Mental Health Among the Resettled Bhutanese

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ABSTRACT
The resettled Bhutanese, most specifically in the US, have widespread mental health issues. The problem had skyrocketed in early years of resettlement in the US and in other countries where Bhutanese refugees were settled. Centre for Disease Control and Prevention reported at least 16 suicides between 2009 and 2012 standing at 21.5 per 100,000 people. This was higher than the national average. The cases of such suicides have not been reported in the last couple of years, though. The issue is not completely absent in other countries where they have been resettled but due to the small population size, they receive less attention. There have been very few studies made on the cause of the issue to prescribe tentative solution. This article looks into the current situation of the mental health issues in the resettled communities and efforts made to address them.

Keywords: Refugees, suicide, social support, torture, trauma

Introduction

The resettlement of the Bhutanese refugees began in 2008 and since then over 90,000 of them have been resettled only in the US, in one of the largest refugee resettlement programs coordinated by

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the United Nations High Commissioner for Refugees in recent years (Gurung & Baidya, 2010; Shrestha, 2015). These refugees had fled the torture, rape, genocide and other forms of discriminations from officials of the Royal Government of Bhutan. They took asylum in Nepal for over two decades. Nepal denied them citizenship despite their cultural ties to the country (Chase & Sapkota, 2017), even though refugees themselves never formally approached Nepal for citizenship, Bhutan denied taking them back and the only solution remained was the resettlement in third countries.

When evicted out of the country, they were separated from family, displaced from their original homestead and lost citizenship rights of the country they lived for generations. Bhutan and Nepal continued to deny any rights to them. The separated family members never saw each other for decades. Many male members of the family remained in Bhutanese jail – bearing inhuman torture and mistreatments to this day.

Already unstable mental health status of these refugees compounded following their resettlement in the third countries. Cultural shock, adjusting to a new social environment, lack of employment, absence of trustworthy social services, and language barriers caused Bhutanese refugees to suffer from mental health issue (Ellis et al., 2016). Mental health is a public health concern among Bhutanese refugees, and these problems are experienced across generations (Rinker & Khadka, 2018).

The resettled refugee also did not receive proper guidance and support in their new country. They suffer from substance misuse, depression, anxiety, and PTSD (Cochran et al., 2013). There have been several cases of suicide in the resettled countries (Meyerhoff et al, 2018) including in US and Australia. One of the studies among the Bhutanese resettled in the US showed depression, anxiety and PTSD to be at significantly higher rates than the

general US population (Vonnahme et al., 2015). The way community understands mental health significantly differs with the understanding and approaches in the country they settled. Mental health used to be a dogmatic issue and public acceptance of having mental health problem is seen negatively in the community.

Despite this alarming situation, the resettled Bhutanese have been hesitant in utilising the publicly available mental health support and resources. Cultural barriers, acculturation stressors, economic barriers, language barriers, gaps in culturally responsive services, and the larger political environment of visible minority status (Adhikari et al., 2015) were some of the reasons for low adoption of these available support services.

Culturally responsive interventions, deeper understanding of the cause of mental health problems, public awareness, and direct community engagement would be some of the way to address the problem.

Challenging misconceptions

Personal stigma refers to the stigmatising attitudes and beliefs held by an individual, whereas perceived stigma refers to an individual's beliefs about the views of others (Aromaa et al, 2011; Golberstein et al, 2008). The resettled Bhutanese community has 'perceived stigma' around mental health. Although data are not available for Bhutanese refugees, the perception that a person who seeks psychological treatment is undesirable or socially unacceptable (Kitchener et al, 2006; Vogel et al, 2007). They don't want to be labelled as mentally unstable patient. The prevalent stigma shapes negative perceptions of mental illness and psychological treatment, and the fear of bringing shame to themselves as individuals and to their family are key reasons why they do not seek mental health services (MacDowell et al., 2020;

Poudel-Tandukar et al., 2019). Mental health is linked to 'brain–mind dysfunction' and seeking treatment for heart–mind distress seemed more socially accepted (Kohrt & Hruschka, 2010). This is not just within the resettled Bhutanese community. The stigma is prevalent in communities in Bhutan too. Most Bhutanese associate mental illness with madness, hence any kind of mental ill health is stigmatised (Zam, 2018).

Causes

When Bhutanese refugees started flying to third country under resettlement programme, they encountered many shocks – cultural, languistic, social, and economic stability. Further, the resettlement exacerbated the problem of family separation. The initial years of resettlement were traumatic for the refugees because they had no idea if their family separated by the resettlement would ever meet again.

Bhutanese refugee resettlement in Australia was held by policy makers and politicians in Australia as one of most successful resettlement programmes of the Australian government. The community quickly adopted to new way of life, enrolled to education and readily available to work. This has been the case in the US as well. Employment has been deemed the most important factor for successful refugee adaptation (Porter & Haslam, 2003). The resettled community in the US quickly became a new workforce while in other countries, it took years. Lack of adequate social security in the US forced them to seek employment while in other countries, social security support encouraged them for more time in education institutions than in the work field.

However, economic stability was another contributor in community's mental health crisis. Economic stress has been shown to be the most salient stressor that stems from difficulty finding employment and opportunities, largely because refugees

arrive with premigration challenges in resettlement spaces with underdeveloped networks and environments that often stigmatise refugee status (Baranik et al., 2018). Economic stressors, including cost, time off work, and childcare, compound the difficulties of navigating structural barriers to mental health treatment (van der Boor & White, 2020). Financial stressors and social stressors that cause disruption of family life among Bhutanese refugees were found to lead to increased risk of depression and suicidal ideation (Vonnahme et al., 2015).

Historical trauma

Refugees from Bhutan experienced prejudice in refugee camps in Nepal, as well as political violence and torture in their home country. It was extremely uncomfortable for the community to discuss the shared experience of marginalisation and isolation that refugees had, since it elicited unpleasant feelings and contributed to the stigmatisation of mental health. Generations after that did not witness the collective cultural trauma, but they still have to carry the burden of a severely disturbed life that caused them emotional, psychological, and physical harm.

People don't like to talk about the painful past. They feel they will become more isolated by expressing themselves as mentally ill or mentally unable to do things. They feel further isolation if their stories are told and shared. The fears stem from a history of political repression, perpetual threats, and disconnection and disempowerment in new spaces that leave refugees helpless and speechless (Shannon et al., 2015a, b). Even after achieving safety in places of resettlement, refugees are less likely to speak freely about their past and current suffering due to decades of silent survival (Shannon et al., 2015a).

Treatment

Existing misconception has been the significant challenge towards addressing the issue. There have been efforts made to address the problem, but they remain inadequate considering the magnitude of the issue.

The lack of help-seeking behaviour in the Bhutanese population may also highlight a gap between the need for mental health services and their use, as well as the availability, accessibility, and perceived efficacy of such services (Hagaman et al., 2016). Individuals would prefer to treat the problem at an individual level, than seeking professional advice and guidance. The most commonly reported reasons for not seeking treatment were a will to solve the problem on one's own and a hope that the problem would get better by itself (Aromaa et al, 2011). Bhutanese refugees feel more comfortable seeking help from friends and family than from professionals (Chase & Sapkota, 2017), and community generally views care seeking as negative and a sign of weakness (MacDowell et al., 2020). The traditional approach often relies on home remedies, and medical treatment is only sought when conditions are not resolved, presenting a potential challenge to health care provision (Maack & Willborn, 2018).

A large section of the community have lower level of education and a limited English fluency. Language barriers lead to fear and uncertainty regarding health outcomes, especially when interpreters are not available for important steps such as scheduling appointments or filling out paperwork (van der Boor & White, 2020). When interpreters are offered (e.g., for meetings with a service provider), concerns arise over the translation's accuracy and completeness, interpersonal dynamics, and the insertion of unsolicited personal attitudes or advice (van der Boor & White, 2020). At psychiatric care centres, language barriers and lack of interpreters can also lead to inappropriate treatment and reduced access to care. Lack of trust in translators/interpreters

results in many individuals not genuinely explaining their mental health status to the professionals. Lack of expertise in interpreting in the health care context leads to miscommunication between the health professionals and patients, resulting in wrong diagnosis and treatment. Community has limited well versed Nepali language interpreters in medical field to help patients and medical practitioners communicate accurately. The Nepali language has limited terminologies to describe mental health.

Culturally appropriate services are not readily available – which are effective in addressing the problem. Culture influences how people understand and make meaning of mental health, and exploring cultural dimensions of mental health behaviours necessitates qualitative modes of inquiry to actively "engage" culturally embedded points of view (Staples & Widger, 2012). While US has large population making it possible to institutionalise culturally sensitive care services, this may not be possible in other countries where Bhutanese have settled, such as Australia, Canada or New Zealand where population is coparatively small.

Mental health professionals are challenged with providing culturally responsive services because of significant gaps in their understanding of the cultural belief systems of subpopulations (Maleku & Aguirre, 2014, 2018). Further, they experienced discrimination from providers and staff members, which diminishes the likelihood they will seek additional services (Teunissen et al., 2014).

One study in the US found that the collective mental health experience of the Bhutanese refugee community remains largely unexpressed and unaddressed, which further contributes to the stigma associated with mental health (Maleku et al, 2022). Their collective survival, traumatic history of violence, discrimination, and marginalisation; along with the collective normalisation of

emotional distress in daily life, contribute to suppression of mental health expression (Sangalang & Vang, 2017). The resettled refugee community find it less helpful to share their suffering with community members sharing collective trauma (Shannon et al., 2015b). In Australian context, the support system for treating the trauma is almost absent. The community perception that health professionals merely prescribe remedies was diluted when these professionals instead focus on understanding the patient's perspective and finding possible solutions.

Community finds religious and spiritual practices better than the medical practices in treatment of the mental health. Engaging in culturally supportive rituals have helped promote mental well-being (Calabrese & Dorji, 2013); and religious and spiritual affiliation provide a sense of belonging and agency (Amit & Bar-Lev, 2015; Benson et al., 2012).

In a consultation in Australia, Service for Treatment and Rehabilitation of Torture and Trauma Survivors found that the interpersonal relationship and the close-knit community structure has a significant impact in keeping the community healthy, including minimising mental health issues (STARTTS, 2018).

Community-based initiatives formed around Bhutanese arts and literature, women's support groups, youth clubs, and sports have been used as mechanisms to bring the community together based on shared identity and experiences. Because refugee populations rely more on their social networks, community-based initiatives can provide collective platforms for cultural healing that promote positive mental well-being. As culture is a significant coping mechanism that helps to build resilience, the identified cultural ways of coping are crucial protective factors that can minimize risk factors for the overall psychosocial well-being of Bhutanese refugees (Pulla, 2016).

Holistic interventions that target culturally based collective healing and not just symptoms of mental health are crucial to bolstering resilience in this population (Maleku et al, 2022).

Conclusion

Generalised methods are insufficient to address mental health issues. Furthermore, addressing mental health in a society that has endured collective trauma from torture, family separation, relocation, and culture shock is more unsuitable. Westernised medications are not the only way to treat mental health issues with a stronger cultural component, that has been the attempt so far in address the mental health crisis among the resettled Bhutanese.

Services that are both socially and culturally acceptable are necessary. The community of Bhutanese emigrants needs to be made aware of the problem on a local level as well. The truth is that individualised services are necessary for older community members who did not receive formal education to alter their perceptions of what mental health is.

References

Adhikari, S. B, Kelly, Y., Acharya, J. N., & Jaclyn, K. (2015). *Epidemiology of mental health, suicide and post- traumatic stress disorder among Bhutanese refugees in Ohio, 2014.* Ohio Department of Mental Health and Addiction Services.

Aromaa, E., Tolvanen, A., Tuulari, J., & Wahlbeck, K. (2011). Personal stigma and use of mental health services among people with depression in a general population in Finland. *BMC Psychiatry 11*, 52(2011). Doi: 10.1186/1471-244X-11-52

Amit K, Bar-Lev S. (2015). Immigrants' sense of belonging to the host country: The role of life satisfaction, language proficiency, and religious motives. *Social Indicators Research*. 2015 124(3). doi: 10.1007/s11205-014-0823-3.

Benson, G. O., Sun, F., Hodge, D. R., & Androff, D. K. (2012). Religious coping and acculturation stress among Hindu Bhutanese: A study of newly-resettled refugees in the United States. *International Social Work*, 55(4)

Betancourt, T. S., Frounfelker, R., Mishra, T., Hussein, A., & Falzarano, R. (2015). Addressing health disparities in the mental health of refugee children and adolescents through community-based participatory research: A study in 2 communities. *American Journal of Public Health*, 105(S3)

Calabrese J. D., & Dorji C. (2013). Traditional and modern understandings of mental illness in Bhutan: Preserving the benefits of each to support gross national happiness. *Journal of Bhutan Studies 30* (2013).

Chase L, & Sapkota R. P. (2017). In our community, a friend is a psychologist: An ethnographic study of informal care in two Bhutanese refugee communities. *Transcultural Psychiatry*. 2017. 54(3). doi: 10.1177/1363461517703023.

Cochran J., Geltman P. L., Ellis, H., Brown, C., Anderton, S., Montour, J., Vargas, M., Komatsu, K., Senseman, C., Lopes Cardozo, B., Sivilli, T. I., Blanton, C., Shetty, S., Taylor, E., Lankau, E., & Ao, T. (2013). Suicide and suicidal ideation among Bhutanese refugees—United States, 2009–2012. *Morbidity and Mortality Weekly Report*, 2013. 62(26).

Ellis, B. H., Hulland, E. N., Miller, A. B., Bixby, C. B., Cardozo, B. L., & Betancourt, T. S. (2016). Mental health risks and resilience among Somali and Bhutanese refugee parents. *Migration Policy Institute*. https://www.migrationpolicy.org/sites/default/files/publications/FCD-Ellis-FINAL.pdf

Golberstein, E., Eisenberg, D., & Gollust, S. E. (2008). Perceived Stigma and Mental Health Care Seeking. *Psychiatric Services*. 2008; 59 (4).

Gurung, N., & Baidya, P. (2010). A fresh start: Refugees from Bhutan arrive in the UK. *United Nations High Commissioner for Refugees*. http://www.unhcr.org/print/4c6026059.html

Hagaman, A. K., Sivilli, T. I., Ao, T., Blanton, C., Ellis, H., Cardozo, B. L., & Shetty, S. (2016). An investigation into suicides among Bhutanese refugees resettled in the United States between 2008 and 2011. *Journal of Immigrant and Minority Health*, 18(4)

Kitchener, B. A., Jorm, A. F. (2006). Mental health first aid training: review of evaluation studies. *Australian and New Zealand Journal of Psychiatry* 40 (2006).

Kohrt, B. A., & Hruschka, D. J. (2010). Nepali concepts of psychological trauma: The role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma. *Culture, Medicine, and Psychiatry*. 2010. 34(2). doi: 10.1007/s11013-010-9170-2.

Maack B., & Willborn R. (2018). Description of tobacco use and cessation among Bhutanese refugees participating in a tobacco cessation program. *Ethnicity & Health*. 2018. 23(4). doi: 10.1080/13557858.2017.1280134.

MacDowell H., Pyakurel S., Acharya J., Morrison-Beedy D., & Kue J. (2020). Perceptions toward mental illness and seeking psychological help among Bhutanese refugees resettled in the US. *Issues in Mental Health Nursing*. 2020. 41(3). doi: 10.1080/01612840.2019.1646362.

Maleku, A., & Aguirre, R. (2014). Culturally competent healthcare from the immigrant lens: A qualitative interpretive meta-synthesis. *Social Work in Public Health*, 29(6).

Maleku, A., Soukenik, E., Haran, H., Kirsch, J., & Pyakurel S. (2022). Conceptualising Mental Health Through Bhutanese Refugee Lens: Findings from a Mixed Methods Study. *Community Mental Health Journal*. Feb 2022. 58(2). doi: 10.1007/s10597-021-00835-4.

Meyerhoff, J., Rohan, K. J., & Fondacaro, K.M. (2018). Suicide and Suicide-related Behavior among Bhutanese Refugees Resettled in the United States. *Asian American Journal of Psychology*. Dec 2018. 9(4). doi: 10.1037/aap0000125.

Porter M., & Haslam N. (2003). Pre displacement and post displacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of the American Medical Association*. 2003. doi: 10.1001/jama.294.5.602.

Poudel-Tandukar K, Jacelon CS, Chandler GE, Gautam B, Palmer PH. Sociocultural perceptions and enablers to seeking mental health support among Bhutanese refugees in Western Massachusetts. *International Quarterly of Community Health Education*. 2019. 39(3). doi: 10.1177/0272684X18819962.

Pulla, V. (Ed.). (2016). *The Lhotsampa People of Bhutan: Resilience and Survival*. New York: Palgrave Macmillan

Rinker, J. A., & Khadka, N. (2018). Bhutanese refugees: On understanding the links between trauma, displacement, and community resilience. *Global Journal of Peace Research and Praxis*, 2(1).

Sangalang CC, & Vang C. (2017). Intergenerational trauma in refugee families: A systematic review. *Journal of Immigrant and Minority Health*. 2017. 19(3). doi: 10.1007/s10903-016-0499-7.

Shannon, P. J., Wieling, E., Simmelink-McCleary, J., & Becher, E. (2015). Beyond stigma: Barriers to discussing mental health in refugee populations. *Journal of Loss and Trauma*. 2015. 20(3). doi: 10.1080/15325024.2014.934629.

Shannon, P. J., Wieling, E., Simmelink-McCleary, J., & Becher E. (2015). Exploring the mental health effects of political trauma with newly arrived refugees. *Qualitative Health Research*. 2015. 25(4). doi: 10.1177/1049732314549475.

Staples, J., & Widger, T. (2012). Situating suicide as an anthropological problem: ethnographic approaches to understanding self-harm and self-inflicted death. *Culture, Medicine and Psychiatry*, 36(2).

STARTTS (2018). *Bhutanese Community Consultation Report 2018*. Service for Treatment and Rehabilitation of Torture and Trauma Survivors, 2018. Australia.

Teunissen, E., Sherally, J., van den Muijsenbergh, M., Dowrick, C., van Weel-Baumgarten, E., & Van Weel, C. (2014). Mental health problems of undocumented migrants (UMs) in the Netherlands: A qualitative exploration of help-seeking behaviour and experiences with primary care. *BMJ Open*. 2014. 4(11). doi: 10.1136/bmjopen-2014-005738.

van der Boor, C. F., & White R. (2020). Barriers to accessing and negotiating mental health services in asylum seeking and refugee populations: The application of the candidacy framework. *Journal of Immigrant Minority Health 22*. 2020. doi: 10.1007/s10903-019-00929-y.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The Mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*. 2007. 54(1).

Vonnahme, L. A., Lankau, E. W., Ao, T., Shetty, S., & Cardozo, B. L. (2015). Factors associated with symptoms of depression among Bhutanese refugees in the United States. *Journal of Immigrant and Minority Health*. 2015. 17(6). doi: 10.1007/s10903-014-0120-x.

Zam, N. (2018). Bhutan: The Mental State of the Happy Kingdom. *The Diplomat*. 2 November 2018. https://thediplomat.com/2018/11/bhutan-the-mental-state-of-the-happy-kingdom/