in the area of mental health for their attention to cultural contexts. While ethical codes must be more inclusive and contextualised, it is unlikely that there can be an overarching set of rules that addresses all ethical conundrums manifested in traditional societies. Training and continuing development programmes with a strong focus on culturally relevant decision making process are recommended.

Ethical dilemmas may arise from a complex interplay of cultural beliefs and processes, economics, social justice paradigms and existing mental health care systems in traditional and resource-poor societies like India. Mental health care may involve long-term treatment and expensive investigations, and decisions about future help-seeking can be strongly influenced by economic factors. For instance, relatives of a patient may be perplexed about what would be an appropriate use of their limited funds – for children's education or marriage or for the patient's mental illness. Patients may be denied the best practice treatment in terms of medication and psychological interventions due to the additional costs that may be incurred and this presents ethical dilemmas to the practitioner. Larger contextual concerns like the lack of comprehensive insurance or adequate government supported health benefits can tilt the response to these ethical dilemmas. Hanlon, Tesfaye, Wondimagegn and Shibre (2010) argue that violations of individual autonomy in low- and middle-income countries are not always related to traditional cultural beliefs and processes alone, but may also reflect the mental health care system. In their words:

> When access to the least restrictive, culturally relevant, evidence-based care is limited to the privileged few, caregivers may be forced to over-ride the individual autonomy of the patient in order to ensure receipt of effective treatment or protection of others. (p. 245)

The scaling of mental health care, effective monitoring mechanisms for professional conduct and the enactment of modern mental health legislation in these contexts can protect patient rights and support adherence to ethical standards (Hanlon et al., 2010). The emerging concept of 'structural competency' (Metzl & Hansen, 2014) calls for practitioners to be aware of the range of social and economic determinants, biases and inequalities that shape health and illness. Practitioners are advised to develop an attitude of 'structural humility' in conversations with patients, in which 'clinicians are at once speakers and listeners, leaders and collaborators, experts and benighted' (Metzl & Hansen, 2014, p. 131).

The Mental Health Act will soon pave way for the new Mental Health Care Act of India. Many sections of the proposed legislation have been viewed as progressive in terms of the focus on the protection of the rights of patients (Thippeswamy, Goswami, & Chaturvedi, 2012). Questions have been raised about the marginalisation of families, with the proposed involvement of a Mental Health Review Board in mental health decisions and involuntary admissions (Narayan & Shekhar, 2015). There is continuing concern about the use of advance directives in a cultural context that defines 'autonomy' differently from Western contexts (Das, 2012; Thippeswamy et al., 2012). In traditional societies with limited resources, families shoulder much of the responsibility of ongoing care and some of the new provisions could push patients and families into adversarial legal positions (Kala, 2013).

Conclusion

While social paradigms, legal frameworks and mental health care systems are often touted as the reasons for differing interpretations of ethics across cultural contexts, the influence of both practitioner personal-cultural value systems and patient and caregiver perspectives are less well understood. The definitions and interpretations of ethical frameworks are undoubtedly influenced by the cultural context, but respect for culture cannot be an excuse for bypassing ethical guidelines or disregarding patient rights (Okasha, 2008).

The field of ethics involves learning to question rather than a search for single answers; viewing reality as interpretative and becoming comfortable with ambiguity and multiple perspectives. If ethical positions are rooted in modern, Western contexts, then the differences seen in traditional societies may be seen as 'deviations' from the ethical line that must be defended or altered, rather than as reflections of the local ethos. When all realities are examined contextually, then issues such as concealed medications can be debated and discussed openly. While ethical relativism cannot be used to justify questionable mental health care practices, equally, traditional societies should not be required to justify their practices against the dominant and privileged position held in modern societies. Both may have spaces of clarity and lessons to offer each other. The question is about whether we are treating the disorder or the person (or the person in a context) and the answer shapes the way we view and interpret the ethics of the practitioner-patient interaction.

Disclosure statement

No potential conflict of interest was reported by the authors.

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