

Mental Illness and Disability Among Elders in Developing Countries:

The Case of Nepal

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Objectives: This article attempts to document the prevalence of psychiatric disorders among elders in a rural village in Nepal. In addition, we investigate the relationship between psychiatric illness and functional disability to assess the impact of disorder on social functioning. **Method:** A semistructured interview checklist to diagnose six disorders was used ($N = 182$). In addition, elders older than age 60 were examined to assess the functional impact of mental health conditions by measuring functional disability. **Results:** Eighteen percent of elders seem to have a diagnosable psychiatric disorder. Furthermore, in general these elders were also less likely to receive assistance with the disabilities they report, compared with those who do not experience a psychiatric disorder. **Discussion:** Documenting the extent of psychiatric disorder among elders in developing societies sensitizes health planners to the growing reality of aging in their societies and the need for expanded physical and psychiatric health care services.

Keywords: *developing countries; psychiatric disorder; functional disability; Jirels of Eastern Nepal*

The mental health status of elderly persons in developing countries is a matter of increasing interest and concern to international health experts and economic development planners. This concern stems from two significant population-related processes: the aging of the world population and the projected increase in disability (including psychiatric) that will accompany this increase—especially in developing societies (Gwatkin, Guillot, & Heuveline, 1999; Murray & Lopez, 1996). Between 1980 and 2025, the global population older than age 60 will grow by 198% overall and by 293% in developing countries. Moreover, by 2025, 72% of all those older than age 60 will live in developing societies (Levkoff, Macarthur, & Bucknall, 1995). In 1990, mental illnesses represented 10% of the overall burden of disease from all causes as measured by total disability-adjusted life years (DALYs). This figure, too, is expected to rise dramatically to 15% by 2025 (Üstün, 1999). Moreover, although we are uncertain if elders account for a greater proportion (compared to younger persons) of psychiatric disorders in the world, the growth of this segment of the population will inevitably result in increases in the diagnosis of dementia as well as the prevalence of nonorganic psychiatric disorders. These trends may have profound effects on economic and societal development. Persons with disabilities are less economically productive, and elders may also consume greater amounts of social resources because of their illness-related care needs. They also may have greater care needs than nonaffected elders.

We know very little about the true prevalence of mental illness in developing countries. We know even less about the mental health of elders living in such countries. To the extent that the mental health of elders has been investigated, studies tend to focus on dementia as the central disorder that is documented (Henderson & Hasegawa, 1992; Levkoff et al., 1995). Although dementia is certainly a component of mental disorder among elders, it is also not characteristic of mental disorder in general. Demographic trends and the recognition that

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mental health is a significant component of the disability disease burden suggest that we need to improve our knowledge in this area. To date, few diagnostically specific, cross-culturally valid measures of psychiatric well-being in developing countries have been used to assess population rates of psychiatric disorder or among elders (see these studies for exceptions: Awas, Kebede, & Alem, 1999; Bhagwanjee, Parekh, Paruk, Petersen, & Subedar, 1998; Mumford, Saeed, Ahmad, Latif, & Mubbashar, 1997; Ruiz-Doblado, 1999; Rumble, Swartz, Parry, & Zwarenstein, 1996; Smith, 1994). It is, however, crucial to assess the community prevalence of psychiatric disorder to organize health services to deal with these disorders (Andrews, 1987).

Sociologists in the United States need to increase their awareness of these issues, as well. As these issues arise in the United States and we become increasingly aware of our global citizenship, we need to contribute our expertise to address these problems. In addition to the paucity of data, there is an almost complete lack of sociological theorizing and explanation related to mental health issues—including those related to aging—in developing countries. This may be particularly important for understanding family caregiving in developing societies. Given that family structures are changing because of national family planning initiatives and internal migration to cities, the informal support systems for elders with any type of disability need to be understood. Care systems in traditional societies are entirely a matter of responsibility by the extended family and, if the extended family is threatened because of development, then the care system must be replaced or elders will be in considerable danger (Levkoff et al., 1995).

Mental Health of Elders

It is only relatively recently that investigators have realized that mental health is an issue for elders. Heretofore, evidence of mental illness among elders was attributed to organic deterioration or the “natural” depression that accompanies aging but not recognized as mental illness per se. Our growing understanding of the physical and social dimensions of the aging process has convinced us that neither is true. Rather, mental illness—although it can be related to age-specific loss

of roles, income, or physical health—is independent of biological aging. Mental health is now recognized as an issue that is relevant across the life span.

In societies such as the United States, the stereotype of elders as retired, roleless individuals waiting to die has been replaced with a multifaceted view of elders as individuals with continuing roles and goals who learn, grow, and contribute to social well-being. As such, we now realize that disorders such as depression are not natural, inevitable consequences of aging but treatable conditions that can be largely improved or “cured.” Elders have increased value in modern societies and, as such, are entitled to mental health services.

The situation is different in developing societies. This is the first time in history that older populations even exist in such societies. For example, in Nepal average life expectancy is still 58 years, and elders (older than 65 years) represent only 3.5% of the population (World Health Organization [WHO], 1998) compared to 13% in the United States. Moreover, public health interventions have been aimed at the opposite end of the age distribution. Effort has gone into reducing infant and maternal mortality rather than into elder care. Economic development has been directed to education of the young and the expansion of employment opportunities. As a consequence, there are few, if any, services directed to elders and even fewer toward the mental health of elders. National health planners and agencies are either unaware of the need or unable to afford the services to meet those needs. Under these circumstances, it will be helpful to document the prevalence of mental disorder and to examine the potential societal impact of disorder on functional disability.

The purpose of this article, then, is to document the prevalence of psychiatric disorder among elders in a rural village in Nepal. In addition, we investigate the relationship between mental illness and functional disability to provide a more concrete gauge of the impact of disorder on social functioning. Although our data came from a single village in a single developing country, our intent is to begin documenting the overall scope of this problem. There are current efforts being undertaken that will give us much better worldwide estimates, and the analysis here outlines a way of utilizing the forthcoming data.¹

Obtaining high-quality estimates of psychiatric disorder in developing societies is not an easy task, and it is most difficult in rural areas.

Although there are substantial debates about the cultural meaning of mental disorders across societies and, therefore, about the ability to compare rates of disorder (Kleinman, 1986, for example), there are also compelling reasons to measure disorder using a common set of criteria (Üstün, 1999). Assessment of psychological disorder across cultures has been facilitated by the development of the Composite International Diagnostic Interview (CIDI) (World Health Organization, 1989). The CIDI reflects current U.S. (*Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., rev. [*DSM-III-R*], 1987) and international (ICD, International Classification of Disease) diagnostic categories. It has been validated across a number of societies (Wittchen et al., 1991). However, the full CIDI requires 1 to 3 hr to administer (longer if respondents are not literate), and it requires extensive training of interviewers. These features make the CIDI less than ideal for use in rural settings such as Nepal.

However, a diagnostically specific symptom checklist instrument that reduces administration time and simplifies the training of interviewers has been developed. The *DSM-III-R* Criteria Checklist was designed “for clinicians’ assessment of the major *DSM-III-R* adult psychiatric disorders. It is a semi-structured diagnostic instrument” (Helzer & Janca, 1988). This checklist has been compared to the CIDI and been found to produce good concordance of diagnoses (Janca, Robins, Bucholz, Early, & Shayka, 1992). Tausig, Subedi, Broughton, Subedi, and Williams-Blangero (2003) described the use of a shortened version of the checklist that can be used to provide diagnostic prevalence estimates in community populations in developing countries. The instrument measures symptoms for six disorders based on *DSM-III-R* criteria and has been shown to have good psychometric properties.

Method

SAMPLE

Nepal is a small, independent Hindu kingdom of approximately 141,000 km² situated between the Tibetan Autonomous Region of China to the north and India to the south, east, and west. A nation of 23 million persons, it is predominately a rural country (90% of the

population is rural) with an economy characterized by low productivity and growth, with a paucity of known natural resources, a lack of capital, a labor surplus, and a heavy dependence on external aid. By virtually any standard, Nepal is one of the most underdeveloped countries in the world. Culturally diverse, the country encompasses more than 75 ethnic groups collectively speaking more than 35 different languages (Bista, 1981).

The Jirel are a Tibeto-Burman ethnic group of about 4,000 individuals indigenous to the Jiri Valley of eastern Nepal. They are subsistence farmers whose domestic economy is based on agro-pastoral production. They are geographically concentrated in nine villages in the Jiri region of the Dolakha District, 190 km east of the capital city of Kathmandu. The villages have access to electricity and tap water. A few houses have radios and television sets as well. As a group, the Jirels are somewhat aware of Western ideas and modernization due to mass media and foreign tourist influences. Jiri is the first stop for trekkers on their way to the Mount Everest region. In 1996, a long-term study of this population to investigate genetic susceptibility to hookworm infection was initiated by researchers from the Southwest Foundation for Biomedical Research. During that research, our study of adult mental health was "piggybacked" onto that study.

The main goal of the survey was to study the psychological health of Jirel adults. A random sample of 221 Jirel households with 1,200 residents was drawn for the study. All individuals 18 years of age and older in these households ($N = 768$) were then enumerated, and interviews were attempted with all listed individuals. Interviews were actually conducted with 85% of these adults (15% refused) giving us a sample of 653 persons. Of these adults, 182 were 50 years or older.

The survey interview obtained demographic, economic, and health information; psychiatric symptom data; and for those older than the age of 60, information on needs for assistance with activities of daily living (ADL). Each item in the questionnaire was translated into Nepali and then retranslated into English to ensure accuracy. The translation was done by qualified translators who were well versed in both languages. Interviews were conducted through door-to-door visits. Each interview was scheduled for about 1 hr. The actual average interview was 47 min. We did not distinguish the time needed to

answer the psychiatric symptom questions from the rest of the survey. However, it is clear that the length of the interview is considerably shorter than for the full CIDI. All the data for this study were collected between August 1996 and May 1998. Three interviewers (one woman and 2 men) with graduate degrees in social science, past research experience, and familiarity with the social, cultural, and behavioral conditions of the population under study were used for the data collection. Interviewers were required to do practice interviews to ensure quality and accuracy. A female interviewer was assigned to a female respondent and a male interviewer to a male respondent.

THE DSM-III-R CRITERIA CHECKLIST

The *DSM-III-R* Criteria Checklist consists of a list of symptoms that are diagnostically indicative of each psychiatric disorder assessed by the checklist (Helzer & Janca, 1988). Screener questions determined if respondents will be asked about a particular set of disorder symptoms. Scoring is done by counting symptoms and using specified criterion cutoff values to make a diagnosis. Diagnostic criteria are intended to be identical to those used in instruments such as the CIDI and the Diagnostic Interview Survey (DIS) (Robins, Helzer, Croughan, & Ratliff, 1981).

The version of the checklist used in this study assessed symptoms for five Axis I disorders and one Axis II disorder: Somatization disorder (screening criteria), generalized anxiety disorder, depression, mania, schizophrenia, and antisocial personality disorder were assessed. These disorders were chosen because they were expected to occur with some frequency and, in the case of somatization, because Asians have been found to express some disorders through physical rather than psychological symptoms (Kleinman, 1986). The *DSM-III-R* Checklist contains symptom lists for 21 disorders; however, using the entire checklist would have made the survey too lengthy for the target population. The reliability and validity of the instrument used in this study have been examined in considerable detail and have been shown to be acceptable (Tausig et al., 2003). The diagnoses of depression and anxiety have the highest reliability as indices, whereas the diagnosis of antisocial personality disorder is subject to considerable uncertainty (no data for antisocial personality disorder will be

reported). Overall, the instrument has good psychometric properties given the fact that the diagnostic sections are not designed to have such characteristics (i.e., they are designed to reflect common clinical standards).

We also measured age, gender, years of Western education, marital status, occupation, and income of respondents. For the most part, our definition of an *elder* will be a person older the age of 50. Although from a Western perspective this is not considered elderly, in Nepal, with a life expectancy of 58 years, this is an old age. As indicated earlier, only 3.5% of the Nepali population is older than age 65 (WHO, 1998) (compared to 13.3% in the United States). Eleven percent of Nepalis are older the age of 50. We also used a modified version of the Cornell Medical Index (CMI) to assess physical health symptoms (Lin, Dean, & Ensel, 1986). This measure of physical health records symptoms rather than specific diagnoses. Respondents were asked to indicate any of 40 physical symptoms (45 for women) that they experienced in the past 2 years. For the purposes of this article, the presence of each symptom was coded 1 and no symptom presence was coded as 0. This measure is used only compute the somatization diagnosis where we wish to exclude all respondents who reported a history of physical complaints that are related to the diagnosis of identifiable illness before diagnosing somatization disorder. We diagnosed *somatization* as a screening diagnosis simply because the screening diagnosis required the assessment of far fewer symptoms.

We also assessed disability with a series of 23 questions that asked respondents if they need help with common household chores or activities of daily living. We computed a disability index by summing the number of activities that respondents reported being unable to accomplish without assistance. This index is available only for respondents older than the age of 60 years because the questions were originally limited to those with physical disabilities (younger than 60 years) and those older the age of 60. Persons younger than 60 with physical disabilities were not included in the calculations reported later. The index has an alpha reliability coefficient of .81.

Finally, we investigated caregiving structures by assessing if the elder lived in an extended or nuclear family (0 = extended, 1 = nuclear), what the total household size was, and whether someone helps

the elder with such things as going to the public water tap, housework, bathing, dressing, or mobility (0 = no, 1 = yes).

Results

DEMOGRAPHIC CHARACTERISTICS OF ELDERS

The demographic characteristics of elders and those younger than the age of 50 are presented in Table 1. Elders are slightly more likely to be male when compared to the gender distribution among those younger than 50 years. This differs from the typical gender profile in developed countries where women greatly outnumber men in older segments of the population. In less-developed countries, however, high maternal mortality associated with childbirth probably explains the observed gender percentages for elders. Women are less likely to survive to old age as suggested by the high percentage of elders who report being widowed. Western educational experience is very low. Only 1.6% of Jirel elders reported any years of Western education. This appears to be a cohort effect as almost one half of younger adults report some exposure to Western education. Incomes are very low. The average income is approximately \$51 per year (U.S.\$1 = 68.2 NPR-Nepal rupees). Although older Jirels reported slightly lower incomes than younger Jirels, the differences were not substantial. Finally, older Jirels were more likely than younger Jirels to report farming as their occupation. Notwithstanding "retirement," older Jirels are more likely to work in this traditional occupation.

The overall demographic profile is that of a traditional, rural society. The village population is largely engaged in pastoral-agricultural pursuits, has little Western education, and has low incomes. Elders are more thoroughly traditional than younger Jirel adults in that they have less Western education and are more likely to be engaged in farming. Moreover, elders are more likely to have lost a spouse.

PREVALENCE OF MENTAL DISORDERS

Estimates of disorder prevalence are presented in Table 2. Approximately 18% of elders (not different from the rates among younger

Table 1
Demographic Characteristics of Jiri, Nepal, Sample (N = 652)

<i>Demographic</i>	<i>Frequency</i>		<i>Frequency</i>	
	<i>50 and Under</i>	<i>Valid Percentage</i>	<i>Over 50</i>	<i>Valid Percentage</i>
1. Gender				
Female	284	60.4	99	54.4
Male	186	39.6	83	45.6
2. Marital status				
Married	383	81.5	116	63.7
Not married	82	17.4	14	7.7
Widowed	5	1.1	52	28.6
3. Years of Western education				
0 years	267	56.8	179	98.4
1 to 5 years	41	8.7	2	1.1
6 to 8 years	39	7.2	—	
9 to 10 years	80	17.0	1	0.5
11 to 12 years	39	8.3	—	
13 to 14 years	7	1.5	—	
15+ years	2	0.4	—	
4. Income (Rupee-Nepal) (U.S.\$1 = 68.2 NPR)				
0 to 999 rupees	9	1.9	12	6.6
1,000 to 1,999 rupees	52	11.1	28	15.5
2,000 to 2,999 rupees	152	32.2	59	32.6
3,000 to 3,999 rupees	173	36.8	59	32.6
4,000 to 4,999 rupees	62	13.2	19	10.5
5,000+ rupees	22	4.7	4	2.2
5. Occupation				
Farming	286	60.9	142	78.0
Business	43	9.1	7	3.8
Service	43	9.1	10	5.5
Teacher	26	5.5	—	
Other	31	7.1	5	2.7
Housework (not employed)	6	1.3	17	9.3
Student (not employed)	35	7.4	—	

Jirels) reported at least one diagnosable disorder. Somatization (screening criteria) was detected in 5.5% of the older group. This rate is statistically different (lower) than among younger Jirel adults. In our computation of somatization, we excluded from diagnosis any respondent who also reported any recent physical illness symptoms on the CMI as required by diagnostic criteria specified in the *DSM-III-R* Checklist. Thus, our estimate of this disorder is not biased

Table 2
 Percentage Prevalence of DSM-III-R Checklist Disorders Among Elders (50+) in Jiri

	<i>Generalized</i>					
	<i>Somatization (lifetime)</i>	<i>Anxiety (lifetime)</i>	<i>Depression (recent)</i>	<i>Mania (recent)</i>	<i>Schizophrenia (recent)</i>	<i>Any Disorder</i>
Total elders (<i>n</i> = 182)	5.5 (14.3)**	5.5 (2.8)	4.4 (2.6)	1.1 (0.4)	2.7 (0.9)	17.6 (18.7)
Gender						
Female	3.0	7.1	5.1	0.0	1.0	16.2
Male	8.4	3.7	3.6	2.4	4.8	19.3
Marital status						
Unmarried	3.0	9.2	3.0	0	3.0	16.7
Married	6.9	3.4	5.2	1.7	2.6	18.1
Income (rupees)						
0 to 999	0	8.3	16.7	0	0*	25.0
1,000 to 1,999	7.1	14.3	0	3.6	3.6	25.0
2,000 to 2,999	3.4	3.4	5.1	0	1.7	11.9
3,000 to 3,999	6.8	3.4	3.4	0	0	13.6
4,000 to 4,999	5.3	5.3	5.3	5.3	15.8	31.6
5,000+	25	0	0	0	0	25.0

Note. Figures in parentheses are rates for those younger than 50 years.

* = one-way ANOVA significant at $p < .05$. ** = one-way ANOVA significant at $p < .01$.

by the high rates of physical illness found in the general population and especially among older adults (Subedi et al., 2000). This rate of somatization for elders is at the upper end of rates found in other surveys (Üstün & Sartorius, 1995; U.S. Department of Health and Human Services [U.S. DHHS], 1999) and is equivalent to that reported in the Epidemiologic Catchment Area Study (ECA) findings for somatization syndrome (Swartz, Landerman, George, Blazer, & Escobar, 1991).

The lifetime rate among older adults for generalized anxiety disorder is 5.5% and 4.4% for recent depression. Both of these rates are at the low end of prevalence estimates found in other cross-national studies (Üstün & Sartorius, 1995; Weissman et al., 1996). They do not differ from the rates found for younger adults. Estimates for mania (1.1%) and schizophrenia (2.7%) are consistent with those reported for the ECA surveys in the United States (Keith, Regier, & Rae, 1991; U.S. DHHS, 1999; Weissman, Bruce, Leaf, Florio, & Holzer, 1991). Based on the relatively small size of the elder sample, however, these latter rates are not considered reliable estimates of prevalence.

Table 3
The Relationship Between Psychiatric Diagnosis and Degree of Disability for Elders 60 Years and Older (n = 93)

<i>Psychiatric Diagnosis</i>	<i>Mean</i>	$r_{\text{disability}}$	$r_{\text{household type}}$	$r_{\text{household size}}$	$r_{\text{assistance}}$
	<i>Disability Score</i>				
Somatization	3.20	.11	-.24**	.22*	-.17
Anxiety	3.00	-.07	-.27**	.10	-.13
Depression	7.33	.39***	.06	-.01	-.10
Mania (no cases over 60)	—	—	—	—	—
Schizophrenia	4.67	.05	-.08	-.09	-.22*
Subsample mean = 3.61					

Note. Household Type: 0 = Extended; 1 = Nuclear.

* $p < .05$. ** $p < .01$. *** $p < .001$.

We also examined prevalence by several sociodemographic characteristics within the elderly population. Table 2 shows the computed rates of disorder by gender, marital status, and income. One-way ANOVAs indicate that rates did not vary as a function of demographic status. However, these comparisons may not be reliable because of the small number of respondents in some categories and the low rates of disorder for some diagnoses. The sole significant contrast relating schizophrenia to income is not readily interpretable.

DISABILITY AND CARE RECEIPT

Finally, we want to examine the association between psychiatric disorder, the ability to perform normal economic activities or ADL without assistance—our disability index and the structure and use of caregiving resources. These associations can only be examined for Nepali's older than the age of 60 because of the way the data were collected (i.e., the questions were only asked of those aged 60 or older). Table 3 shows the mean disability index scores for each type of mental disorder and the Pearson product-moment correlations between each psychiatric disorder and the index of disability, the type of household, the number of persons in the household, and whether someone assists the elder with care needs. Elevated disability scores are associated with the diagnosis of depression, only. This is reflected in the

correlation coefficients and in the mean disability score that is 2 times as high for those with depression compared to the average elder.

Those elders with an anxiety disorder or somatization disorder were more likely to live in an extended family context, although they were not more likely than other elders with disabilities to receive help with disability. The size of the household is positively related to somatization disorder but otherwise unrelated to diagnosis that suggests that those with disorders are not excluded from family households. Those diagnosed as schizophrenic are less likely to receive assistance with the disabilities they report, though in all cases, those with psychiatric diagnoses report fewer helpers compared to elders with disabilities who do not experience a psychiatric disorder. In a regression analysis controlling for whether the elder requires assistance, a diagnosis of depression is the only diagnosis associated with increased social, economic, or ADL disability (results not shown).

Discussion

The aging of the world population and the consequent expected increase in the occurrence of disability as part of the societal disease burden poses a substantial challenge to all societies in the coming years. The impact in developing societies is likely to be greater than in the developed world because health resources in general are less adequate and well distributed. In this context, it is important that we obtain good estimates of the prevalence of disability (mental illness, in particular) to assess the contribution that disability makes to the disease burden and to plan services. Much of the existing data focuses on dementia as the principal form of psychological disability. This result distorts the characterization of psychological disability among elders and results in an underappreciation of the extent to which psychiatric disorders affect elders. Under such circumstances, it would be unlikely that adequate services would be created.

In this article, we estimated community prevalence of psychiatric disorder using a short version of the *DSM-III-R* Criteria Checklist. Of elders in Jiri, 18% have a diagnosable mental disorder using this instrument. This rate is not different than that found for younger adults and suggests that mental health care be conceptualized as a health

need for the entire population. Only the rate of somatization disorder differs between younger and older Jirels. Older Jirels have lower rates of this disorder, probably because they have higher rates of actual physical disorder. This fact makes it difficult to distinguish somatization of psychological problems from genuine physical symptomatology. There were no sociodemographic correlates with disorder; however, in many instances the categories for sociodemographic variables have too few cases to put much meaning into this finding. Elders who suffer from depression are more likely to report disability in economic and daily living skills than elders diagnosed with other disorders or no disorder. This is consistent with findings from the global burden of disease study (Murray & Lopez, 1996). Depression is one of the leading causes of disability-lost years within the global burden of disease. It is relatively frequent in occurrence and seems to interfere with normal daily functioning to a greater degree than other types of disorder. Elders with depression are not more likely to receive help for their disability, however. Elders with anxiety disorders are more likely to live in extended family households, the traditional site for care. Those diagnosed with schizophrenia are least likely to receive assistance—a fact consistent with a strong cultural stigma attached to people with this disorder. These patterns of family caregiving are likely to be disrupted by migration to cities that implies more nuclear families and by lower fertility that means there will be fewer household members who can be caregivers—exactly the pattern found in the West (Levkoff et al., 1995). Care systems must be monitored to ensure that the traditional caregiving that occurs in families is not jeopardized by demographic change.

From one perspective, distinguishing the mental health problems of elders from younger adults is not consistent with the more general need to define the disease burden for all persons. On the other hand, documenting the extent of disorder among elders also sensitizes health planners to the new and growing reality of the aging of their societies and the consequent need for an expanded notion of health care services.

Epidemiological surveys are only a first step in the health-planning process. Data from such surveys define the extent and distribution of the problem but do not specify the types of services that need to be offered nor how they should be offered. More research on the impact

and treatment of disorders needs to follow. Our study is illustrative, rather than definitive, in these regards. Our principal objective was to begin the documentation of the psychological health of elders and their care needs in developing countries where we expect dramatic increases in the prevalence of disorder among older adults. We need to conduct additional studies to ensure the generalizability of observed rates in various contexts (e.g., urban vs. rural), and we need to better assess the functional impact of disorders on daily living and on societal resources. Finally, we need to recognize the need to replace or reinforce systems of care for those elders who experience mental illness.

NOTE

1. The WHO Mental Surveys Project is sponsored by the World Health Organization. The project collaborators are conducting structured interviews with representative population samples in 27 countries using the CIDI2000. The goal of the project is to provide comparable diagnostically specific estimates of psychiatric disorder. The data collected will include extensive sociodemographic information as well as assessment of disorder-related disability. Our research group is participating in this project by collecting data in Nepal. However, the data discussed in this article are from a preliminary study.

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