

Nepali Resilience



Nepalese Mental Health in an International Comparison

Based on the peer-reviewed publication Scott et al. 2021 in *Psychological Medicine*

The people of Nepal experience many different sources of stress, but they have higher levels of positive mental health than those in wealthier countries. Nepali resilience is a source of both national pride and optimism, and mental health policies and interventions in Nepal and similar settings should build on a nuanced assessment of the sociocultural factors that underlie it.

High Quality Measures

The **Chitwan Valley Family Study (CVFS)** used a carefully crafted, clinically validated Nepali version of the World Mental Health (WMH) Composite International Diagnostic Interview (CIDI) survey in a study of 10,714 CVFS members aged 15-59 (2016-2018).

- The WMH consortium uses a rigorously designed and standardized CIDI to measure population prevalence of various mental disorders across more than 35 countries (Kessler and Üstün 2004). Thorough cultural adaptation along with clinical validation allows the WMH-CIDI to perform comparably across a wide range of settings, languages, and cultures.
- The CVFS measures included lifetime and 12-month prevalence of selected anxiety, mood, alcohol use, and impulse control disorders. Recall of the timing and sequence of lifetime events was enhanced using a Life History Calendar, or LHC (Axinn et al. 2020).
- Twelve-month prevalence suffers much less from recall bias than lifetime prevalence, so it is a better metric for comparing prevalence across surveys using the WMH-CIDI.

Rigorous Multi-Country Research Documents Nepal's Special Position

The most common mental disorders worldwide are also the most common mental disorders among the study population of the Chitwan Valley Family Study: Major Depressive Disorder (MDD), Alcohol Use Disorder (AUD), Generalized Anxiety Disorder (GAD), and Post-traumatic Stress Disorder (PTSD) were the most common in the Nepal study (Scott et al. 2021). For example, over 15% of Nepalese in Western Chitwan suffer from MDD.



There were substantial gender differences in Nepal: Nepali females are much more likely to experience MDD than Nepali males and Nepali males are much more likely to experience AUD than Nepali females. These major gender differences are also true worldwide.

The 12-month prevalence of common mental disorders in Nepal fell either below, or within the range observed for other low-income countries using the WMH-CIDI. For example, 12-month prevalence of MDD, the most prevalent disorder in Nepal, was 2.7%; the comparable prevalence averaged across Colombia, Iraq, Nigeria, Peru, Ukraine, and three regional surveys in the Peoples' Republic of China was 3.6% (Scott et al. 2021).

Why is Nepal Different?

Levels of exposure to potentially traumatic experiences (PTEs) are quite high in Nepal (Scott et al. 2021). In addition to high poverty and hardship, the CVFS population in Chitwan experienced a widespread, medium-intensity armed conflict from 1998-2006 (Axinn et al. 2012). Central Nepal, nearby the CVFS study population, also experienced a catastrophic earthquake in 2015. The Nepal version of the WMH-CIDI found more than 80% of the study population reported exposure to a PTE and nearly 65% reported exposure to two or more PTEs; these rates are higher than some but comparable to other WMH countries (Benjet et al. 2016). Given the high levels of poverty, trauma, and social disadvantage in Nepal, the low 12-month prevalence is counter-intuitive, although they are consistent with the cross-national pattern noted earlier. Methodological factors cannot be ruled out for impacting the results, but this study incorporated a number of methodological features to increase the quality of disorder detection and reporting. So it is reasonable to consider substantive explanations for the lower-than-expected rates of disorder in countries like Nepal.

One possibility is that there may be sociocultural factors in non-European diaspora countries that offer some protection against the development of mental disorders (Scott et al. 2021). Social capital may be one such factor. In a recent cross-national study, the association between social capital and health outcomes was found to be significantly stronger in low-income countries than in high-income countries. This may reflect the distinction between interdependent cultures that place high value on fitting in and maintaining harmony within the social world, versus independence-oriented cultures that emphasize the desire to discover and express unique attributes. In a similar vein, social and cultural differences in the way people see themselves, their relationships, and the world they live in have recently been proposed to help explain the lower rates of affective disorders in Asian countries. Researchers suggest that in holistic cultures, there is a tendency to embrace contradiction, to expect change, and to understand the self in context. As a result, negative emotions are seen as less negative, less threatening, more manageable, and less intrinsically tied to the individual self than in more individualistic cultures.

SOCIAL CAPITAL

In a recent cross-national study, the association between social capital and health outcomes was found to be significantly stronger in low-income countries than in high-income countries.



COLLECTIVIST SETTING

Researchers suggest that in holistic cultures, there is a tendency to embrace contradiction, to expect change, and to understand the self in context.



EXPECTATIONS MATCHING CIRCUMSTANCES

Wealthy countries may facilitate a potential mismatch between high expectations and the realized outcomes for the majority of the population.



ECONOMIC EQUALITY

Income inequalities are typically higher in high-income countries than in low-income countries and mental disorders have been found to be substantially more prevalent in unequal societies.



There may also be sociocultural factors in high-income, European-diaspora countries that are bad for mental health. Income inequalities are typically higher in high-income countries than in low-income countries and mental disorders have been found to be substantially more prevalent in unequal societies. Moreover, independent of actual objective socioeconomic status, the perception of lower relative socioeconomic status is also associated with higher odds of mental disorder and this association is significantly stronger in high-income countries (Scott et al. 2021). It may be that the emphasis on individual achievement and status in the European diaspora renders individuals in those countries vulnerable to social comparisons that undermine mental health. Relatedly, it has been suggested that wealthy countries facilitate a potential mismatch between high expectations and the realized outcomes for the majority of the population. By contrast, in a setting like Nepal, expectations are relatively low, which may facilitate concordance between expectations and experience (Axinn, Ghimire, Williams, & Scott 2015).

Sociocultural factors that differentiate non-European diaspora countries may offer some protection against the development of mental disorders.

Scott et al. 2021

Conclusion

In this large and carefully implemented study designed both to measure the prevalence of key mental disorders and to compare the results in Nepal's low-income setting to other countries, we found that 12-month prevalences were low. These results are consistent with the reduced prevalence of mental disorders in other low-income countries, leading us not to focus on possible cultural effects on reporting, but instead on identification of sociocultural factors that may mediate the reduced prevalence of mental disorders in low-income settings. **Understanding the special conditions that facilitate resilience in Nepal will allow us to propose and develop clinical and general mental health policy and interventions for Nepal and other similar settings.**

References

Axinn, William G., Stephanie Chardoul, Heather Gatny, Dirgha J. Ghimire, Jordan W. Smoller, Yang Zhang, and Kate M. Scott. 2020. "Using Life History Calendars to Improve Measurement of Lifetime Experience with Mental Disorders." *Psychological Medicine* 50(3):515-22. doi: 10.1017/S0033291719000394.

Axinn, William G., Dirgha J. Ghimire, Nathalie E. Williams, and Kate M. Scott. 2015. "Associations between the Social Organization of Communities and Psychiatric Disorders in Rural Asia." *Social Psychiatry and Psychiatric Epidemiology* 50(10):1537-1545. doi: 10.1007/s00127-015-1042-1.

Axinn, William G., Dirgha J. Ghimire, and Nathalie Williams. 2012. "Collecting Survey Data during Armed Conflict." *Journal of Official Statistics* 28(2):153-171.

Benjet, C., Bromet, E., Karam, E.G., Kessler, R.C., McLaughlin, K.A., Ruscio, A.M., Shahly, V., Stein, D.J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J.M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., Lepine, J.P., Kawakami, N., Kovess-Masfety, V., Medina-Mora, M.E., Navarro-Mateu, F., Piazza, M., Posada-Villa, J., Scott, K.M., Shalev, A., Slade, T., Ten Have, M., Torres, Y., Viana, M.C., Zarkov, Z., Koenen, K.C. (2016). The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium. *Psychological Medicine*, 46(2), 327-43.

Kessler, Ronald C, T. Bedirhan Üstün. 2004. The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *International Journal of Methods in Psychiatric Research* 13(2):93-121.

Scott, Kate M., Yang Zhang, Stephanie Chardoul, Dirgha J. Ghimire, Jordan W. Smoller, and William G. Axinn. 2021. "Resilience to Mental Disorders in a Low-Income, Non-Westernized Setting." *Psychological Medicine*

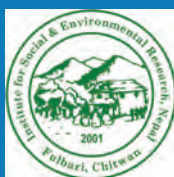
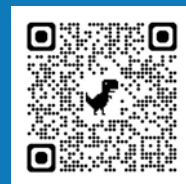


Contact Us



Institute for Social Research
Ann Arbor, Michigan, USA

WEBSITE | <https://cvfs.isr.umich.edu>



Institute for Social and Environmental Research - Nepal
Chitwan, Nepal

WEBSITE | <https://isernepal.org.np>

Email: isernepal@outlook.com

