Political violence and mental health: A multi-disciplinary review of the literature on Nepal

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Implementation of current international consensus guidelines regarding mental health and psychosocial support in emergencies requires the consideration of findings from both the medical and social sciences. This paper presents a multi-disciplinary review of reported findings regarding the relations between political violence, mental health and psychosocial wellbeing in Nepal. A systematic search of six databases resulted in the identification of 572 studies, of which 44 were included in the review. These studies investigated the influence of political violence on contextual variables that shape mental health and psychosocial wellbeing, and examined psychological distress and mental disorders in the context of political violence. The majority of studies addressed the mental health of Bhutanese refugees in Nepal and the impact of the Maoist People’s War. Based upon these results from Nepal, we discuss a number of issues of concern to international researchers and practitioners and present policy and research recommendations. Specifically, we consider (a) the need for longitudinal multi-disciplinary research into protective and risk factors, including agency, of psychological distress and mental disorders in situations of political violence, (b) the continuing controversy regarding the PTSD construct, and (c) the lack of robust findings regarding the effectiveness of mental health and psychosocial support.

Introduction

Mental health problems constitute a crucial public health problem, contributing 14% to the global burden of disease (Prince et al., 2007). Unipolar depression, for example, is the single leading contributor to years lived in less than full health (Patel, 2007). In spite of their importance, mental health infrastructure, human resources, and policy are critically lacking in low- and middle-income countries (LAMIC) (World Health Organization, 2005b). Settings of political violence, which are disproportionately represented by LAMIC, also demonstrate a high burden of psychosocial and mental health difficulties (de Jong, Komproe, & van Ommeren, 2003; Mollica et al., 2004). The changing nature of warfare since the second half of the 20th century, from mostly inter-state to intra-state conflicts in civilian-populated areas, has resulted in increased vulnerabilities of civilian populations to human rights violations, including disappearances, torture and sexual violence (Pedersen, 2002).

Scientific and humanitarian efforts aimed at preventing or reducing the psychosocial and mental health burden associated with political violence have been characterized by a divide between psychiatric and psychosocial approaches (van Ommeren, Saxena, & Saraceno, 2005). A dominant biomedical (psychiatric) approach, focused primarily on posttraumatic stress disorder (PTSD) symptoms, has been criticized for a lack of attention to the socio-cultural context in symptom expression and help-seeking, the medicalization of normal distress reactions, and an under-appreciation of existing ways of dealing with distress (Batnij, van Ommeren, & Saraceno, 2006; Bracken, Giller, & Summerfield, 1995). Currently, however, a trend towards an increasingly multi-disciplinary focus can be observed in both research and practice (de Jong & van Ommeren, 2002; Kirmayer, Lemelson, & Barad, 2007; Miller,
Kulkarni, & Kushner, 2006). For example, recent international consensus guidelines on mental health and psychosocial support in emergency settings emphasize the importance of both social strategies to promote wellbeing and providing care for those with severe mental disorders (Inter-Agency Standing Committee [IASC], 2007).

Humanitarian and other actors attending to the consequences of political violence therefore need to increasingly build on fields of knowledge that have traditionally been associated with different academic disciplines (i.e. medicine and the social sciences). One way to advance multi-disciplinary understanding of the relationship between political violence and psychosocial wellbeing and mental health is to synthesize existing literature from different fields. Our aim here is to provide a multi-disciplinary review of the published scientific literature addressing these relationships in Nepal, in order to (a) facilitate an increased understanding of the complex consequences of political violence on mental health, and (b) identify gaps in current knowledge.

Nepal presents a typical case example of post Cold War political violence (Harbom & Wallensten, 2007). Its recent Maoist armed insurgency was an intra-state conflict, mainly fought in civilian-populated areas affected by chronic poverty. Similar to the situation in other political violence-affected LAMIC, political violence was rooted in deep-seated structural causes, which are discussed in more detail below. Studying the specific case of Nepal provides an opportunity to report an overview of current state-of-the-art research findings in a typical setting. At the same time, concentrating on one country facilitates the possibility to combine medical and social science findings for a more in-depth analysis.

To guide this multi-disciplinary inquiry, we organize our paper on the basis of the theoretical framework depicted in Fig. 1. This framework synthesizes a number of key notions from good practice guidelines regarding mental health and psychosocial support in emergency settings (de Jong, 2002; Inter-Agency Standing Committee [IASC], 2007; Mollica et al., 2004; Psychosocial Working Group, 2003; van Ommeren et al., 2005).

First, the framework emphasizes the importance of contextual factors in shaping the mental health and psychosocial consequences of political violence. Rather than assuming a direct causal effect of traumatic events in creating symptomatology, mental health in LAMIC is associated with socio-contextual factors such as poverty, gender, education (Patel, Araya, de Lima, Ludermir, & Todd, 1999), and social connectedness (Hobfoll et al., 2007).

Second, the framework recognizes that political violence can have different levels of consequences for mental health and psychosocial wellbeing. Two of the six core principles of the IASC guidelines state that support systems should be integrated and multilayered, given the diverse ways in which people may be affected by emergencies (Inter-Agency Standing Committee [IASC], 2007). Depending on existent protective and risk factors, living in situations of political violence can result in (a) compromised psychosocial wellbeing/mental health (i.e. suffering which does not lead to impairment in daily activities), (b) psychological distress (i.e. emotional anguish accompanied by impairment in daily

![Theoretical framework](Fig. 1. Theoretical framework.)
activities), or (c) mental disorders (i.e. specific psychiatric suffering meeting diagnostic criteria) (cf. International Federation of Red Cross and Red Crescent Societies, 2009; World Health Organization, 2005a). A current controversy relates to how a distinction between psychological distress and mental disorder can be made (Horwitz, 2007). Epidemiological studies aimed at establishing prevalence rates of mental disorders often employ (non-validated) symptom checklists (Bolton & Betancourt, 2004). Such studies are likely to overestimate prevalence rates, because they lack ability to differentiate between psychological distress and mental disorder (e.g. because clinical significance of symptoms is not assessed) (Rodin & van Ommeren, 2009). For the purpose of this paper, we have pragmatically chosen to report findings according to the authors’ use of terminology. In other words, if authors report findings in terms of Western psychiatric classification, we categorize them as studies concerned with mental disorders and not psychological distress.

Third, the framework stipulates the importance of existing socio-cultural resources in mediating the consequences of political violence for psychosocial wellbeing and mental health. Researchers have stressed the importance of attention to factors that can promote wellbeing in the adverse circumstances of political violence, in order to (a) avoid undermining existing coping capabilities through the introduction of new programs, (b) increase the sustainability of introduced mental health and psychosocial support, and (c) start the repair of damage to the social fabric associated with political violence (e.g. diminished traditional leadership or religious practices) (Boyden & de Berry, 2006; Tol, Jordans, Reis, & de Jong, 2009; Wessells & Monteiro, 2004).

Finally, the framework conceptualizes political violence as a phenomenon that both arises within a given socio-cultural context (e.g. structural inequalities) and one that influences it (e.g. violence aimed at transforming gender relations), in a dynamic relationship. Threats to mental health and psychosocial wellbeing in such situations may be conceptualized as ‘social suffering’, a category of suffering which “results from what political, economic, and institutional power does to people, and reciprocally from how these forms of power themselves influence responses to social problems” (p.37 Kleinman, Das, & Lock, 1997).

Below, we discuss the findings of our review of the literature in relation to this model. We discuss (a) the influence of political violence on contextual variables that shape mental health and psychosocial wellbeing and (b) the consequences of political violence in terms of psychological distress and mental disorders. We first describe the politico-historical setting of Nepal and outline the review methodology.

### Setting

Table 1 provides an overview of the political history of Nepal, which since its inception as a nation state has been far from peaceful. From undocumented armed rebellions against early autocratic rule (Karki & Seddon, 2003), an armed insurrection in 1950, the Jhapa uprising in 1971, to the recent decade-long Maoist insurgency, organized violence has a longer history in Nepal than the Western imaginations of Nepal as Shangri-La would suggest (Gellner, 2003; Metz, 2003). The major situations involving political violence in Nepal are (i) the general use of political violence by state security forces throughout Nepal’s history, including torture (Lykke & Timilsena, 2002; Stevenson, 2001) and use of excessive violence (Shrestha, 2007), (ii) the plight of refugees in Nepal from Tibet and Bhutan (Dolma, Singh, Lohfeld, Orbinski, & Mills, 2006; Hutt, 1996), and (iii) the recent decade-long Maoist conflict (1996–2006). Most of the studies identified in this review concerned Bhutanese refugees and the Maoist conflict.

Nepali-speaking Bhutanese settled in Southern Bhutan at the end of the 19th century constituting a minority ethnic group. Following a number of government policies favoring majority ethnic group dress and language, including the 1987–1992 “one nation, one people” 5-year plan, a violent struggle by Nepali-speaking Bhutanese met with an aggressive crackdown of the state, which included the use of torture by Bhutanese security forces (Hutt, 1996). Since the early 1990s, this resulted in a mass exodus of around 100,000 people to UN-administered camps in south-eastern Nepal. Following continuing political deadlock, refugees have recently been offered resettlement to five industrialized countries.

The origins of the armed Maoist insurgency have been attributed to poverty, unequal division of wealth, ethnic, regional and caste discrimination, disappointment with state governance and violent state responses to the Maoist movement (see Hutt, 2004; Thapa, 2003; Thapa & Sijapati, 2004). With a GDP of $260 per year, Nepal is one of the poorest countries in the world (World Bank, 2007) and as mentioned above, this poverty, is unequally divided.

**Table 1**

**Overview of Nepal’s political history.**

<table>
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<tr>
<th>Period</th>
<th>Events</th>
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<tbody>
<tr>
<td>1740 to 1768–1769</td>
<td>Pritivi Narayan Shah conquers disparate fiefdoms, establishing the kingdom of Nepal.</td>
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<tr>
<td>1846–1950</td>
<td>Rana family seizes power, and takes on an autocratic hereditary prime minister role with King from Shah family as figurehead.</td>
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<tr>
<td>1956–1990</td>
<td>Armed insurrection by the Nepali Congress with support from the Red King Tribhuvan leads to peace negotiations which end Rana autocracy.</td>
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<tr>
<td>1950</td>
<td>China occupies Tibet, which starts a currently ongoing flow of Tibetan refugees into Nepal and India.</td>
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<tr>
<td>1960–1996</td>
<td>King Mahendra seizes power and introduces the Panchayat system in 1962, which bans political parties.</td>
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<tr>
<td>1999–2001</td>
<td>Parties unite and start the first People’s Movement (Jana Andolan). Start of politically unstable multi-party democracy</td>
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<tr>
<td>2001–2002</td>
<td>On February 13th the Communist Party of Nepal (Maoist), attacks police posts and a state-owned agricultural development bank in five districts, starting the “People’s War”.</td>
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<tr>
<td>2002–2005</td>
<td>In October 2002, King Gyanendra dismisses parliament. Maoists control large parts of countryside and have set up parallel administrations in a number of districts. King Gyanendra assumes direct control over the state.</td>
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<tr>
<td>2006–2008</td>
<td>Coordinated protests by political parties and Maoists in April 2006 (Jana Andolan II). Political parties and the CPN(M) broker fragile peace agreement, form an interim government and declare an interim constitution, which designates Nepal as a federal republic. Elections for a constituent assembly take place in April 2008 and CPN(M) becomes largest party.</td>
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<tr>
<td>2009</td>
<td>A coalition government, led by the CPN(M), falls in relation to ongoing dispute over the integration of former Maoist combatants in the national army. Political instability continues.</td>
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Thapa and Sijapati (2004) state that the economy of Nepal has favored the urban, the rural rich, and a handful of elites. Moreover, economic and political power is centralized in the capital, with minor representation from rural regions. In addition, Nepal tops the gender inequality index in South Asia, with a higher workload for women, lower literacy, earlier average mortality, and myriad discriminatory laws (Gautam, Banskota, & Manchanda, 2001). These gender disparities have fueled the armed conflict, evidenced by an approximate 30 percent of the Maoist political wing comprised of women and 17 percent of the Maoist military comprised of women (Pettigrew & Shneiderman, 2004; Sharma & Prasain, 2004). Ethnic inequality, institutionalized through the Hindu caste system, is visible in the lack of representation of ethnic diversity in government positions; in 2001, 98% of people passing civil service examination were from Hindu hill groups, even though they constitute 29% of the population (Thapa & Sijapati, 2004). After fleeting political optimism following the 1990 transition to multi-party democracy, the public has blamed the government for lack of economic growth, political instability, and institutionalized corruption (Gellner, 2003; Karki & Seddon, 2003). Moreover, widespread human rights abuses and strong repression of dissent by the state, and specific police operations have been cited as driving conflict (Shneiderman, 2004; Thapa, 2003).

Methods

To ensure inclusion of studies from both medical and social science disciplines we searched the following databases: MEDLINE (1950 – present, and in process), PsychInfo (1804 – present), PILOTS (Published International Literature on Traumatic Stress; 1871 – present), RLG’s Eureka Anthropology Plus (late 19th century – present), as well as the JSTOR, and AnthroSource (both no limitation in years) websites. Our search was performed on June 22nd 2007 and repeated February 13th 2009 with the following search terms: ‘Nepal violence’, ‘Nepal armed conflict’, ‘Nepal war’, ‘Nepal torture’, ‘Nepal mental health’, ‘Nepal psychosocial’, ‘Nepal psychological’, ‘Nepal social’, ‘Nepal trauma’, and ‘Nepal PTSD’.

All studies resulting from this search were checked on title, key words and abstract on inclusion criteria: (a) study contains original data or is a systematic review, (b) concerns a study population in Nepal, (c) makes specific reference to political violence, and (d) focuses on mental health/psychosocial wellbeing. Book reviews and editorials were excluded, but we did not set any exclusion criteria based on the design or quality of studies. Only English language publications were included. Subsequently, all included studies were divided into groups representing specific target groups or disciplines, and divided over authors specialized in these disciplines.

Cross-referencing took place by examining all cited references of included studies on title, abstract and key words. Authors responsible followed a central format that ensured standardization of adherence to inclusion and exclusion criteria. The latter was checked for all studies by the first author. Finally, we asked a group of authors working on this topic in Nepal if they knew of relevant studies that could be checked for inclusion. Relevant text passages were summarized and entered into a structured format. This format listed title, authors, year of publication, sources of publication, short summaries and information relevant to the review category with page numbers. Subsequently, the authors collaboratively drafted a summary of findings which formed the basis of this text.

Our 2007 search resulted in 525 references. Out of those studies, 31 met inclusion criteria. A further seven studies were identified through cross-referencing. The 2009 follow-up search identified an additional 47 studies of which six met inclusion criteria. The final total number of studies included in the review was 44 (31 on first review, seven from cross-referencing, and six from follow-up review). An overview of these studies is provided in Table 2.

Results

Political violence and context: challenges to psychosocial wellbeing and mental health

A number of – mainly qualitative – studies have described the impact of the Maoist insurgency on contextual variables that shape psychosocial wellbeing and mental health. Conforming to the global trend of armed conflicts, which increasingly puts non-combatants at risk, a number of authors have emphasized the local population’s engagement in the armed conflict, both as victims and participants. Ogura (2004), in her account of the Maoist military attack on the town of Beni, describes how populated schools were used as military sites, how children were forced to provide medical care and carry supplies, and how local people were forced to aid in the attack. Similarly, Pettigrew (Pettigrew, 2001) describes how the State of Emergency resulted in civilians bearing the brunt of increased human rights violations by both warring parties, including torture, disappearances, extra-judicial and execution style killings.

Participation in the fighting is described in ethnographic studies by Shneiderman (Shneiderman, 2004), Shah (Shah, 2008) and Wilmore (Wilmore, 2008). Shneiderman concentrates on how the formation of political consciousness in a specific village over time contributed to people’s decisions to join the Maoist movement. She argues this political consciousness emerged in the context of a 1984 massacre in which police forces killed seven people after villagers’ expressed discontent with local landowners’ behavior. Shah, in contrast, analyzes local resistance in Dalikhel district against the Maoists imposing a “new regime”, which involved a number of cultural reforms by the Maoists (e.g. discouraging religious festivals/worship and supernatural practices). What both papers share in common is a focus on the agency of local people to either join or react against the Maoist movement, and the skeptical reception of this “peasant agency” by Western and urban intelligentsia. In this addition, Wilmore (Wilmore, 2008) has suggested the burgeoning of new media such as television in rural areas changes the perception of power and the public’s ability to transform power relations, ultimately contributing to increased support for Maoists and decreased endorsement of monarchical rule.

This proximity of the Maoist insurgency in the daily lives of people resulted in a number of challenges to the very institutions and social notions that help shape the daily lives of people in

<table>
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<th>Table 2</th>
<th>Overview of identified studies.</th>
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<tr>
<td>Type of study</td>
<td>Focus</td>
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<tr>
<td>Ethnographic and other qualitative studies</td>
<td>Bhutanese refugees</td>
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<td>Tibetan refugees</td>
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<tr>
<td>Identification of human rights abuse</td>
<td>Maoist insurgency</td>
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<tr>
<td>Reviews of (grey) literature</td>
<td>Bhutanese refugees</td>
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<td></td>
<td>Maoist insurgency</td>
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<tr>
<td>Quantitative: cross-sectional studies</td>
<td>Police brutality</td>
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<td></td>
<td>Maoist insurgency</td>
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<td></td>
<td>IDP</td>
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<tr>
<td>Quantitative: case control studies</td>
<td>Bhutanese refugees</td>
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<td></td>
<td>Former child soldiers</td>
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<tr>
<td>Treatment</td>
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<td>Total</td>
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conflict-affected areas. Studies of the conflict between Maoists and government security forces have described (a) decreased access to healthcare, (b) militarization of economic relations and infrastructure development, (c) changes in social relations in communities with stronger Maoist presence, and (d) threats to child development.

Numerous studies describe reduced access to health care (Collins, 2006; DFID, 2003; Ghimire & Pun, 2006; Stevenson, 2002) including impoverished children’s healthcare (Boyden, De Berry, Feeny, & Hart, 2006; Singh, Bahlar, Dahal, & Mills, 2006). Maoists destroyed health infrastructure by bombing health posts (DFID, 2003; Singh et al., 2006). They also stole medications from pharmacies and suppliers (Ghimire & Pun, 2006). In addition, their closure (Nepali: bandh) of roads and businesses throughout the country through strikes and other protests prevented the transport of needed medical supplies (DFID, 2003; Ghimire & Pun, 2006). Government policies stopped the provision of medical care through a directive issued during the State of Emergency in 2001. The directive stated that all health professionals were to deny treatment to suspected Maoists (Stevenson, 2002). Health professionals who did not report alleged “terrorists” were at risk of imprisonment and at least one physician was incarcerated (DFID, 2003; Pettigrew, 2001; Stevenson, 2002). The lack of confidentiality and arbitrary detention by security forces of people seeking healthcare led to a reduction of help-seeking at medical facilities (Singh, 2004; Stevenson, 2002). Some health practitioners reacted against these and other state-sponsored forms of oppression resulting in their imprisonment as well (Orbinski, Beyrer, & Singh, 2007). Ultimately, the general lack of security exacerbated the rural-urban divide in provision of healthcare with 40% of doctors now working in Kathmandu where 15% of the population resides (Collins, 2006).

The militarization of economic relations and infrastructure is exemplified by stagnation of human development in Nepal (Boyden et al., 2006; Kumar, 2003). Both the government and Maoists sidelined economic development; the government through its “security first” approach (Kumar, 2003) and the Maoists through their ideology of “destruction before construction” (Singh, 2004). The government increasingly directed funding towards military spending (Bhattarai, Conway, & Shrestha, 2005; Thapa & Sijapati, 2004). Access to education and healthcare became restricted to those who could pay for it out of pocket. This resulted in an increasing gap between rich and poor. In 2003, the bottom 20% of the population subsisted of 3.7% of the national income, while the top 10% monopolized 50% of the wealth (Kumar, 2003). Tourism, the third largest industry, also decreased dramatically due to both the internal conflict and the global war on terror (Bhattarai et al., 2005).

Thirdly, qualitative research has pointed to the conflict changing social relations in a number of affected communities. For instance, social networks in villages in central Nepal were reported to be constricted due to increased levels of suspicion (Pettigrew, 2003). Pettigrew described the challenges made in these majority ethnic Tamu-Gurung villages to older people’s pre-existing notions of gender, age, and hierarchy when Maoists mobilized women and provided village youth with an alternative entry into agency and modernity. Similarly, women were reported to assume roles traditionally restricted to men (Sharma & Prassain, 2004). In reaction to the threatened communal bonds, religious leaders in predominantly Buddhist regions have advocated for more attention to traditional religious practices and more conservative practices (Berg, 2003).

The Maoist rebellion also was reported to threaten child development through a number of pathways. Children suffered forced separation when caregivers were killed or abducted (Boyden et al., 2006). Maoists forced children to watch the humiliation of adults by Maoist insurgents, often consisting of violent harassment of teachers and parents (Boyden et al., 2006; Pettigrew, 2007). Berg (2003), for instance, describes the public beating of the Hillary Secondary School headmaster by Maoist cadres. There is anecdotal evidence which suggests that young women’s marriages were arranged at increasingly earlier ages to evade recruitment by Maoists (Pettigrew, 2001); the conflict may have also increased children’s use of violence (Boyden et al., 2006). Also, boys in villages in central Nepal were reported to take on adult male roles, as men fled to safety and work outside the village (Pettigrew, 2007). During the attack of the Beni district headquarters, Maoists forcibly recruited children to care for the wounded and transport the injured and dead (Ogura, 2004). Children have been described to live in fear of violent battles on school grounds and abductions by Maoists to attend indoctrination programs or to be trained as child soldiers (Singh, 2004; Singh et al., 2006). Specifically, the effects on children in villages in central Nepal have been described as ‘learning to be silent’; caregivers socializing children not to interact or speak with strangers (Pettigrew, 2007).

These challenges to psychosocial wellbeing and mental health in the wake of the Maoist insurgency must be evaluated in light of other difficulties. Pettigrew (Pettigrew, 2007) notes that conflict-related problems of villagers in Maoist-affected areas in central Nepal should be viewed in the context of pre-existing hardship, including poverty and the general difficulties of rural life in remote villages. Similarly, Kohrt et al. (Kohrt et al., 2005) found that somatic complaints and depressive symptoms were tied strongly to age, lack of education, poverty, female gender, family stress, and financial stress in addition to political stress.

**Political violence and psychological distress**

As with the research on political violence and contextual variables, most studies reporting on political violence and psychological distress in Nepal were conducted in the context of the Maoist insurgency and were qualitative in nature. Increased presentation of psychological distress was reported by doctors at a rural hospital during the conflict period despite the overall decrease in hospital visits for fear of referral to security forces (Singh et al., 2006). Similar observations on distress were made by health professionals in other areas, including urban areas (DFID, 2003). Pettigrew (Pettigrew, 2003) has described the fear among rural women living in a community in central Nepal frequented by Maoists and the security forces. Non-aligned villagers could be accused of aiding the opposite side and severely punished. Villagers were forced to feed Maoists traveling through villages, which placed them at risk for accusations by security forces of being involved in rebel activity. Pettigrew adds that villagers believed that the souls of those who died violently without proper funeral rites wandered through the hills and valleys and potentially disrupted the well-being of the living. This fear manifested as sleep disturbances and chronic illness characterized by somatic complaints such as headaches.

Based on ethnographic data from the same area, non-aligned villagers are described as being deeply fearful, and fear is institutionalized as a means of social control (Pettigrew, 2004). With regard to children, Pettigrew observes that living in this particular conflict zone resulted in both increased competencies as well as increased psychological distress. Ten year old 'Raju' is considered to be raba (Tamu for 'streetwise', competent; i.e. knowing how to answer the Maoists' questions about his family’s possessions), but as a child, he is also considered to be more susceptible to fear and emotional distress than adults, because of an underdeveloped sai (Tamu for 'heartmind') (Pettigrew, 2007). Similarly, Boyden et al. report psychological distress in children, including feelings of
extreme shock, sadness, impaired concentration, and social reluc-
tance, based on a review of the grey literature in Nepal and inter-
views with stakeholders (Boyden et al., 2006).

Political violence and mental disorder

Increased mental disorders have been reported for (a) people
affected by the Maoist insurgency (including the general pop-
ulation, internally displaced populations (IDPs), and former child
soldiers), and (b) (tortured) Nepali-speaking Bhutanese refugees
(see Table 3 for an overview of epidemiological findings).

Prevalence rates vary greatly over these different populations, as
well as within populations. For instance, PTSD rates range from 3 to
4% (non-tortured Bhutanese refugees) to 60% (help-seeking torture
survivors). For tortured refugees, the prevalence of depressive
disorders ranged from 8% to 25%. These differences might be
attributed to differences in sampling (e.g. help-seeking vs. random),
contextual factors (e.g. exposure to different levels of political
violence, poverty, lack of access to basic services), and the afore-
mentioned difficulty to separate psychological distress from mental
disorder in an active conflict setting (for an overview see (Rodin &
van Ommeren, 2009). Despite these important limitations, Mills
et al., in their review of findings with tortured Bhutanese refugees
in Nepal, feel confident to state that findings display “a consistent
long-term impact on the mental health of the refugee population”

A general strength of the identified epidemiological studies
considers the application of locally validated (criterion) instru-
mentation, in contrast to the general literature on political violence
and mental health. However, the majority of studies (67%) applied a
cross-sectional design and the remaining were case control studies,
limiting the ability to confirm a causal relationship between
exposure to political violence and mental disorders. Three out of
seven epidemiological studies (43%) applied random sampling. The
other studies relied on convenience sampling, limiting external
validity of findings.

Identified studies report a number of protective and risk factors
for mental disorders. With regards to people affected by the Maoist
insurgency, Duncan et al. (Duncan, Gidron, Shrestha, & Aryal, 2005)
found that, among a convenience sample of a generally affected
population, older age, less education, residing in rural areas, and a
subjective measure of psychological closeness to political violence
predicted more PTSD symptomatology. Thapa and Hauff’s (S. B.
Thapa & Hauff, 2005) survey with a convenience sample of inter-
ally displaced persons (IDPs) – a generally neglected population
(Singh, Sharma, Mills, Poudel, & Jimba, 2007) – in seven districts
showed that feeling miserable on immediate arrival at a new place
was associated with depression, anxiety and PTSD symptoms at a
later time-point. Illiteracy was associated with anxiety whereas
female gender, and being aged 41–50, was associated with depression
symptomatology. Experiencing more than three traum-
atic events was associated with PTSD, whereas evacuation to
placement locations after a weeklong preparation and “low” caste appeared as protective factors for PTSD (S. B. Thapa & Hauff,
2005). Furthermore, being a former child soldier has been identi-
cified as a risk factor for mental health problems (Kohrt et al., 2008);
former child soldiers had more PTSD (especially girls) and depression symptoms in comparison to children never conscripted
by armed forces, also after controlling for trauma exposure.

Studies among Nepali-speaking Bhutanese refugees also
specifically report a number of protective and risk factors for
mental health. First, qualitative research has identified coping
strategies used among tortured Bhutanese refugees (Sharma &
van Ommeren, 1998). Positive coping strategies included performing
worship, visiting a traditional healer, and singing songs, whereas
negative coping strategies included drinking alcohol, fighting or
arguing, and isolating oneself from other people. A subsequent
quantitative case–control study confirmed a relation between
negative coping strategies, social support and psychiatric symp-
toms; negative coping was related to higher scores on all symptom
measures, and perceived social support (as opposed to received
social support) was associated with somatic symptoms and
depression. Second, the qualitative study identified a number of
idioms of distress, including the importance of medically unex-
plained somatic symptoms (Sharma & van Ommeren, 1998). PTSD
symptoms (independent of anxiety and depression) predicted both
the number of reported somatic complaints as well as the number of
organ systems involving such complaints in a case–control study
(van Ommeren et al., 2002). Further research was conducted to
identify risk factors for an epidemic of medically unexplained
illness in the Bhutanese refugee camps, involving fainting and
dizziness among adolescents in fear of spirit possession. Risk
factors for illness identified in this case control study were recent
loss, childhood trauma, and pulse rate (van Ommeren et al., 2001).

In addition to protective and risk factors, two studies have
addressed disability associated with psychiatric symptomatology.
In both studies disability was assessed using a Nepali version of
the World Health Organization Disability Assessment Scheme (WHO
DAS 2.0, 12-item version), which was developed as a cross-cultural
instrument in 19 countries, assessing difficulties related to health
problems; including household work, communal functioning, work
and friendships. The first concerned further analyses on the case
control study involving a randomly selected sample of tortured and
non-tortured Nepali-speaking Bhutanese refugees. These analyses
revealed that although tortured refugees had more mental health
problems, they did not show more disability than non-tortured
refugees. In addition, different predictors for disability were
present among both groups; PTSD, specific phobia and present
physical disease were predictive of disability among tortured
refugees, whereas present physical disease, greater age and
generalized anxiety disorder were associated with disability among
non-tortured refugees (S.B. Thapa, van Ommeren, Sharma, de Jong,
& Hauff, 2003). Tol et al. (Tol et al., 2007) explored relations
between psychiatric symptoms and disability among non-refugee
torture survivors in rural Nepal in a cross-sectional study. Applying
statistical modeling techniques, the best fitting model showed a
central role for PTSD; PTSD had a direct relationship with disability,
and an indirect relationship mediated by anxiety and depression.

Available Mental Health and Psychosocial Support (MHPSS)

In general, a dearth of literature exists regarding available
MHPSS for populations affected by political violence in Nepal. This
is especially problematic given the large gaps in mental health
policy and human resources for emergency preparedness
(including conflict) identified in a review of Acharya et al. (Acharya,
Upadhy, & Kortmann, 2006). They conclude that further
strengthening of the mental health and psychosocial aspects of
disaster preparedness is strongly recommended. Although mental
health services are largely lacking at the district level, the authors
refer to the common availability and uptake of faith healing.

With relevance to political violence, support for the prominence
of faith healing is found in an explorative qualitative study by
Schwartz et al. amongst Tibetan refugees in the Kathmandu Valley.
They emphasize the importance of Tibetan conceptualizations
of mental illness, especially the relevance of balance between the
three body humours (wind, bile, and phlegm). Eighteen of the
twenty-one participants were observed to use the Tibetan healing
system for mental health complaints, including Tibetan medicine
and Buddhist religious practices (Schwartz, Tol, Sharma, & de Jong,
Table 3
Overview of epidemiological findings.

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample/Design (N)</th>
<th>Psychiatric symptoms assessed (Instrumentation)</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shrestha et al., 1998</td>
<td>Random sample of tortured Bhutanese refugees/Case-control (n = 1052)</td>
<td>PTSD (DSM-III-R criteria), anxiety &amp; depression (HSCL-25°)</td>
<td>Refugees:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: 34%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression: 14%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tortured refugees:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 14%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: 43%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression: 25%</td>
</tr>
<tr>
<td>van Ommeren et al., 2001</td>
<td>Random sample of tortured Bhutanese refugees/Case-control (n = 810)</td>
<td>Psychiatric diagnoses (CIDI)</td>
<td>Refugees:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Persistent pain disorder: 28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Affective disorder: 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Generalized anxiety disorder: 6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Specific phobia: 26%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dissociative disorder: 3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tortured refugees:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 43%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Persistent pain disorder: 51%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depressive disorder: 8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Generalized anxiety disorder: 6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Specific phobia: 22%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dissociative disorder: 10%</td>
</tr>
<tr>
<td>Kohrt et al., 2005</td>
<td>Random sample of general population in Jumla/ Cross-sectional (n = 316)</td>
<td>Anxiety (BAI°), depression (BDI), local idiom of distress (jhum-jhum self-report)</td>
<td>General population:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: 28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression: 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>jhum-jhum: 42%</td>
</tr>
<tr>
<td>Thapa &amp; Hauff, 2005</td>
<td>Convenience sample of Internally Displaced Persons/ Cross-sectional (n = 290)</td>
<td>PTSD (PCL-C°), anxiety &amp; depression (HSCL-25)</td>
<td>IDP’s:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 53%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: 81%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression: 80%</td>
</tr>
<tr>
<td>Tol et al., 2007</td>
<td>Convenience (help-seeking) torture survivors/ Cross-sectional (n = 201)</td>
<td>PTSD (PCL-C), anxiety &amp; depression (HSCL-25)</td>
<td>Torture survivors:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: 86%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression: 81%</td>
</tr>
<tr>
<td>Kohrt et al., 2008</td>
<td>Former child soldiers and children never conscripted/Cross-sectional cohort (n = 282)</td>
<td>Depression (DSRS), anxiety, (SCARED-5), PTSD (CPSS), general psychological difficulties (SDQ), function impairment (CFI°)</td>
<td>Former child soldiers:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 55%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: 46%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression: 53%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>General psychological difficulties: 39%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Function impairment: 62%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Children never conscripted:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PTSD: 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: 38%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression: 24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>General psychological difficulties: 19%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Function impairment: 45%</td>
</tr>
</tbody>
</table>

Note: BAI° Beck Anxiety Inventory, BDI° Beck Depression Inventory, CFI° Child Function Impairment; CIDI° Composite Diagnostic Interview; CPSS° Child PTSD Symptom Scale, DSRS° Depression Self-Rating Scale, HSCL-25° Hopkins Symptom Checklist-25, PCL-C° PTSD Checklist – Civilian version; SCARED-5° Screen for Child Anxiety Related Emotional Disorders – 5 item version; SDQ° Strength and Difficulties Questionnaire. Information on Nepali scales can be requested from authors.

jhum-jhum (Nepali) concerns a form of parasthesia, involving sensations of numbness and tingling.

° The HSCL-25 was later validated by Thapa & Hauff, 2005.

b The BDI and BAI were validated against a clinical diagnosis.

c The PCL-C and HSCL-25 were validated against local corresponding syndromes and a CIDI diagnosis.

d 12-month prevalence is reported for all psychiatric diagnoses.

e DSRS, SCARED-5°, PTSD, SDQ, and CFI were validated against standardized indication for a psychosocial intervention as determined by a local counselor using the Global Assessment of Psychosocial Disability as external criterion.
2005). Similar observations about the benefit of (Hindu) religious practices were made with regards to Nepali-speaking Bhutanese refugees in a qualitative study (Sharma & van Ommeren, 1998). In addition, Tol et al. describe the significance of informal social networks to share distress and symptoms, as well as traditional (shamanistic) healing practices for those suffering mental health complaints in relation to political violence in a conceptual analysis (Tol, Jordans, Regmi, & Sharma, 2005).

As government mental health services are scarce, non-governmental organizations have been prominent actors in the provision of mental health and psychosocial support for specific target groups. Services delivered by a specialized center for torture survivors are described by Van Ommeren and coworkers (van Ommeren, Sharma, Prasain, & Poudyal, 2002). They described a treatment package given to 680 torture survivors within a one-year period. This largely clinic-based care provision consisted of the following three components: (1) intake, assessment and assigning of case-manager; (2) multi-disciplinary case discussions and treatment planning; (3) provision of service package, with eclecthic counseling and psychiatric referral as the core psychosocial services. The effectiveness of this care package was examined in a non-randomized controlled study (Tol, Krompe, et al., 2009). The authors conclude that although services seemed effective with regards to non-specific consequences of torture (somatic complaints, subjective wellbeing and functioning), they were not effective for reducing psychiatric symptoms (PTSD, depression, anxiety symptoms). They advise that other options for the treatment of psychiatric symptoms in torture survivors need to be identified, while keeping in mind the resource poor setting of Nepal.

Finally, Jordans et al. reported the perspectives of direct and indirect beneficiaries of psychosocial counseling for children and young adults that have been survivors of trafficking for sexual exploitation and other high-risk situations (Jordans, Keen, Pradhan, & Tol, 2007). The studied intervention, problem solving and supportive counseling, consisted of non-specific therapeutic elements, such as empathy, intercultural sensitivity and basic communication skills, with structured steps that aimed to reduce both stressor-induced symptoms of distress as well as problem situations. The research showed most beneficiaries to be satisfied with the service, which they considered culturally appropriate.

Discussion

The findings of this multi-disciplinary review on political violence, mental health and psychosocial wellbeing in Nepal touch upon a number of key issues and controversies present in the international field of research and practice. We discuss these key issues below, in relation to the assumptions underlying the theoretical model outlined in the introduction: (a) the importance of socio-cultural factors in mediating the impact of political violence, (b) the diversity of mental health and psychosocial consequences, (c) the value of existing resources, and (d) the interaction between political violence and context.

First, our review identified a number of – mainly qualitative – studies focused on the adverse impacts of the Maoist insurgency on aspects of daily life. Such studies evidence reduced access to basic needs (health care and livelihood) and changed social relations at family and community levels, and thereby compellingly suggest the importance of social determinants for mental health and psychosocial wellbeing. These findings are congruent with the first principle of ecological theory, which stipulates that ecological interventions should aim to alter problematic settings rather than disturbed intra-psychic functioning (Miller & Rasco, 2004). Moreover, these findings from Nepal mirror the conclusion of a global review of qualitative studies that “social scientists appear to call for a social response that more actively engages the political, social, and economic causes of suffering” (Batniji et al., 2006 p.1853). In essence, this can be said to reflect the core assumption of the psychosocial paradigm in humanitarian response, in which psychological states are closely related to social conditions.

However, no research in Nepal was identified that aimed at establishing a causal relation between contextual variables, psychological distress and mental disorders. In general, there is a lack of rigorous studies in low- and middle-income countries that confirm causal relations between social determinants and mental health (Patel & Kleinman, 2003). Such research in our opinion would need to be inter-disciplinary, longitudinal, and multi-level in nature. In Nepal, research on the effects of war has been mainly cross-sectional in nature rather than longitudinal, as is the case internationally (Mollica et al., 2004). Without longitudinal research, however, a causal relation between political violence and psychological distress and mental disorders cannot be confirmed. Such longitudinal research would need to take into account local conceptualizations of mind and body (Kohrt & Harper, 2008), and local concepts and idioms of distress. These can be identified through qualitative research methods, e.g. in mixed methods designs (de Jong & van Ommeren, 2002). Longitudinal research in conflict-affected settings is of course difficult to organize, given a volatile situation, displacement of populations and the general scarcity of research capacity in LAMIC.

Second, we found few studies that examined the possible positive consequences of changed social relations during the Maoist insurgency. This concerns a major gap in the Nepali literature, given the frequent calls for psychosocial programs to incorporate the strengths and resources of local populations (Wessells & Monteiro, 2004). For instance, initial Maoist actions against alcohol abuse, gambling, and domestic violence and Maoist advocacy for gender and caste equality could have resulted in improved well-being of underprivileged communities. Focusing on the structural inequalities existent in Nepal was a successful Maoist recruitment strategy. On the other hand, it must be noted that in the wake of the insurgency the rural–urban divide in access to health care increased, as did gender inequality. Because current armed conflicts are often related to exactly such deep-seated structural causes as access to resources and social inequalities (Pedersen, 2002), in which civilians are engaged both as victims and participants, knowing what negative and possibly positive consequences political violence has for wellbeing should be an issue of central concern.

In our opinion, the review points here to the importance of agency, an area of investigation usually overlooked in biomedical studies. In contrast, social scientists have been increasingly interested in the influence of individuals in transforming their socio-political environments rather than them falling victim to structural social forces (Boyd & de Berry, 2006). Likewise, “participation” of the local population in humanitarian interventions is a core principle in the IASC guidelines. In our review, three ethnographic studies described the direct interaction of rural populations – in diverse ways – with the Maoist insurgency, but no explicit link with mental health or psychosocial wellbeing was made. Agency may constitute a protective factor in situations of armed conflict. In Nepal, continued affiliation with an armed group was associated with fewer mental health difficulties among former child soldiers (Kohrt et al., 2008). Similarly, previous research in Turkey has found that political affiliation protected against psychological problems in torture survivors (Basoglu et al., 1997). Despite consensus on participation in humanitarian response, a review of the international literature on children in emergencies only found anecdotal evidence to support it (Morris, Van Ommeren, Belfer, Saxena, &
Saraceno, 2007). More (multi-disciplinary) research on this topic, internationally and in Nepal, is necessary in order to inform interventions on how best to engage war-affected populations from the grassroots in humanitarian interventions.

Third, the studies included in this review suggest diverse impacts of political violence, ranging from psychological distress to mental disorders. In general, the review showed a tendency for qualitative studies to focus on context and psychological distress, whereas quantitative research predominantly focused on psychiatric symptoms and mental disorders. Relatively little attention was given to assessment of idioms of distress; a serious gap in knowledge given Nepal’s varied cultural landscape. In comparison, increasing reports in the international literature have been made of quantitative assessment of psychological distress (Jordans, Komproe, Tol & de Jong, 2009).

Although we made a distinction between studies addressing distress and disorder, this distinction is problematic in the Nepal literature in a number of cases. A recent meta-review of research on mental health outcomes after exposure to political violence has shown that non-random sampling, smaller sample sizes and the use of self-report questionnaires are associated with higher reported prevalence rates (Steel et al., 2009). Although three out of seven identified epidemiological studies in Nepal applied random sampling, only one applied a diagnostic tool (the CIDI), and only one involved more than 1000 participants. In addition, most studies were undertaken either in refugee camps or an ongoing situation of adversity. This leaves open the possibility that measured complaints present psychological distress rather than mental disorders. Prevalence rates must thus be interpreted with caution.

With regards to increased mental disorders, we also would like to draw attention to the international controversy regarding the importance of PTSD (Miller et al., 2006; van Ommeren et al., 2005). Based on our findings, we emphasize the risks inherent in a narrow focus on PTSD. Research with former child soldiers, torture survivors, and the general population show a high burden of common mental disorders, including anxiety, depression and somatic symptoms, rather than heightened levels of PTSD symptoms. Moreover, in most of the studies reviewed the prevalence of the common mental disorders was as great as or greater than the prevalence of PTSD. However, in contrast to the often all-or-nothing character of the current debate, we argue against throwing out the baby with the bathwater. Research with torture survivors in Nepal identified a clear role for PTSD symptoms with regards to disability in daily life, thereby supporting the cultural validity of this set of symptoms for this particular target group (de Jong, 2005). Validity of the PTSD construct is also supported by a dose-response relation (i.e. the more exposure to political violence the more PTSD symptoms) found in a number of studies. We argue that prioritization of treatment for mental disorders should be done on the basis of an investigated relation with disability.

Fourth, with regards to existing mental health and psychosocial support, we sadly note the scarcity of studies from Nepal. Patel et al., in their review of mental health treatments in emergency settings, noticed a similar gap in the international literature (Patel et al., 2007). The lack of effectiveness with regards to psychiatric symptoms of a popular multi-disciplinary package to help torture survivors, shows that effectiveness of mental health and psychosocial support cannot be taken for granted. More research is clearly necessary. Moreover, given the popularity of religious and traditional healing practices, we recommend research into the effectiveness of such practices for psychological distress and mental disorders.

In conclusion, a multi-disciplinary review of existent literature – synthesizing findings from the social and medical sciences – was deemed helpful in providing an overview of the complex interplay between political violence, mental health and psychosocial well-being in Nepal. Further multi-disciplinary research would be useful to fill current gaps in knowledge.

References


