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# Attitudes and Perceptions of Mental Disorders among Individuals from Nepal

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# Attitudes and Perceptions of Mental Disorders among Individuals from Nepal

by

Sonam Lama, M.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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Nouchie Xiong, M.A.

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of School Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Attitudes and Perceptions of Mental Disorders among Individuals from Nepal

**By Sonam Lama**

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Research Committee:

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Abstract

The growing population of immigrants and refugees in the United States increases the need for culturally sensitive and appropriate mental health care. The purpose of this research project is to explore the attitudes and perceptions of mental disorders among individuals from Nepal who reside in the United States. Using a qualitative design, data was collected through an online survey. Thirty respondents completed the online survey. Data was analyzed using descriptive and inferential statistics to investigate the relationship between the participant's level of education, their beliefs and perceptions about mental disorders and the participants' length of stay in the United States. The findings showed no statistically significant relationship existed between these variables for the 30 participants who completed the survey.

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University of St. Thomas and St. Catherine University

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## Introduction

The immigrant population is growing rapidly in the United States. In Minnesota alone, the foreign-born population has increased from 260,463 in 2000 to 378,483 in 2010. Of the total immigrant population in Minnesota, Asians were the largest group in 2010 (Migration Policy Institute, 2012). Some researchers have also projected that in the U.S. elderly Asian immigrants population will grow by 246% from 2000 to 2025 (Mui & Kang, 2006). It is important to consider how the changing demographic of the immigrant population affects future needs for mental healthcare. According to Nguyen, Shibusawa, & Chen (2012), the Asian American populations have “high levels of mental health need across the[ir] lifespan” (p. 136). In addition, Asian Americans and Pacific Islander women and adolescents have the highest rates of suicide among their age groups in the U.S. (Office of Minority Health, 2007). Compared with non-Hispanic white elders, Asian American elders have greater rates of mental disorders (Mui & Shibusawa, 2008). Due to the high prevalence of mental illnesses and less mental health care seeking behavior among these populations, it is important to understand the immigrants’ beliefs and perceptions of mental disorders in order to provide culturally appropriate intervention.

In 2010, a total of 73,293 refugees arrived in the U.S. The majority of refugees came from East Asia and near East and South Asia. Among this group of refugees, 12,363 (17%) were Nepali-speaking Bhutanese refugees (Martin, 2011). Many immigrants and refugees have endured trauma before coming to the U.S. as a result of political upheavals and violence in their countries (Nguyen et al., 2012). Most Asian immigrants and refugees have limited knowledge about mental disorders (Chung, 2010). Similarly, in Nepal, the majority of people lack knowledge about mental disorders and turn their trust to traditional healers. Many people in Nepal believe that mental illness is caused by bad fortune (Kohrt & Harper, 2008; Kohrt and

Hruschka, 2010). According to Jha and Adhikari (2009), “at least 35 percent people in the community in Nepal experience some sort of mental illness at any one point in time”. In Nepal, mental illnesses carry a huge stigma which results in people avoiding association with individuals who suffer from mental illness as well as their families. Furthermore, untreated mental disorders may produce negative health consequences (Kohrt & Harper, 2008).

Tol, Kohrt, Jordans, Thapa, Pettigrew, Upadhaya, and Jong (2010) found that a high percentage of mental disorders, such as posttraumatic stress disorder, anxiety, and depression that existed in Nepalese and Nepali-speaking Bhutanese refugees were reportedly due to political upheavals in Nepal. According to Kinzie (2006), many immigrants and refugees suffer from mental distress because of the effects of migration to a foreign country. It is also found that Asian Americans are less likely to seek mental health services than other racial groups (American Psychological Association, 2009).

Mental disorders are treated with psychotherapy. Psychotherapy plays a crucial role in assisting people in understanding their illness and is a common treatment of mental disorders, such as emotional disturbances and behaviors. Psychotherapists teach clients/patients strategies and ways to “deal with their stress and unhealthy thoughts and behaviors” (National Institute of Mental Health [NIMH], para 1, 2012). Psychotherapists employ different forms of psychotherapy in treatment to reduce the symptoms of mental disorders.

The growing number of immigrants and refugees indicates the necessity of culturally sensitive mental health services. However, the researcher of this project could not find studies conducted in the United States on attitudes and perceptions toward mental disorders and psychotherapy among Nepali-speaking individuals. It is important to explore and learn about their perceptions and attitudes toward mental disorders and psychotherapy in order to deliver

mental health services to the Nepali-speaking population in the United States. Therefore, this research aims at exploring the relationship between the perceptions and attitudes of Nepali-speaking individuals toward mental disorders, the length of stay and the level of education. This research project answers the following questions: What is the relationship between the length of stay in the U.S. (acculturation) and attitudes toward mental disorders? What is the relationship between the level of education and attitudes toward mental disorders? The findings to these questions may assist social workers to develop outreach programs and strategies to help promote mental health care to this distinct group.

## **Literature Review**

This literature review examines the mental health needs of refugees and immigrants, followed by a summary of the history of psychology and psychotherapy in Nepal and a brief discussion on mental health policy in Nepal. This is followed by the examination of the role of traditional healers, and finally, a look at Nepalese cultural beliefs, myths, and perceptions about mental disorders.

### **Mental Health Needs of Asian Refugees and Immigrants**

Recognizing and treating mental health issues among immigrant and refugee populations in the United States can be challenging because of cultural and language differences. Several cultural factors may contribute to the mental health problems of Asian immigrants and refugees, such as language barriers, feeling of social isolation, homesickness, social discrimination, and social role changes (Sher, 2010). Mental health issues get augmented due to limited job skills, limited financial assistance for health care needs, and lack of knowledge of mental health (Chung, 2010).

Among Asian refugees and immigrants, older adults and children are at a high risk of developing mental health disorders. Children of Asian immigrants are at greater risk of developing mental health problems in comparison to white children in the United States. Two key factors that contribute to their mental health problems are fewer interpersonal relationship skills and higher internalizing problems (Huang, Calzada, Cheng, & Brotman, 2012).

Like Asian immigrant children, older adult immigrants are also susceptible to developing mental health problems. Narra, Ruecker, and Sundaram (2012) conducted a qualitative research study in order to understand the worldviews of Asian Indian older adults living in the U.S. The



main purpose of the study was to explore their experiences living in the U.S. and their ways of coping with changes. A semi-structured interview method was adopted. 18 participants (8 men and 10 women) between the ages 61 to 82 were interviewed. Eight participants immigrated to the U.S. between ages 24 and 35, and 10 participants moved to the U.S. after the age of 49. The findings suggested that Asian Indian population is susceptible to developing mental health disorders. More than half of the participants (n=11) felt lonely and isolated due to separation from family and friends and seven participants revealed that they had difficulties learning English.

Kim, Worley, Allen, Vinson, Crowther, Parmelee, & Chiriboga (2011) also found a similar result in terms of psychological distress associated with limited English proficiency. The research design included cross-sectional analysis of existing secondary data. The study found that older Latino (n=783) and Asian (n=962) immigrants who were 60 and older with limited English proficiency have significantly higher rates of psychological distress in comparison to their counterparts' proficiency in English. The researchers used a 4-point Likert-type scale to assess the participants' English proficiency. The study also found that the participants with limited English proficiency are less likely to seek mental health care due to difficulty understanding doctors.

One of the other predictors to psychological distress among immigrants is acculturation. Acculturation can be defined as the process which involves changes in a person's attitudes, behaviors, and values (Schwartz, Unger, Zamboanga, Byron, & Szapocznik, 2010). Berry (2012) describes acculturation as "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members." Wang and Mallinckrodt (2006) surveyed Chinese/Taiwanese international students and found that the

low level of acculturation is associated with psychological symptoms because of adjustment difficulties. The difficulties associated with their new and unfamiliar environment induce psychological distress because of language barriers and cultural differences. Besides international students, low acculturation may lead to psychological distress among other immigrants because of social isolation, employment difficulties, and financial issues (Suinn, 2010). However, Dellanira, Simoni, Alegria, and Takeuchi (2012) found that acculturation had no direct association with psychological distress; however, it was directly associated to access to mental health services among Latino women.

Many individuals who come to the U.S. experience some sort of psychological distress for various reasons, such as language and cultural differences. For most refugees, mental distress is usually experienced before coming to the U.S. Gong, Fujishiro, & Takeuchi (2011) surveyed “non-institutionalized” Asians (n=2095) and Latinos aged 18 years or older residing in the U.S. (p. 1620). They used data from the National Latino and Asian American Study to test their hypotheses. One of the hypotheses was that individuals who migrate to the U.S. voluntarily with adequate preparation before leaving their home countries are less likely to experience psychological distress. Their findings support the hypothesis that Asian immigrants with well-planned migration had lower levels of psychological distress and other mental disorders than their counterparts who moved to the U.S. without any adequate preparation.

Most refugees leave their home countries without any resources or preparation. Most immigrants and refugees who come to the United States have different cultures, languages, beliefs, and values and make attempts to adapt to their new and unfamiliar environment. In the process of acculturation, they often experience acculturation stress, which can lead to psychological distress (Lueck & Wilson, 2010). Among these immigrants and refugees, many of

them experience traumatic events. Survivors of war like Cambodian refugees, in addition to physical injury, suffer from psychiatric disorders, such as Post Traumatic Stress Disorder (McDonald & Mollica, 2002). According to Ringold, Burke, and Glass (2005), refugees are more likely to experience chronic mental health disorders because “of the multiple stressors they experience before, during, and after their flight” (para. 1).

Immigrants and refugees face multiple risks and stressors prior to and after they come to the United States. The process of immigration itself can be stressful because of the loss of extended family and kinship networks. Some may have been detained in refugee camps for a prolonged time; some might have been exposed to traumatic events in their home countries such as witnessing deaths, war, torture, natural disasters, and famine. As a result of exposure to traumatic events, sometimes overwhelmed parents may fail to attend to their emotional needs and these emotional stressors can later “re-activate the emotions and memories” for children and adolescents (Pumariega, Rothe, & Pumariega, 2005, p. 583).

Exposure to traumas and stressors can lead to mental health problems among immigrants and refugees. Adults may suffer from depression and anxiety disorders, and children and adolescents may also suffer from similar conditions; mental health conditions that can affect their level of functioning such as occupational or academic, and impairment in social functioning (Pumariega et al, 2005). Their symptoms or expression of psychological distress can be different from Western-oriented psychological symptoms. Symptoms can result in dysfunctional behavioral consequences, such as domestic violence and pathological gambling. Therefore, it is crucial to have culturally competent mental health services available to meet their mental health needs.

### **Psychology and Psychotherapy in Nepal**

Psychology is still a developing field of study in Nepal. In 1947, psychology courses were first introduced at Tri-Chandra College as part of philosophy in the intermediate level (Aich, 2010). Later, the Master level program was introduced in 1980 (Subba, 2011). In 1961, the first psychiatric outpatient service at Bir Hospital in Kathmandu city came into existence which was started by Dr. Bisnu Prasad Sharma. Later in 1984, a new hospital was built for a psychiatry outpatient services (Aich, 2010). A five-bed in patient unit was added in 1965, and later seven more beds were added in 1971. In 1980, only two psychiatrists and two neurologists were available in the country (Regmi, Pokharel, Ojha, Pradhan, & Chapagain, 2004). In 1983, a 400-bed Tribhuban University-Teaching Hospital was established, and they began to provide psychiatric out-patient services in February 1986. A 12-bed psychiatric inpatient unit was added in December 1987. Eventually, in 1997, the hospital started to offer clinical psychological services (Aich, 2010).

According to Kohrt and Harper (2008), only five clinical psychologists were available in the country in 2004 followed by an addition of one more clinical psychologist in 2006. There is less than one clinical psychologist per 100,000 population. There were no social workers at this time. In 2004, only 30 psychiatrists were accessible in Nepal (Regmi, Pokharel, Ojha, Pradhan, & Chapagain, 2004). The number of psychiatrists grew to about 40 as of 2008 (Kohrt & Harper, 2008). Only 18 outpatient adult mental health facilities have existed in the country in 2006. Furthermore, almost all mental health services are located in urban areas (World Health Organization, 2006). According to Jha and Adhikari (2009), on average only four psychiatrists per year graduate from the private medical colleges in the country of 30 million people.

Having few numbers of mental health professionals can be attributed to the stigma attached to this profession. Kohrt and Haper's qualitative study (2008) claimed that people chose not to enter into the field of psychiatry despite their interest due to the stigma associated with this profession. They followed two cases (subjects) who were seeking mental health care from different traditional healers. The researchers also randomly interviewed people on the street and physicians in Nepal. A physician explained that despite his interest in psychiatry, he chose not to become a psychiatrist, because "for families, it is a bigger shame to have a child who is a psychiatrist than to have a child who is not a doctor at all" (p. 480). Many people in Nepal refer psychiatrists as "crazy doctors" and refer mental hospital as "crazy prison" (p.480).

On the contrary, Jordans, Keen, Pradhan, and Tol (2007) had a different finding. Their study involved semi-structured interviews with clients (n=34), para-professional counselors (n=26), and managers (n=23) of organizations that provide psychosocial counseling. The main goals of the study were to increase the understanding of psychosocial counseling in Nepal and to gather information in order to make improvements to the current mental health services. They found that the participants of their qualitative study had positive attitudes toward psychosocial counseling; the participants also reported their satisfaction with counseling services because of their ability to express their emotions openly in the session, which is not always appropriate in Nepali culture.

In Nepal, people have negative connotations about psychotherapy and psychotherapists. Since mental health professionals make an attempt to focus their clients toward problematic emotions, cognitions and relational problems this contradicts their traditional beliefs. (Kohrt & Haper, 2008). Many clients are not able to understand and relate problems to psychological

causes. These clients either prematurely terminate treatment or ask for medication (Kohrt & Haper, 2008).

### **Legislation, Policy, and Mental Health in Nepal.**

The main purpose of Mental Health Legislation is “to protect, promote, and improve the lives” of individuals with mental disorders (World Health Organization -Assessment Instrument for Mental Health Systems [WHO-AIMS], 2005, p.1). Mental health in Nepal is still struggling to receive attention. To demonstrate what a low priority mental health needs are, the Government of Nepal in 2004 only committed about one percent of health care expenditure toward mental health services (Regmi et al., 2004). As of 2004, no mental health policy has been enacted. Even though National Mental Health Policy was formulated in 1996-1997; it is still under construction (American Psychological Association, 2011; Regmi et al., 2004; WHO-AIMS, 2006). Four key components of the policy proposed include: “(1) to ensure the availability and accessibility of minimum mental health services for all the population of Nepal; (2) to prepare human resources in the area of mental health; (3) to protect the fundamental human rights of the mentally ill; and (4) to improve awareness about mental health” (WHO-AIMS, 2006, p. 1).

According to the American Psychological Association (2011), the law in Nepal does not have a clear definition of mental disorders. In Nepal, mental illness is still equated with “madness” (para 2). The language of the legislation also refers individuals with mental illness as having a “broken mind.” According to National Mental Health Policy, in 1996, severely mentally ill patients were incarcerated without any other offence than their mental disorders because of lack of medical facilities (Mental Health Policy Group, 1996).

According to The World Health Organization's Assessment Instrument for Mental Health Systems, as of 2006, Nepal does not have "emergency/disaster preparedness plan for mental health" (p.1); only a plan for general health. In terms of affordability, a small portion of the population receives free psychotropic medicines; however, a big portion of the population pays out of their pocket for mental health services for their severe mental health issues. As of 2006, no social insurance system is in Nepal (WHO-AIMS, 2006).

### **Traditional Healers and Mental Health in Nepal**

Traditional healers, sometimes called faith healers, are also known as shamans. The term shaman is borrowed from the Siberian Tungus word, saman, which means "a person who has direct experience of the mysteries of life and the universe" (Singh, 1999, p. 131). It refers to the gifted individual who mediates between the physical and spiritual worlds while in a trance state resulting in gaining supernatural strength and power to find the cause of illness. Many forms of shamanisms exist in the world with its own beliefs, practices, and rituals. In Nepal, the terms *dhami* and *jhakri* are used interchangeably to refer shaman and often used as a single term *dhami-jhakri*. Dhami-jhakri are seen as individuals "who possess the ability to embody local deities or spirits" (Walter, 2003, para 1). Traditional healers use two central elements to address illness: body and spirit. Traditional healers explain the illness (physical and mental complaints) "as the loss of vitality through the loss of the soul" (Kohrt & Harper, 2008, p. 477). Traditional healers perform rituals to recall the sufferer's lost spirit and treat his/her physical and/or mental complaints (Kohrt & Harper, 2010).

A qualitative research study was conducted by Kohrt and Harper (2008) with the aim of understanding how mind-body dichotomy plays a role in terms of mental health seeking behavior

and the stigma attached to mental health disorders. The study showed that many people in rural areas in Nepal still believed in traditional healers. In 2002, the number of traditional healers in Nepal was between 500,000 to 1,000,000 (Cohen, Kleinman, & Saraceno, 2002). Most of the rural populations still believe in witch-craft or evil spirits as the cause of psychological distress and seek help from faith healers (Cohen et al., 2002). Individuals showing symptoms of mental disorder, specifically in rural areas, pay a visit to traditional healers for help. Traditional healers trace the cause of illness to the ill-wishing by some other individual or an offended spirit. One form of ill-wishing is the superstitious occurrence of the “evil eye” which casts a curse or ill-thoughts to a person through the human gaze. Sometimes animals are sacrificed as an offering to please deities to avert their wrath. In addition, to treat the mental disorder of a person, hot water or hot coals are poured on the person in order to ward off evil spirits, and sometimes the individuals are beaten with sticks and brooms as well. Sometimes the traditional healers prohibit the sick one(s) from seeking professional mental health services (Cohen et. al., 2002).

As part of a research study, Kohrt and Harper (2008) interviewed a 37 years old woman who became sick after the demise of her sister-in-law. In the interview, the woman told one of the researchers that she visited many traditional healers for her illness before going to see a physician. The traditional healers explained to the woman that her illness was the loss of her soul due to her visit to the location of her sister-in-law suicide. According the woman, faith healers helped relieve her illness but only for a temporary amount of time; so, she made a trip to see a physician. The physician gave the woman antidepressant medication and diagnosed her with depression. Despite the physician diagnosis, the woman continued to believe in supernatural powers and deny that she had a mental illness. This example illustrates that the woman rejected the fact that she was suffering from a mental disorder.



Most of the people who are educated in Nepal view traditional healers as “backwards” and “superstitious”. They perceive traditional healers as barriers to those seeking mental health services (Kohrt & Harper, 2008, p. 477). Sometimes health workers describe traditional healers as suffering from psychological distress (Kohrt & Harper, 2008). Since faith healers have been a part of Nepali tradition for a long period, it can be difficult to minimize the role of traditional healer; however, traditional healers can be used as “auxiliaries to biomedical care” (Kohrt & Harper, 2008, p. 477).

### **Stigmatization and Mind-Body Relation in Nepal**

According to the World Health Organization (2001), 20 to 30 percent of the population in Nepal might suffer from one or more forms of mental illnesses, and an “estimated 1 to 3 percent of the population suffers from chronic and severe mental illness” (as cited in Koshish Nepal, 2010, para. 1). However, people are reluctant to seek professional mental health care due to the stigma attached to mental disorders. Stigma related to mental health is getting attention among health professionals in Nepal because of its negative impact on individuals with mental disorders and their mental health care seeking behaviors.

Stigma can manifest in different forms, such as fear, bias, embarrassment, rejection, and avoidance (Bantman et al., 2011). It worsens the experience of having a mental disorder by becoming a barrier that holds people and their families back from seeking professional help (Weiss, Ramakrishna, & Somma, 2006). Adhikari, Pradhan, and Sharma (2008) have divided stigma into three categories (a) public stigma, (b) self-stigma, (c) courtesy stigma (stigma experienced by family and care givers). Public stigma can be recognized as negative reactions from the public about mental disorders resulting in the forms of shame, blame, discrimination,

and stereotyping. Some people are embarrassed by individuals with mental disorders (Adhikari et al., 2008). As a result of negative opinions about mental disorders, individuals tend to self stigmatize, which results in either not seeking professional mental health care or hindering the treatment and recovery of the person with a mental disorder.

Individuals with mental disorders in Nepal not only experience stigma and social rejection but they and their families also face employment, economic, social, and education marginalization (Mannarath, Patel, Raja, Shrestha, Sundar, & Underhill, 2012; Kohrt & Harper, 2008). The stigma also prevents other relatives of sufferers from marrying because of the assumption that “madness” is contagious (Kohrt & Harper, 2008). This view of stigma is supported in a similar study by Bantman, Gupta, Jiloha, and Kishore (2011). They conducted a cross-sectional study in Delhi, India, with the aim to assess the myths, beliefs, and perceptions about mental disorders and health seeking behavior in the general population from urban and rural communities (n=360) and medical professionals (n=76) from Delhi. The study included a pre-tested questionnaire on perceptions, myths, and beliefs about causes, treatment, and mental health seeking behavior. In their study, a significantly high number of participants (36.9% of rural subjects, 43.2% of urban subjects, and 44.7% of the medical professionals) reported that they were not comfortable having a marriage with an individual recovered from mental disorder. Due to a burden of stigma associated with mental disorders, people in Nepal are less apt to seek mental health services.

In an attempt to reduce the stigma associated with mental disorders and to encourage people to seek needed mental health care, mental health professionals in Nepal are resorting to mind-body or heart-mind relations. Kohrt and Hruschka (2010) found distress related to dysfunction of brain-mind (*dimaag* meaning brain in Nepali) contributed to stigma. However,

distress associated with heart-mind (*mhan* meaning heart in Nepali) was a “socially acceptable reason to seek mental health care” (p. 322). Even though they perform different functions, they must work in coordination. The *mhan* (heart) reflects desires, likes, dislikes, and wants, and the *dimaag* (brain) is the one which controls one’s desires. An individual who fails to control his/her desires results in his/her *dimaag* (brain) functioning improperly.

According to Jackson (1994), stigma is associated with mental disorders because it is considered “less-than-real” pain, which means the pain is not in the body but in the mind. Therefore, psychological issues which are related to the mind taints one’s social status because of the stigma attached to it being “less-than-real.” As a result, people visit a general physician who addresses the “real” physical problem. Sometimes physicians are hesitant to explain to their patients and patient’s families about having a mental disorder, such as depression, due to the stigma attached to it and because the families of the patients expect the worst, such as spouses considering to leave their partners (Kohrt & Harper, 2008).

### **Cultural Beliefs, Myths, and Perceptions about Mental Disorder in Nepal**

The main culprit that is influencing people’s attitudes toward mental illness is the stigma associated with mental disorders, which is rooted deep in the cultural beliefs and myths about mental disorders. For a long time, individuals with mental disorders have been seen as threats to Nepalese society. Those who suffer from mental disorders are discriminated and marginalized, and sometimes experience acts of violence (Shakya, 2012; Kohrt & Harper, 2008).

An interviewed with Dr. Shakya (2012) revealed one of the myths about individuals with mental disorders which is that they are dangerous and violent. Various studies have contradicted this myth by demonstrating that individuals with mental disorders are more likely to be

victimized by others. A study by Dr. Tanveer Khan at the BP Koirala Institute of Health Sciences in Nepal concluded that of the 100 acute mentally ill inpatients, “70 percent were victimized physically, 62 percent were victimized psychologically, 32 percent were neglected or deprived of their basic needs, and 3 percent were victimized sexually” (Shakya, 2012, para 3). According to the study, the perpetrators were people who knew the victim such as family members, neighbors, security personnel, faith-healers, or medical professionals (Shakya, 2012).

Some people associate psychological distress with bad karma. A study conducted in Nepal by Kohrt and Hruschka (2010) concluded that trauma survivors perceived their mental dysfunction as karma of a past life. Their experiences of mental illness were sins manifesting in their present lives. The trauma survivors perceived the sufferings and psychological trauma as bad karma and avoided seeking mental health service because of the stigma associated with revealing their bad karma. The authors of this study sampled 25 individuals (19 females and 16 men) ages 18 to 72. Bantman et al. (2011) describes a similar finding where participants believed that God was punishing those suffering from mental health for their past sins.

Psychological distress is also viewed as “incurable” and a “permanent condition” in Nepal and India (Kohrt & Harper, 2008, p. 471). Moreover, it is also seen as contagious and a “socially dangerous” health concern by some people in Nepal (Kohrt & Harper, 2008, p. 480). Bantman et al.’s cross-sectional study (2011) conducted in Delhi, India, also revealed the similar views of the participants; surprisingly 7.9% of 76 medical professionals believed that mental disorders are untreatable. As part of a study by Kohrt and Harper’s (2008), one woman interviewed in Kathmandu explained how she removed her children from the house in the fear of contracting their father’s disease, a man who was suffering from schizophrenia. She also added that they did not share utensils with her husband.

Cultural beliefs, myths, and misconceptions about mental disorders develop negative attitudes toward mental disorders and those who suffer from it. As a result, the stigmatization of individuals who are going through psychological distress creates hurdles for people from seeking mental health care; as a result, they may tend to seek help from traditional healers. Some people may visit a general physician for help because it is not as stigmatizing as it is to see mental health professionals. These individuals and their families turn to mental health services as a last resort. Some families even register patients under false names at the mental hospital to remain anonymous. Sometimes families with financial resources take the ill to India for mental health care to minimize public exposure (Kohrt & Harper, 2008).

The literature review indicates that cultural beliefs, myths, and lack of education about mental health attach a stigma to mental disorders. As a result, individuals in Nepal are reluctant to seek mental health care. The literature review also points out that it is important to explore the attitudes and perceptions about mental disorders and mental health seeking behavior. However, only few studies have been conducted in the U.S. on the attitudes and perceptions of mental illness and mental health services seeking behavior among this population.

## Methodology

### Research Design

By utilizing a quantitative non-probability design, this research project investigated the variables that shape attitudes and perceptions of mental health disorders in the Nepalese population residing in the United States. The research question investigated whether cultural beliefs, level of education, and length of residence in the United States influence the perceptions and attitudes of individuals from Nepal toward mental disorders.

### Sample

This research project utilized a non-probability, convenience sample. The participants were individuals from Nepal who have been residing in the United States. 30 participants took part in the research. All participants were at least 18 years old. The participants had been in the U.S. for at least one year and completed the online survey without any assistance from another party. The researcher obtained the sample online using Fluid Surveys website. The collection of data began in January after receiving the Internal Review Board approval from St. Catherine University and University of St. Thomas for the research proposal.

**Demographics.** Seventeen respondents (56.7%) identified themselves as male and 13 respondents (43.3%) identified themselves as female. The ages of the respondents ranged from 18 – 69. Of the 30 respondents, the mean age group was 3.1 (30- 39 age group) with a standard deviation of .885, and the mean residency was 2.57 (6-15 years) with a standard deviation of 1.406 (Figure 2). The majority of respondents (36.7%) had a Master's degree and was in the information technology field (Figure 1).

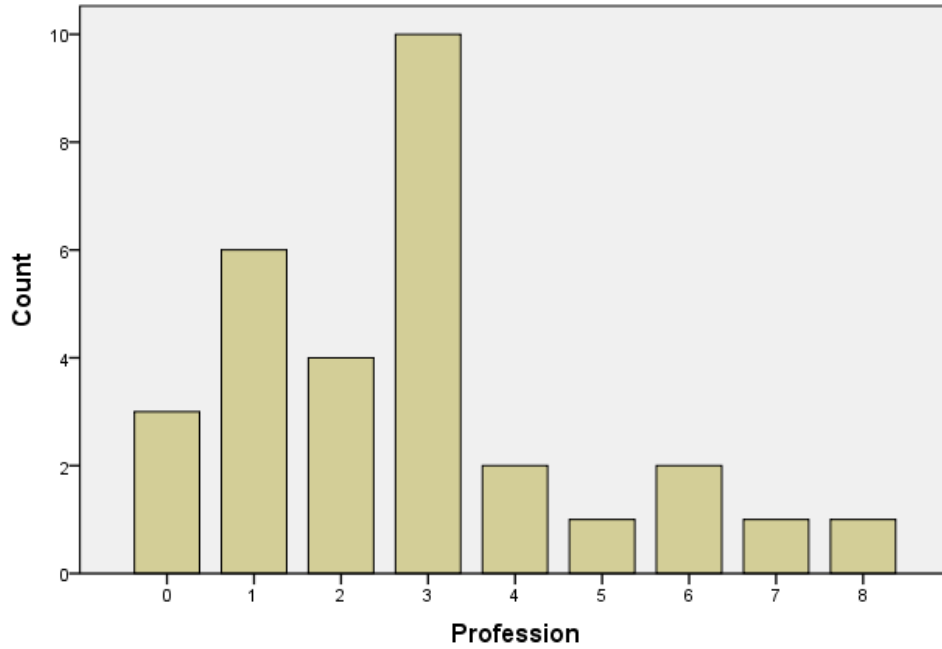


Figure 1. Profession/Job Type

0= No Response, 1=Business & Finance, 2=Education & Social Work, 3=Technology, 4=Student, 5=Medicine, 6=Food and Beverage, 7=Babysit, 8=Unemployed

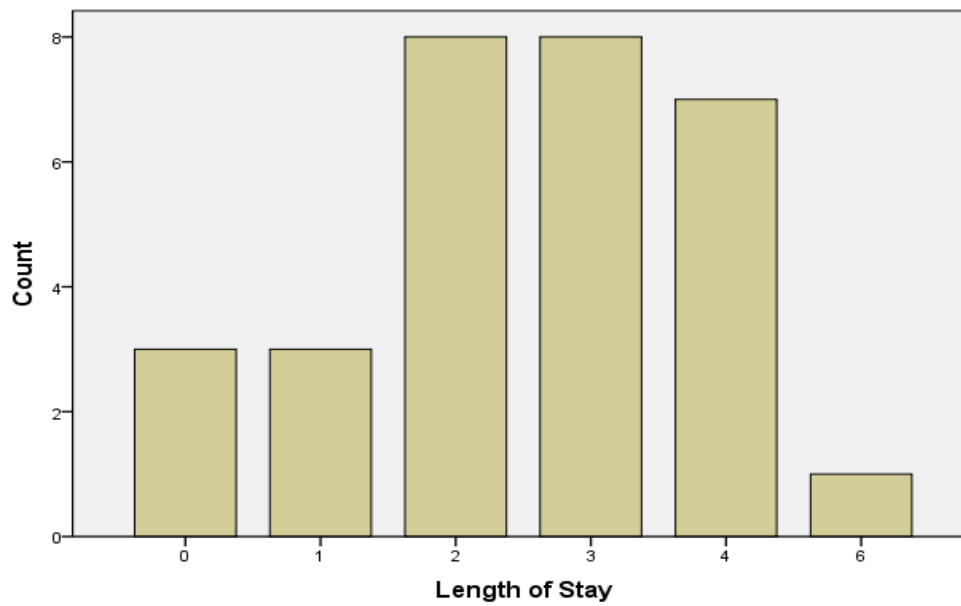


Figure 2. Length of Stay

1=1-5, 2=6-10, 3=11-15, 4=16-20, 5=21-25, 6=26 and above.

### **Data Collection or Procedures**

The researcher posted the advertisement on her Facebook page (Appendix B), a social networking website, requesting individuals from Nepal to participate in the survey, and the link to the survey was included. A member of the Association of Nepalese in Minnesota helped the researcher by emailing the link to other Nepalese residing in the United States. The email message included a brief introduction about the research with the link to the survey. The responses to the survey were collected online survey using Fluid Surveys. It was entirely the participants' decision whether or not to participate in the research survey.

### **Measurement**

Seventeen questions on the survey (Appendix A) were created after a review of the literature. Themes of the survey were focused on demographics, knowledge about mental disorders, cultural beliefs, and perceptions about mental disorders.

### **Protection of Human Rights**

The protection of human rights is an important aspect of the research. Therefore, the researcher assured that the participants who chose to take part in this research were protected in terms of confidentiality and safety.

After receiving an approval from the IRB for the research proposal, the researcher created the survey online using the Fluid Surveys website. The researcher sent the inactivated survey link to the chair for his review prior to opening the survey to the public. The survey did not contain any identifiable questions, such as names and addresses of the participants. The survey contained a short introduction to the research including its objective, and risks and benefits. It



was also made clear that the participation in the survey was entirely voluntary, and the participants could withdraw anytime during completing the survey online. Their responses were unidentifiable and anonymous and the gathered data was destroyed in May 2013.

### **Data Analysis**

The researcher used the statistical software program Statistical Package for the Social Sciences (SPSS) to analyze the collected data. Descriptive statistics was used to analyze the frequency distribution and inferential statistics were used to investigate the relationship between the dependent and independent variables.

### **Conceptual Framework**

The current study is based on the theoretical works of Ludwig von, Kurt Lewin, Talcott Parson, Robert Merton, and Uri Bronfenbrenner (Hutchinson, 2008). During 1960s the systems perspective was adopted in the social work field (Hutchinson, 2008). According to system theory, “system is dynamic”, which encompasses different subsystems. The fundamental ideas of systems theory are: “all systems have subsystems and environments” (Miley, O’Melia, & DuBois, 2010, p. 43). This means every single system is a part of a larger system and every system is composed of smaller systems. At the same time, larger systems become environments for their subsystems; the subsystems are interconnected; every system impacts all other parts of the whole system. In other words, any system is an outcome of a dynamic relationship between its parts and its whole. This researcher employed the systems theory to understand the human behavior as the result of the impact of a larger system.

For this research, the United States is considered as a larger system that is only a part of the international system in which the United States is situated. Societies within the United States are considered as subsystems. Similarly, communities within a society are viewed as subsystems of the society, and the system’s environment is the larger system that contains a social system (Miley, O’Melia, & DuBois, 2010). Therefore, society is the social environment for communities. The systems theory is used to study how the society and Nepalese people residing in the United States influence the attitudes and perceptions of mental disorders among individuals from Nepal.

As indicated in this research and the literature review, in the United States, immigrants hold different beliefs and perceptions of mental disorders compared to the mainstream population. These contrasting beliefs and attitudes, and misconceptions towards toward mental

disorders create a barrier in seeking mental health services. Similarly, individuals in Nepal also have different perceptions regarding mental disorders. As a result, immigration populations of Nepali people in the United States are less likely to seek mental health services. Their hesitancy to seek mental health care prompts the need for psychoeducation among this particular population. What is needed is culturally appropriate mental health care and culturally competent mental health service providers. The purpose of employing the systems theory is to compare a review of the literature with this research was to determine the influence residency within the United States has had on their beliefs and perceptions of seeking or receiving mental health services.

## Findings

The findings below are collected from the survey: “Attitudes and Perceptions of Mental Disorders among Individuals from Nepal.” Analysis from the results explore two key relationships among Nepalese immigrants: 1) the relationship between the education level of Nepalese participants and perceptions of mental disorders, and 2) the relationship between the length of stay in the U.S. and perceptions of mental disorders.

**Table 1. Crosstabulation for the Relationship between Education Level and the Perception that Mental Disorders are Contagious**

Table 1 shows that there is no significant relationship between the participants’ level of education and their beliefs that mental disorders are contagious. One respondent (3%) with a master’s degree strongly agreed that mental disorders are contagious and 3 respondents (10%) with a master’s degree agreed that mental disorders are contagious.

Education * Mental Disorders are Contagious Crosstabulation						
Count						
		Mental Disorders are Contagious				Total
		Strongly Agree	Agree	Disagree	Strongly Disagree	
Education	High School Diploma	0	1	2	0	3
	Some College	0	1	1	2	4
	4-Year College	0	3	2	3	8
	Master’s Degree	1	3	4	3	11
	Doctoral Degree	0	0	1	2	3
	Professional Degree	0	0	0	1	1
Total		1	8	10	11	30

p. =.915

**Table 2. Crosstabulation for the Relationship between Education Level and the Perception that Mental Disorders are Permanent**

Table 2 demonstrates that there is no significant relationship between participants' education level and their perceptions that a person with mental disorder cannot be restored to sound emotional health. ( $p = .415$ )

<b>Education * Mental Disorders are Permanent Crosstabulation</b>						
Count						
		A person with mental disorder cannot be restored to sound emotional health				Total
		Strongly Agree	Agree	Disagree	Strongly Disagree	
Education	High School Diploma	0	0	1	1	2
	Some College	0	1	3	0	4
	4-Year College	1	2	4	1	8
	Master's Degree	0	1	9	1	11
	Doctoral Degree	0	0	1	2	3
	Professional Degree	0	0	0	1	1
Total		1	4	18	6	29

$p = .415$

**Table 3. Crosstabulation for the Relationship between Education Level of Participants and Their Recommendations for People with Mental Disorders**

As table 3 indicates, there is no significant relationship between participants' level of education and their recommendations for the kind of treatment that would be the best suit individuals with mental disorders. ( $p = .105$ )

<b>Education * Recommendation Crosstabulation</b>							
Count							
		Options and Recommendations for Individuals with Mental Disorders					Total
		Mental Health Professional	Traditional Healer	General Physician	Mental Health Professional and General Physician	Mental Health Professional and Traditional Healer	
Education	High School Diploma	1	1	0	0	1	3
	Some College	4	0	0	0	0	4
	4-Year College	5	0	1	2	0	8
	Master's Degree	11	0	0	0	0	11
	Doctoral Degree	3	0	0	0	0	3
	Professional Degree	1	0	0	0	0	1
Total		25	1	1	2	1	30

$p = .105$

**Table 4. Crosstabulation for the Relationship between Education Level and the Perception that Mental Disorders may be caused by Difficulties in Human Development**

The majority of respondents (N= 21; 70%) as shown in Table 4 agreed that mental disorders may be caused by difficulties in human development, such as how one was raised as a child. However, there was no significant relationship between participants' education level and their perceptions that mental disorders are caused by difficulties in human development.

(p. =.181)

Education * Human Development Crosstabulation						
Count						
		Mental Disorders may be caused by difficulties in human development				Total
		Strongly Agree	Agree	Disagree	Strongly Disagree	
Education	High School Diploma	0	3	0	0	3
	Some College	2	2	0	0	4
	4-Year College	0	4	3	1	8
	Master's Degree	0	8	2	1	11
	Doctoral Degree	0	3	0	0	3
	Professional Degree	0	1	0	0	1
Total		2	21	5	2	30

p. = .181

**Table 5. Crosstabulation for the Relationship between the Length of Stay and the Belief that Mental Disorders Bring Shame**

The majority of respondents either disagreed (N=10; 33.33%) or strongly disagreed (N=15; 50%) that having a mental disorder brings shame to his/her family. No significant relationship existed between the participants' years of residency and their perceptions about mental disorders as illnesses that bring shame to their families. ( $p = .505$ )

Length of Stay * Mental Disorders bring Shame Crosstabulation						
Count						
		Mental disorders bring shame to one's family				Total
		Strongly Agree	Agree	Disagree	Strongly Disagree	
Length of Stay	No response	1	0	0	2	3
	1 – 5 years	0	1	1	1	3
	6 – 10 years	1	0	2	5	8
	11 – 15 years	0	1	4	3	8
	16 – 20 years	0	1	2	4	7
	26 years & above	0	0	1	0	1
Total		2	3	10	15	30

$p = .505$



**Table 6. Crosstabulation for the Relationship between the Length of Stay and the Level of Comfort in Interacting with an Individual with a Mental Disorder**

As table 6 demonstrates, the majority of respondents either strongly agreed (N=6; 20%) or agreed (N=17; 56.66%) that they are comfortable interacting with individuals who have mental disorders. There is no significant relationship between the participants' length of stay in the United States and their level of comfort in interacting with individuals with mental disorders. (p. =.159)

Length of Stay * Interaction Crosstabulation					
Count					
		Comfortable interacting with a person with mental disorder			Total
		Strongly Agree	Agree	Disagree	
Length of Stay	No Response	2	1	0	3
	1 – 5 years	1	0	2	3
	6 – 10 years	1	6	1	8
	11 – 15 years	1	6	1	8
	16 – 20 years	1	4	2	7
	26 years & above	0	0	1	1
Total		6	17	7	30

p. = .159

**Table 7. Crosstabulation for the Relationship between the Length of Stay and Beliefs that Mental Disorders are caused by Karma/Sins of a Past Life**

Table 7 displays that 3 respondents (10%) agreed that mental disorders are caused by karma or the sins of a past life. No significant relationship existed between the length of stay in the U.S. and the respondents' perceptions that mental disorders are caused by karma or the sins of a past life.

<b>Length of Stay * Mental Disorders Caused by Sin or Karma Crosstabulation</b>					
Count					
		Mental disorders are caused by past life's Sin or Karma			Total
		Agree	Disagree	Strongly Disagree	
Length of Stay	No response	1	0	2	3
	1 – 5 years	0	2	1	3
	6 – 10 years	1	2	5	8
	11 – 15 years	1	2	5	8
	16 – 20 years	0	3	4	7
	26 years & above	0	1	0	1
Total		3	10	17	30

p. = .659

**Table 8. Crosstabulation for the Relationship between the Length of Stay and Beliefs that Mental Disorders are Genetic**

As table 8, demonstrates almost equal number of respondents either agreed or disagreed that mental disorders are genetic. There was no significant relationship between the participants' length of stay and their perceptions that mental disorders are genetic. ( $p = .634$ )

Length of Stay * Genetic Crosstabulation						
Count						
		Mental disorders are genetic				Total
		Strongly Agree	Agree	Disagree	Strongly Disagree	
Length of Stay	No response	0	1	0	2	3
	1 – 5 years	0	1	2	0	3
	6 – 10 years	0	3	2	2	7
	11 – 15 years	0	3	4	1	8
	16 – 20 years	1	5	0	1	7
	26 years & above	0	0	1	0	1
Total		1	13	9	6	29

$p = .364$

**Table 9. Crosstabulation for the Relationship between the Length of Stay and the Attitudes towards a Person with a Mental Disorder**

The p-value ( $p = .244$ ) indicates that there is no significant relationship between the participants' length of stay in the United States and the participants' approval of his/her son or daughter's relationship with a person who is recovering from a mental disorder.

Length of Stay * Relationship Crosstabulation					
Count					
		Relationship with a person who is recovering from a mental disorder			Total
		Approve	Disapprove	I don't care	
Length of Stay	No response	2	0	1	3
	1 – 5 years	1	1	1	3
	6 – 10 years	2	1	5	8
	11 – 15 years	0	4	4	8
	16 – 20 years	0	2	5	7
	26 years & above	0	0	1	1
Total		5	8	17	30

$p = .244$

**Table 10. Crosstabulation for the Relationship between the Length of Stay and Attitudes toward the Profession of Psychology**

The majority of respondents (N=25; 83.33%) support their children's interest in psychology or psychiatry as a profession. No significant relationship exists between the length of residency in the United States and the respondents' support for their children's interest in psychology or psychiatry as a profession. ( $p = .346$ )

Length of Stay * Psychology Profession Crosstabulation					
Count					
		Support for Psychology Profession			Total
		Approve	Disapprove	Stay Neutral	
Length of Stay	No response	3	0	0	3
	1 – 5 years	3	0	0	3
	6 – 10 years	8	0	0	8
	11 – 15 years	6	2	0	8
	16 – 20 years	4	1	2	7
	26 years & above	1	0	0	1
Total		25	3	2	30

$p = .346$

**Table 11. Crosstabulation for the Relationship between the Length of Stay and Beliefs in Traditional Healers**

Almost equal number of participants believed in traditional healers. No significant relationship existed between the length of stay of participants in the United States and their beliefs in traditional healers. ( $p = .372$ )

Length of Stay * Traditional Healers Crosstabulation					
Count					
		Belief in Traditional Healers			Total
		Agree	Disagree	Strongly Disagree	
Length of Stay	No response	1	0	2	3
	1 – 5 years	1	2	0	3
	6 – 10 years	3	2	3	8
	11 – 15 years	4	3	1	8
	16 – 20 years	4	3	0	7
	26 years & above	1	0	0	1
Total		14	10	6	30

$p = .372$

**Table 18. Crosstabulation for the Relationship between the Length of Stay and the Perceptions that Individuals with Mental Disorders are Violent**

Table 18 shows that the majority of respondents either disagreed (N=18; 60%) or strongly disagreed (N=3; 10%) that individuals with mental disorders are most likely to become violent. No significant relationship existed between the respondents' length of residency in the United States and their perceptions that individuals with mental disorders are violent. ( $p = .335$ )

Length of Stay * Violence Crosstabulation						
Count						
		Individuals with Mental Disorders are Violent				Total
		Strongly Agree	Agree	Disagree	Strongly Disagree	
Length of Stay	No response	0	1	1	1	3
	1 – 5 years	0	1	2	0	3
	6 – 10 years	0	4	4	0	8
	11 – 15 years	0	1	5	2	8
	16 – 20 years	1	0	6	0	7
	26 years & above	0	1	0	0	1
Total		1	8	18	3	30

$p = .335$

## Discussion

### Summary

The purpose of this study was to examine the relationship between the participants' education level, their beliefs and perceptions about mental disorders and the length of time spent in the United States. The study found that no statistically significant relationships between these variables for 30 participants who completed the survey regarding attitudes and perceptions toward mental disorders.

Although no significant relationships were found, the study showed that 14 respondents (48.27%) agreed that mental disorders are genetic and believed in traditional healers while 9 respondents (31.03%) agreed that mental disorders are contagious. One respondent indicated that s/he would recommend a traditional healer for mental health concerns. Twenty-five respondents (83.33%) indicated that if their children were interested in the psychology profession then they would approve, and the same amount of participants disagreed that suffering from a mental disorder brings shame to their family.

The majority of participants (N=23; 76.66%) agreed that mental disorders may be caused by difficulties in human developmental and agreed that they were comfortable interacting with individuals with mental disorders. There were only 3 participants (10%) who indicated that mental disorders are caused by past's sin or karma. Twenty-four respondents (82.75%) disagreed that individuals with mental disorders cannot be restored to sound mental health. Five respondents indicated that they would approve their sons or daughters' relationship with a person who is recovering from a mental disorder. Of 30 participants, 9 respondents (30%) agreed that individuals with mental disorders are most likely to be violent.



### **Previous Research**

The findings of this research paper do not support some of the previous research findings regarding attitudes and perceptions of mental disorders among individuals from Nepal. Kohrt and Harper (2008) found that in Nepal people do not choose a psychology or psychiatry profession despite their interest because of the stigma attached to this profession. However, this study found that the majority of respondents support their children's interest in psychology or psychiatry as a profession. This study was not conducted in Nepal; therefore this paper was not able to draw conclusions on an individual's decision to choose a psychology or psychiatry profession because of different geographical locations.

This study concurs with other studies regarding beliefs in traditional healers. Kohrt and Harper (2008) discussed in their qualitative study that individuals from Nepal believe in traditional healers. In this study, almost half of the respondents agreed that they believe in traditional healers. Kohrt and Harper also discussed that most people with an education in Nepal perceived traditional healers as "backwards" and "superstitious" (p. 477), and those who believed in traditional healers resided in rural areas. The finding by Kohrt and Harper contradicted the findings of this study because all the participants of this study resided in the United States, and half of them indicated that they believe in traditional healers.

This study found that outcomes were varied in the respondents' perceptions of mental disorders as contagious, and their attitudes toward their children's relationships with individuals who are recovering from mental disorders. Kohrt and Harper found that people in Nepal assumed that mental disorders are contagious; therefore it prevented the relatives of sufferers from marrying. The study could not confirm the findings of Kohrt and Harper (2008). Kohrt and Harper (2008) also found that mental disorders are perceived as incurable and permanent

condition. The finding of this study did not support the notion that a person with a mental disorder cannot be restored to a sound emotional health.

A study conducted by Dr. Tanveer Khan at the BP Koirala Institute of Health Sciences in Nepal concluded that of the 100 acute mentally ill in-patients who were suffering from mental disorders are not violent; rather they were more likely to get victimized by others including family members, neighbors, faith healers, and medical professionals (Shakya, 2012). This study could not address this notion because of the variance in the participants' responses in regard to their perceptions that individuals with mental disorders are violent.

Beliefs that mental disorders are caused by past's life sin or karma was addressed by this study. Kohrt and Hruschka (2010) and Bantman et al. (2011) found individuals who survived trauma viewed their psychological disorders as karma or past life's sin, or god's punishment for their sins. The majority of respondents of this study indicated that they disagreed with the belief that mental disorders are caused by past life's sin or karma.

### **Limitations**

There are some limitations to this study. Participants who completed the survey might have selection bias. It is possible that those who completed this survey might have positive attitudes toward mental health. The study is based on a small sample of individuals from Nepal who reside in the United States; therefore, it is difficult to extrapolate the findings of this study to the general population who reside in Nepal or in the United States.

Since participants might be from different ethnic backgrounds, they may have different connotations of traditional healers. For instance, Buddhist participants may view monks and

lamas as traditional healers, whereas participants who follow Hindu religion may perceive shaman and/or pundits as traditional healers.

### **Implications for Practice / Future Research**

The findings show that Nepalese who reside in the United States have various beliefs and perceptions of mental disorders. It is important for social workers to acquire knowledge about various beliefs about mental disorders among different ethnic minority communities in the United States, such as those in the Nepalese community. Learning about perceptions and beliefs about mental disorders helps mental health service providers to deliver culturally competent care to their clients or patients.

Future implications for practice include psychoeducation to individuals from Nepal regarding mental disorders. Some Nepalese believe that mental disorders are contagious and permanent. It illustrates that it is important to educate clients or patients from this community about mental disorders. In addition, many Nepalese do not seek mental health care because of the stigma associated with mental disorders. Social workers may be able to help them understand about mental disorders in a less stigmatizing fashion relevant to their culture, such as educating about mental disorders in terms of “heart-mind relations” instead of “brain-mind” relations. By providing psycho-educational material that considers mental health issues as socially acceptable, the Nepalese community may increase their mental health seeking behaviors.

Since many Nepalese believe in traditional healing it may be valuable to include some aspects of traditional healing into mental health treatment with this population. Additionally, Nepalese do not share their problems with others; they tend to keep the problems within their

families. Therefore, social workers may need to focus on brief and task-oriented therapy to respect their privacy.

### **Conclusion**

Social workers and other mental health service providers need to understand different cultural beliefs and views about mental disorders by investigating various beliefs and perceptions of mental disorders associated with cultures. This study and previous studies have demonstrated differences in people's beliefs and perceptions of mental health concerns.

People have different beliefs and perceptions of mental disorders. Some people may have misconceptions of mental disorders, such as: mental disorders are contagious, and every individual with mental disorders is violent. The attitudes and perceptions of mental disorders are important because it can influence mental health care seeking behaviors. It can also help reduce the stigma attached to mental disorders created because of misconceptions. Previous literature has focused on many different aspects of the impact of attitudes and perceptions of mental disorders. This study focused on the impact of the length of residence in the United States and the education level on individuals' beliefs and perceptions of mental disorders.

This research suggests that social workers in mental health services need to understand the importance of a person's beliefs and perceptions regarding mental disorders and their beliefs in traditional healers, especially Asian immigrants. Having knowledge and understanding about immigrants' beliefs and perceptions of mental disorders can have a positive impact on influencing their mental health care seeking behaviors. Therefore, it is effective to have social workers equipped with knowledge about their clients' worldviews regarding mental health.

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## Appendix A

### Survey

#### **Attitudes and Perceptions of Mental Disorders among Individuals from Nepal**

The purpose of this study is to explore and understand Nepalese perceptions of mental disorders. The study has no direct risks or benefits for you in participating in this study. If you decide to participate, you are free to withdraw at any time without penalty. You may refuse to answer any questions on the survey you choose. You may ask questions you have now. If you have question later, please feel free to contact me at [lama7821@stthomas.edu](mailto:lama7821@stthomas.edu). All responses will be stored on a password secured computer. The survey data will be destroyed on May 15, 2013. Please complete the following survey and submit it online by clicking the submit button. If you click on the project and submit it, you are giving the researcher your consent to your information in the study. Your participation in this study is entirely voluntary. The survey is anonymous.

#### **Part I. Please answer the following questions regarding your demographics.**

1. Gender:

- Male
- Female
- Other

2. Age

- 18 - 21
- 22 – 29
- 30 – 39
- 40 – 49
- 50 – 59
- 60 – 69
- 70 and above

3. What is the highest level of education you have completed?

- High School
- Some College
- 2-Year College Degree (Associates)
- 4-Year College Degree (BA, BS)
- Master's Degree
- Doctoral Degree
- Professional Degree (MD, JD)

4. What is your Profession /Job Type?

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5. How long have you been in the United States?

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**Part II. Please check off the box that most resembles your opinion and beliefs.**

6. Mental disorders are contagious.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

7. A person whom has a mental disorder cannot be restored to sound emotional health.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

8. If a member in my family was diagnosed with a mental disorder, it would bring shame to my family.
- Strongly Agree
  - Agree
  - Disagree
  - Strongly Disagree
9. I am comfortable interacting with individuals whom have a mental disorder.
- Strongly Agree
  - Agree
  - Disagree
  - Strongly Disagree
10. If someone you know has a mental disorder, whom would you recommend to see for help with this disorder? (Check all that best fit with your perspective)
- Mental Health Professional
  - Traditional Healer
  - General physician
11. Mental disorders are caused by past life's sin/karma.
- Strongly Agree
  - Agree
  - Disagree
  - Strongly Disagree

12. Mental disorders are genetic.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

13. Mental disorders may be caused by difficulties in human development, such as how one was raised as a child.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

14. If you have a son or daughter, would you approve his/her relationship with a person who is recovering from a mental disorder?

- Approve
- Disapprove
- I don't care

15. If you have a son or daughter, who is interested in psychology or psychiatry as a profession, would you support their efforts in this direction?

- Approve
- Disapprove
- Stay neutral

16. I believe in traditional healers.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

17. Individuals with mental disorders are violent.

Strongly Agree

Agree

Disagree

Strongly Disagree

**Thank you for taking your time to complete this survey. Your valuable time is greatly appreciated.**



**Appendix B****Advertisement**

**Are you interested in being part of a study that explores perceptions of mental disorders?**

The purpose of the study is to investigate the attitudes and perceptions of Nepalese, who are residing in the United States, regarding mental disorders. The study will help mental health professionals in the United States in tailoring their services to fit the mental needs of our Nepali community.

The study is being conducted by Sonam Lama, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. Hollidge, Ph.D., LICSW. If you have any questions regarding the study, please contact me at lama7821@stthomas.edu

**Interested in participating?**

Please click the survey button below. It will navigate you to the survey page.

**Thank You.**