# Public mental health across cultures: the ethics of primary prevention of depression, focusing on the Dakhla Oasis of Egypt

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## 1. Introduction

For over a decade there has been an active and ambitious movement concerned with reducing the 'global burden' of mental disorders in low- and middle-income countries (Horton, 2007; Prince et al., 2007; Saxena, Thornicroft, Knapp, & Whiteford, 2007). Global Mental Health, as its proponents call it, aims to close the 'treatment gap', which is defined as

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the percentage of individuals with serious mental disorders who do not receive any mental health care. According to one estimate, this amounts to 75%, rising in sub-Saharan Africa to 90% (Patel & Prince, 2010, p. 1976). In response to this, the movement recommends the 'scaling up' of services in these communities in order to develop effective care and treatment for those who are most in need. This recommendation, the movement states, is founded on two things: (1) a wealth of evidence that medications and psychosocial interventions can reduce the disability associated with mental disorder, and (2) closing the treatment gap restores the human rights of individuals, as described and recommended in the Convention on the Rights of Persons with Disabilities (Patel et al., 2011; Patel & Saxena, 2014).

In addition to its concern with *treatment*, the movement has identified *prevention* among the 'grand challenges' for mental and neurological disorders. It states, among its key goals, the need to identify the 'root causes, risk and protective factors' for mental disorders such as 'modifiable social and biological risk factors across the life course'. Using this knowledge, the goal is to 'advance prevention and implementation of early interventions' by supporting 'community environments that promote physical and mental well-being throughout life' and developing 'an evidence-based set of primary prevention interventions' (Collins et al., 2011, p. 29). Similar objectives have been raised several years before by the World Health Organisation, who identified evidence-based prevention of mental disorders as a 'public health priority' (WHO 2004, p. 15).

Soon after its inception, the movement of Global Mental Health met sustained and substantial critique.[1] Essentially, critics argue that psychiatry has significant problems in the very contexts where it originated and is not a success story that can be enthusiastically transported to the rest of the world (see Fernando, 2011; Mills & Davar, 2016; Summerfield, 2008, 2012, 2013; Whitley, 2015). The conceptual, scientific, and anthropological limitations of psychiatry are well known and critics appeal to them in making their case. Conceptually, psychiatry is unable to define mental disorder, with ongoing debates on the role of values versus facts in distinguishing disorder from its absence (e.g., Bolton, 2008, 2013; Boorse, 2011; Varga, 2015; Kingma, 2013). Scientifically, the lack of discrete biological causes,

[1] Most recently there was vocal opposition to a Global Ministerial Mental Health Summit that was held on the ninth and 10th of October 2018 in London. The National Survivor and User Network (U.K.) sent an open letter to the organisers of the summit, objecting to the premise, approach, and intention of Global Mental Health along the lines outlined in the main text.

or biomarkers, for major psychiatric conditions has resulted in the reliance on phenomenological and symptomatic classifications. This has led to difficulties in defining with precision the boundaries between disorders, and accusations that psychiatric categories lack validity (e.g., Horwitz & Wakefield, 2007; Kinderman et al., 2013; Timimi, 2014).[2] Anthropologically, while the categories themselves are associated with tangible and often severe distress and disability, they remain culturally constructed in that they reflect a 'Western' cultural psychology (including conceptions of the person and overall worldview) (e.g., Fabrega, 1989; Littlewood, 1990; and Rashed, 2013a).[3] Given this, critics see Global Mental Health as a top-down imposition of 'Western' norms of health and ideas of illness on the 'Global South', suppressing long-standing cultural ideas and healing practices that reflect entirely different worldviews. It obscures conditions of extreme poverty that exist throughout many non-Western countries, and which underpin the expressions of distress that Global Mental Health now wants to medicalise. On the whole, Global Mental Health, in the words of the critics, becomes a form of 'medical imperialism' (Summerfield, 2008, p. 992) that 'reproduces (neo)colonial power relationships' (Mills & Davar, 2016, p. 443).

We acknowledge the conceptual, scientific, and anthropological critiques of psychiatry and have written about them elsewhere (e.g., Bingham & Banner, 2014; Rashed, 2013b; Rashed & Bingham, 2014). At the same time we do not wish to speculate about and judge the intention of Global Mental Health, or whether it's a 'neo-colonial' enterprise that serves the interests of pharmaceutical companies. Our concern is to proceed at face-value by examining a particular kind of interaction: on one hand, we have scientifically grounded public mental health prevention campaigns that seek to reduce the incidence of mental disorders in low- and middle-income

[2] Often, the problem is framed by asking whether mental disorders are natural kinds, e.g., Jablensky (2016), Kendell and Jablensky (2003), Zachar (2015), and Simon (2011).

[3] The problems with utilising psychiatric categories across cultures for purposes of diagnosis, research, and treatment have been pointed out and discussed for several decades. Examples include the work of Kleinman (1987), Littlewood (1990), Hopper (1991, 2004), Kirmayer (2006), and Barrett (2004). This research operated at the intersection of Medical Anthropology and Cross-Cultural Psychiatry and had no illusions about the complexities involved. For example, before we can work with psychiatric categories across cultures, there is a need to establish if these categories have validity and that we are not committing a 'category fallacy'. Additionally, questions of translation loom large, for example concerning the meaning of the terms that make up the diagnostic criteria and whether it is possible to render them in different contexts. It is therefore unusual that the movement of Global Mental Health has chosen to bypass this important research and the complexities it definitively raises.

countries; on the other hand, we have the cultural contexts in these countries where there already are entirely different frameworks for categorising, understanding, treating, and preventing various forms of distress and disability. What sort of ethical principles ought to regulate this interaction, where prevention of mental disorders is at stake?

The meaning of prevention with which we are concerned in this chapter is primary, universal prevention, to be distinguished from mental health *promotion*, from *secondary* prevention, and from primary prevention that is of a *selective* or *indicated* nature. Primary prevention 'aims to reduce the onset of mental ill-health, thus reducing the incidence of mental disorders' — it is concerned with tackling the risk factors for mental disorders (Peterson, Barry, Lund, & Bhana, 2014, p. 3; see also; WHO 2004, p. 16). Secondary prevention, on the other hand, 'seeks to lower the rate of established cases of the disorder or illness in the population (prevalence) through early detection and treatment of diagnosable diseases' (Saxena, Jane-Llopis, & Hosman, 2006, p. 5; cf.; Radden, 2018, p. 127). In contrast to prevention, mental health promotion 'employs strategies for strengthening protective factors to enhance the social and emotional well-being and quality of life of the general population' (Peterson et al., 2014, p. 3). It is not directly concerned with risk factors for disorders but with positive mental health. With universal prevention the entire population is within view of the interventions, whereas with selective and indicated prevention, the target groups are, respectively, those 'whose risk for developing the mental health disorder is significantly higher than average' and those who have 'minimal but detectable signs or symptoms' (Evans, Foa, Gur, & Hendin, 2012, p. 5). While there is overlap among these various efforts, we focus on primary, universal prevention. Our decision to do so stems from the fact that such interventions, in being wholly anticipatory and population wide put marked, and perhaps even unique, ethical pressure on the encounter between the cultural context (and existing ideas on risk and prevention of distress and disability) and the biomedical public mental health approach.

It is helpful for ethical analysis to begin with a sufficiently detailed understanding of the contexts and interactions that are the subject of analysis. With these details at hand, what matters in a particular interaction is brought to light and the ethical issues become easier to grasp. Accordingly, we begin in Section 2 with an ethnographic account of the primary prevention of depression in the Dakhla Oasis from the perspective of the community. The Dakhla Oasis is a rural community in the Western desert of Egypt where there is no psychiatric presence, yet like most communities around

the world there is no shortage of mental health related distress and disability.[4] It is a paradigmatic example of the kind of community where Global Mental Health would want to implement its campaigns. In Section 3 we move on to the perspective of a Public Health Team concerned with preventing depression in light of scientific and evidence-based risk factors and preventive strategies. Section 4 outlines the conflict between the perspective of the Team and that of the community. Given this conflict, Sections 5 and 6 discuss the ethical issues that arise in the case of two levels of intervention: family and social relationships, and individual interventions.

## 2. Primary prevention of depression: the perspective from Dakhla

From an emic (or insider) perspective, symptoms and signs that fall under the psychiatric category of depression cut across a range of local categories.[5] The main categories are spirit possession (*labs*) and mental illness (*marad nafsi*).[6] The term depression (*ekte'ab*) is known but is understood as a term-of-art that doctors use. Spirit possession and mental illness, as understood in Dakhla, are serious problems that can manifest in moderate to severe depression-like symptoms. Before describing these categories and their associated risk factors from the local perspective, we distinguish them from everyday expressions of distress.[7]

[4] Extending west of the Nile-valley and occupying two-thirds of the land surface of Egypt, the Western Desert – otherwise an arid expanse of over 680,000 square kilometres – is dotted by six depressions: the oases of Siwa, Fayyoum, Bahariyya, Farafra, Dakhla, and Kharga. Beyond the Western political border of Egypt, it becomes the Libyan Desert, and shortly after it merges with the Sahara. With Cairo as a reference point, Fayyoum is the closest, largest and most populated of the six oases. Siwa lies only 50 km east of the Libyan border and, traditionally, has been the most isolated. The other four oases lie on an arc that starts at Cairo, curves West into the desert and 1330 km later returns to the Nile-valley at Luxor. Farafra lies at the Western-most point of that arc, followed by Dakhla.

[5] Coined in linguistics to denote the relationship between units of language and linguistic systems, the terms emic and etic were adopted into cultural anthropology by Marvyn Harris in 1964 (Headland, Pike, & Harris, 1990, p. 2). Harris described statements created in a fashion regarded as appropriate by the actors themselves (emic) and statements which depend on distinctions 'judged appropriate by the community of scientific observers' (Harris, 1968, p. 575). The terms gradually took on their more general use in contemporary medical and psychological cross-cultural work to distinguish an insider (emic) from outsider (etic) perspective or understanding (Headland et al., 1990, p. 2).

[6] In this section the transliteration of Arabic terms is provided in italics.

[7] The ethnography reported on here was carried out by the first author during 2009 and 2010. The full ethnography can be read in Rashed (2012).

Unlike in psychiatry and its cultural milieu, psychological distress in Dakhla is not expressed in terms of a low mood — a 'phenomenological sinking downwards of the self' (Littlewood, 1990, p. 312) — but in terms of a constriction of the space available for the self. In the face of the inevitable troubles and obstacles of day-to-day life such as problems at work, a drying well, impending exams and, in the domestic sphere, the curtailment of freedom and movement that many women experience in the marital home, people may experience a change in mood. This is expressed in several idioms; the most common is *makhnu'* (suffocated) and, less commonly, *deiq* (to constrict or close-in). These idioms refer primarily to space and are accompanied by a desire to 'run away' and 'let in some air'. The advice in such cases is to reclaim one's space, literally, through a drive at dusk to the sand dunes adjacent to town or a trip to the nearest city, Asyut, while married women who are more constrained in what they can do seek respite from home through a visit to their families. All of this is considered a normal reaction to the difficulties of life and does not invite people in Dakhla to think about risk factors and prevention. With spirit possession and mental illness, the stakes are higher.

## 2.1 Spirit possession (*labs*)

***Description*:** Spirits (known locally as *jinn*) are frequently invoked to account for an individual's mental states and behaviour. For example, mood changes, dysphoric states, and behaviours that are out of character or bizarre, are understood as manifestations of spirit possession. The effects of the spirit can be direct in the sense that the behaviour witnessed is literally the spirit's, or they can be indirect if the spirit influences the person by targeting the centres of volition. Behaviours understood in this way include aimless roaming, frequenting deserted places, isolating oneself, avoiding people, preoccupation with fire, inattention to appearance and grooming, inability to remain in one place for long, irritability, aggressive outbursts, talking to oneself, and praying, washing, and eating either excessively or not at all. In Dakhla, possession is frequently referred to as an illness and the possessed as a patient. In such cases possession is the primary problem and finds expression in a variety of symptoms and signs, some of which recall depression.

***Causes*:** When spirit possession results in depression-like symptoms and signs, the proximal cause is the spirit's activity. But spirits and humans do not ordinarily interact, accordingly a further (distal) cause is required to explain why this person in particular has been targeted by the spirit. In Dakhla,

a person can be targeted in several situations, two of which are most common: magic (*se'hr*) and inadvertent touch (*mas'*).

*Magic:* Suspicions of magic lurk at the background of many attempts to make sense of misfortune. It is thought that a neighbour with a grudge or an envious relative visits a magician who directs a spirit at the victim in order to affect their health and behaviour. The identity of the perpetrator could be revealed during an exorcism episode upon direct questioning by the healer. More commonly, the victim guesses who might have a reason to harm him or her. Usually, that would be a person whom they had slighted in the past and who now has a motive to retaliate. The same process applies to the presumed perpetrators who, should they encounter a problem, might suspect that the original party had blamed them for their misfortune and may harbour an intention to retaliate. This initiates a cycle of mal-intentions that operates implicitly and is fuelled by real or presumed interpersonal conflicts. These conflicts are understood to have initiated a chain of events directly connected to the persons' mood and behaviour.

*Inadvertent Touch:* Contrasting with the deliberate nature of magic, the inadvertent touch is a pure chance encounter. It involves a human trespassing onto areas where spirits reside and the unintentional infliction of harm upon them, say by falling or stepping on the spirits. Angered by the attack and unwilling to forgive, the spirit responds by possessing the person.

***Risk Factors*:** Whether the cause is magic or an inadvertent touch, weakness of faith renders the individual vulnerable to spirit possession. Faith is characterised as a protective sheath that envelops the individual. The metaphor here is thoroughly mechanical: lapses in religious observance form holes in the sheath thus allowing the spirit to enter. A person must constantly strengthen and repair his sheath through prayer and recitation of the Qur'an. With regards to inadvertent touch specifically, a risk factor is ignorance of the places and times where spirits are common. With regards to magic, a risk factor is social discord; to the extent that I quarrel with others and disrespect or harm them, I provide them with reasons to want to harm me back through magic.

## 2.2 Mental illness (*marad nafsi*)

***Description*:** The psychological and behavioural problems cited in Section 2.1 are sometimes understood outside the framework of spirit possession. The main category here is *marad nafsi* which translates as mental illness. The distinction between these two categories depends on various factors. For any person *suddenly* presenting with psychological and behavioural

changes, the consensus will be that he is possessed. Additionally, possession is a contingent event, and it is expected that a healer or magician would be able to undo it. The longer the problems persist, the presence of a key and intensely difficult event in the person's life, and the consistent ineffectiveness of treatments offered by healers and magicians push the narrative surrounding the person from the domain of possession and magic to that of mental illness.

***Causes*:** *Key shock:* A sudden loss or realisation that a state-of-affairs is contrary to what the person thought it was. For example, a man working abroad has been sending money to his fiancée in Egypt for safe-keeping; he returns home to find that she had married another man and spent all his money. A man regularly stored part of his income under a brick in the basement of his house; a water leak damaged his life-savings. In such cases, it is theorised that the experienced shock results in a rush of blood to the brain. The blood forms a 'drop' that settles on the brain, stimulating and damaging the nerves, and producing the problematic behaviours and experiences.

*Spiritual Deviance:* An alternative explanation for mental illness ties it to reduction in faith or religious practice. If you do not lead a truly religious life, your values, motives and desires are constituted by the givens and concerns of the material world. You end up fighting with others over the same things and exposing yourself to the petty disappointments and grievances that such fights inevitably lead to. Mental illness is the state of a person who leads this kind of life and who has become so absorbed in his failures to the extent of developing a psychological complex (*'oqda*).

*Magic:* Magic can be at the root of mental illness as a special category of spirit possession. The community recognises a particular kind of magic known as madness magic.

***Risk Factors*:** With regards to key shock as a cause of mental illness, it is not possible to predict what the risk factors are: anyone can be affected at any time. With regards to madness magic, risk factors are similar to those for spirit possession. With regards to spiritual deviance as a cause of mental illness, the risk factor is living an irreligious life. The account here is grounded in Islamic cultural psychology where the self is understood to have three modes: the inciting self (the source of carnal passions and vices), the peaceful self (the fruit of the individual's moral and spiritual development), and the blaming self (a mediating means of reproach and correction) (see Rashed, 2015). When the person is distracted from worship, begins to have doubts about God, and stops living an ethical life in accordance with the Qur'an and the Sunna (the Traditions attributed to the Prophet

Mohammed), the inciting self takes hold. It is a selfish, egoistic self, absorbed in the world and prone to envy, bitterness, vanity, greed, suspicions, anxieties, and frustrations.

### 2.3 Primary prevention

Drawing on the aforementioned risk factors, healers in Dakhla suggest a range of preventive measures. These can be regarded as primary universal interventions concerned with reducing the incidence of spirit possession (*labs*) and mental illness (*marad nafsi*) (as they are understood in Dakhla).

***Spirit possession:*** Weakness of faith is a central risk factor for all causes of spirit possession. Prevention consists in strengthening one's faith through prayer, reciting the Qur'an, visiting the mosque, regularly invoking God's name, and avoiding sinful activities. Other protective measures that can reduce the risk for possession and magic include drinking and bathing from holy water, lighting incense at home, and placing amulets with inscribed Qur'anic verses on one's clothing and around the house. A preventive intervention specific to the inadvertent touch is education about the nature of spirts, where they are found, and when to avoid these locations. A preventive intervention specific to magic draws on social discord as a risk factor and recommends measures that promote peaceful social relations thus minimising the occasions where people might want to harm each other.

***Mental Illness:*** With regards to living an irreligious life as a risk factor for mental illness, prevention would consist in reversing this state of affairs. This could be through educational campaigns about, for example, the various Islamic virtues, how to cultivate them in everyday life, and how, through this, one might be able to elevate the self to the mode of the peaceful self.

So far we have described the risk factors for depression and their prevention in the Dakhla Oasis from an emic (or insider) perspective. This is given as an example of a perspective from inside one community that might be the recipient of an external intervention in the event of a roll-out of a public mental health programme in the region. We now turn to the model employed at the level of the Global Mental Health approach, before moving to consider the ethical issues that arise when these two perspectives meet.

## 3. Primary prevention of depression: the Global Mental Health approach

In their report on the prevention of mental disorders, the World Health Organization (2004) identify two kinds of determinants that have

an evidence-based causal influence on the development of disorders: risk factors and protective factors. The former are 'associated with an increased probability of onset, greater severity and longer duration of major health problems', and the latter 'refer to conditions that improve people's resistance to risk factors and disorders' (2004, p. 20). Both kinds of factors, the report continues, 'can be individual, family-related, social, economic and environmental in nature' (World Health Organization (2004)). A related formulation is the 'socio-ecological framework', which identifies 'three broad nested and interactive levels of risk and protective factors'; the innermost level consists in intrapersonal factors (e.g., genetic make-up, cognitions, and skills), the middle level consists in personal factors (e.g., factors related to family, school, and community), and the outermost level consists in distal factors (e.g., economic and environmental policies Peterson et al., 2014, p. 9). Primary prevention of mental disorders must tackle this multitude of factors by countering risk factors and strengthening protective factors 'along the lifespan in order to disrupt those processes that contribute to human mental dysfunction' (Peterson et al., 2014, p. 9).

There are a range of known generic risk and protective factors. With regards to social, environmental and economic risk factors these include displacement, isolation and alienation, lack of housing and education, poverty, and war. Protective factors include social support and community networks, social tolerance, integration, and empowerment. With regards to individual and family-related risk factors these include child abuse, chronic pain and insomnia, substance use, family conflict, bereavement, and sensory disabilities. Protective factors include ability to face adversity, adaptability, exercise, literacy, positive early attachments, self-esteem, problem-solving and conflict managements skills (WHO, 2004, pp. 21, 23).

In relation to depression specifically, preventive interventions need to tackle 'depression-specific risk factors (e.g., parental depression, depressogenic cognitions) and generic risk factors (e.g., inadequate parenting, child abuse and neglect, stressful life events, bullying) and protective factors (e.g., sense of mastery, self-esteem, self-efficacy, stress resistance, social support)' (WHO, 2004, p. 39). Additionally, marital discord is associated with depression among women (ibid.). Given this, preventive interventions can range from seeking to reduce child abuse and extreme poverty to changing thought processes that can lead to depression, and strengthening skills for coping with stress. With regards to the latter two, Evans and colleagues (2012) report on a number of universal prevention programmes involving children, adolescents, and families. While they vary in some of the details,

they all consist in brief (10–15 sessions) interventions based on cognitive behavioural therapy and interpersonal therapy principles. The aims of the programmes include reducing 'vulnerability to future depressive episodes', and preventing first episodes of depression through 'cognitive restructuring and problem-solving approaches' (2012, p. 13, 14).[8]

What are the possibilities for interaction between the public health perspective just outlined and the perspective of the community in the Dakhla Oasis?

## 4. Conflicts in primary prevention

Sections 2 and 3 describe two different visions for the primary prevention of depression. Each vision proceeds, as it must, with a certain view of the condition (for example, depressive disorder or spirit possession), its causes, and the risk factors relevant to these causes. From there, interventions are proposed that can play a role in preventing the condition. In Dakhla these interventions include activities to strengthen one's faith (such as regular prayer, recitation of the Qur'an, and wearing protective amulets), educational efforts concerning spirits and how to avoid them, social efforts to minimise discord (and therefore the risk of harmful magic), and religious efforts to educate people in the Islamic virtues and how to achieve the peaceful self. From a Global Mental Health perspective, interventions to reduce the incidence of depression must tackle the three dimensions identified earlier and which can be characterised as follows: macro interventions (e.g., to address poverty, unemployment, education, and housing), family and social relationships interventions (e.g., to address domestic abuse, restrictions of freedom, and social isolation), and individual interventions (e.g., to improve cognitive skills and abilities to cope with life-events).

Consider a meeting between representatives of the Dakhla community and a Public Health Team with a Global Mental Health perspective. The Team could be international or representing the Ministry of Health in Cairo. Their aim is to launch a project to reduce the incidence of depression and to improve mental health in the community. They have completed

[8] The jury is out on the effectiveness of such psychological interventions. Evans et al. (2012) point towards some evidence that they do reduce the incidence of depression, while a more recent Cochrane review is more circumspect (Hetrick, Cox, Witt, Bir, & Merry, 2016).

their needs assessment, identified a prevalence of depression, identified locally evidenced risk factors together with an ameliorative strategy. They have familiarised themselves with local context and practices as described in Section 2 of this chapter. The Public Health Team come to the table armed with expert knowledge on preventable risk factors and the theory and practice of planning a community level intervention. But as we have seen, there is disagreement between them and the community on all the relevant issues: description of the condition, causes, risk factors, and preventive strategy. How can the Team implement evidence-based interventions in an ethical manner, given the radical difference between their vision and the community's vision with regards to the primary prevention of depression? In what follows we examine this question, dividing our account into the ethical issues raised by two of the three levels of intervention identified earlier: family and social relationships, and individual interventions.[9]

## 5. Family and social relationships interventions

In many communities, social and family relationships can generate risk factors for mental health problems including depression. In Section 3, we identified family conflict, stressful life events, marital discord, social isolation and alienation as possible risk factors. In Dakhla, the constellation of beliefs, values, and practices surrounding marriage and gender roles generate ample opportunities for these risk factors. Marriage in Dakhla is a non-negotiable milestone that all men and women must achieve by their mid- to late-twenties at the latest. It is regarded as a 'completion of one's religion',

[9] Macro socio-economic and political factors such as poverty, unemployment, lack of access to education, poor quality or overcrowded housing, and conflict or war, are among the most impactful risk factors for depression. Indeed, as noted in the Introduction, the Global Health Movement has been criticised for emphasising the risk of mental health problems at the individual level, thereby facilitating the neglect of the social, economic, and political determinants of wellbeing. Despite their paramount importance, we do not consider macro interventions in this chapter for two reasons: First, due to the nature of such interventions, they lie outside the immediate expertise of a Public Health Team as they concern political and governmental action that has an impact beyond health. What the Team can and should do is advocacy for governmental action at the macro level; indeed, this may be an ethical imperative relating to principles of justice and equality. Second, from an ethical standpoint, interventions to improve access to healthcare and education, create jobs, and increase economic prosperity are ones over which we can expect significant consensus and, therefore, less opportunities for ethical disagreement. With regards to the latter point, however, we must add that there can be controversy over the details, for example in some contexts, education for girls is still not recognised.

'half of one's faith', and the 'natural progression of life". For the men and particularly the women of Dakhla, it is frequently their first and only sexual outlet. To be unmarried in your thirties is considered a disaster (*musiba*) and a blow to a person's worth and social standing. Further, divorce and second marriages are frowned upon and, accordingly, are rare. This lends to the choice of marriage partner the weight of finality, yet it is a choice that cannot be informed in many ways, due to restrictions on interactions between men and women before they get married.

These ideas and practices create significant stress for those who are within the ideal marriage age as well as for those who have passed that age. For the former, the early twenties become a battleground of sorts: on one hand, there is constant pressure from parents on their children to marry; on the other hand, these young men and women must make a more or less final decision under conditions of limited knowledge. The pressure is intensified by the fact that not getting married is a disaster, and that getting married to an unsuitable person can lead to a life of misery that might be hard to get out off. Those who do not marry, risk social isolation and alienation from the community. Given that marriage is a non-negotiable milestone, drifting into your thirties without getting married is not perceived as a possible choice, but as an occasion to inquire into the reasons behind the failure to fulfil this important milestone, much like a child failing to walk at the appropriate age invites speculation as to his constitution and health.[10] Within marriage itself, women face an additional range of stresses owing to rigid gender roles that restrict their life to the confines of the family home with very limited possibilities for interaction with anyone who is not immediately family. For example, married women in Dakhla are only expected to leave the house to visit their parents' home or for a very urgent matter. This loss of freedom creates opportunities for marital discord and plays a direct role in the experience of suffocation and constriction commonly reported by people in the community, and which, as discussed in Section 2, is the main idiom for expressing unhappiness. A public mental health campaign concerned with the prevention of depression may, therefore, concern itself with aspects of the community's ideas and practices surrounding gender roles and marriage that contribute to the risk factors.

[10] The unmarried person risks being seen as socially undesirable. People may reason that he or she was unable to marry due to a tarnished moral reputation or perceived mental health problems.

## 5.1 Communicating the message: the role of transparency

The first challenge the Public Health Team faces is how to communicate the idea that aspects of gender roles and expectations and practices around marriage are connected to risk factors for a mental health condition known as depression. This is especially complicated given that the community have an entirely different perspective over what the Team calls depression.

In general, information in public health campaigns ought to be communicated *transparently*. Transparency refers to the information provided and to the process of providing information. It is frequently cited in international public health as an important principle. For example, the World Health Organisation define two aspects of transparency in communication in the event of a disease outbreak. The first is the quality of communication, which 'should be factually accurate, timely and easily understood'; this includes information 'about actual or potential health risk, including behaviours [the community] should adopt to avoid disease' (WHO, 2008, p. 12). The second aspect relates to building trust with the public and other stakeholders. This requires transparency about the evidence used to inform policy and programme management decisions, and information about decision-making processes and outcomes.

The ethical principle underlying the importance of transparency is the necessity for communities to be able to give informed consent for the intervention. For example, in a document titled *Principles of the Ethical Practice of Public Health*, the American Public Health Association notes:

> *Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.*
>
> ***(Public Health Leadership Society, 2002, p. 4).***

Accordingly, in its formulation in the public health ethics literature, transparency has been conceived as an equaliser, regulating the relations between parties and preventing coercion. In an exposition of the principles of public health ethics, Upshur (2002, p. 102) defines the transparency principle as follows:

> *This principle refers to the manner and context in which decisions are made. All legitimate stakeholders should be involved in the decision-making process, have equal input into deliberations, and the manner in which decision-making is made should be as clear and accountable as possible. As much as possible, the decision-making process should be free of political interference and coercion or the domination by specific interests.*

Alongside the ethical justification, there is also a pragmatic rationale for transparency, as the effectiveness of public health programmes and institutions relies on the trust of the public (Oliver & Lewis, 2009, p. 468). Moreover, provision of information is not only a requirement for ethical intervention but an intervention in itself; for some, it is the ideal means to behavioural change. Thus, advocates of a liberal framework for public health ethics argue for public education and information provision as 'non-coercive ways of bringing about improvements in health' (Nuffield Council on Bioethics, 2007, p. 22). This has been conceived as the least ethically problematic branch of health promotion: 'if the strategy is successful, it is because the individuals or groups found it useful or persuasive and chose to act on it' (Gardner, 2014, p. 31).

This apparently innocuous principle, however, is not without problems. During the Ebola outbreak of 2015 in Guinea, Liberia, and Sierra Leone, traditional funeral rites and burial practices, including washing of the dead, were identified as a factor in the spread of the Ebola virus. International teams provided transparent information alongside education and interventions such as mass cremation (see Maxman, 2015). These strategies raised both practical and ethical concerns. For example, a subsequent collection of informant narratives stressed that alienation of populations may have led to non-compliance with the recommended measures, which may have increased the risk of virus transmission (Pellecchia et al., 2015). In this case, information was necessary, but biomedical information alone — about how to avoid the disease — was often of limited relevance. People had other pressing priorities such as caring for the sick and burying the dead in accordance with longstanding rituals.

Additionally, the transparent provision of public health information — though necessary and appropriately motivated — can erode meaningful cultural practices. It can leave people in an uncertain place with regards to practices that provide for a shared community and identity. And it can alienate the community so that it refuses to engage with the interventions. This applies to a paradigmatically biomedical problem such as Ebola as well as to the prevention of depression. In relation to our case study, the Public Health Team's information relies on categories of distress and their scientifically established causes and risk factors that differ markedly from those of the community. The community are being told that they need to reconsider aspects of gender roles and marriage practices as a way of preventing some of the risk factors for depression, i.e. the community is being asked to change its culture in order to reduce the incidence of depression.

## 5.2 Bringing about change: health beliefs and culture

The Public Health Team seek change in those aspects of gender roles and marriage practices that constitute risk factors for depression. In order to do so they could design messages of possible alternatives and publicise these through advertising campaigns and through home visits by health workers and promoters. Family Planning campaigns in Egypt in the 1990s proceeded in similar terms. In a country where it was common for rural families to have up to ten children, and where a big family was highly prized, the key message was the health, economic, and social benefits that would befall families if they limited their progeny to two or three. Campaigns of this sort, we want to argue, aim to change the culture and not just health beliefs.

The expression health beliefs is self-explanatory. What is apposite for us here is the distinction between it and the broader cultural context. For the purpose of this discussion, we understand culture as

> *socially acquired and shared symbols, meanings and significances that structure experience, behaviour, interpretation and social interaction; culture 'orients people in their ways of feeling, thinking, and being in the world' (Jenkins & Barrett, 2004). (Rashed, Bingham, Poole, Sanati, & van Staden, 2018, p. 73)*

The frameworks of understanding distress and disability posited by the community in Dakhla and by the Global Mental Health movement are examples of different cultures in the sense we intend. Spirit possession is not an isolated set of beliefs about illness, but is connected to people's orientation to the world in domains such as personal identity, morality, agency, and cosmology. And so with the biopsychosocial, naturalistic, secular understanding of distress and disability advanced by Global Mental Health. Within each cultural framework, there are beliefs specifically about health. In Dakhla, for example, a person could be judged by a healer to have incorrect health beliefs about spirit possession; he might attribute to spirits maladies that they cannot cause, as determined through expert, local knowledge. And in England, for example, a person could be judged by medical opinion to have incorrect health beliefs about vaccinations, such as with the MMR/autism controversy. In either case, a public health campaign can aim to correct these beliefs (about spirits and about vaccinations) without having to change people's overall cultural orientation.

Other times, the attempt to change health beliefs can intentionally or unintentionally overstep the mark and become an attempt to change the culture. This is particularly clear with anti-obesity campaigns and partly explains the ethical controversies that surround them (e.g., Couch, Fried,

& Komesaroff, 2018; Fry, 2012). On the face of it, anti-obesity campaigns seek to change health beliefs relating to BMI and health. Those who object to the campaigns argue that they advance a particular bodily norm and justify it by appeal to health. In doing so, the objectors continue, these campaigns might impact the broader culture by stigmatising individuals who do not fit that norm. So, what started with an attempt to change health beliefs can, in some cases, end up changing, and having a negative effect upon, the culture.

In light of the distinction between health beliefs and culture, and returning to the case study under consideration in this chapter, does the Public Health Team want to change the health beliefs of the people of Dakhla or their culture? First, it does not make sense to talk about changing health beliefs outside of a shared cultural context, for health beliefs (whether correct or incorrect) arise and acquire their sense from that context. For example, in conversation with those who argued (wrongly) that the MMR vaccine causes autism, we can assume, at the least, a range of shared biological, psychological, and behavioural concepts, and a scientific understanding of experiment and evidence. Where such assumptions cannot be made, it is hard to see how we can discuss the matter with others, say by pointing out that their interpretation of the evidence was incorrect or that the experimental design was flawed. And relating to the matter at hand, as we have seen in Sections 2 and 3, the community and the Team have different views on the nature, causes, risk factors, and prevention of depression, views that reflect differences in culture. Second, in aiming to change how people conceive of gender roles and marriage, the Team is targeting social practices that go deep in the community's worldview and are connected to religious, moral, and social commitments. On these two points, we can see that what the Team is really targeting here is the culture of the community. Unlike anti-obesity campaigns which start with health beliefs and might end up having a negative impact on the culture, the public health prevention campaign we have been describing targets the culture from the start. However, aiming to change a community's culture due to an interest in their wellbeing is a different prospect to changing a set of health beliefs; it cannot be approached with the ethical mindset of a public health intervention - as changing health beliefs might - but with the mindset of an intercultural encounter. One reason behind this is the importance of culture to identity.

Like religion, gender, and sexual orientation, culture can be understood as a component of individual identity, the latter being a person's

understanding of who he is. Such an understanding is constitutive of the person in the sense that it provides him with an ethical and agentic orientation in the world — when that orientation is lost, we talk about an identity crisis. When a person endorses the various components of his identity, he becomes deeply committed to them in a way that precludes thinking of such components as garments that one can remove and change at will. This point is recognised in political-philosophical discussions on cultural rights (see Rashed, 2019). Initial liberal justifications for cultural rights centred around the argument that culture provides a context of choice for its members, a range of options from where people can select what is valuable and worth pursuing. In the absence of a secure cultural context, the capacity for autonomy cannot be properly exercised (see Kymlicka, 1991, 1995, 2001). This argument implies that as long as people are provided with *any* cultural context (in which they can be integrated), they would be able to exercise their autonomy. However, responses to Kymlicka point out that it is not cultural belonging *per se* that matters but belonging to a *particular* culture. Taylor (1994b, pp. 259–260) writes that 'for the people concerned, their way of life is a good worth preserving; indeed, it is something invaluable and irreplaceable, not just in the absence of an alternative, but even if alternatives are available'. Margalit and Halbertal (1994, p. 503) note that 'an individual has a right to *his* or *her* culture' and not just to any culture, a right that derives from the interest individuals have in preserving the sources of their *identity*, the things that give meaning to their lives. Similarly, Gans (1998, p. 164) writes that people have an interest in their culture because it is a 'component of their identity':

> *They have an interest in adhering to it as it is the interest of people to adhere to every component of their identity they wish to adhere to (their sex, sexual orientation, religion), even though it may not serve other interests they have.*

If we accept this view, we can appreciate the seriousness of attempting to change aspects of people's culture. The connection between culture and identity explains, in part, the resistance often shown to attempts to change cultural beliefs and practices. It also clarifies the harms that can arise where such change is imposed rapidly from without, as opposed to gradually and organically from within. Individually, there is the risk of loss of orientation, identity crises, and failed acculturation, all of which can result in further psychological harms. Collectively, communities that undergo rapid change and are disenfranchised of their culture can experience harms such as breakdown

in communication between generations as well as destabilisation and, possibly, violent conflict.

All of this, however, does not deny the fact that sometimes, certain aspects of culture cause significant and unnecessary harm, and that efforts to change these practices are required. The issue is how to approach such efforts, given the problems we have just outlined. Here we return to what we mentioned earlier, which is that the Team ought to approach the situation with the mindset of an intercultural encounter and not a public health intervention. This requires, first, that there is a certain parity in the interaction, which a typical public health campaign might not have; both parties have something to learn from each other, even if it is the Team who approached the community with ideas about health improvement. Second, the Team needs to make its concerns clear and to point out what it thinks might help, but at the same it has to be open to correction on these matters subject to further engagement with the community. Engagement here needs to be substantial and long-term, ideally of an ethnographic nature, as demonstrated in this chapter. Writing in the context of an intercultural encounter where the understanding and evaluation of cultural practices are at stake, Taylor (1994a, p. 67) draws on a Gadamerian metaphor to describe the ideal of such encounters:

> *What has to happen is what Gadamer has called a 'fusion of horizons'. We learn to move in a broader horizon, within which what we have formerly taken for granted as the background to valuation can be situated as one possibility alongside the different background of the formerly unfamiliar culture. The 'fusion of horizons' operates through our developing new vocabularies of comparison, by means of which we can articulate these contrasts.*

When this is successful, and some overlap is achieved, a basis for creative cooperation becomes possible. An example of this can be found in a controversial area of cross-cultural health promotion: campaigns to end the practice of female genital mutilation/cutting (FGM/C). In some regions, health promoters have been able to support communities in identifying ways to retain core traditional values while abolishing harmful practices. Here, an intervention much celebrated and promoted by international women's rights organisations is alternative rites of passage, which seeks to avert the practice of FGM/C while respecting local values. In this case, the rite of passage is conceived as having fundamental importance, not the practice of FGM/C itself. Accordingly, interventions aim to facilitate events and ceremonies for girls as they reach the age at which they might otherwise undergo

FGM/C.[11] It is this sort of collaborative creativity and flexibility that is afforded by an encounter conducted as an *intercultural* encounter. Public health prevention campaigns that seek to change a community's culture, ought to be conducted in this manner.

## 6. Individual interventions

In Section 3 we identified several risk and protective factors of relevance to depression at the level of the individual. These include: 'depressogenic cognitions' such as the tendency for the negative appraisal of events and of oneself; the extent of a person's skills at problem-solving and conflict management; the person's ability to deal with stressful life events. A Global Mental Health approach concerned with the primary prevention of depression recommends psychological interventions modelled on Cognitive Behavioural and Interpersonal approaches. As cited earlier, there is some evidence that such approaches reduce the incidence of future depressive episodes when delivered in schools to children and adolescents. Returning to the case of Dakhla, from the perspective of the Public Health Team, psychological approaches of this sort are important interventions that can be rolled out in schools and community centres. From the discussion in the previous two sections, we can anticipate that the Team may run into problems in trying to impose a framework radically different to that of the local community. In the present example, we consider a possibility for avoiding this through collaboration with the local community. This depends on being able to adapt the intervention to the local context: Is it possible to find an overlap?

Consider an intervention designed between the Public Health Team and traditional healers of Dakhla. In Sections 2.2 and 2.3 we outlined the causes, risk factors, and preventive strategies for the category of *marad nafsi* (mental illness) as understood in Dakhla. One of the causes, from the emic perspective, is spiritual deviance; the risk factor is living an irreligious life; and the preventive strategy is grounded in Islamic cultural psychology. It requires education in the Islamic virtues, the religious meaning of suffering, and the life of the Prophet Mohammed who was regarded as a model of virtuous

[11] See, for example Amref Health Africa's campaign (online: https://www.amrefcanada.org/get-involved/stories/the-maasai-alternative-rituals-to-fgm/), and CIFORD's campaign (online: https://child.org/news/alternative-rites-of-passage).

behaviour. And, in light of this, prevention requires training of the self to adopt the qualities of the content/peaceful self and hence to contain the impulses of the inciting self, the dominance of the latter being the source of psychological maladies. Such an intervention, therefore, has a pedagogic and a practical component. The practical component requires of the person to recall, reinterpret, and recalibrate key beliefs, values, and emotions. In this sense, a possible intervention from the community's perspective shares features with common psychological interventions such as those proposed by Global Mental Health, for example cognitive restructuring and Cognitive Behavioural approaches more generally. The pedagogic component provides the content for the practical component. The overlap between the Team and the community would then consist in combining the general framework of evidence-based psychological interventions with an Islamic understanding of the self and the connections with spirituality and wellbeing.[12]

The feasibility of such a collaboration depends on establishing a functioning partnership, mutual respect, and other practicalities that have been well-described in guidance in the HIV/AIDS arena (Kayombo et al., 2007; King, 2005). Of particular relevance is the extent to which those with a biomedical perspective are able to engage with a spiritual dimension to an intervention. For example, it has been noted that physicians collaborating with traditional healers in some contexts preferred herbalists to spiritual healers. This preference has been attributed to the belief that 'herbs could be subjected to rigorous empirical methods of analysis as opposed to the use of spirits which are too abstract and subjective and therefore devoid of scientific objectivity' (Mokgobi, 2013).

This brings us to a core ethical challenge posed by collaboration across cultures: to what extent are both parties prepared to compromise their value system? A challenge for traditional healers collaborating with the Public Health Team is that the latter's view of depression might be seen to undermine their fundamentally spiritual understanding. Similarly, the Public Health Team are required to implement a programme that includes spiritual and ideological components that may not coincide with their own.

A related ethical issue arose in campaigns to end the practice of FGM/C, which we referred to in Section 5.2. Alternative rites of passage ceremonies

[12] Within academic and clinical psychology, there have been a number of attempts to develop cognitive behavioural and psychological principles from an Islamic perspective (see Hamdan, 2008; Haque, Khan, Keshavarzi, & Rothman, 2016; Husain & Hodge, 2016; Yaacob, 2013).

aim to minimise harm while respecting local culture. Yet, such ceremonies are not ethically unproblematic for external facilitators and funders. For example, in Kenya, this 'hybridised cultural assemblage' was observed to promote particular concepts of citizenship, morality and virtue, heavily underpinned by certain interpretations of Christianity:

> *In teaching girls to be good wives and mothers, to fear God, and to obey their parents, husbands and elders (in mimicry of traditional instruction), there is a risk of outmoded gender roles being reinforced that may not fit these girls for life as empowered 21st century women.*
>
> **(Hughes, 2018, pp. 285–286).**

None of which is to determine the cost-benefit analysis in this case, but to illustrate that attempts to initiate change through collaboration across cultures may require of both parties a difficult compromise. Likewise, in the mental health case under consideration, the compromise on behalf of the Public Health Team might consist in promoting virtues and values (of a religious nature) that they might not agree with, and which go against notions they subscribe to, such as liberal notions of autonomy. Such ethical discomfort may be amplified by the related issue that psychological preventative interventions are normally targeted at children and adolescents who might not have made up their mind about their religious views, yet will be instilled with a particular worldview that can limit their future options.

A second ethical problem that can arise in the case under consideration has to do with the piecemeal nature of the suggested collaborative intervention. Risk factors for depression, as we discussed in Section 3, traverse a range of causal levels and have an impact across the life-course. To address them properly, a comprehensive prevention campaign is required. Yet as we have seen in Section 5, there are difficulties with actioning such a campaign since it requires of the community to change its culture and not just a few health beliefs. Accordingly, what the Team is left with is the potential for collaboration outlined here, a useful endeavour no doubt, but one that is likely to be of limited efficacy in preventing depression. Given this, care must be taken that the community is not misled by an overestimation of what such an intervention can achieve.

## 7. Conclusion

Our description of the Dakhla Oasis of Egypt illustrates the need for public mental health ethics to accommodate a detailed, contextualised

understanding of the types of distress that are targeted for intervention. In our example, the different visions for the primary prevention of depression between the community and public health practitioners include differences in conceptualisation at every level: the description of the condition, its causes, the risk factors, and possible interventions to prevent the condition. We asked how a public health team can provide ethical evidence-based interventions across these worldviews. Targeting deeply held beliefs or valued social practices is often tantamount to targeting the culture itself. Given the close ties between culture and identity, we need to take seriously this aspect of the exchange. Yet, for a public health team to accommodate the local culture by adapting their intervention to fit local beliefs and practices (as seen in our discussion of individual-level interventions), they might face a difficult compromise with regards to their own value system. Notwithstanding the good intentions of the public health practitioner, we argue that public health ethics, narrowly conceived, cannot suffice to regulate this encounter. Targeting culture requires the approach not of an ethical public health intervention, but of an intercultural encounter. Accordingly, if the movement of Global Mental Health is to address the accusation that it imposes norms of health and ideas about illness on other communities, then its practitioners might have to rethink the nature of what they are doing.

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