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Editorial Perspective: Adapting western psychological interventions for children and adolescents in LMICs: lessons from Nepal

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Childhood and adolescence are particularly important times of psychological and neurological development with clear implications for the promotion of mental wellness and the prevention of mental ill health. A conservative estimate is that 10%–20% of young people will experience mental illness in lower- and middle-income countries (LMICs). Across the age range, 80% of the people with a mental illness reside in LMICs, yet only 5%–10% of the mental health resources are being delivered to them. In practical terms, this means that the treatment gap is effectively almost 90%.

Compounding this is the heavily westernised evidence base for mental health interventions. Western societies represent about 12% of the world's population, but reflect up to 80% of the world's research participants (Henrich, Heine, & Norenzayan, 2010).

This being the case, an important body of research has sought to characterise if and how non-western cultures differ psychologically from western ones. A common, although not uncriticised, distinction is made between individualist and collectivist cultures. Psychologically, individuals from western societies are broadly characterised by an analytic style of cognition which prioritises objects over their context and by a perspective on social interactions which characterises people's independence. By contrast, people from collectivist cultures are characterised by a holistic style of cognition prioritising context, alongside a view of social interactions as interdependent (Muthukrishna et al., 2020). This will have implications for the appropriateness of psychological interventions. For example, relatively individualist therapies like cognitive behavioural therapy (CBT) tend to locate psychological distress in problematic cycles of cognition, emotion and behaviour within the individual, rather than the interdependence between individuals and their cultures.

However, these distinctions are broad and can be problematic where cultural variation within a country is forgotten beyond its 'individualist' or 'collectivist' label. Furthermore, this moves beyond the academic when western mental health interventions are implemented in LMICs with limited consideration of cultural differences, rendering them ineffective at best, and potentially harmful at worst. Whilst the

implementation challenges in LMICs have been documented, the tendency remains to import western psychological interventions into LMICs. Beyond the obvious cost implications of training, supervising and delivering a psychological intervention with good fidelity to its protocol, subsequent scale up and rollout, the thorny issue of the cultural appropriateness of western interventions is significant.

Nepal is an interesting case study in this regard. Labelled a collectivist culture, Nepal is also known as the 'land of diversity' with 125 distinct ethnic groups and more than 92 languages being spoken. This diversity is complicated by the deeply rooted Hindu caste system and beliefs associated with it, which have been a predominant means of oppressing the 'lower caste' people, such as Dalits, by the 'higher caste' people, such as Brahmins. In this context, how and where to adapt psychological interventions is far from clear. Yet, with regard to mental ill health, there is a clear need. Data on the prevalence of mental health conditions in Nepal are broadly consistent with international rates; Chaulagain, Kunwar, Watts, Guerrero, and Skokauskas (2019), for example, find that between 12.9% and 17.03% of adolescents in Nepal report emotional and behavioural problems in school surveys. The existing qualitative research on adolescent mental health and culture in Nepal has explored their mental health issues in specific, often traumatic, contexts such as the Maoist People's War and the devastating earthquakes of 2015. Some other studies are in the context of the caste system in Nepal and its impact on adolescents' mental health, whilst a few studies examine their mental health in rural settings.

Public awareness of mental health issues is remarkably low in Nepal compared with physical health issues, and this is in part due to the lack of mental health resources in primary health care and mental health treatment. Stigma compounds these difficulties and leads to few people seeking mental health treatment when needed. For example, in Nepal, people with mental health issues have fears of being seen as 'weak' (Nepali: *kamjor*), 'crazy' (*pagal*) or 'mad' (*boulaha* or *dimag khuskeko*) by family, friends and the wider society. As a result, they have fears of not being accepted by them and so they tend to hide their mental health problems.

There is also an issue of honour or prestige (*ijjat*) of the family when people know that someone in a family has mental health issues. This can be a particularly big burden to the family if an unmarried woman/daughter has a mental health problem. The family will struggle to find a person to marry her. Families who have financial resources tend to go to India or big cities for treating their family members, far away from the local mental health facility and their communities so that other people do not know about the mental health disorder.

As in western countries, mental health interacts with other social factors in important ways; education and economic prosperity are seen by Nepalese parents as life goals of their children. Indeed, previous studies focusing on adolescents' mental health and culture indicated that adolescents are under pressure from their parents to succeed in their education and become economically secure. This pressure causes conflicts and tensions in adolescents who are also affected by sociocultural practices, religious expectations and the caste system in the country. The picture that emerges is one of Nepalese adolescents treading a line between economic progress and the adoption of western ideas, and the collectivist values of their elders and society, in the context of caste and religious traditions. Arguably, when delivering psychological interventions, this interconnection needs to be understood not only in a community context but also in an education context such as schools.

Taking a data driven-approach to examine this issue, our scoping review aimed to examine the context, cultural adaptation and outcomes of psychological intervention studies with young people in Nepal. Of the nine eligible studies, four showed significant effects following intervention.

With the support of the local community, Rose-Clarke et al. (2022) adapted an interpersonal psychotherapy (IPT) protocol for group delivery in a school setting. The comprehensive adaptation process included qualitative interviews to understand adolescent's experience of depression in Nepal, and a session with the adolescents and their parents to mobilise parental support and build rapport. In parallel, Nepali therapists were trained in IPT and asked about their experiences of training in and the appropriateness of IPT for adolescents in Nepal. This information was fed through to the project team and subsequently in consultation with a Nepali youth mental health advisory board, to support adaptations to the IPT manual. The resulting IPT programme reported an improvement in depression, anxiety and PTSD scores, which was maintained at 8–10 week follow-up. Improvements did not differ by caste, ethnic group, income level or family type, but boys improved more than girls across all outcomes. The authors also report adverse events during the project, for example one child being called a 'psycho' by a teacher, and some participants concerned that

attending the group would impact on their family's 'prestige' (*ijjat*). Antle, Chesick, Sridharan and Cramer, (2018) worked with Nepali counsellors and teachers to adapt the materials of an online mindfulness intervention so that it mapped closely to culture-specific stressors. Both the counsellors and teachers were arguably already 'engaged' with western approaches, having been trained by western psychotherapists. Girls living in poverty at a residential home completed mindfulness sessions three to four times a week over 6 weeks with their counsellor. There was an improvement in the children's regulation of attention and anxiety after the intervention and at 2-month follow-up. Adhikari et al. (2018) engaged with community members through over a hundred interviews prior to adapting a western stepped-care intervention for children with behavioural difficulties. The adaptation process was via a 1-day workshop at which psychosocial counsellors, a teacher, a psychiatrist and researchers collaborated to adapt the intervention for use in rural Nepal. The intervention was delivered via trained local counsellors who worked with the children, school and parents using psychoeducation and support groups, and there were significant reductions in problem behaviours following the intervention. Notably, children from the Brahman and Chhetri castes and those from extended families showed the greatest reductions, whilst Dalit children and those from single-parent families benefited the least. Finally, Jordans et al. (2010) evaluated a classroom-based psychosocial intervention for children exhibiting psychosocial distress in the context of civil war. The intervention was delivered by trained community members, with the support of a trained counsellor. The authors do not report whether any cultural adaptations were made to the intervention. However, the programme was offered as part of a range of activities that aimed to strengthen community resilience including parent support groups, recreational activities and psychoeducation. The 5-week programme included elements from experiential therapy, cooperative play and CBT. They reported moderate short-term improvement on social-behavioural and resilience indicators. The higher caste Brahmin, Chhetri or Thakuri castes were over-represented in the sample compared with lower caste Dalit or Janajati; boys showed greater improvement on aggression, whilst girls improved more on pro-social behaviours. Of the studies which did not report benefit from their interventions, cultural adaptation was used, but it is noticeable that there was no community engagement, and indeed in one study, children were separated from the community in the UNICEF developed 'Child-Friendly Spaces' where children are provided with a safe space away from the local community in response to natural disaster or war (Hermosilla, Metzler, Savage, Musa, & Ager, 2019).

When we examine the scope of the literature in Nepal, the following implications are apparent. First,

the content of the intervention appears less important than prefacing it with robust community engagement work. Some studies labelled this specifically as an engagement process (Adhikari et al., 2018; Rose-Clarke et al., 2022), and others were arguably already engaged with western approaches through their training (Antle, Chesick, Sridharan, & Cramer, 2018) or it occurred as part of the way the intervention was situated within wider community-based activities (Jordans et al., 2010). Second, there needs to be a closer consideration of the impact of caste and gender on the acceptability of interventions and outcomes. There are insufficient data from intervention studies to draw conclusions in this area, yet qualitative research suggests it is worthy of consideration. For example, Cole, Tamang, and Shrestha (2006) discuss how social status determines the value placed on each emotion and consider how these values permeate early-childhood child socialisation practices as caregivers model and react to children's emotional responses. They note that, '...When properly regulated, anger may serve important aspects of Brahman competence' (Cole et al., 2006, p. 1249), whilst for the minority Tamang, who hold a Buddhist value structure, shame is a more salient and acceptable response in challenging situations. Caste also appears to interact with gender in important ways. Kiang, Folmar, and Gentry (2020) find that females across society are more susceptible to mental health problems and low self-esteem, and Dalit girls suffer a compounded minority status of both gender and caste and are especially vulnerable. In addition, insecurity caused by threats to their social status adversely impacts high-caste boys. This is important as there is some evidence in the existing literature for differential effects of the interventions on boys compared with girls (Jordans et al., 2010; Rose-Clarke et al., 2022).

These findings suggest that if we are to develop thoughtful cultural adaptations, we need to understand what determines risk and resilience for a given presenting problem, and how that differs across gender, cultural and ecological contexts. With regard to resilience, it may be that indigenous practices are best placed to support young people. In the west, there has been an explosion of interest in mindfulness-based interventions (MBIs) which is used to prevent and treat mental health difficulties in youth. MBIs originate from the Buddhist practice of Vipassana meditation, which is part of cultural practices in Nepal, known as *Dhyan*. Ironically, western mindfulness-based interventions have been brought back to Nepal and culturally adapted for young people (Antle, Chesick, Sridharan and Cramer, 2018).

Where interventions for collectivist cultures are designed by western researchers, a shift in focus is likely needed. In western cultures, psychological wellness and difficulties typically reside within the individual. There is often a desire for therapy to 'fix'

what is wrong. Essentially, collectivist cultures 'hold' emotional states in the spaces between individuals, within families or communities. Separating groups of individuals for psychological therapy detaches them from their place within their social network, which may further increase stigma and suspicion (e.g. adverse events reported in Rose-Clarke et al., 2022). In the Nepali studies with positive outcomes, it may be that 'community engagement' was a key ingredient in the successful outcomes. In this regard, engagement work that builds positive social relationships and develops awareness of patterns of social interactions, alongside alternative ways of responding, is supporting the essential building blocks for resilient and supportive social networks. Clinically, working in this systemic way is often benefitted by a 'light touch' approach rather than intensive interventions. Facilitating one shift and bringing awareness to patterns of responding within the system can have positive reverberations throughout the whole system.

Our scoping review of studies in Nepal suggests that before western interventions are adapted to collectivist LMICs, community engagement is critical. Furthermore, the context for the intervention needs to be considered, ideally delivering within a school or other community settings. The importance of collectivism in both the mode and content of delivery is woven throughout the existing literature on psychosocial interventions for young people in Nepal. That said, there are important differences in how emotions are experienced and responded to as a function of gender and caste. A systemic approach of bringing these differences to collective awareness in a safe way rather than offering an intervention to individual 'problems' will align more easily within collectivist cultures. Finally, and perhaps most importantly, is there a case for developing interventions in LMICs from the bottom up, building on existing practices for resilient responding, such as *Dhyan* in the case of Nepal, rather than importing western ones? Interventions such as mindfulness and yoga originate from eastern traditions, and we can be 'lost in translation' from east to west as easily as from west to east. If we are to remove the issue of the cultural appropriateness of western interventions, perhaps we need to move away from uprooting practices from their cultural ecosystem, only to return them in westernised form?

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Data availability statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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