Ongoing Effects of Pre-migration Traumas on the Mental Health of Bhutanese Refugees in the United States: A Qualitative Inquiry

Dissertation

Submitted to School of professional studies.

School of Strategic Leadership and Administrative Studies

in Partial Fulfillment of the

Requirements for the Degree of

DOCTOR OF PHILOSOPHY

by

Narad Pokhrel

March 21, 2022

MARYWOOD UNIVERSITY
COLLEGE OF PROFESSIONAL STUDIES

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Signature

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Abstract

The focus of this research is to explore how Bhutanese refugees resettled in Northeast Pennsylvania i.e., Dauphin and Lackawanna counties perceive the ongoing effects of pre-migration traumas on mental health and the overall post-migration challenges and well-being. Such a study is important to address the mental health needs and to seek the causes of suicidal ideation and stressors of Bhutanese refugees currently living in the United States. When migrating out of South Asia Nepali speaking Bhutanese refugees experienced trauma resulting from persecution and discrimination. Their pre-migration traumas negatively impact their post-migration challenges and mental health and wellbeing, which makes it difficult for them to become positive contributing members of American society. This group of people has experienced significant post-migration stressors related to acculturation, including culture shock, intergenerational conflict, loss of authority and prestige among dependent elders, consequences of language barriers such as isolation and inability to obtain citizenship and social services, and lack of skills affecting employability. These post-migration stressors have been linked to negative mental-health outcomes in Nepali-speaking Bhutanese refugees, including depression, anxiety, and suicidal ideations. The research approach adopted is a generic qualitative design due to a balanced emphasis on the subjective and the external aspects of experience, as well as on individual and collective experiences that are ideal for exploring participants' perceptions of the ongoing effects of pre-migration social and historical traumas. Semi-structured interviews will be used to collect data that will be analyzed thematically. The findings from this research provide evidence that contributes to addressing the mental health needs of Nepali-speaking Bhutanese refugees in the United States.

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Chapter 1

The Problem and its Setting

Introduction

Much like America, Bhutan is a land of immigrants; diversified and pluralistic; except for the fact that the government is taking measures to reverse this diversity. A country of 38,000 square miles in area, Bhutan lies in the southern slopes of the eastern Himalayas, between Tibet and India. It is bordered to the south, east, and west by India and to the north by China. Bhutan does not have a direct border with Nepal, another neighboring country in the South Asian region. An unknown and landlocked country, secured by a century of isolation, Bhutan has been reluctant to open itself to the outside world.

Since the early 1990s, over 100,000 refugees of ethnic Nepalese origin from southern Bhutan have been living in camps in eastern Nepal after they were arbitrarily stripped of their nationality and forced to flee Bhutan. These 100,000 people constitute about one-sixth of the population of Bhutan. The Bhutanese refugee situation has become one of the most protracted and neglected refugee crises worldwide. Since 1991, approximately 18% of the Bhutanese population has fled the country (108,000 refugees), mainly to Nepal and India. The vast majority of these refugees are Nepali-speaking Bhutanese, a Hindu population of ethnic Nepali descent. More than 100,000 Nepali-speaking Bhutanese wound up in refugee camps in eastern Nepal between 1990 and 1993. Many languished in those camps for three decades or more, before being resettled in the U.S. and elsewhere. About 7000 refugees still lived in the two remaining camps as of late 2020, according to the United Nations. Resettlement of Bhutanese refugees surpasses 108,000 marks as of 2015.

Nepali-speaking Bhutanese refugees fleeing ethnic persecution are the largest population of Southeast Asians in the United States, with more than 96,000 residing in the states of Pennsylvania, Ohio, Texas, New York, Indiana, North Carolina, Missouri, Georgia, and Kentucky (United Nations High Commissioner for Refugees, 2019; White House Initiative on Asian Americans and Pacific Islanders, 2016). Many Bhutanese refugees who reside in the United States are known to experience significant post-migration stressors related to acculturation, including culture shock, intergenerational conflict, loss of authority and prestige among dependent elders, consequences of language barriers such as isolation and inability to obtain citizenship, and social services, and lack of skills affecting employability (Allen, 2016; Kim & Till, 2015; Kim, Witt, Burch, & Jenson, 2017; Lumley, Katsikas's, & Statham, 2018; Roka, 2017; Sriram, 2019; Trieu & Vang, 2015). These post-migration stressors have been linked to their negative mental-health outcomes, including depression, anxiety, and suicidal ideations (Allen, 2016; Kim & Till, 2015; Kim et al, 2017; Lumley et al., 2018; Roka, 2017; Sriram, 2019; Trieu & Vang, 2015).

Many refugees are affected by post-traumatic stress disorder (PTSD), major depression, cognitive impairment, and traumatic events such as acute trauma, chronic trauma, social traumas, psychological trauma, historical trauma, and interpersonal violence traumas because of the persecution. Many may experience imprisonment, torture, loss of property, physical assault, extreme fear, rape, and loss of livelihood. Mental health is still considered taboo, and the problem is exacerbated by a lack of cultural competence among the providers (Amnesty International Reports, 1994, 2000, 2002). The CDC's subsequent report on the Bhutanese Refugee suicides pointed out that these cases were primarily attributed to post- settlement challenges. The growing number of deaths by suicide in the Bhutanese diaspora even in

developed countries is a cause of concern. The causes of suicide in the Bhutanese community are very hard to uncover, although they have a correlation with myriad health, soico-psycho-cultural, and integration-related challenges in the aftermath of resettlement. The lack of the interrelated concepts of social connection, social bonding, social belongingness, cultural integration, cultural adaptation, and acculturation stressors have been seen as a burning issue in the Bhutanese refugee population. The Bhutanese refugees have been exposed to a long period of extreme humiliation, torture, and fear-invoking techniques before fleeing Bhutan. Having been forcefully removed from their country of residence, refugees inevitably experience identity transition with a loss of social identity.

All refugees resettling in the United States may be subject to these stressors, but researchers have observed that all negative mental-health indicators are significantly elevated among Bhutanese refugees. As a case in point, the high prevalence of depression symptoms among Bhutanese refugees (21%) compared to other refugees resettled in the United States (5%) strongly suggests that post-migration stressors potentially common to all refugee populations do not exhaust the causes of negative mental-health outcomes among Bhutanese refugees (Vonnahme et al.,2015). Suicide, hazardous alcohol use, anxiety, and other indicators of poor physical and mental health are also significantly higher in Bhutanese refugees residing in the United States in comparison to other populations (Kim et al., 2017; Mirza, Harrison, Chang, Salo, & Birman, 2018; Nath, 2016; Vonnahme et al., 2015). It is, therefore, necessary to examine the potentially ongoing effects of pre-migration stressors to fully characterize the needs of and challenges confronting Bhutanese refugees in the United States (Mirza et al., 2018; Vonnahme et al., 2015).

Pre-migration stressors among Bhutanese refugees in the United States include severe traumas. From the 1970s onward, the government of Bhutan planned and executed an ethnic cleansing program against the Nepali Speaking Bhutanese, the population from which Bhutanese refugees residing in the United States is derived (Nath, 2016). The campaign began with discriminatory legislation such as the Citizenship Acts, which revoked the citizenship of the Nepali Speaking Bhutanese (Nath, 2016). Other policies mandated all citizens to wear the dress of the northern Drukpa (non-Nepali Bhutanese) culture and prohibited the use of the Nepali language in schools. Moreover, Nepali Bhutanese were subject to harassment, fines, imprisonment, and assault for violating those laws (Amnesty International Reports, 1994, Nath, 2016). A Nepali Speaking Bhutanese revolt for civil rights was suppressed through the government's closure of schools and suspension of health care, among other human rights violations. Moreover, Bhutanese soldiers were forcibly evicted citizens by setting their houses on fire, throwing detained persons into rivers, robbing people of their valuables and citizenship documents, raping village women, as well as beating, torturing, and murdering women and children (Frelick, 2007; Giri, 2005; Maxym, 2010).

As a consequence of this intense persecution, more than 100,000 Nepali Bhutanese fled or were forced to seek asylum in Nepal, India, and other countries around the world from 1990 to 1993. Both Bhutan and the Republic of Nepal refused to grant citizenship to the refugees, who were impelled to live in camps until large third-country resettlement programs began in 2007 (Amnesty International Reports, 1994, 2000, 2002). By the time resettlement efforts began, some refugees had spent 15 to 20 years in the refugee camps, many having borne children during that time (United Nations High Commissioner for Refugees [UNHCR], 2014, 2019). Life in the refugee camps was particularly onerous especially during the early years (Nath, 2016). The

refugees had no support or supplies, even as the numbers of refugees in the camp grew exponentially through 1991. Health conditions in the camps deteriorated, resulting in epidemics of cholera, malnutrition, dehydration, diarrhea, and measles. Records and testimonies have indicated that apart from many suicides, an estimated 50 deaths occurred in the camp per day, which included around 30 children. Sexual exploitation and rape of Bhutanese women in refugee camps were common, and are well-documented (Donnini, 2008; Hans, 2008; Human Rights Watch, 2003).

Researchers have identified clear connections between ongoing effects of unresolved pre-migration traumas of the kind experienced by Bhutanese refugees on post-migration mental health outcomes in other refugee populations, and in resettled refugees in general (Ellis, Winer, Murray, & Barrett, 2019; Jackson et al.,2016; Terasaki, 2016; Procter et al., 2018; Shannon et al., 2015; Vonnahme et al., 2014). Concerning Bhutanese refugees in the United States, quantitative research by Vonnahme et al. (2015) indicated a correlation between pre-migration traumas and negative post-migration physical- and mental-health outcomes, including diabetes, heart disease, and depression. However, Vonnahme et al. (2015) noted, “Despite the documented high risk, mental health burdens in Bhutanese refugees have not been characterized in published literature” (p. 1706).

Subsequent researchers have not addressed this gap in the literature, as a result of which Rinker and Khadka (2018) remarked, “the Bhutanese refugee experience, replete with a high rate of suicide, heart disease, and diabetes, is a story largely left untold” (p. 1). In elucidating the significance of this gap in the literature in 2015, Vonnahme et al. (2015) stated, “Understanding the burden of depression in the Bhutanese refugee population is essential for developing

culturally appropriate resources and intervention programs to improve quality of life for resettled Bhutanese refugees and to prevent suicides" (p. 1706).

The specific pre-migration stressors experienced by Bhutanese refugees suggest that culturally appropriate resources and intervention programs should be trauma informed. Pre-migration stressors experienced by Bhutanese refugees align with conventional definitions of trauma (Vonnahme et al., 2015). *Interpersonal violence traumas*, such as rape and assault, may be an appropriate classification for pre-migration atrocities against Bhutanese refugees reported by several researchers (see, e.g., Donini, 2008; Frelick, 2007; Giri, 2005; Hans, 2008; Human Rights Watch, 2003; Maxym, 2010; Nath, 2016). *Social traumas*, which may include inequality, marginalization, statelessness, and poverty, may align with Bhutanese refugees' experiences of segregation in unsafe and unsanitary camps, dispossession of property and citizenship, and disenfranchisement (see, e.g., Amnesty International Reports, 1994, 2000, 2002; Kingston & Stam, 2017; Nath, 2016). Sweeney et al.'s definition of trauma also includes *historical traumas*, which are the traumatic legacy of violence committed against groups of people, potentially including the ethnic persecution of Bhutanese Nepalis (see, e.g., Amnesty International Reports, 1994, 2000, 2002; Nath, 2016).

A trauma-informed social worker, counselor, or public-health administrator is sensitive to how a client's present struggles are contextualized by past traumas (Knight, 2015). In addition to validating and normalizing client experiences, trauma-informed practitioners assist survivors in understanding how past traumas influence the present, empowering them to manage their present lives more effectively. Ostrander, Melville, and Berthold (2017) argue that practitioners and administrators who work with refugee populations need to understand the impact of pre-migration traumatic experiences to promote policies, social work training, and clinical practices

that further the health and well-being of refugees and society. Although trauma-informed approaches have been used successfully with multiple refugee populations (Benson et al., 2018; Mitschke et al. 2017; Ostrander et al., 2017), no studies have reported the use of trauma-informed interventions with Bhutanese refugees in the United States. Therefore, additional research into Bhutanese refugees' experiences of pre-migration stressors and their influence on post-migration health is needed to tailor culturally sensitive, trauma-informed interventions and resources to optimally serve this vulnerable population (see Rinker & Khadka, 2018; Vonnahme et al., 2015).

Theoretical Framework

Bronfenbrenner's (1979) ecological systems theory (EST) is the framework guiding this study. Bronfenbrenner (1979, 1994) based EST on the conclusion that individual outcomes are a result of the individual's interaction with a series of nested, mutually influential social contexts ranging from the household to society as a whole. He compared it to the nested Russian dolls that contain one inside another. The smallest and most immediate social context with which the individual interacts is the *microsystem*, which comprises social units such as the family, the neighborhood, as well as other entities with which the individual is in close, frequent, interactive contact. The *mesosystem* refers to a set of direct connections between microsystem entities, such as the individual's parents' direct relationship with a local church, which is also attended by the individual. The *exosystem* consists of social groups and settings that affect the individual without directly involving the individual, such as the employment situation of a member of the individual's household (Bronfenbrenner, 1994).

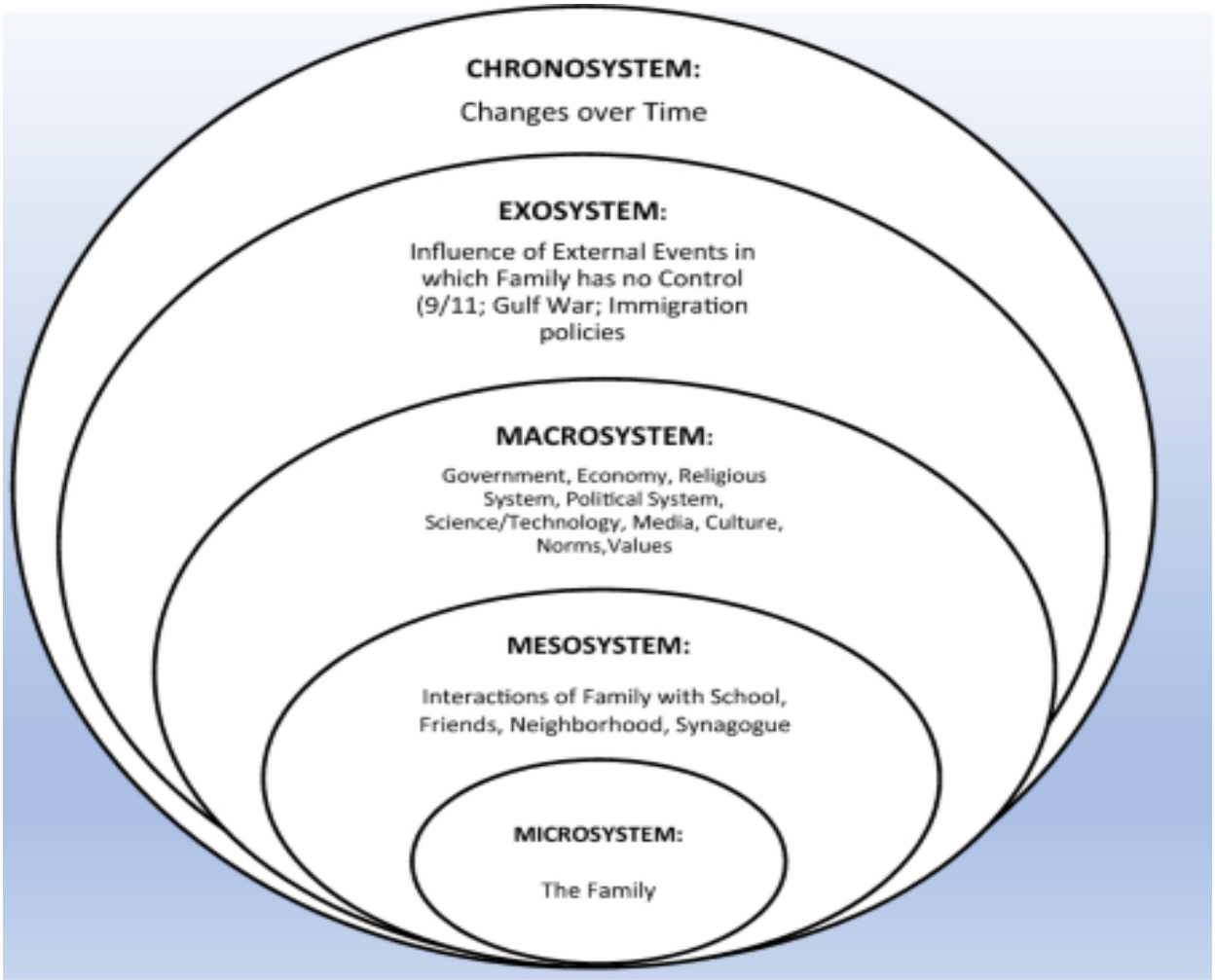
As the established framework for public health administration research (Onwuegbuzie, Collins, & Frels, 2013), EST is an appropriate framework for this study because it will allow

findings to be structured to emphasize the influence of the relevant social contexts and interactions on Bhutanese refugees in the United States. As a holistic theoretical approach, EST is a lens through which researchers can understand and organize information about refugees and their socio-political environments in the United States (Onwuegbuzie et al., 2013). Ostrander et al. (2017) has recommended the use of EST as a lens for understanding the effects of pre-migration traumas on refugees' post-migration mental health.

Figure 1.1 shows a diagrammatic illustration of the EST of Bronfenbrenner and possible links with a trauma situation. The larger societal systems—chronosystem and macrosystem—that involve the historical events and national policies and influence in the lives of individuals and embody national influences (Bronfenbrenner, 1994), the impacts thereof in a war or social cleansing situation which the Nepali Bhutanese were exposed, will influence the oppressed community. What exacerbates the situation further is the ongoing and cumulative traumatic events as refugees often face years of displacement in refugee camps where they immigrate to a foreign country that offers safety and shelter but also hardship due to social, language, and employment issues (Crosby, 2015; Martin, 2015).

Figure 1.1

Diagram of the ecological systems theory, adapted for refugee trauma



Conceptual Framework

A conceptual framework is typically more precise than a larger theoretical framework (Varpio et al., 2020). As such, it is appropriate to discuss the more targeted elements of macro, meso, and micro systems in addition to the individual level of ecological systems theory. As mentioned, Bronfenbrenner's (1979) ecological systems theory will serve as the conceptual framework for the study.

The largest aspect of the theory is the macrosystem within the framework (Kail & Cavanaugh, 2010). This part of the system is characterized by various large-scale systems that may impact a person's development. Socioeconomic status, ethnicity, and even cultural heritage

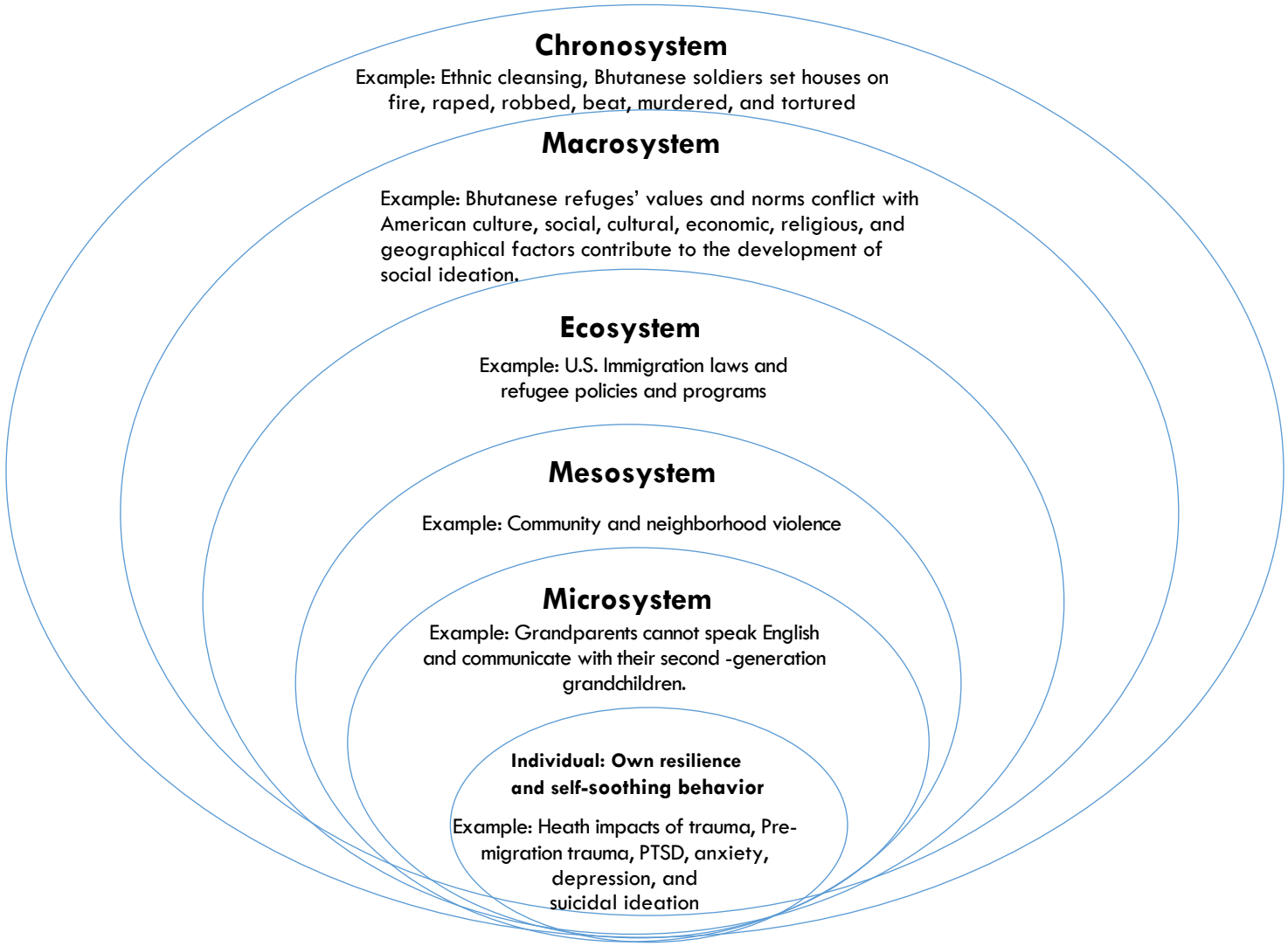
can be a part of the macrosystem. This is attributed to the fact that each of these is a large-scale influence despite not being a concrete organization of themselves, such as a church. Rather, they are the products of multiple influences that, in turn, influence the individual.

The microsystem refers to the institutions and groups that have the most immediate impact on a person's development (Kail & Cavanaugh, 2010). These typically range from family to school and religious organizations. Even neighbors can be considered a part of a person's microsystem, given their immediacy and influence. Meanwhile, the mesosystem refers to the connections between parts of the microsystem. Thus, within a person's micro system, parents and teachers may interact with religious leaders and school leaders. Wherever these interactions occur, that is the mesosystem at work. At the heart of this is the individual level (Kail & Cavanaugh, 2010). Despite these multiple layers of influence, the individual still has to engage with the world and make sense of it. The individual engages with each level of the microsystem along with its mesosystems and is impacted by the larger macrosystem contextualizing these interactions. A visual breakdown of these systems can be found in Figure 1.1, and Bronfenbrenner's (1977) ecological theory of human development is represented in Figure 1.2.

In Figure 1.2, the larger outside circle (*macrosystem*) embodies national influences that impact the family situation in which children are raised. "The macro-system may be thought of as a societal blueprint for a particular culture or subculture" (Bronfenbrenner, 1994, p. 40). The second-largest circle, (*mesosystem*) represents organizations assisting family life, which includes the parents' workplace, school, health, and other immediate community systems. The *ecosystem* functions as an enlargement of the *mesosystem* and may be inclusive of relationships such as employers of parents and teachers' professional development (Bronfenbrenner, 1977).

Although interactions in the *ecosystem* do not directly influence the developing individual, individuals within the *microsystem* are involved, which then indirectly influences the developing child. The smallest circle directly surrounding the individual represents the *microsystem*. Bronfenbrenner (1986) added another outer circle, the *chronosystem* that involves elements of time and historical events in later models. The *Chronosystem*, represented by the outer largest circle, is elucidated as including policy influences (Bronfenbrenner, 1986). For the purposes of this proposed study, the *chronosystem* is important as it represents influences within a specific time (and duration) in the history of Nepali-Bhutanese refugees laced with traumatic events that came about through policy change.

Figure 2.2 *Bronfenbrenner's ecological systems theory of human development*



Note: Adapted from "Working with refugees in the US: Trauma-informed and structurally competent social work approaches" by Ostrander, J., Melville, A., & Berthold, S. M. (2017). *Advances in Social Work, 18*(1), p. 71.

EST is appropriate for trauma-informed assistance since it considers interactions within the support system of individuals. Bronfenbrenner's (1994) ecological model of human development provides a framework for appreciating the centrality of families and the immediate community, and the interaction between these systems in the development and maintaining of the group and personal growth and security. Under this ecological model, the child (individual) is at the center of a sequence of systems.

The *mesosystem* was used by Bronfenbrenner (1994) to explain how the interactions within the microsystem networks occur. The network of family and peer relationships allows the child to develop intellectually and socially within political and social society. Partnerships that are established between the family, school, community, as well as the larger political and social network, provide the family with ways of supporting the child's development and achievement. Drawing on Bronfenbrenner's ecological model, the relationship between the larger community of pre-migration traumatized members, together with family, school, and immediate community partnerships, can be theorized as critical to establishing a supportive and resilient environment for the pre-migration child and adult within the traumatizing situation.

Purpose of the Study

The purpose of this generic qualitative inquiry is to explore how Bhutanese refugees resettled in Northeast Pennsylvania perceive the effects of pre-migration traumas, including stress and suicidal ideation, on their post-migration mental health and well-being. Three mental health problems, namely, post-traumatic stress disorder (PTSD), anxiety and depression, and

self-esteem will provide a clear understanding of the risk factors, influence, and potential solutions to the research problem identified.

Generic qualitative inquiry is not one of the five traditional qualitative designs, which include phenomenology, grounded theory, narrative inquiry, ethnography, and case study research (Creswell, 2012; Percy, Kostere, & Kostere, 2015). However, generic qualitative inquiry is frequently used in the field of social sciences because it facilitates explorations of participants' perceptions and experiences of real-world conditions without imposing the emphasis on theory construction, internal structures of subjective experience, processes within bounded contexts, cultures, or individual stories that a traditional qualitative design would involve (Percy et al., 2015).

Central Research Questions

The researcher proposes the following two central research questions to guide the study:

RQ1. How do Bhutanese refugees in Pennsylvania i.e., Dauphin and Lackawanna counties describe their post-migration challenges, mental health, and well-being?

RQ2. What supports do Bhutanese refugees in Pennsylvania i.e., Dauphin and Lackawanna counties perceive as effective or potentially effective in alleviating ongoing effects of pre-migration traumas on their post-migration challenges, mental health, and well-being?

Research Sub Questions

The researcher proposes the following sub-questions to guide the study:

QNO1. How do Bhutanese refugees in Northeastern Pennsylvania i.e., Dauphin and Lackawanna counties perceive pre-migration traumas as influencing their overall post-migration challenges, mental health, and well-being?

QNO2. How did pre-migration factors like social, cultural, economic, religious, and geographical factors contribute to the development of suicidal ideation and actions among the

Bhutanese refugees resettled in Northeastern Pennsylvania i.e., Dauphin and Lackawanna counties?"

QNO3. How do Bhutanese refugee community members understand suicide and the perceived causes, and risk and protective factors for suicidality, at the individual, family, community, and societal levels?

QNO 4. How do the work experiences of Bhutanese refugee community members differ from those of American work experiences?

QNO 5. Does Bhutanese refugee community members' language barrier affect their daily lives in the USA? What are the challenges they are facing because of the lack of fluency in the English language?

QNO 6. How do the Bhutanese refugee community members deal with their pre-migration issues while living their post-migration life in the United States?

Definitions of Key Terms

The following key terms are defined according to their usage in this study:

Bhutanese refugees. Refugees who came from the Bhutanese Refugee Camp in Nepal from 2008 through 2018 (United Nations High Commissioner for Refugees, 2019). In this study, Bhutanese refugees will be individuals who currently reside in Northeast Pennsylvania.

Effects of pre-migration trauma. The extant literature suggests that pre-migration trauma is associated with social isolation, difficulty communicating, stress related to legal immigration status, and race-based discrimination (Amnesty International Reports, 1994, 2000, 2002; Kingston & Stam, 2017; Nath, 2016).

Historical trauma. Trauma, which is the legacy of violence committed against groups of people, potentially including the ethnic persecution of Bhutanese Nepalis, is relevant in this study (Amnesty International Reports, 1994, 2000, 2002; Nath, 2016).

Interpersonal violence traumas. This includes trauma such as rape and assault. In this study, these traumas may be an appropriate classification for pre-migration atrocities against Bhutanese refugees reported by several researchers (Donini, 2008; Frelick, 2007; Giri, 2005; Hans, 2008; Human Rights Watch, 2003; Maxym, 2010; Nath, 2016).

Mental health. Emotional, psychological, and social well-being (Nath, 2016). This study will specifically examine the mental health of Bhutanese refugees.

Potentially effective support. Mental health support that is potentially effective in providing relief and comfort to individuals experiencing trauma. Evidence of effectiveness will be at least partially demonstrated in the literature (Knight, 2015).

Post-migration mental health. In this study, post-migration means the period when individuals resided in the host country (United States) after the resettlement period. Post-migration mental health refers to the mental health of individuals in the post-migration phase.

Post-migration challenges. Post-migration challenges in this study refer to the post-migration challenges faced by the Bhutanese refugees such as sociocultural, economic, psychological, and other day-to-day life challenges in the post-migration era in the United States.

Pre-migration mental health. In this study, pre-migration means the period when individuals resided in their home country of Bhutan before arriving in refugee camps. Pre-migration mental health refers to the mental health of individuals in the pre-migration phase.

Refugee. A refugee is a person forced to flee his or her native country because of war, persecution, or violence (United Nations High Commissioner for Refugees, 2019).

Social trauma. This refers to trauma that may include inequality, marginalization, statelessness, and poverty. In this study, social trauma may align with Bhutanese refugees' experiences of segregation in unsafe and unsanitary camps, dispossession of property and

citizenship, and disenfranchisement (Amnesty International Reports, 1994, 2000, 2002; Kingston & Stam, 2017; Nath, 2016).

Suicide. The act of an individual ending their own life (Nath, 2016).

Suicidal ideation. Imagination, planning, or fantasizing about suicide (Nath, 2016).

Trauma. Trauma is an experience of a threat to life or well-being that has ongoing effects on mental and physical health (Sweeney et al., 2016).

Trauma-informed care. Physical or mental health care that is sensitive to how an individual's present struggles are contextualized by past traumas (Knight, 2015).

Well-being. A state of being comfortable, healthy, or happy. In this study, well-being will focus on the mental well-being of Bhutanese refugees (Nath, 2016).

Delimitations

A delimitation is a deliberately chosen research characteristic that defines the scope of the study (Theofanidis et al., 2019). The study's delimitation to a small geographic area i.e., Dauphin and Lackawanna counties and a specific refugee population may limit the transferability of the findings to other samples and populations. Rich descriptions of the sample and the data will be provided in the presentation of results to assist future researchers in assessing transferability. Elucidations of the population of Bhutanese refugees and their experiences in chapters 1 and 2 will also assist future researchers in assessing the transferability of the findings to other populations and samples.

Assumptions

Research assumptions are problems, ideas, or positions taken for granted and viewed as reasonable and widely accepted (Theofanidis et al., 2019). This study will assume that participants will give honest and accurate answers to the interview questions. This is a necessary

assumption in self-report data as the researcher cannot entirely ascertain the truthfulness in the intentions of participants in answering the interviews (Merriam & Tisdell, 2015). However, participants will be informed that their identities will be kept confidential to encourage their honesty. To assist participants in giving accurate responses, participants will be asked to member-check their transcripts approximately one week after their interview, and to suggest any changes that would increase the accuracy of their responses. Furthermore, the researcher will allow participants to skip any question they wish or to quit the study at any time. This will reduce the need to conceal or modify the truth as the participant could simply choose not to answer the question or quit the study instead.

Another assumption of the study is that the participants have experienced social and historical trauma in Bhutan as well as in the Refugee camp in Nepal. Members of the population may or may not have experienced interpersonal violence trauma, but all are assumed to have experienced social and historical traumas on the basis of their refugee status. The literature provides a basis for this assumption (Kim et al., 2017; Nath, 2016). Previous researchers have found correlations between post-migration stressors and poor mental-health outcomes in the Bhutanese refugee population, including the language barrier, loneliness, and social isolation, inadequate bilingual delivery of healthcare and social services, and inadequate access to transportation (Kim et al., 2017; Nath, 2016).

Significance of the Study

The practical significance of the study is that it will contribute to addressing the mental health needs of Bhutanese refugees in the United States. Researchers have previously indicated that when migrating out of South Asia, there are a number of stressors that the Bhutanese face. This group faces ethnic persecution (UNHCR, 2019) and experience trauma resulting from persecution and discrimination (Nath, 2016). By the time they arrive in the United States, these

various experiences have negatively impacted their ability to adjust and integrate into the larger American society. Their pre-migration traumas negatively impact their post-migration mental health and wellbeing, which could make it hard for them to become positive contributing members of society. In fact, research has shown that their post-migration conditions often exacerbate their existing negative mental health conditions (Allen, 2016; Kim & Till, 2015; Kim et al., 2017; Lumley et al., 2018; Roka, 2017; Sririam, 2019; Trieu & Vang, 2015).

Once in the United States, these people often encounter barriers that again marginalize them. They face language barriers, lack skills that will lead to a strong income, become culturally isolated, and find it difficult to access social services. In more ways than one, the experiences these people have once in the United States mirrors the marginalization they experienced while in their home country. Identifying how this group perceives all of those traumas impact their post-migration lives and understanding their perspectives on mental health and integration in the United States may lead to the development of programs that can address the unique concerns of these refugees. The findings of this study will help the resettlement agencies to further explore the questions and concerns of the newly arrived refugees for making the transition to this new community. If stakeholders address their concern in time, they feel relief and honored in the community. This, in turn, would lead to positive outcomes whereby the refugees at large are more prepared, feel relief, mentally healthy and, consequently, are more productive members of society.

Chapter 2

Literature Review

Introduction

Around the globe, 10 million people have been displaced from their homes (Oxfam International, 2007). The magnitude of this issue has promoted a large body of research. However, as Richard Black (2001) notes, the development of refugee studies has always been closely tied to policy developments. While an open dialogue between researchers and practitioners is one of the strengths of this field, it is also one of its greatest weaknesses. In the early 1990s, the nation expelled close to 100,000 ethnic Nepali Speaking Bhutanese, who resided in the southern half of the country, in what some have called an ethnic cleansing exercise (Hutt, 2005, p. 44). While little is known about Bhutan itself, even less is known about the Bhutanese refugee crisis, as it seems most unlikely for a country that measures growth in terms of happiness and has a reputation as a peaceful place to forcibly expel tens of thousands of people.

Resettlement is a viable option for less than one percent of the 84 million people worldwide who were forced to flee their homelands due to persecution based on their race, religion, nationality, political opinion, gender, or sexual orientation and Bhutanese refugees are among them. In 2016, Nepali-speaking Bhutanese refugees who had been in the U.S. since 2008 comprised more than 83,000 (Yun et al., 2016). This figure has risen, as the 2019 reports from the United Nations stated that 96,000 Nepali-speaking Bhutanese refugees are residing in the United States (United Nations High Commissioner for Refugees, 2019). Before fleeing their country, the refugees suffered at the hands of their oppressors and were exposed to post-migration stressors, which takes its toll on the mental, physical, and social wellbeing of the refugees. Although the Nepali-speaking Bhutanese refugees living in the United States

have also suffered from stressors before and after immigration, this group experienced significant mental health symptoms such as depression (24%) (Poudel-Tandukar, et al., 2019) compared to the general population in the United States (8.5%) who reported depression before the COVID pandemic (Ettman et al., 2020). Furthermore, Nepali-speaking Bhutanese refugees are 10 times more likely to experience PTSD than citizens in their home countries that were age-matched (Heermans, 2018). This discrepancy strongly suggests that the stressors potentially common to all refugee populations may not be the only cause of negative mental-health outcomes among Nepali-speaking Bhutanese refugees.

Researchers have found that Nepali-Bhutanese refugees living in the United States suffer considerable acculturation related stressors, such as culture shock, intergenerational conflict, loss of authority and prestige among dependent elders, consequences of language barriers such as isolation and inability to obtain citizenship and social services, and lack of skills affecting employability (Kimet al., 2017; Lumley et al., 2018; Roka, 2017; Sriram, 2019). Therefore, the proposed study is to conduct additional research into Nepali-speaking Bhutanese refugees experiences of pre-migration stressors and their influence on post-migration mental health to tailor culturally sensitive, trauma-informed interventions and resources to optimally serve this vulnerable population (Rinker & Khadka, 2018). This issue assumes significance because mental-health outcomes such as depression, anxiety, and suicidal ideations were linked to the post-migration stressors in Nepali Speaking Bhutanese refugees (Kim et al, 2017; Lumley et al., 2018; Roka, 2017; Sriram, 2019). However, there is a gap in the literature about how Nepali-speaking Bhutanese refugees perceive the ongoing effects of pre-migration traumas (Mirza et al., 2018). Addressing this gap in the literature would benefit U.S. medical and mental-health practitioners serving Nepali-speaking Bhutanese refugees by providing the evidence-based

guidance needed for delivering culturally sensitive, trauma-informed care (Ostrander et al., 2017).

This section entails a brief overview of the strategy adopted for the literature review followed by a review of key literature explored in this study. The review provides an exploration of the effects of trauma on an individual's physical and mental health, as well as social relationships. This is followed by a succinct overview of the historical events leading to the ethnic cleansing that caused the Bhutanese to flee their homes. A more detailed exploration of the pre-immigration situation, including life in the refugee camps, then follows. The post-migration situation and stressors the Nepali-Bhutanese refugees (who currently reside in the United States) were exposed to will also be discussed. Specific attention will be paid to the culture and customs of the Nepali Bhutanese that could exert an influence on their mental health and acculturation process. A comparison between other refugees with similar pre- and post-immigration situations will also be made. A summary of the literature findings concludes this chapter.

Literature Search Strategy

The strategy located key literature on the phenomenon under scrutiny involved identifying key search terms and combinations thereof to search the worldwide web. The database of the University library was used to locate peer-reviewed works on refugees, specifically Nepali-speaking Bhutanese refugees, trauma, trauma-informed assistance, refugee camps, mental health, and physical health issues of refugees. The search terms were used in isolation and phrases; *mental health documentation, and trauma-informed assistance theory and practice* were included. Search engines utilized in finding and accessing peer-reviewed literature include Google Scholar, ProQuest, EBSCOhost, Researchgate.net, Centers for Disease Control, and the website of United Nations.

Review of Key Literature

In the literature review, trauma as a phenomenon will be defined and discussed. The section on trauma will focus on categories of trauma, the influence of trauma on the individual's physical and mental health, social relationships, employment, and learning. Before analyzing the pre-migration situation of which their prolonged stay in refugee camps form an integral part, considering the Nepali-speaking Bhutanese refugee situation requires a comprehensive study at their history. The post-migration situation, with its unique stressors, will be explored to examine the cultural influences that could contribute to the Nepali-speaking Bhutanese refugees' mental health issues. This study focuses on all the age groups within the Nepali-speaking Bhutanese refugee population. However, more attention will be paid to the adults within this population, since this is a rather large group ranging from infants to the elderly.

Trauma

The American Psychology Association (2019) defines trauma as an "emotional response to a terrible event like an accident, rape, or natural disaster" (para. 1). Shock and denial are typical immediately after the event. "Longer-term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives" (APA, 2019, para. 1). Psychologists can help these individuals find constructive ways of managing their emotions (APA, 2019). Other definitions of trauma are linked with distinguishing different types or categories.

Categories of trauma linked to definitions. According to Bryant et al. (2017), acute trauma as a short-lived event (e.g., natural disaster) that could have long-lasting psychological effects. In contrast, chronic trauma refers to a traumatic situation that lasts for a long time, e.g. ongoing community violence, ethnic persecution, or war (Bryant et al., 2017). Bryant et al. (2017) defined

trauma as an experience of a threat to life or well-being that has ongoing effects on mental and physical health. The researchers have distinguished between interpersonal, historical, and social trauma.

Several researchers have reported that interpersonal violence traumas, such as rape and assault, may be an appropriate classification for pre-migration atrocities against Bhutanese refugees (Donini, 2008; Frelick, 2007; Giri, 2005; Hans, 2008; Human Rights Watch, 2003; Maxym, 2010; Nath, 2016). Social traumas, which may include inequality, marginalization, statelessness, and poverty, may align with Bhutanese refugees' experiences of segregation in unsafe and unsanitary camps, dispossession of property and citizenship, and disenfranchisement (Amnesty International Reports, 1994, 2000, 2002; Kingston & Stam, 2017; Nath, 2016).

Marie Yellow Horse Brave Heart (Brave Heart 2003; Brave Heart & DeBruyn 1998) developed her seminal work on historical trauma, which has been documented by others (Atallah, 2017; Gone et al., 2019; Hartmann et al., 2017). Historical trauma "is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003, p. 7). This definition potentially includes the ethnic persecution of Bhutanese Nepalis (Adhikari et al., 2021; Kingston & Stam, 2017).

Influence of trauma. The effects of trauma on an individual or group could be immediate or have a delayed onset. Moreover, trauma could cross generations, socially, emotionally, as well as epigenetically (Yehuda, 2018). Epigenetics entails modifications in the DNA of a person, which essentially involves changing how the genes function instead of changing the DNA sequence (Yehuda et al., 2018). Chen et al. (2020) emphasized interpersonal differences in people's reactions to traumatic events, which makes it important to understand an individual's responses to trauma within the unique context of the person's ecological situation, including their culture,

social network, gender, and age, among others. The wide-ranging of trauma include physical or biological effects (Chen et al., 2020). as well as impacts on establishing social relationships such as trust, daily coping skills, cognitive skills, and the ability to work or learn (Punamäki et al., 2019; Terrasi & de Galarce, 2017)

Physical and brain anatomy. Yehuda et al. (2018) uniquely demonstrated epigenetic changes in cytosine methylation within the gene encoding that occurred in both Holocaust survivors and their adult children. Put differently, the genetic changes occurring in Holocaust survivor parents were carried to the genetic make-up of their children. This demonstrates that trauma can alter the individual's biology.

Neuroscientists found that refugee patients exhibit a range of neurological complaints, which cannot be explained based on cultural differences. Brinckmann et al. (2018) concluded that the refugees' neurological complaints are the end results of forced dislocation. Refugees with neurological complaints, such as isolated seizures and severe headaches, report at the emergency services of hospitals. The seizures experienced by refugee and immigrant patients were found to be non-epileptic and the headaches were not related to strokes or any other neurological diagnosis. After thoroughly examining and testing refugee patients reporting at emergency services with neurological complaints, Brinckmann et al. (2018) concluded that these complaints were linked with the traumatic events experienced by the patients and were rarely linked with a medical condition. Although Brinckmann et al. (2018) focused their research on refugee patients from Syria, Afghanistan, and Iraq, the results of their study were supported by previous research.

With a global number of displaced refugees of 65.6 million in 2018, the medical systems of the receiving countries are rather stretched due to the variety and severity of complaints together with immunization programs and acute illnesses that break out due to the refugee camp

conditions (Brinckmann et al., 2018). Brinckmann et al. (2018) pointed out that when dealing with refugees, the diagnosis of possible neurological problems takes much longer due to language barriers, incomplete medical histories, and cultural beliefs around visiting doctors. Refugees fleeing their countries as a result of war may present with war injuries that need immediate medical attention and hospitalization in some cases, which further compromises the medical services of the receiving country (Saghir et al., 2018). Sweileh et al. (2018) reported that several infectious diseases reemerged in Turkey as a result of the influx of Syruan refugees. Conditions in refugee camps cause infections, such as gastrointestinal and skin infections, to spread more easily (D'Anna et al., 2018).

Mental health issues. Neuropsychiatric disorders, including post-traumatic stress disorder (PTSD), sleep disturbances, depression, and anxiety have also been linked with the traumatic events refugees endured (Brinckmann et al., 2018; Giacco et al., 2018; Ibrahim & Hassan, 2017; Kienzler, & Sapkota, 2020; Riley et al., 2017). The effects of PTSD, depression, and anxiety influence the refugees' ability to concentrate, remember, and consequently, their work and learning (Morina, 2018; Riley et al., 2017).

Conducting a review of literature on the prevalence of mental health problems among refugees, Morina (2018) reported variations in prevalence reports. Although the researchers primarily used the same assessment instruments, there were variations in the degree of war atrocities the refugees were exposed to and the time between fleeing the war-torn country and when the studies were conducted. These factors were found to contribute to the differences in prevalence figures. Heterogeneity in prevalence figures was also found for depression and anxiety, which complicates reporting on the prevalence of neuropsychiatric disorders. In general, literature consulted by Morina reported that one out of four refugees present with one or more

mental health issues such as PTSD, depression, and anxiety. This tendency also holds true for children and youth of war-torn countries (Morina, 2018).

High-risk factors. Researchers indicated that having suffered torture and mass violence was associated with increased levels of neuropsychiatric disorders (Morina, 2018). Another factor linked with increased neuropsychiatric disorders was losing a close relative, e.g., spouse, during the war. War widows were found to have a higher prevalence of major depressive disorders and anxiety compared to non-bereaved females. Children (younger than 18 years) who lost their fathers during the war presented with a higher prevalence of disorders such as anxiety (11% versus 7%), suicidal tendencies (12% versus 6%), panic disorder, and obsessive-compulsive disorder, compared to those children who had not lost their fathers during the war (Morina, 2018).

Torture is specifically detrimental to the survivor's mental health (Kienzler & Sapkota, 2020; Liddell & Bryant, 2018). Liddell and Bryant (2018) found that torture impacted the structure and working of the brain, specifically perception, the limbic system where emotions are housed, and neurologically based endocrine excretions, all these changes influence PTSD in the patient. Liddell and Bryant asserted that having suffered torture significantly increases the likelihood of mental health issues. Among interpersonal violence, torture and sexual violence are associated with a high prevalence of PTSD cases among refugee patients. Survivors who were exposed to sexual violence exhibited increased rates of PTSD, anxiety, and depression (up to 75%) (Ba & Bhopal, 2016). Kienzler and Sapkota (2020) reported similar findings in their study on Bhutanese refugees. According to Spiller et al. (2016), torture is associated with different neuropsychiatric conditions, including headaches, difficulty with memory and concentration, and disturbed sleep patterns (Coşkun & Ahlers, 2019).

Social interaction. Betrayal experienced in pre-immigration events with associated trauma serves to erode refugees' trust (Khadka, & Rinker, 2018; Strang & Quinn, 2019). Strang and Quinn (2019) explored the correlation between mental health and social relationships of single Afghanistan male refugees. The researchers found that the participants reported little social contact with family and friends and local services based on their difficulty with developing trusting relationships. The researchers emphasized the importance of interpersonal bonding in maintaining healthy relationships and mental health. Correspondingly, Khadka and Rinker (2018) asserted that the outcomes of trauma that refugees were exposed to are complex and multifaceted. As this trauma is linked with actions from the government and formerly perceived countrymen, it is embedded in the refugees' perceptions of society. The unfortunate result of interpersonal trauma during ethnic clashes is the victims' loss of trust and safety, both basic aspects of humanity and difficult to rekindle (Khadka & Rinker, 2019).

Having been forcefully removed from their country of residence, refugees experience identity transition with a loss of social identity (Alfadhli & Drury, 2017). As discussed earlier, PTSD is commonly associated with trauma. Carpenter et al. (2018) found in a meta-analysis that social anxiety disorder (SAD) is often associated with PTSD. Researchers indicated that similar to PTSD, SAD is also an end result of trauma experienced by the refugees. Sufferers of SAD constantly fear judgment and criticism of others, which stymies their ability to work, learn at school, or develop social relationships, thus impacting their quality of life (Alfadhi & Drury, 2017).

World of work and learning. Post-traumatic stress, anxiety, depression, aggressive and oppositional behavior, and suicidal ideation are linked with experiencing violence. A meta-analysis based on data from 96 countries concluded that at least 50% of all children in North America, Asia, and Africa had experienced violence in the past year, which means that over one

billion children are victimized by violence worldwide (Hillis et al., 2017). Children exposed to violence have been found to have lower academic achievement levels (Griggs et al., 2019). Dysregulation within the hypothalamic-pituitary-adrenal gland axis that can be linked with either hypo or hyperarousal in the face of distressing stimuli is a result of traumatic events and experiencing community violence (Williams & Borgogna, 2020; Wright et al., 2017). Furthermore, neurotransmitters, peptides, neurohormones, and other abnormalities were found in adults who had experienced violence (Rasmusson & Pineles, 2018).

In sum, trauma causes multiple problems to victims. On a biological level, trauma interferes with brain physiology by changing the functioning of different brain areas such as the endocrine regulation. Refugees have to live in refugee camps where the living arrangements are all but ideal. The overcrowding and poor hygiene, linked with a scarcity of food and medical care, lead to outbreaks of acute illnesses such as gastrointestinal diseases that quickly spread throughout the camps. Refugees often suffer particularly harsh traumatic events such as torture and sexual violence, which are risk factors for neuropsychiatric disorders such as PTSD, depression, and anxiety. The loss of their country and culture leaves refugees feeling as if they do not fit in anywhere. Moreover, being violated by previous countrymen gives rise to fear and a loss of trust. These factors influence the refugees' social interaction causing them to isolate themselves and mistrust others.

Story to tell. In the early 1900s (Kim et al., 2017), the Bhutanese community consisted of four groups. Distinguished by the geographical regions, the groups included central Bhutan, eastern Bhutan (Sharchop), western Bhutan (Ngalong), and Southern Bhutan (Nepali Speaking Bhutanese). It is the latter group that is of interest in this study, as the Nepali-speaking Bhutanese occupied the southern part of Bhutan (Bhatta et al., 2017). In 1865, the Nepali farmers moved to Bhutan after the Anglo-Bhutanese war (Toll, 2020). Seeing that the southern section of

Bhutan was malaria-infested and sparsely inhabited, Bhutan accepted the immigration of the Nepali-speaking Bhutanese (Pal & Banerjee, 2017). This community flourished and soon became the main food producer in Bhutan.

Several restrictions were placed on the Nepali-speaking Bhutanese communities in Bhutan, including that they could not obtain land in the north. This rule isolated the group to a large extent. The Nepali-speaking Bhutanese maintained their culture, Hindu religion, and language, which was the only known language to many (Evans, 2010; Gulf Coast Jewish Family & Community Services: Refugee Services, 2015). Prior to 1958, Nepali-speaking Bhutanese had to pay taxes either with money or in labor—a practice different from the rest of Bhutan. In addition, they were not allowed to join the armed forces or the police. In 1958 the Nepali-speaking Bhutanese gained citizenship in Bhutan (Evans, 2010); however, this was soon invalidated with the Citizenship Acts of 1977 and 1985 (Kim et al., 2017). Only those Nepali-speaking Bhutanese who could produce their 1958 tax certificates were recognized as Bhutanese citizens, however, only a few could do so (Kim et al., 2017).

The Nepali-speaking Bhutanese remained culturally and linguistically different from the rest of Bhutan. Pulla (2016) reported that with their integration into the Bhutanese society after gaining citizenship, their cultural heritage became even more important to this community. The Nepali-speaking Bhutanese acquired some of the Bhutanese cultures but in essence remained close to their Nepalese heritage (Pulla, 2016). Revoking the citizenship of the Nepali Bhutanese inaugurated yet another phase of this community's ethnic isolation and repression (Kim et al., 2017).

Spurred by a Bhutanese movement of strengthening the Bhutanese culture, the king promulgated the Citizenship Acts of 1977 and 1985 (Kim et al., 2017). In building the Bhutanese culture, the king decreed that Drukpa clothing must be worn by everybody and that the Nepali

language may no longer be taught in schools. As a result, Nepali-speaking Bhutanese teachers were replaced by western Bhutanese (Ngalong) teachers. These arrangements elicited many conflicts and revolts from the Nepali-speaking Bhutanese. Retaliation from the government came in the form of closing of schools and stopping health services (Kim et al., 2017). "Violence, torture, and systematic oppression against the Nepali speaking Bhutanese became sanctioned by governmental bodies" (Meyerhoff et al., 2018, p. 3). The ethnically Nepali, Nepali-speaking Bhutanese ("People of the south"), are a largely Hindu people who moved from Nepal to Bhutan. They lived peacefully in Bhutan until the mid-1980s when Bhutan's king and the ruling Druk majority feared that their population could end up overrunning the majority group and diluting the traditional Buddhist culture of the Druk Bhutanese. A cultural campaign known as "One country, one people," or "Bhutanization," was initiated to forge a Bhutanese national identity. The policies forced the Druk dress code, religious practices, and language on all Bhutanese regardless of heritage.

These adopted policies alienated the Nepali-speaking Bhutanese by attempting to forcibly integrate them into the majority culture. Difficult requirements for proving citizenship were also imposed on the Nepali-speaking Bhutanese and even those who could provide documentation were usually denied citizenship. By the early 1990s, the "One country, one people" campaign had precipitated a humanitarian emergency. By 1993, more than 100,000 Nepali-speaking Bhutanese had fled or were forced out of Bhutan and resettled in southeastern Nepal. This Wangchuk regime has tortured, killed, silenced, had their freedom denied, and driven into exile. Generations of Nepali-speaking Bhutanese forced many including my family to flee or be murdered. Between 1990 and 1993, more than 100,000 Nepali-speaking Bhutanese wound up in refugee camps in eastern Nepal. Many languished in those camps for at least two decades, before being resettled in the U.S. and elsewhere. Between 1990 and 1993, more than 100,000 Nepali-

speaking Bhutanese, many of whom came from families that had lived and farmed in southern Bhutan for generations, wound up in refugee camps in eastern Nepal.

By 2001, an estimated 100,000 Nepali-speaking Bhutanese refugees stayed in seven different refugee camps in Nepal (Meyerhoff et al., 2018). In the early 1990s, more than 100,000 ethnic Nepalis left Bhutan and resettled into seven refugee camps in southeast Nepal: Beldangi I, Beldangi II, Beldangi II extension, Goldhap, Khudunabari, Timai (all in Jhapa District), and Sanischare (Morang District) near the township of Damak. In February 2011, the Nepalese government expressed the intent to consolidate the camps into two settlements due to the decline in camp populations. Of the seven original camps, two (Timai and Goldhap) have been closed and the remaining population moved to Beldangi and Sanischare. The last camp of the Eastern group, Khudunabari were relocated in March-May 2012. Three Beldangi camps (Beldangi I, II, and II extension) are now collectively named Beldangi (though all three remain), and Sanischare remains. By the end of May 2012, there were official camps – Beldangi (three camps in one) and Sanischare. The Association of Medical Doctors of Asia (AMDA)-Nepal, a non-governmental organization, provides inpatient and outpatient medical care and community health education in all refugee camps in Nepal. UNHCR collects health information in refugee camps and reports this information in their Health Information System (HIS). Notably, much of the camp-level information in this profile comes from HIS. Services include pediatrics and integrated management of childhood illness, reproductive health, psychiatric consultation, emergency medical services and referrals, basic laboratory services, tuberculosis (TB) management (Directly Observed Therapy with first-line agents), voluntary testing and counseling for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) with referral services for antiretroviral treatment, and nutrition promotion.

Pre-Migration Atrocities and Violence

As Meyerhoff et al. (2020) indicated, violence and torture of the Nepali-speaking Bhutanese were sanctioned by the Nepalese government. The extent of it may not be fully known; however, the Gulf Coast Jewish Family and Community Services (2015) provide a list of atrocities. Security services arrested people without any warning or reason and isolated them from family and legal representatives, which left them without hope to ever see their families again. In addition, false reports of family members' deaths or rape would be given to the detainees, also noting that their graves were already waiting for them. Public humiliation often took place where men were stripped naked and forced to march in front of the public and their families with weights tied to genitals. Other torture methods included tying detainees in awkward positions, denying food and water, or isolating and blindfolding them. Repeated gang raping of women and girls for up to a month on end took place—moreover, the community ostracized such women and girls on account of based on religious customs. Due to these torturing methods, several Nepali Speaking Bhutanese lost their lives or were emotionally scarred (Gulf Coast Jewish Family & Community Services: Refugee Services, 2015). Reportedly, life in Nepali-speaking Bhutanese refugee camps was all but normal.

The Bhutanese refugees have been exposed to a protracted period of extreme humiliation, torture, and fear-invoking techniques before fleeing Bhutan (Gulf Coast Jewish Family & Community Services: Refugee Services, 2015). As refugees, they could only take along jewelry and what amounts of money they had available; however, everything was stolen from them by Bhutanese soldiers, leaving the refugees without any manner of self-support (Khatoon et al., 2018). Having suffered such atrocities and living in fear took its toll as many refugees presented with PTSD, depression, and anxiety (Ellis et al., 2018; Khadka, & Rinker, 2018; Kienzler, &

Sapkota, 2020). Stripped from their homes and land of birth, the Bhutanese refugees were only further traumatized by the duration of their stay in the refugee camps (Singh, 2017).

Trauma of the Bhutanese Children

Millions of unaccompanied children and adolescents undertake risky journeys to flee war, political persecution, and adverse circumstances worldwide (Khan et al., 2020). In 2015, the number of unaccompanied migrant children was 90,000 worldwide, and these children are inexorably the most vulnerable (ISSOP, 2018). "The need to be safe and ensure family safety is a primary driver of displacement" (Shaw et al., 2020, para. 10). According to Stathopoulou et al. (2019), both ongoing effects of pre-migration experiences and the surrounding environment shape perceptions of safety. Correspondingly, Bermudez et al. (2018) found that feeling safe varied in the refugee camps by gender, national origin, access to medical services, economic insecurity, and intergenerational conflict.

The ISSOP Migration Working Group put out a position statement on the health of migrant children in 2018. Children's health, along with the mental and physical health of their caregivers, is related to their health before the start of their journey, conditions during their journey, and at their destination. Different types of traumas these children have suffered include violence, war, exploitation, and separation from their family (ISSOP, 2018; Cleary et al., 2018; Greenbaum & Bodrick, 2017; Sawyer & Márquez, 2017). Health issues often include communication diseases, which are preventable if they were vaccinated, and malnutrition (ISSOP, 2018). Social isolation is another risk factor for all migrant children even after resettlement. Barriers to lack of health care for children may be language, lack of health information, and cultural differences. Despite the difficulties, migrant children are entitled to the same healthcare standards provided by their host country according to the CRC (ISSOP, 2018).

Migrant children's healthcare must involve collaboration with education, social sectors, as well as the voices of the child and their family regardless of the child's legal status (ISSOP, 2018).

UNICEF of Bhutan, the National Commission for Women and Children, and the Royal Government of Bhutan reported on the types of violence involving children in May 2016, which included physical, emotional, and sexual violence, according to the survivors' testimonies. Based on a national survey, 64% or more than 6 out of 10 children between the ages of 13-17 have experienced some type of physical violence in their lifetime, the majority before their teenage years. Corporal punishment was the most common form, but others comprised carrying stones and doing heavy work (50.5%), being forced to stand for a long time, being hit with an object (43.8%), being slapped kicked, and punched, having their ear pulled or twisted, having their hair pulled or knuckles rapped on their forehead (22.8). Moreover, 2.8% had been stabbed or cut with a knife or sharp object (The violence against children report, 2016).

More than 1 in 10 children have experienced at least one incident of sexual violence at some point in their lifetime (12.8%) (The violence against children report, 2016). The children reported unwanted sexual acts ranging from pulling down underwear to touching girls' breasts and buttocks to 'forcing sex'. Sexual touching was the most common type of sexual violence reported. Commercial sexual exploitation such as violence and harassment and an estimated 50% of female commercial sex workers are Bhutanese and Indian girls under the age of 18. Belonging to poor families, they worked alongside women in karaoke bars, snooker halls, hotels, and drayanges (bars); many are addicted to alcohol or drugs (The violence against children report, 2016). Sexual harassment was common among adolescents with 19.2% occurring at schools, mostly by peers (over 20%). Others claimed that it occurred at home, other people's homes, at boarding schools, and in drayanges. Digital pornography was also added based on reports of the children, with 20% exposed to it at home or someone else's home (11%). However, with the

increase in mobile devices, children share images and videos among themselves both voluntarily and involuntarily, making videos of themselves naked and involved in sex acts (The violence against children report, 2016).

Two other forms of violence are emotional and structural violence (The violence against children report, 2016). Emotional violence of one form or another was reported to happen to nearly half of all children (47.4%) and 20.2% said it happened before they were 13 years old (The violence against children report, 2016). The most common form was feeling of being unloved (27.8%), humiliation or public shaming (24.5%), and threats or intimidation (21.1%). Emotional violence was reported to come from stepparents, parents, and adult caregivers. Common forms were witnessing both verbal abuse and physical fighting between their parents, or stepparents (The violence against children report, 2016). Structural violence was also reported mostly stemming from poverty, as parents were unable to provide for their family's needs. Thus, even young children were required to work outside the home to ensure the survival of the family. If they were required to work full time, they had to forego their education.

Violence stems from alcohol misuse, economic status, social norms, and traditional practices such as the belief in karma and the acceptance of 'light beating' for disciplining children (The violence against children report, 2016). A child monk aged 13–17 years explained what karma was.

Karma, which is 'the situation of the present life, whether it is good or bad, is caused by your deeds in the past life' is strongly believed in the Buddhist religion. An example would be if a boy abuses or does some harm or injury to a girl in this life, then the boy will face the same deed in the next life from a boy. This is also called 'lay jum drey', which means 'cause because of one's deeds in the past life'. If a teacher beats a child in this life, that child will beat another one in the next life. This is sort of a cycle that goes on endlessly. (p. 32)

Other causes of violence are divorce, extended family care, and disability or non-academic children, where teachers often think they could force a child to learn better by punishing them. A child with a disability is at increased risk of violence because many cannot defend themselves or protest verbally. Disabled children are frequently locked in their room while parents are at work all day long (The violence against children report, 2016).

In 2019, Bhutan made moderate advancements to eliminate child labor, especially that of child trafficking. Human trafficking is sometimes used to force children into domestic work and commercial sexual exploitation (Findings on the Worst Forms of Child Labor, 2019). While the government has hired 11 more inspectors, the minimum age for work does not meet international standards and education is not compulsory. Children as young as 5 work and the percentage between the ages of 5 to 14 that work is 3.8 percent or 6,338. However, 84 percent attend school, and 3.3 percent work and attend school (UNESCO Institute for Statistics, 2020). Child labor occurs in agriculture, industry, and in services such as hospitality services (UNESCO Institute for Statistics, 2020). However, as no national survey has been conducted, there is a lack of data about child labor in Bhutan (Findings on the Worst Forms of Child Labor, 2019). Media outlets have reported child labor in automobile workshops and restaurants. Bhutan provides 11 years of free education; however, children of nomadic communities, migrant populations, children who live in remote villages, and those with disabilities have significant difficulties accessing education.

One in four children in the United States is now a part of immigrant families (Linton & Green, 2019). Like all children, immigrant children have experiences that intersect with biopsychosocial development (Linton & Green, 2019). The arduous journey and multiple stressors the refugee children faced, both accompanied and unaccompanied during the pre-migration, migration, as well as in the resettlement country, increase their possibility for mental

illnesses and other medical conditions. Unaccompanied refugee migrant children and adolescents have a higher rate of mental health disorders than those accompanied by refugee families. Even long after reaching the resettlement country, juveniles face acculturation adversities. Khan et al. (2020) proposed that in assessing healthcare for migrant children, special consideration should be given to particular areas such as their distinct history, regardless of whether they are with their family or unaccompanied, and whether they have been left behind or peddled. There are specific health challenges for migrant children that Khan et al. (2020) collected from a meta-analysis of the literature.

- Depression
- Anxiety
- PTSD
- Conduct problems
- Increased risk of chronic infections
- Trauma and injuries from fleeing war and persecution
- Lack of health and dental care
- Lack of vaccination and other preventive health care
- Disabilities (p. 6)

The Convention on the Rights of the Child (CRC), which was adopted by the United Nations General Assembly in 1989, is an international human rights treaty that fosters the rights of all children globally (The Campaign for U.S. Ratification of the CRC, 2018). Children have the right to develop mentally, physically, and socially to their fullest potential, to participate in decisions affecting their future, and to freely express their opinions. CRC legally binds cultural, civil, social, economic, and social human rights into a single text. Though the United States played a pivotal role in the drafting of the CRC based on the Bill of Rights and the Constitution,

it has failed to ratify it. It came into force after being ratified by more than 196 countries in 1990 (The Campaign for U.S. Ratification of the CRC, 2018). The United States is the only member of the United Nations not to have ratified CRC (United Nations, 2020).

Butteris et al. (2020) stressed that pediatricians need to distinguish between common childhood diseases in the United States from others such as Ebola, zika, measles, and coronavirus (Butteris et al., 2020). Because of the trauma immigrant families usually experience, the cumulative effect of stress is common, which is why psychosocial dynamics should be explored. Butteris et al. (2020) distinguished between three groups of children: refugees, immigrants, and those traveling internationally. The objective of the study was to determine if international global health experience, which some pediatricians voluntarily seek out, is related to greater comfort in providing care to these groups of children. As per the findings, the majority of pediatricians provide care for children traveling internationally and immigrant children (Butteris et al., 2020). Previous experience treating all three populations indicated that pediatricians were more comfortable caring for them. However, not all pediatricians are comfortable caring for immigrant children. Refugee children were the least comfortable for pediatricians to treat, probably due to a lack of knowledge of refugee status, the volume of patients, or the specific needs of refugee children. Therefore, special attention should be paid to immigrant children in refugee families and asylum-seeking families with children who have not attained legal refugee designation, as well as unaccompanied minors (Butteris et al., 2020).

Refugee Camps

Refugee camps usually offer temporary shelter to refugees. Such camps do not have a lot of resources and care facilities available (Cooper et al., 2020). The camps in eastern Nepal were created after the Bhutanese were forced out of their homes by the military at night, leaving loved ones behind, which is especially traumatizing for collectiveness cultures (Volkan, 2017). After

being chased across another border by Indian troops, they finally arrived in the makeshift camps (Rinker & Khadka, 2018; Volkan, 2017).

The first camp named Maidhar camp was established at the Kankai Mai River. At this camp, the refugees did not have any food supplies or assistance. Throughout 1991, new refugees arrived at the camp and the problems were exacerbated with the outbreak of widespread cholera (associated with diarrhea and dehydration), malnutrition, and measles. Approximately 50 deaths a day, of which 30 were children, resulted from these illnesses (Nath, 2016). Later in 1992, Nepali-speaking Bhutanese refugees were shifted to seven different camps. The exodus of new Bhutanese refugees in Nepal continued from 1992 to 1994 and the pace of this influx began slowing down only in 1995 (Nath, 2016). At the end of 1995, roughly 90,000 Bhutanese refugees were reported to be in different camps in Nepal. By the end of 2006, this number grew to 107,000 as a result of children being born in the camps (Nath, 2016).

The UNHCR took responsibility for providing several services such as medical support, food, and water to the Bhutanese refugees after the UNHCR stepped in. The refugees participated by developing internal structures, e.g., Camp Management Committee, to support the daily living of the large number of people within the camps (Nath, 2016). Despite all the support and the refugees' concerted efforts to make life bearable for everyone, overcrowding, poor infrastructure, and the duration of their living in the refugee camps depleted aid organizations' budgets. Due to agencies' budgetary constraints, the refugees were rationed in terms of food, water, clothing, and housing.

The refugees started their own schools, pre-primary to grade X, which was a positive move (Nath, 2016). More than 70,000 students attended these schools taught by 10,000 Bhutanese teachers who provided such high-quality instruction that the students' literacy rates exceeded those of the surrounding countries (Gonzalez et al., 2018). Those Bhutanese refugees

with good English skills were hired to teach Nepalese students at boarding schools, which went a long way in improving the living conditions of some families. However, the refugees' movements were restricted to the camps. They could not officially work outside the camps. Many refugees, especially youth, did succeed to land some work to support their families. However, most of the 107,000 refugees were impelled to depend on outside help for their daily sustenance. This unfortunate situation was addressed in 2006 when announcements were made regarding the resettlement of refugees in third nations (Gonzalez et al., 2018; UNHCR, 2016).

Neikirk and Nickson (2017) explained that refugee camps are usually conceived due to an ongoing conflict. However, as conflicts continue to become increasingly complex, camps become places of post-conflict reconstruction. Reconstruction of their lives, economy, and community for the Bhutanese refugees has been experienced numerous times. The lack of citizenship has led to another post-conflict state in which exploitation and corruption are rampant. Neikirk and Nickson (2017) concluded that "when post-conflict reconstruction is used to transform populations rather than states, these efforts may foster corruption because they allow the original perpetrating state to act with impunity" (p. 37). Countries have sovereignty and can easily determine who is a citizen and who is not. However, when this citizenship is revoked, as it was for Bhutanese, forced migration or ethnic cleansing often ensues and international organizations try to mitigate the accompanying suffering, as the lack of citizenship also implies the lack of state protections. International organizations mainly distribute goods and services. Camps are frequently transformed from transitory places into places of a more permanent space with the establishment of skill-building programs and universal education. Yet, this post-conflict reconstruction is without justice as states can change laws; thus, easily overcoming criminality. Therefore, Neikirk and Nickson (2017) defined state crimes as follows:

> When a state violates customary international laws as well as conventions to which the state is a signatory. In the case of Bhutan, the relevant state crimes were the arbitrary removal of citizenship and the ethnic cleansing of a minority population. (p. 38).

However, Nepal denies the occurrence of any crime, saying they were maintaining their sovereignty. Bhutan claims that the majority of refugees were not citizens, to begin with and have no right to return (Banki et al., 2019). Neikirk and Nickson (2017) argue that humanitarian aid, though certainly needed, may foster impunity and reveal factors that privilege state sovereignty in the larger social, political, and legal systems.

In 1992, a refugee wife explained her husband's arbitrary imprisonment to Amnesty International who investigated the plight of political prisoners (Neikirk & Nickson, 2017). The effort led to the release of 313 political prisoners who had been shackled in solitary imprisonment for criticizing integration policies (Amnesty International, 1992b). The king pardoned 1,500 upon release, but many found that their citizenship had been revoked and much of their land had been confiscated. Tensions escalated and remained unabated until an estimated 90,000 Bhutanese were stripped of their citizenship and impelled to flee the country because of ongoing harassment, physical attacks, arbitrary arrests, kidnapping of family members, torture, and rapes. It is these harrowing experiences that have shaped the Bhutan refugees (Neikirk & Nickson, 2017). Kritz (1996) noted, "doing nothing in response to war crimes and related atrocities adds to the injury of victims and perpetuates a culture of impunity that can only encourage future abuses" (p. 127).

Through education programs, many Bhutanese refugees became relatively well educated, yet resources were rudimentary (Neikirk & Nickson, 2017). There was no electricity, wood fires were used for heat, and oil lamps were utilized, thus resulting in frequent fires that rapidly spread through the cramped quarters. Nine family members lived in one 6 by 3.5-meter (19.6850 feet by

11.48294 feet) bamboo hut that turned bitterly cold in the winter (Desai, 2018). Due to the absence of indoor plumbing, one public tap of water for collecting water twice a day for the surrounding 21 huts (Desai, 2018). However, many locals thought the camp residents had it better than they did in terms of food, medical care, and education (Neikirk & Nickson, 2017). Nevertheless, corruption was ever-present that made the refugees vulnerable to exploitation such as withholding wages and high fines that had to be paid to the police. Bhutanese refugees had no legal recourse as victims due to the lack of citizenship. According to Neikirk and Nickson (2017), most Bhutanese refugees unequivocally made a connection between a lack of international political or legal pressure and Bhutan's ability to cleanse its minorities with impunity.

Talks were commenced between Bhutan and Nepal about the right of return of the Bhutanese refugees, but after seventeen rounds, the only alternative was resettlement in a third country (Kamalipour, 2018). The United States took the largest number of Bhutanese refugees, the first of whom arrived in 2008. By 2014, approximately 75,000 refugees were resettled in the United States (Nath, 2016). According to the UNHCR (2016), well over 101,600 Bhutan refugees were resettled. The eight countries that took refugees include – "Australia (5,692), Canada (6,667), Denmark (874), the Netherlands (327), New Zealand (1,002), Norway (566), the United Kingdom (358), and the United States (86,166)" (UNHCR, 2016, p. 2). At the time of this publication. Another 16,851 Bhutanese refugees were living in two refugee camps. Adequate solutions for these refugees who chose to remain in the camps were still being negotiated between the UNHCR and the Government of Nepal (UNHCR, 2016).

Post-Migration Situation

For many years, the government of Nepal did not allow resettlement for Bhutanese refugees. The country's decision changed only in the second half of the 2000s after lengthy

negotiations. Bhutanese refugees were an attractive group for receiving countries as they posed much less of a security risk as, for example, Iraqi, Somali, or Afghan refugees. In 2007, the UNHCR and different partners that formed the "Core Group on Bhutanese Refugees in Nepal" announced their decision to resettle the majority of the 108,000 registered Bhutanese refugees. The U.S. offered to take 60,000 and began receiving them in 2008. Australia, Canada, Norway, the Netherlands, and Denmark offered to resettle 10,000 each, whereas New Zealand offered to resettle 600 refugees over a period of five years starting in 2008 (Silove et al., 2017). By January 2009, more than 8,000 and by November 2010, more than 40,000 Bhutanese refugees were resettled in various countries. By the end of 2014, Canada offered to accept additional 6,500 Bhutanese refugees. Norway has already resettled 200 Bhutanese refugees and Canada has agreed to accept up to 5000 through to 2012. In November 2015, it was announced that 100,000 refugees have been resettled abroad (85 percent of them to the U.S.) and in February 2017, the number rose to a total of 108,513. By January 2019, around 112,800 have been resettled abroad (Silove et al., 2017). These include British Bhutanese people, who have settled in the United Kingdom. This resettlement process has provided the refugees with an opportunity of starting a new life, but the challenges that they are facing in the labor market of these new countries are a major impediment (Silove et al., 2017).

In using the ecological model to research the interaction between pre-and post-immigration trauma, it is necessary to consider everyday stressors in the lives of refugees and the pre-existing mental health problems of individuals, families, and the refugee community (Silove et al., 2017). Kim et al. (2017) reported on several difficulties created by the resettlement in the United States Most importantly, the refugees were not sufficiently prepared for the post-immigration situation as they might have been blinded by the American dream ideology. The language barrier proved to be significant as English proficiency is tied with employment,

housing negotiations, transport, health services, and schooling. Acculturation was fraught with impediments associated with inaccurate expectations, misunderstandings between organizers and refugees regarding employment seeking, and the psychological trauma that the refugees had to endure since they were forcibly removed from Bhutan (Kim et al., 2017; Nath, 2016). These factors increased the Bhutanese' post-immigration stress.

Although the prospects of moving to a permanent home may sound promising and even exciting, older Bhutanese who were born in Bhutan longed to move back to their birth country. This was unfortunately not possible as they were no longer welcome in Bhutan (Meyerhoff et al., 2018). Elderly persons who have to migrate to a foreign country are known to experience more stress and anxiety in comparison to younger generations (Kim et al., 2017). Older people find the burden of learning a new language and culture difficult, which then leads to higher rates of depression in older resettled refugees. Post-migration stressors linked to mental health issues and suicide among the refugees were found to be ubiquitous among Bhutanese refugees who resettled in the United States (Adhikari et al., 2021).

Barriers to Acculturation

Kim et al. (2017) identified different stressors such as the lack of *English proficiency* which was identified as an important stressor as it is linked to finding employment and becoming self-sufficient, as well as a medium to interact socially. Poudel-Tandukar et al. (2019) found a linkage between a lack of proficiency in English with higher rates of depression among the Bhutanese refugees. The relative inability to speak and understand English was identified as a barrier to acculturation in 71% of Bhutanese refugees (Meyerhoff et al., 2018). The researchers found that in addition to being frustrated by their lack of English skills, the Bhutanese refugees also felt more hopeless. Meyerhoff et al. (2018) conducted a qualitative study on the barriers to acculturation in Bhutanese refugees. The refugees' responses confirmed previous findings that

English proficiency is inextricably linked to finding employment and fitting in socially. Roka (2017) also reported that English skills were associated with successfully finding and maintaining employment. Furthermore, English proficiency is linked with finding employment suitable to the individual's educational level; this issue assumes significance because refugees oftentimes were forced to accept a lesser job due to their lack of English skills. English proficiency is also associated with different activities of daily living, such as traveling, visits to health care, and integration into the community (Roka, 2017). A further area of concern for older persons was learning English well enough to pass the citizen classes. Individuals over 50 years indicated that they were afraid of failing the citizen test due to their difficulty with learning English (Roka, 2017). In this regard, Kim et al. (2017) found that Bhutanese refugees place English proficiency as the main barrier to acculturation. The participants noted that all aspects of daily living—transport, health services, employment, and socializing—are predicated on English proficiency.

The level of social integration and social networks available and accessed within the new country assumes importance for the acculturation of refugees and immigrants. As noted earlier, a lack of English proficiency is accompanied by disconcerting feelings of *loneliness and isolation*. Social isolation may also result from refugees living in groups, which affects their integration into the larger society (Roka, 2017). Kim et al. (2017) reported on a study conducted with older Chinese immigrants where regular visits from members of their families were linked with a decrease of depressive symptoms. On the other hand, when people feel lonely, they are more susceptible to physical ailments, poor immune systems, and cognitive deterioration. Kim et al. (2017) asserted that refugees who are more integrated socially, experience fewer depressive symptoms and are happier. Before relocating to the United States, the Bhutanese refugees lived in proximity of their relatives in the refugee camps, this changed with their migration to the

United States (Gautam et al., 2018). Loneliness, especially in older Bhutanese refugees, served as an important stressor (Gautam et al., 2017). The cultural differences between the group focus of the Bhutanese, to the individualistic culture of the Americans, also serve to promote loneliness especially among the older refugees (Khada & Rinker, 2018). The isolation of the elderly becomes more pertinent during the daytime when children are at school and other adults at work, leaving the older refugee alone at home. In the study of Brown et al. (2019), participants explained the link between social isolation and depressive thoughts. These participants remarked on the individualistic life of American citizens by remarking that they only hear the neighbors but never see them, which serves to further isolate the refugees. Participants in the Kim et al. (2017) study noted that they felt stuck at home with only household chores to attend to.

Financial Hardship and Dependence on Children

When older refugees relocate, they may have to rely on their family members for support—financial and living arrangements. Whereas this may assist the family in caring for younger children, for instance, it can also be a burden (Kim et al., 2017). As indicated earlier, older refugees find acculturation particularly difficult which may place an additional burden on the families. In addition, older refugees are less willing to embrace the customs and culture of the host country as they cling to their previous way of living. Holding on to traditions could provide a sense of stability and continuity, but acculturation implies that the culture, customs, and economic activities of the new country should be adopted as well (Kim et al. 2017).

Traditionally, it is the males in the Bhutanese community who are the primary providers (Ellis et al., 2019). This changed after the refugees' relocation to the United States as the issues with language proficiency served to limit their employability and income potential. This situation increases the stress on older males in the Bhutanese refugee community (Meyerhoff et al., 2018). This role reversal and lack of financial stability add to the already stressing post-immigration

situation, which increases the likelihood of mental health issues (Ellis et al., 2019). Socioeconomic problems are strongly linked to suicide ideation and substance abuse (Ellis et al., 2019).

The younger generation refugees are often more able and willing to venture into the new society to find work. This situation brings about a role change as the older people are no longer the providers of the family (Rote & Markides, 2014). Asian cultures do honor children who take care of their parents, so the child-dependency situation is not uncommon, although not all older persons welcome the idea of depending on their children (Dubus, 2014). Rote and Markides found that resettled refugees who live in proximity with others sharing the same culture enjoy better physical and mental health. The degree of acculturation, as well as the neighborhood in which resettled refugees, live to influence their economic situation. Rote and Markides asserted that refugees are often resettled within lower socioeconomic communities resulting in them competing for the same jobs as the locals and being exposed to the neighborhood violence which is often found in these communities. The latter may cause retraumatization of refugees who were exposed to violence prior to their relocation.

Other barriers to acculturation leading to increased stress include culture shock, ethnic discrimination, insufficient translator services at hospitals and clinics (Larchanche, 2020). English proficiency has been identified as the number one barrier to acculturation and integration into society. The post-immigration stressors led to retraumatization with increased mental stress and mental health problems and eventually suicide (Kim et al., 2019; Meyerhoff et al., 2018).

Chronic Exposure to Trauma and Traumatization

Ongoing hardship associated with the relocation of refugees and acculturative stress of the post-immigration situation serves as retraumatization resulting in refugees losing hope and dignity (Sriram, 2019). The refugees' experiences before relocation often erode their trust in

other people, which worsens their social isolation and leads to depression, stress, and hopelessness (Strang & Quinn, 2019). The researchers recommend that the receiving nation should find ways to build trust and interaction with refugees.

Extended families do not always immigrate as a unit, leaving some members in refugee camps or going to different cities, which again ends up increasing stress (McCleary et al., 2019). In some cases, younger refugees are relocated alone without their families as a support network; this leads to loneliness and added stress about the safety of family members. Youngsters who have to cope on their own with a new country, job, or studies find the acculturative stress overwhelming, thus leading to difficulties with their mental health (McCleary et al. 2019). McCleary et al. (2019) found that young, resettled refugees regarded pre-immigration stress as contributing to their mental health issues. Stressful experiences within the post-immigration situation aggravated their mental health problems, whereas the inability to talk about their mental health with people outside the direct family group also added to their issues with mental health.

Ongoing acculturative stress and traumatization associated with the stressors discussed above are likely to cause further deterioration of refugees' mental health, leading to suicide. Deterioration of mental health is associated with suicide and should be avoided at all costs (Procter et al., 2018). Refugees who perceive their situation as hopeless face the ongoing uncertainty and exposure to retraumatization experience a crushing sense of being a burden to everyone, including themselves (Schippert et al., 2021).

Factors contributing to the deterioration of mental health include lengthy periods of uncertainty and inconsistency in life circumstances, which exerts a negative influence on an individual's memory of personal history and interpersonal trust relationships (Cange, 2019; Procter et al., 2018; Schippert et al., 2021). There are only limited options to protect these individuals against deterioration of their mental health as social support by immediate family

members may not be sufficient seeing that they are exposed to the same circumstances (Schippert et al., 2021). Due to the pre-immigration traumatic experiences, the relationships between spouses and family members were often ruined, leading to isolation and disconnection and further deterioration of mental health (Procter et al., 2018). Family disconnect can be linked to intimate partner violence, substance abuse, instances of self-harming, and suicide (Kim et al., 2017; Schippert, 2021), which serves to exacerbate feelings of hopelessness (Adhikari et al., 2021; Schippert, 2021). Procter et al. (2018) urged counselors to use trauma-informed practices to defuse the lethal hopelessness experienced by these individuals who only regard death as a plausible outcome.

Bhutanese Refugees' Death Desire

In 2008, shortly after arriving in the United States, more than 30 Bhutanese refugees died by suicide (Meyerhoff et al., 2018). These suicides were linked with post-immigration stressors, the fact that the number of suicides increased between the end of 2013 and the beginning of 2014 was found worrying (Kim et al., 2017). Kim et al. (2017) pointed out that several post-immigration suicides resulted from a degree of disconnect between the refugees' expectations and the reality of the relocation situation. Concordantly, Meyerhoff et al. (2018) reported that suicide rates within the Bhutanese refugee community have increased by twofold as compared to the general population in the United States. The authors cautioned that risk factors of suicide must be properly determined and identified by those who are in a position to help the refugees.

The world suicide rate has decreased from 13.1 per 100,000 in 2000 to 10.7 per 100,000 (World Health Organization (WHO), 2017). WHO released estimated suicide rates of Bhutanese refugees in the Nepali refugee camps, which came to 20.76 per 100,000. This indicates that the Bhutanese refugees have a higher death wish compared to surrounding nations. As per a study

conducted by the Centers for Disease Control and Prevention (CDC), the global rates of the 2012 suicide figures of Bhutanese refugees in the United States of 24.4 per 100,000 is of grave concern (Ao et al., 2012)? The CDC noted that underreporting of suicidal behavior and ideation is part of this problem. In this context, Adhikari et al. (2021) and Meyerhoff et al. (2019) have pleaded for culturally sensitive suicide management.

Linton et al. (2020) launched an investigation on Bhutanese refugee suicides to determine the circumstances that led to these suicides intending to provide effective and timely prevention measures. Contributing factors to suicide were frustrations surrounding the resettlement situation including services, social assistance, and being lonely due to separation from family members. In addition, refugees may experience the acculturation process as too challenging, problems with family members, and perceptions that they do not care. According to Linton et al. (2020), out of 23 countries, refugees from Bhutan had the highest suicide rate. According to Linton et al. (2020) and Ao et al. (2016), the mental health problems of refugees who died by suicide stemmed from the pre-immigration conditions of uncertainty, depression, fear, and anxiety caused by the acts of violence and torture by Bhutanese soldiers. The refugees' situation may further deteriorate due to chronic trauma and retraumatization after being relocated. The dire socioeconomic situation of relocated refugees is associated with substance abuse and suicide. Meanwhile, ethnic discrimination serves to further marginalize the refugees, causing retraumatization (Linton et al., 2020).

Hagaman et al. (2016) found that the suicide cases did not speak about suicide before the act. Female refugees who died by suicide did so within 1.1 months after arrival in the United States while men tend to hold on for longer. The most common method was hanging, a finding corroborated by Ao et al. (2012) and Meyerhoff et al. (2018). Utilizing the psychological autopsies of pre-immigration suicides, coupled with mental health screening questionnaires

performed by Hagaman et al. (2016), it was determined that 50% of the suicide cases had PTSD, depression, and anxiety symptoms. From the discussion with the participants, it was evident that having to flee for their safety and the fact that the suicide cases did not officially have a nationality were the most disturbing factors to them.

In a study involving 423 refugees, Ao et al. (2016) determined that refugees with suicide ideation experienced multiple traumatic events pre-immigration, as 36% reported seven and 34% reported eight traumatic events. Similar to the findings of Hagaman et al. (2016), Ao et al. (2016) found that having to flee suddenly and being without nationality were most often mentioned. Other stressing factors included insufficient food, water, and clothing as well as safety needs. Male participants more often reported physical violence and torture by governmental officers.

Post-migration suicides resulted from acculturation stressors such as language proficiency, inability to find employment or becoming more educated, and cultural differences were commonly cited by participants as leading factors to the suicide act. In two cases, the participants remarked on the suicide victims' social isolation behavior. The participants elaborated on family relations and constant concern for the wellbeing and safety of family members who were not nearby due to fragmentation. Post-immigration risk factors for suicide were identified as no longer being in a provider role, a lack of social support, family conflict, and presenting with mental health problems such as depression and anxiety (Ao et al., 2016; Ellis et al. 2018; Hagaman et al., 2016). Age-related accessibility barriers to mental health by older refugees were studied by WHO (2018) found that there were language skills, physical limitations, and intergenerational struggles. In addition, the Office for Refugee Resettlement (2019) in the United States sets aside a designated number of monies for older adults, yet with an age restriction of those only over the age of 60 and older and no longer than up to 5 years since settlement in the United States. Furthermore, these restrictions do not take into consideration

views on what old means in other cultures along with what the long-term mental health needs are in reality (Frounfelker et al., 2020).

Ellis et al. (2018) distinguished suicide risks expressed as perceived burdensomeness, between men and women. Men who experienced reverse provider roles, inability to afford resources for daily living, household disputes, and unemployment were the strongest contributors to perceptions of burdensomeness. Men were more concerned about poor access to mental health services compared to women. Women experienced increased burdensomeness due to the inability to access mental health and public health facilities, family disputes, unemployment together with a lack of funds for daily necessities and being separated from family members. Women did not have equal education opportunities in Bhutan and their lack of education and literacy together with poor English proficiency led to perceptions of burdensomeness. Both genders experienced increased feelings of burdensomeness due to inadequate finances, family stressors, and unemployment. Experiencing poor physical and/or mental health led both men and women to perceive themselves as a burden to the family, which was found to be a suicide risk factor also (Ellis et al., 2018).

Help-Seeking Behavior

Even though some refugees who were found to be a suicide risk indicated that they would speak to a family member or friend upon experiencing suicidal thoughts, few actually do so (Hagaman et al., 2016). Contacting a suicidal helpline was not perceived as a viable option by refugee participants. Johnson et al. (2021) discussed immigrants' difficulty to navigate the medical care system in the United States, thus suggesting that some refugees perceive it as too hard to master. Added to this is the lack of translation services, which leads to misunderstandings between patients and medical staff that could result in misdiagnosis (Kim et al., 2017). Interactions with healthcare and medical insurance were frustrating and burdensome which

caused the Bhutanese to disregard the possibility to obtain medical support in times of need (Kim et al., 2017). Resettled Bhutanese refugees who require assistance in managing the United States healthcare system prefer speaking to someone familiar as opposed to health insurance professionals.

Bhutanese Culture

Brown et al. (2019) argued that most of the studies on suicide were quantitative using questionnaires. The qualitative study by Hagaman et al. (2016) contributed significantly to the literature. Brown et al. conducted a qualitative study, using an ecological framework, to explore perceptions on the suicide of the Bhutanese refugees in the United States. The themes yielded by a thematic data analysis brought four different themes. Language proficiency was indicated as the main barrier on a social level, although other acculturative stressors were also discussed. In addition, participants mentioned a timing issue as an adjustment to the new living space had an element of limited time associated with it. The help-seeking behavior of the refugees was influenced by the all-important need to speak and understand the English language (Brown et al., 2019). Culturally, mental health issues were stigmatized, which acted as a deterrent to seeking outside help (Johnson et al., 2021).

On the community level, participants indicated that although suicide is widespread due to stigmatization, it is not a topic of discussion (Brown et al., 2019). Suicides have already started in the refugee camps and continued in the resettled Bhutanese community in the United States. However, suicide is not something the Bhutanese talk about. In a sense, suicide has achieved a normal status in the community, especially when it was by hanging. Any other method of suicide drew some attention due to the novelty of the method used. Even though suicide was not a rare phenomenon in refugee camps and post-immigration, community members did not discuss mental health issues within the community. Participants indicated that Bhutanese refugees

preferred not to discuss these issues with strangers. Therefore, mental health issues will not be discussed unless there is a significant trust relationship between the refugee and the therapist (Brown et al., 2019).

On a relationship level, the participants discussed the differences in acculturation between the older and younger generations (Brown et al., 2019). The younger generation found acculturation easier as they had to go beyond the home to study and find work. This brought conflict in the homes because the younger generation had to become Americans outside the home and Bhutanese at home. The younger generation found acculturation easier and made the necessary transition sooner, which created tension at home. In line with previous findings (Hagaman et al., 2016; Meyerhoff et al. 2018), the refugees experienced feelings of loss and sorrow about everything they had to leave behind when fleeing their country. Feelings of isolation and being lonely are intensified by the American way of living where front doors are closed while the Bhutanese culture involves leaving the door open so that people may enter then close them after the person has entered (Brown et al., 2019).

Refugees from other Countries

A comparison between Bhutanese refugee situations with those involving other refugee groups (Somali) was conducted by Ellis et al. (2019). Both refugee groups fled their countries under circumstances of violence and oppression where they had to leave all their worldly possessions behind. Both groups had a long stay in refugee camps before being resettled. However, the Bhutanese refugees experienced a prolonged stay of approximately 20 years in these refugee camps. While around 60% of the Somali being resettled moved directly from the camps to America, 100% of Bhutanese lived in refugee camps before immigrating to America. Due to the political unrest in both Bhutan and Somalia, both groups experienced trauma and present with elevated levels of mental health issues. Another area of commonality is the relative

lack of English skills and formal education in the two ethnic groups, which is associated with low levels of employment and financial hardship. Findings indicated that the Bhutanese had significantly less formal education compared to the Somali (Ellis et al., 2019).

A comparison of the mental health problems of Bhutanese and Somali refugees did not reveal major differences despite the differences in trauma experienced pre-immigration. This comparison, however, does not account for differences in suicide rates between the two groups. In an interview with Preiss, Shetty speculated that the reason for the different suicide rates lies within the cultures and religious views of the two groups (Preiss, 2013). The Somali follow the Islamic principles that see suicide as an act against God. In Hinduism, the views about suicide are nebulous, whereas the Bhutanese came to regard suicide by hanging as a way out of unfortunate circumstances (Preiss, 2013). In another interview with Preiss (2013), Pincus suggested that the Bhutanese were more sensitive to what happened to them as a result of their living situation in Bhutan prior to the ethnic cleansing drive. To develop suicide preventive measures, the extent to which these speculations are true must still be determined. An approach in dealing with trauma-related problems is the trauma-informed approach, which will be discussed next.

Trauma-informed (TI) Assistance

Exploring the literature on the effects of trauma, specifically, the trauma faced by Bhutanese refugees that resulted in their involuntary relocation to other countries, the pressing question remains as to why these refugees have a higher suicide rate compared to other refugees. It has become evident though that care delivery should focus on preventing suicide by recognizing refugees' traumatizing history and considering their cultural and personal needs (Brinkmann et al., 2018). Healthcare professionals need to consider not only the physical and emotional results of the violence suffered by the Bhutanese refugees but also the repercussions of

their prolonged stay in refugee camps accompanied by personal travails and the effects of overcrowding. In addition, the effects of being involuntarily relocated to another country, and being without a nationality in a foreign culture bring a range of disorders signified by the relocation (Brinkmann et al., 2018).

An approach to service delivery that avoids retraumatization of the refugees and acknowledges their traumatic journey whilst embedded in the recognition of their Bhutanese culture is needed to address the refugees' mental health needs. The trauma-sensitive approach offers evidence-based principles and processes to deliver such assistance. However, the general approach should be tailor-made to the specific needs of the refugee community it serves (Brinkmann et al., 2018), which, in this case, is the Bhutanese refugees living in the United States. Chafouleas et al. (2016) cautioned that embarking on trauma-informed assistance in a real-life setting requires a multi-tiered approach, which is vastly different from scholarly research on the topic. The pervasiveness of trauma-induced mental health issues within a community of refugees, calls for a community-based approach (Cange, 2019). Reaching whole refugee communities is challenging and the question arises if such a goal is feasible.

During the APHA annual meeting and expo, Cange (2019) discussed and advocated a WHO-developed trauma-informed program, self-help plus (SH+) in refugee communities. This discussion included examples of successful use of the SH+ among Syrian refugees. During the same meeting and expo, Dickson (2019) led a discussion on how the trauma-informed approach can be utilized in the larger community by instilling these practices in all healthcare services. Dickson contended that physical illnesses such as heart and lung diseases, and diabetes are comorbid with trauma experienced by refugees, which reinforces the need for a trauma-informed approach in medical practice. Chafouleas et al. (2016) produced a blueprint on the trauma-

informed approach involving school systems, and these examples demonstrate that trauma-informed assistance can indeed reach communities.

Trauma-Informed Assistance Principles

Trauma-informed assistance includes practices focused on building helpful relationships, developing a safe and trusting atmosphere typically including choice and partnership, providing skills training, and reinforcing of skills (Schulman & Menschner 2018). Establishing an environment that instills trust, promotes safety, and facilitates learning of appropriate skills while avoiding retraumatization must include all service providers within a given community (Brinckmann et al., 2018). Within the trauma-informed paradigm, different delivery programs were developed; however, the rudimentary principles of trauma-informed practice must be adhered to (Substance Abuse and Mental Health Service Administration (SAMHSA, 2014).

Trauma-informed practice includes six core principles that underlie the work of the SFDPH's TIS Initiative: (1) Understanding Trauma & Stress, (2) Compassion & Dependability, (3) Safety & Stability, (4) Collaboration & Empowerment, (5) Cultural Humility & Responsiveness, (6) Resilience & Recovery" (Loomis et al., 2018). The principles of recognizing the presence of trauma, stressing safety and being trustworthy, creating opportunities for choice together with teamwork and relationship building, and developing skills were also highlighted by Schulman and Menschner (2018) in a discussion about trauma-informed assistance to refugees. Irrespective of the particular activities being performed, Schulman and Menschner (2018) emphasized the importance of applying the principles in all situations where refugees are assisted.

Previous researchers have focused on trauma-informed assistance in schools (Berger et al., 2018; Blitz et al., 2020; Davis, 2019; Kataoka et al., 2018; Martin et al., 2017), in healthcare (Brinckmann et al., 2018) and refugees (Bajaj, & Suresh, 2018; Im et al., 2018). Researchers

unanimously stress the importance of implementing trauma-informed principles in all spheres of dealing with the target audience. This calls for initial and ongoing training, policy changes, and periodic program evaluation (Haans & Balke, 2018; Martin et al., 2017; Thomas et al., 2019).

Implementing trauma-informed assistance in different therapeutic and community involvement approaches is possible as the principles guide the interaction and relationship-building elements within community activities and/or services. In this context, Fabio et al. (2019) used trauma-informed principles while building the resilience of refugee families in a hospital setting. The researchers put forward an approach whereby cultural sensitivity could be combined with the trauma-sensitive approach to provide translation services. According to Fabio et al., adequate attention should be paid to the refugees' post-immigration situation, needs, and fears to successfully build resilience.

Integrating trauma-informed assistance with a therapeutic approach utilizing songwriting was implemented with great success with refugee groups in Finland (Harrison et al., 2019). The authors asserted that imagery and creative output such as songwriting can address the refugees' perceptions of isolation and relocation-related stressors in a non-threatening and inviting manner. This approach allowed the refugees to visit places of emotional pain, working through it by means of the imagery and songwriting process. The songwriting workshops left refugee participants feeling joyful, proud, and excited while breaking through their isolation and voicing their emotional pain. Through the principles of trauma-informed assistance, the researchers facilitated better social integration of refugee participants while creating mutual understanding for one another's trauma and acculturation journeys. Furthermore, participants were encouraged to explore personal ways of nourishing and self-care as ways to manage stressors and build resilience (Harrison et al., 2019).

Gerber et al. (2017) used a trauma-informed approach to address Bhutanese refugees' need for social interaction, restoring dignity, and producing food by introducing community gardening. The community gardening project assisted participants to break through their isolation and assume social interaction such as assisting people when sick. The gardening enabled participants to build healthy social networks, interactions through engaging in activities of mutual interest, and negotiating services. By overcoming their isolation, the refugees were given the possibility to establish healthy relationships, which could minimize their mental health problems. The opportunity to meet with other Bhutanese refugees during the gardening project allowed the participants to strengthen their cultural heritage and create a sense of belonging. Through their mutual interest in gardening, the refugee participants developed a sense of shared community that broke their sense of hopelessness that came as a result of being relocated to a foreign country. Due to the timing of the gardening opportunities, mostly older refugees benefited from the activities, which was positive since older people lost their roles as providers and caregivers for the family and felt isolated in their homes due to language restrictions and transport difficulties (Kim et al., 2017; Meyerhoff et al., 2018; Nath, 2016).

Trauma-Informed Versus Trauma-Specific Approaches

Trauma-informed assistance recognizes the presence of traumatic events in nearly all persons reporting for therapy for mental health conditions (Sweeney et al., 2018). This approach affords patients the possibility to resume a normal life after trauma. When adopting a trauma-informed approach, the patient does not need a specific diagnosis of trauma as the approach is largely a process-driven one brought about by policy and organizational changes. In essence, it creates an environment of understanding, safety, and trust between service users and service providers.

Contrastingly, trauma-specific intervention is premised on particular knowledge about an individual service user or group. Trauma-specific intervention is aimed at the specific needs of the individual as opposed to the general principled approach of trauma-informed assistance (Gerber, 2019). Trauma-specific intervention is one of the main principles of the trauma-informed approach. Gerber (2019) argued in favor of a culture-sensitive approach to support patients affected by trauma-related mental health problems. The researchers pointed to the strong possibility that since trauma-related mental health patients could be from foreign countries, they may be unable to converse in English and have different cultural and trauma histories. There is a definite need to understand the specific culture and trauma history of these patients to provide them with efficacious and tailor-made assistance (Gerber, 2019)

Summary

This chapter provided an overview of a cursive look at assisting refugees by exploring trauma-informed assistance. Lately, trauma has elicited much attention as it became evident that traumatic events shape not only individuals' emotional and cognitive landscape but also have an impact on physical functioning and development (Brinckmann et al., 2018). Trauma is defined as an emotional response to a terrible event like an accident, rape, or natural disaster (APA, 2019). Typically, long-term reactions to trauma include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea. Traumatized individuals require support to manage their reaction to the trauma and enable them to live a normal life.

The history of the Bhutanese refugees is one of extreme disregard for human dignity as the Bhutanese government officials and soldiers have committed extreme acts of violence against this community. After years of identifying a resolution to the new policies introduced by the king which only brought new waves of torture and humiliation, the Nepali Speaking Bhutanese fled

their homes to find safety in India. Being unwelcome in India, they were housed in refugee camps in Nepal from where they originated many years ago.

Ongoing disputes about finding permanent housing for the refugees were resolved by the UN approximately 20 years later with the relocation of the Bhutanese refugees to third countries. The pre-immigration traumatic events together with the relocation and post-immigration trauma that is experienced due to assimilation difficulties have left their mark on the Bhutanese refugees. Many refugees suffer from mental health and physical health conditions, although this is not more pronounced compared to other refugee groups. What is of concern is the higher-than-expected rate of suicide in this community of refugees. Ongoing investigations regarding the refugees' mental health, social integration, and acculturation did not provide any particular answers as to the reason for the elevated suicide rate among the Bhutanese refugees.

To help address this grave situation, different classification systems of trauma have been developed. One such classification is that of Bryant et al. (2017) who classified trauma into *acute trauma* as a short-lived event (e.g., natural disaster), which could have long-lasting psychological effects. *Chronic trauma* refers to long-lasting traumatic situations such as ongoing community violence, ethnic persecution, or war. Meanwhile, Sweeney et al. (2016) defined trauma as an experience of a threat to life or well-being that has ongoing effects on mental and physical health. The researchers distinguished between *interpersonal, historical, and social trauma*. In the case of Bhutanese refugees, these classifications of trauma provide an appropriate way to explore and describe their experiences as well as their reactions. For instance, *social traumas* include inequality, marginalization, statelessness, and poverty, which could align with Bhutanese refugees' experiences of segregation in unsafe and unsanitary camps, dispossession of property and citizenship, and disenfranchisement (Kingston & Stam, 2017; Nath, 2016). *Historical*

trauma as defined by Brave Heart (2000) includes the traumatic legacy of violence committed against groups of people, potentially including the ethnic persecution of Bhutanese Nepalis.

Experiencing trauma triggers the individual's fight or flight response, which is situated in the amygdala of the reptile brain (Dotson Davis, 2019). Being in a chronic state of fear due to the ongoing trauma induced by violence and torture in the case of the Bhutanese refugees, the brain tends to be constantly alarmed, which leads to overreactions to the slightest disturbance. Chronic trauma interferes with the individual's ability to learn, concentrate, and negotiate daily stressors. Due to traumatic experiences, individuals find it difficult to build trusting relationships and interact on a social level which leads to the isolation that is further traumatizing. This, in many cases, causes them to explore the option of dying by suicide.

It is imperative to prevent suicides and trauma-informed assistance was explored for that reason. Trauma-informed assistance essentially rests on general principles of interaction between service providers and recipients. The principles were developed to address the needs of the individuals who were traumatized. The principles can be adopted by utilizing policy changes and training of service providers to become a way of interacting with a community, thus reaching many persons. The trauma-informed principles were demonstrated to be successfully integrated into different kinds of intervention and with good results. Trauma-specific assistance, which considers the specific needs of an individual or group, is one of the principles of trauma-informed assistance. Culturally sensitive trauma-informed assistance can be regarded as a trauma-specific approach as it considers the cultural responses and reeds of refugees into consideration.

Chapter 3

Research Method

Introduction

The social problem to be addressed in this study is that negative mental-health indicators such as suicide, hazardous alcohol use, depression, and anxiety are significantly higher in Bhutanese refugees residing in the United States than in the native-born or other refugee populations (Kim et al., 2017; Mirza et al., 2018; Nath, 2016; Vonnahme et al., 2015). Previous researchers have found links between poor mental health outcomes in the Bhutanese refugee population and post-migration stressors, including the language barrier, loneliness, and social isolation, inadequate bilingual delivery of healthcare and social services, and inadequate access to transportation (Kim et al., 2017; Nath, 2016). However, researchers have not adequately explored possible links between poor post-migration mental-health outcomes and ongoing effects of pre-migration stressors (Mirza et al., 2018; Vonnahme et al., 2015).

Pre-migration stressors are significant for Bhutanese refugees and may include victimization in ethnic violence and other human rights violations, loss of property and citizenship, separation from family, and forced displacement (Nath, 2016; Vonnahme et al., 2015). Delivery of effective medical- and mental-health services to a traumatized population requires a trauma-informed approach, which, in turn, requires awareness of the traumas a population has suffered and the possible effects of those experiences (Ostrander, Melville, & Berthold, 2017; Wylie et al., 2018). However, the specific research problem is a gap in the literature related to how Bhutanese refugees perceive the ongoing effects of pre-migration traumas (Mirza et al., 2018; Vonnahme et al., 2015). This gap in the literature leaves U.S. medical and mental-health practitioners who serve Bhutanese refugees without the evidence-based guidance that is needed for providing culturally sensitive, trauma-informed care (see

Ostrander et al., 2017). The purpose of this generic qualitative inquiry is to explore how Bhutanese refugees in Northeastern, Pennsylvania perceives the effects of pre-migration traumas on their post-migration mental health and well-being.

Chapter 3 includes a description and justification of the generic qualitative inquiry approach used in the proposed study. It is inclusive of an elucidation of the research methodology and design, followed by descriptions of the population and sample. Next, this chapter includes a description of the study procedures and the scope of the study. Ethical assurances in this study were then described, after which, a summary of the chapter is provided.

Research Design

The methodological approach in this study is qualitative. Quantitative and mixed-methods approaches were considered but were judged inappropriate for answering the research questions. Quantitative approaches, whether they are standalone or included in a mixed-methods approach, are appropriate for determining statistical relationships between quantifiable variables (Creswell, 2013). Quantitative data collection typically involves large samples to facilitate generalizability, using validated questionnaire instruments consisting of closed-ended items. Close-ended questionnaire items limit participants' potential responses to categories conceived in advance by the instrument's designers and do not allow unanticipated themes and insights to emerge. Additionally, quantitative data are typically decontextualized, in the sense that the data and results are abstracted from the contexts of participants' lives, experiences, and cultures.

The purpose and research questions in this proposed study were designed to facilitate an open-ended, contextualized exploration of participants' experiences of complex phenomena. Due to insufficient research on the study's topic in the past, there exists no sound empirical basis for developing response categories of the kind that would be needed in a quantitative instrument. Additionally, unanticipated themes and response categories should be able to emerge because the

lack of research on the study topic indicates that relevant themes and insights may not have been documented by previous researchers. Lastly, the experiences of Bhutanese refugees are assumed to be grounded in their pre-migration experiences of persecution and trauma, so answering research questions about the effects of pre-migration stressors on post-migration mental-health outcomes will necessarily require a rich contextualization of participants' current experiences within each participant's individual history. Because the research questions and purpose in this proposed study require an open-ended exploration of participants' experiences to achieve new insights that are contextualized in participants' own lives and cultures, a qualitative methodology was selected (see Creswell, 2013).

The study design will be a generic qualitative inquiry. Generic qualitative inquiry is not one of the five traditional qualitative designs, which includes phenomenology, grounded theory, narrative inquiry, ethnography, and case study research (Creswell, 2012; Percy, Kostere, & Kostere, 2015). Other qualitative designs were considered for the proposed study but were rejected as inappropriate. In using a phenomenological approach, the researcher develops descriptions of the structure of participants' subjective experiences of a phenomenon (Creswell, 2012). The focus is on the subjective aspect of the experience, and external, real-world components of the phenomenon are accordingly deemphasized (Creswell, 2012; Percy et al., 2015). In this proposed study, the research questions require a careful examination of the relationships between participants' subjective experiences in the present and real-world, as well as pre-migration conditions in the past, so the focus on the internal structure of a subjective experience associated with a phenomenological design would fail to contextualize the influence of pre-migration traumas on present mental health. The researcher believed that generic qualitative inquiry was more suitable for the current research because genetic qualitative inquiry facilitates explorations of participants' perceptions and experiences of real-world conditions

without imposing the emphasis on theory construction. This flexibility allowed for greater consideration of the potential influence of pre-migration traumas on the mental health of participants.

In a case study design, the purpose is to describe a process that occurs within a bounded context, as it is perceived by people familiar with the context (Creswell, 2012). In a case study, the process being described is typically an external one that can be characterized by multiple, independent sources of data to facilitate triangulation. Although the influence of pre-migration stressors on post-migration mental health can be cited as a process, and an individual Bhutanese refugee might be described as a case, the emphasis in this proposed study on individual experiences of an internal, subjective process that may vary significantly between participants makes the convergence of multiple data sources on a single process description impractical. A case study design is therefore inappropriate.

A grounded theory design is appropriate when existing theoretical and conceptual frameworks are found to be inadequate for explaining a phenomenon. The researcher works to develop a theory of the phenomenon that is grounded in the experiences of persons familiar with it (Creswell, 2012). In this proposed study, the researcher believes that ecological systems theory will provide an adequate conceptual framework for organizing the results and relating them to the existing theoretical and empirical literature. A grounded theory design is therefore unnecessary.

An ethnographic approach involves researcher immersion in a distinct culture for the purpose of describing that culture (Creswell, 2012). Although cultural factors will be significant in this proposed study, the emphasis in the research questions on elucidating individual experiences rather than a collective culture makes an ethnographic approach inappropriate. A narrative design can potentially facilitate the focus on individual experiences and processes of

development that the research questions require (see Creswell, 2012), but the emphasis of the narrative approach on individual contexts would be excessive in this study and might impede the identification of themes that are common to the experiences of all or most participants. For this reason, a narrative design was not selected.

Despite not being one of the five traditional qualitative approaches, generic qualitative inquiry is a frequently used method in the social sciences, because it facilitates explorations of participants' perceptions and experiences of real-world conditions without imposing the emphasis on theory construction, internal structures of subjective experience, processes within bounded contexts, cultures, or individual stories that a traditional qualitative design would involve (Percy et al., 2015). A generic qualitative inquiry approach facilitates an open-ended exploration in which the emphasis is on participants' experiences of real-world phenomena. This approach makes possible a balanced emphasis on the subjective and the external aspects of experience, and on individual and collective experiences, which is ideal for exploring participants' perceptions of the ongoing effects of pre-migration social and historical traumas. A generic qualitative inquiry approach was therefore selected.

Sample/Subject

The study population was the first-generation adult Bhutanese refugees residing in the Northeastern Pennsylvania area. Members of the population were of the Bhutanese-Nepali ethnicity who have fled the ethnic persecution and violence in their home country. Members of the population may be male or female, of any age over 18 years, and of any employment, education, or family status. Members of the population may or may not have experienced interpersonal violence trauma, but all are assumed based on their refugee status to have experienced social and historical traumas. Members of the population may or may not be sufficiently proficient in English to provide rich, relevant data to the interview questions in

English. If a potential participant is otherwise eligible for inclusion in the sample but is not sufficiently proficient in English, the researcher may conduct the interview in the participant's native language, which also happens to be the researcher's native language. The researcher translated the transcribed interview into English, in which the researcher is also fluent.

Purpose of Sample

In qualitative studies utilizing nonprobability sampling, the basis for identifying the appropriate sample size is data saturation. Data saturation refers to the instance during data collection and analysis that the researcher cannot identify any new codes, themes, or data, despite adding more information from the previous participants. Collecting more data beyond the data saturation point will not yield significant changes in the number of unique codes for this study. The researcher expected to reach data saturation at around 15-20 participants and was satisfied with 20 Participants.

Type of Sampling

This study utilized non-probability sampling using two approaches: Purposive sampling and snowball sampling. Purposive sampling involves recruiting individuals to participate in the study who possess specific characteristics that are aligned with the research requirements and purpose of the study (Hammarberg et al., 2016). Purposive sampling allows the researcher to recruit participants who can provide relevant information to address the research questions. Because the chosen participants' skills and characteristics were congruent with the research topic, participants recruited through purposive sampling were more likely to provide relevant data than participants recruited through random sampling techniques (Hammarberg et al., 2016). Using purposive sampling is appropriate when a researcher wishes to target a specific group of participants to address the research questions. This is because the researcher can align the sample and the phenomenon with directed interaction (Hammarberg et al., 2016).

In snowball sampling, the researcher gains access to additional participants by asking existing participants for referrals. This technique is particularly effective when the target population is a close-knit community that is likely to have access to other qualified participants (Hammarberg et al., 2016). When each interview ended, the researcher had asked the participant for referrals to the individual who might be interested in participating. The researcher had contacted potential participants directly through the contact information provided by the original participants and had passed along their contact information for the participant to pass on to their referral. The researcher had screened all referred participants for eligibility before commencing with the interview.

Inclusion Criteria

Participants were allowed to participate if they are over 18 years of age. They must also be Bhutanese refugees - refugees who came from the Bhutanese Refugee Camp in Nepal from 2000 through 2018. Participants must be living either in Pennsylvania or the surrounding states. If participants were recruited through snowball sampling and if they were not in Pennsylvania but have social relations or their family members are in Pennsylvania, they were included in the study. Individuals of any gender and employment status were eligible to participate.

Exclusion Criteria

Individuals were not allowed to participate if they are under 18 years of age. Individuals were not allowed to participate even if they are not Bhutanese refugees who came from the Bhutanese Refugee Camp in Nepal from 2000 through 2018. Some participants were recruited through snowball sampling even though they are staying in other states for their job, but their family members are in Pennsylvania. No other exclusion criteria were utilized in this study.

Recruitment Strategy

The sample utilized in this study have included 20 members of the target population. Participants for the semi-structured interviews were recruited through the placement of recruitment flyers (See Appendix A) in public or business-owned in Dauphin or Lackawanna County indoor locations that are frequented by Bhutanese refugees. Before posting the flyer, the researcher had obtained site authorization from each location (See Appendix E). The flyer contained the researchers' contact information as well as information about the study's purpose and significance. Interested individuals were able to use the information on the flyer to contact the researcher directly via a phone number or email. When an individual expressed interest in participating in the study, the researcher screened the individual for eligibility. Only those individuals were allowed to participate if they were 18 years or older of Bhutanese-Nepali ethnicity from Bhutan and have fled the ethnic persecution and violence in their home country.

Participants were recruited through the snowball sampling technique. At the end of each interview, the researcher asked the participant for referrals to an individual who might be interested in participating. The researcher contacted potential participants (See Appendix D) directly through the contact information provided by the original participants. The researcher screened all referred participants for eligibility before commencing the interview.

Instrumentation

Data collection was performed through the semi-structured interviews. Semi-structured interviews are interviews in which the researcher does not strictly adhere to a predetermined set of questions outlined on the research protocol. While the researcher asked each participant the same set of questions, the researcher also asked additional follow-up questions to follow a participant's train of thought or unique experience. This interview technique allows for in-depth and detailed data collection that can reflect the true uniqueness of each participant. However, it

can also lead to interview data that is not directly comparable to other participants. While it is likely that similar themes were found throughout individual experiences, the data collected in semi-structured interviews may be less directly comparable than more structured interview types that do not allow for deviation from the established protocol (Hammarberg et al., 2016).

I was the appropriate person to be the interviewer because I was familiar with the community, and they felt comfortable answering my questions. I am also a member of this community since I was born in Bhutan, while we were living poor, pathetic, and pessimistic life in the refugee camp in Nepal and in the Bhutanese Community in the USA. I was the founding president of the Bhutanese Community in Scranton and have established a reputation for advocating traumatic approaches, human services, health care, education, the environment, economic development, human rights, or the overall physical, social, and economic health of this community. I know their sentiments, socio-cultural sensitivity, and the stress they have been living with. In turn, they are familiar with my leadership and sincere effort to raise their voice to protect and uplift this community. I am also a community leader and have been working for this community ever since I arrived in the USA. I have also published a book named *The Pathetic Journey* about Bhutanese refugee life and journey. I have also written several articles, and research articles about this community. Therefore, I hope participants have given honest answers thinking that I have good knowledge about this community.

The semi-structured interviews in this study were guided by a researcher-developed protocol comprising closed-ended questions to collect demographic information (See Appendix D) open-ended questions to obtain qualitative data relevant to answering the research questions (See Appendix E). The interview protocol was reviewed by an expert in the field who has expertise in trauma counseling before commencing the data collection process. After the interview protocol was approved by the expert, data collection had begun.

Procedure

Marywood Institutional Research Board (IRB) approval was sought for this study. Approval was obtained before starting data collection. Participants for the semi-structured interviews were recruited through the placement of recruitment flyers in public or business-owned indoor locations in Northeastern Pennsylvania that are frequented by Bhutanese refugees. Prior to posting the flyer, the researcher had obtained site authorization from each location. The flyer contained the researchers' contact information as along with information. Interested individuals could contact the researcher via phone or email. When an individual expressed interest in participating in the study, the researcher screened the individual for eligibility. Only those individuals were allowed to participate if they were 18 years and above and Bhutanese refugees from Bhutanese refugee camps or have fled the ethnic persecution and violence in their home country and lived elsewhere.

Once an interested individual has screened eligible to participate in the study and has agreed to do so, the researcher arranged a semi-structured, one-on-one, face-to-face interview. Interviews was conducted at a date and time selected by the participant to ensure the participant can give full, unhurried responses to the interview questions without pressure to attend to other obligations. Interviews was conducted in a place of the participant's choice or in the researcher's office in Harrisburg or Scranton to ensure the participants were as comfortable as possible, and that the participant had as much privacy or access to immediate supports as desired. Most of the interviews were done face- to -face, one-on -one and some were conducted via Zoom. Before commencing each interview, most of the consent forms were signed by the participants if they were interviewed face-to-face and the researcher emailed the informed consent form to the participant who was interviewed via Zoom. The potential risks as well as the potential benefits of participating in the study were clearly mentioned in the consent form. The consent form also

included information about the study, the confidentiality measures that were put in place, and the voluntary nature of participation.

Before the interview, the interviewer used the FRAMES Strategy (Miller & Sanchez, 1994) to encourage participation. In addition, encouragement and motivational technique was used for the trauma-centered interview process. The interviewer informed that the participant has the right to not respond to any question and can take a break at any time during an interview. At that point, it was helpful for the interviewer to inform the person of any internal and external resources available for them should they become upset by the interview experience. Participants' sensitivity and cultural opinions were highly respected during the interview process. The interviewer considered their pre-migration stressors, post-migration stressors, mental health issues, social trauma, psychological trauma at the time of the interviews. Interviewees were described how the interviewer assured their confidentiality of interview data as well as the limits of confidentiality, including information about who has access to the data and how the agency uses collected data.

At the beginning of each interview, the researcher greeted the participant, thanked him or her for volunteering, and briefly reviewed the purpose and nature of the study which was in the consent form. (See Appendix F). Subsequently, the researcher reviewed the terms of informed consent with the participant, asked if the participant had any questions or concerns. The researcher then asked the permission to turn on the audio recorder when the interview started. Follow-up questions were asked as necessary to elicit clarification or elaboration of responses to scripted questions. At the end of the interview, the researcher asked the participant if he or she had anything to add, then turned off the recorder and thanked the participant for volunteering. Most of the interviews took nearly an hour to complete and some interviews were long and almost took two hours. The researcher continued data collection until 20 participants which was

the saturation as no new information were coming from new participants. After ascertaining that data saturation has been reached, the researcher removed all flyers from the sites where they were posted and thanked the proprietor of the business for their contribution to the study.

The interviews were recorded on an audio recorder purchased by the researcher. The recorders were very good quality, so the interviews were easy transcribed. Two recorders were used for each for the backup. Both had worked wonderfully. The interview which took place over Zoom were recorded through the zoom recording system and were downloaded later for transcriptions.

Data Analysis

Recorded interview data were transcribed verbatim and member-checked to ensure accuracy, before being uploaded into NVivo 12 software. Using the six-step procedure developed by Braun and Clarke (2006), data were analyzed thematically. Thematic analysis comprised identifying and labeling patterns emerging from the data during repeated review and comparison. The steps of the thematic analysis procedure were as follows: (1) reading and rereading the data in full to gain familiarity, (2) identifying patterns of meaning in the data as initial codes, (3) grouping similar initial codes into themes, (4) reviewing and refining the themes, (5) naming and defining the themes to indicate their relevance as answers to the research questions, and (6) creating a presentation of results. In phase one, reading and rereading the data in full to gain familiarity, the researcher will read and reread all the transcripts. As a result of this process, the researcher ensured they were deeply familiar with the data and generate some initial thoughts about it.

In phase two, identifying patterns of meaning in the data as initial codes, the researcher coded all sections of the data that were relevant to the research questions into smaller chunks of

meaning. These codes were informed by the researcher's initial thoughts gleaned from step one. The Verbatim Coding Process was employed in my research. In this system, data may be in the form of text, recorded audio, or images. Coders begin building a list called a "codebook" or "code frame" by reading, listening to, or viewing each answer and assigning it a numeric code. With verbatim coding, free-form answers are given a numerical value, making it easier for analysts to interpret and predict actionable results; the number of comments with certain codes will point to important themes that must be examined more fully. This system enables coders to move quickly through the responses. All responses were carefully coded by a trained person. The results fully reflect the true meaning of the open-ended or unstructured data. Quality-assurance monitoring is built into the coding process to ensure codes are applied consistently and precisely.

In phase three, grouping similar initial codes into themes, the researcher reviewed each of the initial codes, considered how they related to one another and combine them into larger themes. These themes captured something significant about the data and research questions. In phase four, reviewing and refining the themes, the researcher reviewed the developed themes and the chunks of text within each theme and refine the themes, combining themes when appropriate, splitting themes when they grow divergent, and removing themes that are not supported by the study. In stage five, naming and defining the themes, the researcher attempted to capture the essence of each theme, consider what the theme really means, what sub-themes exist within themes, and how those sub-themes interact with the main theme. The researcher wrote the findings during the final stage of coding, creating a presentation of the results (Clarke & Braun, 2014). When the interview data of at least 20 participants were analyzed using the process identified by Braun and Clarke (2006), and when analysis of data from the last two consecutive participants has not yielded any new themes or insights, the researcher judged that data saturation was achieved (see Fusch & Ness, 2015).

Research Bias

Bias in research can be introduced through information bias, selection bias, and researcher bias. However, this bias can be reduced by clearly establishing the research procedure, faithfully following that procedure, as well as by clearly identifying the limitations, delimitations, and assumptions used in the research (Theofanidis et al., 2019). In information bias, the information collected in the study is systematically different from the true nature of the phenomenon. The major types of information bias are observer bias, recall bias, and reporting bias. Observer bias stems from the researcher and their own bias. When a researcher's personal biases color their interpretation of the data, observer bias can arise. The researcher will prevent this by carefully laying aside pre-conceived opinions during data collection and analysis. On the other hand, recall and reporting bias occurs when the researcher misremembers or misreports the findings of a study. In this study, these biases will be prevented by supporting reach claim with direct evidence from the participants such as direct quotes. The researcher will not report findings that cannot be supported with direct quotes (Theofanidis et al., 2019).

However, owing to the fact that I have connections to the Bhutanese refugee community, there is the possibility of bias, which could influence the outcome of the study. Overgaard (2015) suggested bracketing as a way of minimizing researcher bias. All assumptions about the world must be bracketed to ensure the researcher can achieve a secure grasp of the participants' experiences in a pure fashion as the participants lived through them and described them. As explained by Husserl (1970), "The first thing we must do, and first of all in immediate reflective self-experience, is to take the conscious life, completely without prejudice, just like what it quite immediately gives itself, as itself, to be" (p. 233). Without deactivating assumptions about life, the researcher runs the risk of these influencing and by extension, falsifying the descriptions of the participants' experiences. Therefore, the researcher will continually note in a journal any

biases that arise during the research process, beginning with an exhaustive list before any data collection is conducted. Continually reflecting on the data requires continually noting biases arising during the process of the research.

Selection bias is introduced when the research participants are fundamentally different from the target population. While purposive sampling cannot achieve proper randomization of participants (Hammarberg et al., 2016), the researcher has no reason to believe the participants in the current study are fundamentally different from the study's target population. However, some difficulties are associated with collecting data from the current study's target population. Depression and anxiety are significantly higher in Bhutanese refugees residing in the United States than in the native-born or other refugee populations (Kim et al., 2017; Mirza et al., 2018; Nath, 2016; Vonnahme et al., 2015). Individuals experiencing anxiety or depression may be unable or unwilling to participate in the study, thus implying that the recruitment may be more daunting among this population as compared to a population with less prevalent mental health concerns. Bhutanese refugees may also struggle to obtain citizenship in the United States (Kim et al., 2017; Lumley et al., 2017; Sriram, 2019). This could make them hesitant to participate in the study due to concerns related to documentation. The researcher will do everything possible to assure the participants that their participation in the study will be kept entirely confidential, but potential participants may have lingering concerns.

Ethical Assurances

The study proposal was reviewed and approved by the university's IRB before the recruitment of participants begins. The researcher acquainted participants with the terms of informed consent during initial phone contact, after which participants had signed a copy of the informed consent form before the data collection. Participants who are not proficient in English

literacy were provided with a copy of the informed consent form translated into Nepali language which is their native language.

Participation in the study was entirely voluntary, and participants were informed that they may withdraw at any time, or refuse to answer any question, for any reason, with or without informing the researcher of the reason. The decision to withdraw from the study won't entail any negative consequences. At the same time, there were no incentives for participating.

Participants' identities were kept confidential. Names and all potentially identifying details were omitted from interview transcripts, and recorded interviews are stored only on a password-protected flash drive accessible only to the researcher. Signed informed consent forms are stored in a private office's locked filing cabinet that can only be accessed by the researcher. Participants' names were replaced in transcripts with P1, P2, P3, and so on.

Finally, the study followed the principles of the Belmont Report, which outlined several key principles that the researcher followed with this research. This includes maintaining respect for participants, beneficence, and justice. The researcher treated each participant with utmost dignity and respect. The researcher treated each participant with courtesy, answering their questions honestly, and by following through on all promises made to participants, such as keeping their data confidential and representing their experiences accurately. The researcher ensured beneficence by treating all participants equally. All participants were asked the same protocol questions, and their data and confidentiality were handled in the same way. Finally, the researcher ensured justice, accomplished by sharing the results of the research with each participant and the academic community at large (U.S. Department of Health and Human Services, 2021)

Chapter 4

Results

The purpose of this generic qualitative inquiry was to explore how Bhutanese refugees resettled in Northeastern Pennsylvania perceive the effects of pre-migration traumas on their post-migration mental health and well-being. The following section of this chapter discuss the evidence of the trustworthiness of the data. Next, it includes a presentation of the study results, which are organized by research question. This chapter then concludes with a summary of the findings.

Trustworthiness of the Data

This section is a discussion of the evidence that the data and findings in this study are trustworthy. Descriptions are provided of the procedures used for enhancing the four components of trustworthiness, which include credibility, transferability, dependability, and confirmability. The four components of trustworthiness correspond to the quantitative constructs of internal validity (credibility), external validity (transferability), reliability (dependability), and objectivity (confirmability).

Credibility

Data and findings are credible to the extent that they accurately represent the reality they are intended to describe. In this study, credibility was first enhanced through audio recording and verbatim transcription of the interviews to ensure that the data were subjected to analysis accurately represented the words participants actually used. Credibility was also strengthened through the use of a thematic analysis procedure. Themes that incorporated all or most participants' experiences were identified as the major findings in the study, thereby minimizing the likelihood that individual participants' errors or biases would influence the findings.

Transferability

Data and findings are transferable to the extent that they hold true of other populations and in other settings than those represented in the study. To assist readers in assessing transferability, detailed descriptions of the target population have been provided in previous chapters, and a description of the sample is provided in the present chapter. Direct quotes from the data are also presented in the Results section of this chapter as evidence for all findings. This use of thick description in presenting the findings will convey participants' individual and social contexts and perspectives in their own voices.

Dependability

Data and findings are dependable to the extent that they can be replicated in the same study context at a different time. To enable the reader to assess the integrity of the study procedures, detailed descriptions of the procedures and their rationales have been provided in Chapter 3. The present chapter includes a description of the execution of the study procedures to enable the reader to verify their integrity independently. The use of the same semi-structured interview guide consisting of open-ended questions in collecting data from each participant has further contributed to the replicability of the study.

Confirmability

Data and findings are confirmable to the extent that they represent participants' opinions and perceptions rather than the researchers. To enhance confirmability in this study, the researcher attempted at all times to remain mindful of potential biases and to document them in a reflective journal. During the study, the researcher continually reflected on and updated the notes in the journal, remained mindful of potential biases, and worked through self-reflection to suspend all potential biases to the greatest possible extent. Confirmability has been further enhanced through the presentation of direct quotes from the data in support of all findings.

Results

This presentation of the results consists of three major subsections. First, the demographics of the study participants are reported. Second, the execution of the thematic analysis procedure is described. Third, the results are presented.

Participant Demographics

The participants were a purposeful, criterion-based sample of 20 Bhutanese refugees who lived in the Bhutanese refugee camp who migrated to the United States prior to 2018. Participants were living either in Dauphin or Lackawanna counties in Northeastern Pennsylvania. All participants were at least 18 years of age. Table 1 indicates the relevant demographic characteristics of the study participants.

Table 1

Participant Demographics

Participant	Gender	Approximate age upon entering refugee camp	Initial place of residence in U.S. (prior to moving to PA, if applicable)	Year of migration to U.S.
P1	Female	Adult	Idaho	2010
P2	Male	Adolescent	New York	No response
P3	Male	Child	New Hampshire	2008
P4	Male	Child	Pennsylvania	2008
P5	Male	Adult	Washington, D.C.	2000
P6	Male	Adult	Minnesota	2009
P7	Male	Adult	Georgia	2003
P8	Female	Adult	Colorado	No response
P9	Male	Adult	New York	2008
P10	Male	Adult	Virginia	2009
P11	Male	Child	Virginia	2009
P12	Male	Adolescent	Pennsylvania	2009
P13	Male	Adult	Massachusetts	2011
P14	Male	Adult	Ohio	2015

P15	Female	Adolescent	New York	2010
P16	Male	Adult	Pennsylvania	2003
P17	Male	Adolescent	California	2009
P18	Male	Adolescent	Pennsylvania	No response
P19	Male	Adult	Pennsylvania	2009
P20	Male	Adult	Pennsylvania	2008

Data Analysis Procedure

The verbatim transcripts of the audio-recorded interviews were imported into NVivo 12 software for analysis. The analysis was conducted using the six-step, inductive, thematic procedure described by Braun and Clarke (2006). In the first step of the analysis, the data were read and reread in full in NVivo to gain familiarity with them, and handwritten notes were made regarding potential points of analytical interest.

The second step of the analysis involved coding the data. The data were first broken down into chunks of text that each conveyed an idea or experience relevant to participants' perceptions of the effects of pre-migration traumas on their post-migration mental health and well-being. Each chunk of text, or data excerpt, included sufficient context to be meaningful when excerpted from its place in the transcript. Each data excerpt was assigned to an NVivo node, which represented an initial code. Each code was labeled with a descriptive phrase summarizing the meaning of the data assigned to it. Data excerpts with similar meanings were assigned to the same code. A total of 438 data excerpts were identified and coded.

As an example of the coding process, P3 described the arrival of his family and that of the Bhutanese refugees in the refugee camp in the following terms:

> When they arrived in the refugee camp, they had nothing to wear, no food to eat, no shelter to live [in]. They had to live for days and months under the tree. Poor sanitation. Nobody was prepared for that situation. No healthy water to drink, no food to eat.

This data excerpt from P3 expressed the relevant perception that basic necessities such as food, clean water, and shelter were lacking in the refugee camp. This description of the deprivation the refugees suffered also included sufficient contextual information to be meaningful when excerpted from its original place in the transcript. It was therefore assigned to an initial code, which was labeled: lack of basic necessities in refugee camps. P5 made the following statement, which was similar to and corroborated P3's previously quoted response:

> People [in the refugee camp] struggled a lot feeding themselves. And then at the same time, finding a place [shelter]. So, there is no sanitation, no drinking water. There were no toilets, so people pooped everywhere they wanted.

Like P3's response, P5's response was relevant in indicating that the basic necessities such as clean water, food, and shelter were lacking in the refugee camp. P5's response was therefore assigned to the same initial code as P3's. Overall, the 438 data excerpts were assigned to 32 initial codes. Table 2 indicates the initial codes identified during Step 2 of the analysis.

Table 2

Data Analysis: Initial Codes

Initial code (alphabetized)	*n* of participants contributing (*N*=20)	*n* of data excerpts included
Community and temples of worship	7	14
Cultural activities and social support	8	14
Cultural stigma surrounding mental health treatment	10	14
Culture shock	14	21
Family separation after immigration	6	6
Family separation in refugee camps	9	14

Initial code (alphabetized)	*n* of participants contributing (*N*=20)	*n* of data excerpts included
Forced migration to refugee camps was traumatizing	12	21
Friends and family in US	4	8
Gaining education in US	6	8
Help from US government	2	2
Honoring Bhutanese service in US	1	1
Inability to work in US	8	10
Inadequacy of translator in medical setting	6	7
Interpersonal violence traumas - Traumatic human rights violations and atrocities	16	32
Isolation in US	11	15
Lack of basic necessities in refugee camps	16	28
Lack of work in refugee camps	2	2
Language barrier impedes effective treatment	5	7
Language barrier in US	10	14
Loss of hope for return to Bhutan	4	4
Mental health repercussions of pre-migration stressors	16	30
Migration to refugee camps was forced	15	19
Need for community partnerships	11	15
Need for culturally competent treatment in US	10	22
Need for healthcare navigators	2	5
Need for mental health education	11	14
Need for more healthcare professionals from the community	1	2
Physical health repercussions of pre-migration stressors	10	13
Social traumas - Traumatic ethnic oppression	17	29
Substance abuse	9	12
Suicide is a repercussion of pre-migration stressors	17	28
Violence in camps	7	7

The third step of the analysis involved searching for themes in the data. To identify themes, related codes were grouped. Codes were related when they were found to represent different aspects of a smaller number of broader patterns in participants' responses. For example, the code

described previously (i.e., lack of basic necessities in refugee camps) was found to be related to four other codes, including family separation in refugee camps, forced migration to refugee camps was traumatizing, lack of work in refugee camps, and violence in camps. The five codes were identified as related because they all indicated pre-migration stressors associated with living in the refugee camps. Accordingly, the five codes were assigned as child codes to the same parent node in NVivo. The parent code represented a theme. The theme was tentatively labeled: pre-migration stressors in refugee camps. In this way, the 32 initial codes were grouped to form six themes.

The fourth step of the analysis involved reviewing the themes. The themes were compared to the original data to ensure they accurately represented patterns in the responses. The themes were also compared to each other to ensure they were sufficiently distinct to be presented separately instead of combined. The codes within each theme were also reviewed to ensure they converged on a sufficiently coherent idea that the theme would not be more appropriately split and represented as more than one smaller theme.

In the fifth step of the analysis, the themes were named. Naming the themes involved reviewing the data in each theme and comparing it to the research questions. The themes were then named with propositional phrases that clarified their relevance in addressing the study objectives. Table 3 indicates how the initial codes were grouped to form the finalized themes.

Table 3

Grouping of Initial Codes into Finalized Themes

Finalized theme Initial code grouped to form theme	*n* of participants contributing (*N*=20)	*n* of data excerpts included
Theme 1. Ethnic persecution prior to displacement was traumatizing	20	80

Finalized theme Initial code grouped to form theme	*n* of participants contributing (*N*=20)	*n* of data excerpts included
Interpersonal violence traumas - Traumatic human rights violations and atrocities		
Migration to refugee camps was forced		
Social traumas - Traumatic ethnic oppression		
Theme 2. Living conditions in refugee camps were traumatizing	18	72
Family separation in refugee camps		
Forced migration to refugee camps was traumatizing		
Lack of basic necessities in refugee camps		
Lack of work in refugee camps		
Violence in camps		
Theme 3. Pre-migration traumas caused post-migration mental illness in some refugees	19	83
Mental health repercussions of pre-migration stressors		
Physical health repercussions of pre-migration stressors		
Substance abuse		
Suicide is a repercussion of pre-migration stressors		
Theme 4. Post-migration stressors compounded pre-migration trauma	20	70
Culture shock		
Family separation after immigration		
Inability to work in US		
Isolation in US		
Language barrier in US		
Loss of hope for return to Bhutan		
Theme 5. Post-migration protective factors included a strong Bhutanese community	13	47
Community and temples of worship		
Cultural activities and social support		
Friends and family in US		
Gaining education in US		
Help from US government		
Honoring Bhutanese service in US		

Finalized theme Initial code grouped to form theme	*n* of participants contributing (*N*=20)	*n* of data excerpts included
Theme 6. Greater availability of culturally competent treatment is needed to address trauma	17	86
Cultural stigma surrounding mental health treatment		
Inadequacy of translator in medical setting		
Language barrier impedes effective treatment		
Need for community partnerships		
Need for culturally competent treatment in US		
Need for healthcare navigators		
Need for mental health education		
Need for more healthcare professionals from the community		

The sixth step of the analysis involved creating the presentation of results provided in the following subsection of this chapter. The presentation is organized by research question. The themes are presented under subheadings for the research question they were used to address. Table 4 is a preview of how the themes were used to address the research questions.

Presentation of the Findings

Two research questions were used to guide this study. The following presentation is organized under headings representing the two questions. Each question-based subsection includes a discussion of the themes used to address the question.

Table 4

Themes Used to Address Research Questions

Research question	Themes used to address question
RQ1. How do Bhutanese refugees in the Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) describe their post-migration mental health and well-being?	Theme 1. Ethnic persecution prior to displacement was traumatizing Theme 2. Living conditions in refugee camps were traumatizing Theme 3. Pre-migration traumas caused post-migration mental illness in some refugees

	Theme 4. Post-migration stressors compounded pre-migration trauma
RQ2. What supports do Bhutanese refugees in the Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) perceive as effective or potentially effective in alleviating ongoing effects of pre-migration traumas on their post-migration mental health and well-being?	Theme 5. Post-migration protective factors included a strong Bhutanese community Theme 6. Greater availability of culturally competent treatment is needed to address trauma

Research Question 1. RQ1 was: How do Bhutanese refugees in Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) describe their post-migration mental health and well-being? Four themes identified during data analysis were used to address this question. The four RQ1 themes were: (Theme 1) ethnic oppression prior to displacement was traumatizing, (Theme 2) living conditions in refugee camps were traumatizing, (Theme 3) pre-migration traumas caused post-migration mental illness in some refugees, and (Theme 4) post-migration stressors compounded pre-migration trauma. The following subsections are presentations of these themes.

Theme 1: Ethnic Persecution Prior to Displacement Was Traumatizing

All 20 participants contributed data to this theme, and no participants provided discrepant data indicating that ethnic persecution prior to displacement was not traumatizing. This theme contributed to addressing the research question by indicating some of the sources of pre-migration trauma that negatively impacted the post-migration mental health and well-being of Bhutanese refugees. The participants indicated that the ethnic persecution prior to their displacement to the refugee camp in Nepal included social and interpersonal violence traumas. Participants noted that the nature of this persecution was sufficiently severe that their displacement to the refugee camp was forced by threats of death, torture, or other grievous harm from the monarchical government.

Social traumas included brutal suppression of Nepali-speaking Bhutanese people's culture, including the banning of their language from public life and institutions, the banning of their traditional style of dress, and the suppression of their religion and its observances. P2 described the traumatic suppression of the Nepali language by stating, "I think it was in 1986, the government banned the Nepali language in all schools, and all the textbooks were burned. That gave a kind of trauma to those people who felt that Bhutan is their country." P2 also spoke of other forms of social trauma in stating, "The One Nation, One People policy demanded that everyone living in Bhutan wear one type of cloth, eat one type of food, speak one language, celebrate one culture." P1 referenced the social trauma of having a major religious holiday observed by Nepali-speaking Bhutanese canceled: "The festival that is one of the biggest of the year, which used to be celebrated as a national holiday, was taken off the calendar. So, the Nepali-speaking population was not given that holiday to celebrate their national holiday." P5 stated that the proscription of the Southern Bhutanese culture was rigorously enforced:

> Everybody who is living in Bhutan has to speak the same language, has to follow the same religion, has to wear the same dress, otherwise, you will be persecuted. And police started going from house to house, and if they [Southern Bhutanese citizens] were found not wearing Baku, or the prescribed dress, they would arrest you.

P10 described these forms of ethnic persecution as so severe and pervasive that they rose to the level of atrocities: "There were atrocities, including taking books in Nepali language and burning them, not being allowed to speak our language, not being able to wear our costumes." Another form of social trauma began with a census, which the government used to assign citizens to any one of seven hierarchically arranged classes. At the top were first-class citizens, who retained all their rights and privileges. At the bottom were non-nationals, whose citizenship was revoked and whose basic human rights were no longer recognized. Families were divided

when different persons in the same household were assigned to different classifications, with different rights and privileges. P5 explained:

> They [government officials] started asking peoples for all sorts of documents, and people or families were categorized. In one family, one member could be a first-class citizen, another family [member] could be non-Bhutanese, and so forth. They would categorize people in seven different categories.

As a result of the census and subsequent classification of citizens in 1988 and 1989, the citizenship of most Nepali-speaking Bhutanese was revoked. Profitable businesses and property belonging to members of this population were seized by the government. People whose citizenship was revoked lost all of their rights, P12 said: "There were no human rights in Bhutan." P15 said of the socially traumatizing dehumanization of Nepali-speaking Bhutanese at this time, "We were seen as less than human beings."

As the persecution escalated, it began to include interpersonal violence trauma. P16 witnessed an incident in which the banning of Nepali-speaking Bhutanese's traditional forms of dress escalated to interpersonal violence perpetrated by police who were acting in their official capacity:

> They [the police] got about seven or eight students from our community. They took them to the ground, and they [the students] were wearing traditional dress. So, all those traditional dresses were torn apart, they were kicked, they were pushed against the wall, they were kicked, they were beaten.

P19 described how the revocation of the property rights of persons designated non-Bhutanese after the census resulted in his family home being looted under threat of violence:

> Looters working as spies for the Bhutanese Government from our community came to my house and started threatening my family. They have threatened to arrest and kill them if

> my family didn't give what they wanted to loot. When I asked them [my family] to give them whatever they wanted, they took it all away. When I returned, the house was empty, the barn was empty.

The violence associated with the ethnic persecution continued to escalate as persons who were deemed critical of the government were arrested, imprisoned, and in some cases tortured and killed, P4 stated: "Nepali-speaking Bhutanese were tortured in various ways, traumatized in several ways. People were kidnapped. People were put into prison for no reason. People were isolated from their families. People were even killed." The seizure of the property of people designated as non-Bhutanese escalated until possessions were routinely taken by the military. The military burned what it did not seize, P5 said: "They [military personnel] went from house to house, and they snatched our property, burned the property, and there was complete arson and looting. The government almost gave a free hand to the security forces in all this."

P5 said the effects of having personal property either looted or destroyed were traumatic, and that for many Nepali-speaking Bhutanese, the trauma was compounded with the trauma of being arrested and tortured: "Those people were already traumatized. But those people who were arrested . . . they were tortured, physically tortured, systematically tortured, for months and days." P6 spoke of interpersonal violence trauma from his personal experience, saying, "I have seen plenty of those tortures and violence, and I have experienced it myself." P7 witnessed the effects of incarceration and torture on prisoners when he served them as a physician:

> I have seen a lot of prisoners who were on the verge of death, or some of them even died, under my care in the hospital . . . I have treated quite a number of them . . . they were not given warm clothes. They were made to do meaningless labor . . . they were not given nutritious food . . . The people who are Hindus, they did not eat beef, they were forced to eat it . . . there was a deliberate way of torturing them from every angle . . . they were

> pouring water, cold water, in the nighttime on the floor so they couldn't sleep. And some of the people got beaten.

Like P6, P9 spoke as a witness and victim of torture, saying, “They hanged me upside down, tied by my limbs, and blood came out from my nose and mouth. Those were everyday activities in the jail.” Corroborating P7’s response, P9 added, “Many, many in the jail died, [and many of those] who survived were paralyzed because of the torture that they had.” P10 added that violent sexual assaults were inflicted on women, saying that the ethnic persecution included, “Beating, disappearing, imprisoning, killing, and raping our daughters and wives.” P16 said of the interpersonal violence traumas of Southern Bhutanese who were suspected to be involved in peaceful demonstrations to demand the restoration of their human rights, “The Army descended on the villages, and they started hunting down, hauling out, and arresting, and raping [suspected demonstrators], and demolishing the houses of these people, those who were identified.” P18 said that the interpersonal violence trauma transitioned into the Bhutanese government’s demand that Nepali-speaking Bhutanese leave the country: “Some people were killed, and some people, they got raped, and we got a warning to leave the country.”

Participants emphasized that they and their families did not leave Bhutan voluntarily, but rather under the threat of further violence and persecution. P3 described the experience of displacement as traumatic:

> All of a sudden, they are kicked out of the country. Imagine you have everything in life, you are prosperous, you are living in peace. All of a sudden, somebody brought a policy against you, and you're kicked out of the country, and you have nothing with you. That's a big shock to people. That gives trauma. That gives PTSD.

Notable in P3’s response was the statement, “You have nothing with you.” This statement was echoed by other participants, who reported that dispossessed Bhutanese refugees had to

attempt to leave the country with only what they could carry and that even those few remaining possessions were often seized before they could cross the border. Participants also emphasized that they were not voluntary migrants, but rather were forced into exile. P12 made this point in stating, “My parents, neighbors, community, all the Southern Bhutanese, asked for their rights. As a result, the government exiled us from the country, threw us out of the country.” Explaining how he was forced to leave Bhutan, P13 stated that the government published his name in a list of wanted persons, at which time, “It was a big fear that if I go back, I'll be tortured. Anything could happen. So, I could never go back to my country.” P17 reported that refugees who were being forcibly evicted from their country were also forced to sign a form stating that their departure was voluntary and that they ceded all their property to the king: “Most people forcefully had to sign a voluntary migration form . . . the content of that paper was, I am leaving this country of my own will, I am leaving all my property under the care of the king.” P17 added that the form was written in Dzongkha, the majority language, which many Nepali-speaking Bhutanese could not read, and no interpreters were provided. Thus, many exiled persons who were forced to sign the form did not know its contents. P20 summarized the experience of involuntary exile in a representative response, stating,

> There were a lot of things going on like raping of women, looting the houses, setting fire in the houses, and even killing the people by the government soldiers. Some innocent people were taken to prison, they were tortured, a lot of turmoil happened, and a lot of people had to flee the country to save their and their children’s lives. That was the reason why we had to come to Nepal to stay there as refugees.

In discussing the traumatic effects of forced exile, P2 stated, “Populations like ours who have been evicted will come with trauma and PTSD.” P12 was part of an organization in a refugee camp that offered seminars to assist displaced Bhutanese with the effects of their trauma,

and described the condition of the people he helped, “We did small seminars and counseling about the traumatic effect in mind after leaving their properties and everything back in Bhutan. They were hopeless, distressed, depressed.” P6 suggested that the traumas experienced before the refugees were displaced to the Nepalese camp were compounded by conditions in the camp: “The refugee camp was horrible, and all these traumas to carry from Bhutan to the refugee camp was really a horrible thing for most of the people.” The following theme addresses the trauma that refugees experienced after they arrived in the refugee camps.

Theme 2: Living Conditions in Refugee Camps Were Traumatizing

Eighteen participants contributed to this theme, and no participants provided discrepant data indicating the conditions in the camps. This theme contributed to addressing the research question by indicating additional sources of pre-migration trauma that negatively impacted the post-migration mental health and well-being of Bhutanese refugees. The conditions were traumatizing partly because participants did not undergo them by choice, with many refugees having left Bhutan from fear of death, torture, arrest, rape, and other interpersonal violence traumas. Additional traumas were associated with family separation, lack of basic necessities, and violence in the camps.

One form of trauma that participants experienced was separation from family members. P1 reported that her husband was arrested and that he subsequently disappeared without any indication of what had become of him around the time she moved to the camp. She was also separated from two of her sons, she said. In a response that suggested the desperation she felt in being separated from part of her family, P1 stated, “We left Bhutan for India overnight to save our lives . . . What could we do when our family was not all there, and we had left our own place of residence?” P5 reported that his parents had to leave Bhutan for the refugee camp without him. In the camp, they were told that P5 had been arrested and killed by having gasoline injected

into his body. P5 was uncertain whether his parents were lied to deliberately, but he described the effect on them as a form of torture: “That was a rumor, right? Somebody told them, or maybe it was deliberate on the part of the government to torture our family, but that was the news going around.” P13 described being separated from his parents and being unable to find them as a painful shock:

> The person who shared information with me could not tell me where my parents are, whether they are in India, or they are in Nepal because many of the people have started going to Nepal. So, it was a very, very big surprise, it was very painful, it's shocking for me.

Much of the trauma associated with life in the refugee camps was attributed to chronic deprivation. Basic necessities such as clean water, nutritious food, and medical care were lacking. As a consequence, pathogens spread quickly, immunity was low, and diseases went untreated. Many refugees died as a result. P12 described the conditions he experienced in a refugee camp as a child:

> My childhood was very miserable. I did not have plenty of food to eat. No nutritious food. We were living in a crowded place with limited space. It was a hut made of bamboo with plastic roofing. It was miserable. Heating and cooking were with coal and firewood. Smoky and miserable . . . Regarding health, it was bad. They did not have clean water, there was limited space, no fresh air, smoke coming from the burning of fire, so health condition was just to survive. There were basic health clinics, but they were just treating basic symptoms. So, they were not treated for other health conditions. My parents and others were having bad health conditions”.

P14 described the poor conditions in the camp as lethal in many instances: “The refugees died from an absence of proper health services. Malnutrition, deficiency of vitamins and calcium

and other minerals affected the functioning of the nervous system." P14 added of the health of the refugees that several diseases were rampant, and that mental illness was also common: "Our common medical conditions included tuberculosis, malaria, dysentery, and respiratory illness. Along with inadequate medical services, mental health services were lacking, despite the need for mental health care." P19 elaborated further on the illnesses that afflicted the refugee population, stating, "There was an outbreak of diarrhea, pneumonia, sores. There was no toilet for people, there were so-called huts, but the wind was blowing their roofs. There were people with no flesh all over their bodies, only bones and skin." P17 discussed the poor diet offered to refugees: "Just a single meal [per day], just imagine, where there are no fresh fruits and vegetables, no dairy products, and no meat products. Me, my family, I survived that situation for 18 years." P17 went on to add, "No warm clothes on your body during the time of winter." P10 described the refugees as suffering more from mental anguish than from physical pain in the camps despite the unhealthy conditions and severe deprivation:

> Having spent more than two decades as a refugee in a refugee camp in Nepal, a poor country in the Third World, we have many stories of mental anguish rather than physical pain. Even in the United States today, we are not completely free from that pain. We are still pursued by nightmares.

Thus, P10 described the conditions in the camp as traumatic. P6, a physician, concurred with P10's perspective, "That has been transformed into Post Traumatic Stress Disorder, anxiety, depression, and all those. All kinds of physical and mental trauma to these persons." Like other participants, P20 expounded on the conditions in the camp as traumatic: "The refugee environment was not healthy, poor sanitation, poor nutrition, and people used to get sick very often. This caused trauma."

Participants further reported that traumatic interpersonal violence occurred in the camps. P4 describes his experiences about the poor life in the camp. I was born and raised in Bhutanese refugee camp in eastern Nepal. My parents, along with 100,000 other Nepali speaking southern Bhutanese were expelled by the Bhutanese regime. They ended up in a makeshift bamboo and plastic huts in Goldhap refugee camp in 1992. When I think about my life in a refugee camp, I consider it "like a parrot living in the cage". I did not get the opportunity to live a healthy and productive life like any other children born and raised in the western countries.

> I had gone through many traumatic experiences in my childhood. For example, I witnessed many episodes of fire break out. The other experience was not being able to have dinner at the table. The food ration provided by the UNHCR was not sufficient for us to last through two weeks. Additionally, the rain, flood and poor childhood continued to engulf us.

P10 stated that the violence affected him even though he was not directly victimized: "I myself did not have to experience violence directly [in the camp]. However, I was exposed to a growing number of violent incidents and indirectly affected by them." P14 reported that sexual violence against women and girls was a serious problem: "Physical safety was another concern for women and girls. Reports of rapes and gender violence in the camp . . . violence occurring inside the camp leant more stress to mental health." P18 reported gang violence in the camps: "People from all parts of Bhutan themselves were fighting and themselves had big gang fights. Because of that, it was an unsafe environment there [in the camp]." P19 agreed with other participants in describing conditions in the camps as anarchic and conducive to lethal fighting and sexual violence:

> Some of them [the refugees] were dying by fighting amongst themselves. There were strangers blaming each other for leaving the country and fighting each other. No security at all. Many daughters lost their chastity. Many people who were able to bring something

> from Bhutan, they had been looted . . . There was a kind of lawless situation. Inhuman and shameful activities were carried out.

In summary, the present theme and Theme 1 both indicated that pre-migration trauma was pervasive and severe. The participants in this study reported suffering from social trauma in the form of ethnic persecution, as well as witnessing or suffering interpersonal violence trauma ranging from the murder of relatives to rape, arrest, abduction, torture, exile, seizure of property and livelihoods, and revocation of citizenship with denial of basic human rights. The participants and their families were forced into exile in the refugee camps to escape these atrocities. Conditions were also traumatizing in these camps. Separation from family members without any information on their well-being or whereabouts was traumatic, as was the deprivation of basic necessities and the resulting severe malnutrition, illness, and frequent deaths. Violence was also pervasive in the anarchic conditions of the camps, including fighting that sometimes led to murder, looting of fellow refugees' property, and sexual violence against women and girls. Under the following theme, the connection between these pre-migration traumas and refugees' post-migration mental health and physical well-being are discussed in more detail.

Theme 3: Pre-Migration Traumas Caused Post-Migration Mental Illness in Some Refugees

Nineteen participants contributed to this theme, and no participants provided discrepant data indicating that pre-migration trauma did not cause post-migration mental illness in some refugees. This theme contributed to addressing the research question by clarifying the perceived connection between pre-migration trauma and post-migration mental health and well-being. Participants indicated that the effects of pre-migration trauma manifested in post-migration mental health and well-being in four major ways. First, many of the refugees experienced negative effects on mental health. Many refugees also experienced negative consequences to physical health resulting from years of chronic deprivation in the refugee camps. Participants

further reported that the incidence of substance abuse was elevated in the Bhutanese refugee population, in part as a consequence of pre-migration trauma. Lastly, participants reported that pre-migration trauma contributed to the elevated suicide rate in their refugee community.

Participants reported that pre-migration trauma was associated with negative effects on post-migration mental health such as depression, anxiety, and PTSD. P1 said of her refugee community in Pennsylvania, "They would have several types of mental diseases because of their past, painful life." P1 added of her own experience, "I am tormented by the memories of the dead family members." P5 spoke of the pre-migration trauma from which members of his family continued to suffer:

> When [refugees] came to the camp, they had all this trauma. Trauma of forced migration, trauma of imprisonment, trauma of losing everything, trauma of torture . . . I have some family members; they still suffer as a result of torture back home [in Bhutan]. The physical torture they had while they were in prison, they still suffer here [in the United States].

P6 stated that he was continuing in the United States in his capacity as a physician, to treat effects of pre-migration trauma in some of the same individuals he attempted to treat in the refugee camp: "We are seeing that effect till today in the people here, even in the United States. I'm treating the same people I was treating there in the camps till today for the more aggressive forms of PTSD." P6 added of other forms of mental illness that refugees experienced as a consequence of pre-migration trauma, "These people started having all those flashbacks, PTSD, Post Stress Traumatic Disorders, then anxiety, and then gradually that will lead on to depression." P10 described Bhutanese refugees as bringing two levels or layers of trauma with them to the United States, including the trauma suffered in Bhutan before they were exiled, and the trauma they suffered in the refugee camps after they were displaced:

> Bhutanese refugees have two levels of mental health problems. The first-level problem came from Bhutan. The second-level problem was added in Nepal. We came to the U.S. carrying the problems of both levels and not being sure about the future . . . They [Bhutanese refugees] cannot easily get rid of the pain and agony of having to leave all their possessions overnight and be driven out of the country where they were born.

From personal experience, P11 spoke of ongoing nightmares about returning to Bhutan and fearing for the safety of himself and his family under governmental persecution. He expected to endure his nightmares and other symptoms of trauma for the rest of his life:

> Whatever violence we [Bhutanese refugees] had [suffered] will be reflected in us lifelong. The violence we experienced is not a kind of trauma that will end soon. We have seen it physically and personally. I believe that it will reflect time and again in life and will help bring mental stress to me, my family, and the community members, too.

P12 described the trauma inflicted on refugees by the violence they suffered in Bhutan as still living in their minds: "Trauma developed in Bhutan due to the brutality of governing using military forces to chase away Southerners from Bhutan. Many were killed. These people still live in their minds about the shooting, killing, and rapes back in Bhutan." P12 pointed out that the effect of living in the camps was also traumatic: "It was a chronic trauma back to 1990 from Bhutan to staying in the refugee camp for 17 years . . . the camp situation caused the mental instability in the people." P4 corroborated P6's response in stating that pre-migration trauma contributed not only to PTSD but to severe anxiety and depression in Bhutanese refugees: "The PTSD, major depression, anxiety, things like these are very serious and they are real."

Participants reported that chronic deprivation of basic necessities in the camps adversely affected some Bhutanese refugees' well-being via chronic health conditions. In serving the Bhutanese refugees as a community, P6 was aware both from his professional experience and

from data-based evidence that chronic health conditions were elevated among them, partly as an effect of pre-migration deprivation in the refugee camps:

> What I'm seeing here [in the United States] is basically chronic diseases like diabetes, high blood pressure, high cholesterol levels, high COPD—that means asthma kind of diseases—have jumped 10-fold in our community when we have arrived in the United States, because of improved techniques of diagnosis, availability of foods that are unhealthy, and coming out from a refugee camp.

Thus, P6 perceived elevated rates of chronic health conditions among Bhutanese refugees as having three causes, including an improved ability to diagnose the conditions in the United States, the wide availability of cheap, unhealthy foods in the U.S., and the conditions in the refugee camps. P11 spoke in more detail about how deprivation in the camps affected post-migration health specifically in the incidence of cancer, which several participants stated was significantly elevated among Bhutanese refugees:

> Our people were confined in camp areas where they were not allowed to go out. They lacked exercise . . . Whatever they ate was excess and that caused some kinds of cancers. They lacked fresh fruits, vegetables, and food in refugee camps. The ones they got were not fresh . . . So, deficiency of some things in our bodies started to cause cancer. The other is lack of sanitation and lack of treatment on time. They [refugees] carried the disease for a long time without any screening and treatment. The treatment was expensive. They did not get right treatment at the right time. The lack of treatment in time caused cancer.

P17 associated deprivation in the camps with a broader range of negative effects on post-migration physical well-being among Bhutanese refugees: “Due to the lack of proper nutrition for 18 years, due to the lack of all those basic nutrients in the body, our people in our community

are suffering from so many types of critical diseases." Thus, although participants such as P6 cited some post-migration conditions as also contributing, chronic deprivation in refugee camps contributed to negative physical well-being among Bhutanese refugees.

Substance abuse was another indicator of low well-being that participants attributed to a combination of pre-migration trauma and post-migration conditions. P4 summarized the substance abuse issues he encountered in the Bhutanese refugee community by stating, "I have encountered many issues that are in rising in the community, for example, DUI problem, drugs and alcohol, and substance abuse." P11 said of "misuse of alcohol" that it was a serious problem in the Bhutanese refugee community in part because of the increased availability of alcohol in the U.S.:

> It is a critical situation in our community. Back in our country, we must wait for our salary to drink beer once a month. But here, a simple entry-level worker can manage alcohol any time and afford whatever they want to drink.

P18 corroborated P11's response, adding that many Bhutanese refugees began drinking as a strategy to cope with pre-migration trauma: "Because of torture in Bhutan and splitting from their family members in the refugee camp, being hopeless, many people started drinking and went off track." P11 described the specific case of a fellow Bhutanese refugee who abused alcohol to cope with pre-migration trauma:

> My cousin was jailed in Bhutan and released from jail. Now he drinks every night to control pain and trauma. He says he cannot afford pain medications. He thinks drinking alcohol with cheap fried snacks substitute for expensive pain medications. He says he has no choice. He is habituated and cannot get rid of this habit. He gets pain every day. He did this because of the torture given to him by the Bhutan government. He cannot sleep without drinks.

Most participants also described suicide as a post-migration consequence of pre-migration trauma. No participants disagreed with this view, although several participants emphasized the perception that some post-migration conditions in the United States also contributed to the elevated suicide rate among Bhutanese refugees. P3 attributed the elevated suicide rate primarily to the atrocities committed by the Bhutanese government:

> Why is the suicide rate so high among Bhutanese refugees? It's because of those many traumas that they had to go through in their life. One, the Bhutanese government is responsible, and it should be responsible for all these pains that people have been going through still, even after 30 years . . . all the suicides that we see around, it's all because of the regime's atrocities.

P6 reported that before the atrocities began in Bhutan, the suicide rate was low in close-knit, Nepali-speaking Bhutanese communities (he estimated only one suicide every two to three years). P6 added that suicide rates increased significantly due to pre-migration trauma. Specifically, P6 attributed elevated suicide rates to three pre-migration factors, including the trauma of displacement, the trauma of chronic deprivation in the refugee camps, and the trauma of losing hope of one day returning to Bhutan:

> We had a good [low] percentage of suicide in all of Bhutan . . . But as soon as the people became refugees, they lost everything . . . One, the starting point, you have to go back to the PTSD, Post Traumatic Stress Disorder, in leaving the country, leaving everything you had, leaving your homeland, leaving your nationality, leaving everything, perpetuated by a refugee life, with no certainties of your food . . . that was the second thing, living in the camp. The third thing was losing the hope of going back to Bhutan.

In summary, participants perceived pre-migration trauma as negatively impacting the mental health and well-being of Bhutanese refugees in four major ways. First, pre-migration

trauma impacted post-migration mental health through PTSD, depression, and anxiety. Second, pre-migration deprivation in the refugee camps contributed to chronic health conditions such as diabetes and high blood pressure, as well as through cancer. Pre-migration trauma was also perceived as contributing to post-migration substance abuse, as well as to an elevated rate of post-migration suicide in the Bhutanese refugee community. However, most participants stated that while pre-migration trauma was the most significant contributor to negative effects on post-migration mental health and well-being, their living conditions in the United States also contributed. The following theme addresses the ways in which some living conditions in the United States compounded negative effects of pre-migration trauma to harm some Bhutanese refugees' mental health and well-being.

Theme 4: Post-migration Stressors Compounded Pre-Migration Trauma

All 20 participants contributed to this theme, and no participants provided discrepant data. This theme contributed to addressing the research question by indicating how some post-migration stressors negatively impacted Bhutanese refugees' mental health and well-being. Participants described several living conditions they experienced in the United States as harmful to themselves and other refugees in their community. These stressors included culture shock, the language barrier, post-migration family separation, an inability to find work in the U.S., and isolation.

The post-migration condition that participants most frequently described as harmful was culture shock, referenced by 14 participants. P3 explained some of the perceived causes of culture shock:

> They [Bhutanese refugees] come from a set of culture, a set of habit, which is totally different from what they experience here. People are different. Cultures are different. Language is different, and everything is different. Food habits are different, right? So,

> people go through culture shock right at the moment they land in this country . . . people are shocked when they are resettled, because they never prepared for it. Even the UNHCR did not do a good job in terms of providing orientation before this population was brought to the third countries.

P5 discussed the difficulty of adjusting from a life spent in rural Bhutan and refugee camps to living in a first-world, urban setting: "We're talking about people who were uprooted from a village setting, to the camp, and then from a camp setting to a completely Western world. You know? . . . There was a terrible culture shock." P16 describes cultural gaps aftermath of resettlement in the third countries:

> Exile was stressful, painstaking, and very uncertain. 'Resettlement' is no less intriguing. Resettlement thousands of miles across, in countries with various political make and models and in society; complex and hitherto unknown, could be full of new realities and challenges. Resettlement offers us a new premise- of opportunity to rebuild our lives; but at the same time, it is as intimidating and stringent, as it is vastly in orderly and naturally challenging. We need to re-discover, re-define, re-shape, and re-frame our landscape in the new environment. But the insecurities we have gone through in the past will motivate us to do anything to live our new dreams; the opportunity and freedom available to us in these societies will inspire us to seek betterment. We look at our stay in the host countries as permanent. As we transition into the political, economic, and cultural life of the host country; the desire to escape the cultural 'melting pit' may not be necessarily easy. The attitude of the host population will make a crucial difference in that adjustment. 'Resettlement' is not an end in itself. It has given us a new experience, a new existence; and some challenges because we need to go through a state of rapid transition. Our experiences sharply contradict the American way of doing things. In America, life

revolves round the clock and the hours people make working; a ritual in our culture could last for weeks and people spend time here without working. Most of the things we were familiar with will not be a part of our social life anymore. The role of the village headman, the priest, and the temple in our lives, perhaps will never be the same. From food habits to work habits, from customs to culture, from ways of life to personal habits and etiquette; everything must change. Technology forms the arteries of western society. The western man is routinely accustomed to the centrally heated houses, bath showers, the western toilet system, air filters, smoke alarms, vacuums, dishwashers, microwaves, barbecue grills, washing machines, dryers, home computers, online payment system, traffic rules, riding a public bus system and trains, paying by credit cards, lifts, and escalators, drug bottles with child lock system, assembling ready-made (packed) furniture child seats, seatbelts pumping gas, school admission, tax filing, vending machines, cell phones, registers at work, the broad hand language; every day of his life. What seems to be so obvious to them is very complex to us. He is often at shock to discover that, many of us are using these for the first time in our life. Our houses used to get heated only when it was burned. We climbed trails, not escalators. Smoke alarms terrify us. Oftentimes, they fail to understand and sympathize with this background of the refugees and are perturbed by our simple questions. The lack of technological know-how and the English language too is a bottleneck in this transition. Even, those of us who speak English still have problems with American spelling, pronunciation, and usage. For instance, gastroenteritis is heartburn, petroleum is gas. Soft drinks are soda. Half pants are sorts. Weight is measured in pounds, liquids in a gallon; distance is measured in miles, etc. The cultural gap is staggering.

P5 also described the transition from the anarchic camp setting to a society governed by the rule of law as a difficult adjustment for many Bhutanese refugees to make:

> Imagine these people in the camp who were deprived for almost two decades, coming here and trying to figure out how to make it, to navigate. There is no rule [in the camps]. There is no law. Nothing governed them. So, within the camp, they're wild. Suddenly, he came to a country where everything is just governed by law.

P7 described U.S. institutions and conveniences as contributing to the culture shock Bhutanese refugees experienced, simply due to their unfamiliarity: "The whole infrastructure, the government system, the healthcare system, the education system, the house we live in, the cooking ranges and the refrigerator and all this, which people had never seen." P7 explained the transition from Third World living standards to First World ones as tantamount to having to "Go through 100 years of experience in a very short time." P10, who in previously quoted language described Bhutanese refugees as having two levels or layers of pre-migration trauma (i.e., violence suffered in Bhutan and life in the refugee camps), described culture shock upon arrival in the U.S. as adding a third level:

> After arriving here, linguistic problems, religion, culture, and cultural problems, problems created in daily life due to not being accustomed to the developed technology, lifestyle, law process-related problems, employment-related problems, family separation during third country immigration—we had to face innumerable problems. That led to a third level of mental health problems in Bhutanese refugees.

Eleven participants elucidated the isolation many Bhutanese refugees experienced in the United States as a significant stressor. P5 described isolation as contributing to alcohol abuse: "You don't have an environment where you can go and enjoy, and relax, and hang out, and socialize . . . You're all by yourself, and you find support in the bottle of wine now." P6

associated isolation with the language barrier: “People are isolated, they come from Nepal, where they could see Nepali-speaking people there . . . but here you come out, you see all the people you don't know, you cannot talk, you cannot communicate.” P10 described isolation in the form of loneliness as a cause of depression among the elders: “We have mental problems such as depression caused by increasing loneliness, especially among the elderly.” P7 also perceived isolation as a significant cause of depression in many Bhutanese refugees:

> They used to talk to other people, they enjoyed being around other people and shared their experience, and now they're living in an apartment or a house, away from other people, and they are by themselves . . . they are becoming isolated and maybe beginning to feel depressed.

Ten participants cited the language barrier as a significant post-migration stressor. P20 described the language barrier and the challenges it caused refugees who were trying to integrate into U.S. society as a cause of suicide: “They [Bhutanese refugees] do not know the language, they feel suffocated, they don’t know how to speak English and that affects their employability, getting a driver’s license, and shopping, which stressed them, and the outcome is suicide.” P4 corroborated P20 response in describing the language barrier as an elevated factor that contributed to the elevated suicide rate: “Because of the language barrier, things like that . . . they are depressed, and they just couldn't think that this [resettlement] will be the right option for me, and they decided to take their own life.” P4 pointed out that the language barrier contributed to the elevated rate of suicide among men aged 40 and older, which several participants described as many multiples as possible higher than that of women. P4 said the problem began with cultural pressure on men to provide for and protect their families: “The male or the father is considered as the head of the household, and he's responsible for taking care of his family financially or in any way possible.” P4 said that the language barrier increased the male’s burden

of responsibility, causing some men to despair over their inability to meet their obligations to their families when they could not integrate into U.S. society because they lacked knowledge of English: “Because of lack of knowledge, language barrier, their responsibility even got bigger. I think because of that, they are depressed.”

Eight participants cited the inability to find employment as a significant post-migration stressor. P3 cited the language barrier as a reason for some refugees’ difficulty in finding work: “They cannot go to work. They were not qualified. They don't understand English. So they cannot go back to work . . . So, they started thinking, well, the life in the refugee camp was better than this.” P12 associated inability to find work with low self-esteem and suicide: “They think, oh, we do not have jobs in this country, and we are not worthy of this country. They then think of ending their lives.”

Six participants cited post-migration family separation as a significant stressor. P6 said family separation contributed to post-migration anxiety: “Many people, they do not have all their relatives. Some are back home in Bhutan, some are in the camp, and few are here. So that family separation created anxiety in them.” P16 associated family separation with suicide. P16 said of the separation of family and friends, “The society they lived in back in Bhutan is not here . . . their friends have been separated, their village people have been separated. Someone is in Australia, someone is in the U.S., and someone is in Norway.”

The Bhutanese refugees resettled in the United States faced several post-migration challenges such as forced migration, mental health, cultural and religious differences, social factors, geographical differences, economic hardships, and psychological trauma. As a result of such unfriendly experiences, some refugees faced severe mental health issues such as depression, anxiety, and posttraumatic stress disorders. Based on previous studies and literature reviews, the

adverse consequences of forced migration made them develop suicidal ideation and actions that resulted in several deaths, despite being resettled and integrated into the host country.

In that regard, the Bhutanese refugee's forced migration, resettlement, and suicidal ideation and behaviors can be explained using some of the following relevant theories and models. P3 expressed about suicide in his community.

> Suicidal behavior as well as death are huge and squeezing issues in the Bhutanese refugees' network. As of now, resettled Bhutanese refugees are dying by suicide at a rate almost multiple times that of the overall United States population.

P 17 said "One thing that has come out about the suicidal actions among the resettled Bhutanese refugees is that most of them were "trying to hide their troubles" and developed mental health complications. P 17 further expressed "suicide is one of the leading causes of death among refugees worldwide and the Bhutanese refugees resettled in the United States were extremely affected by suicidal thoughts. Since individual thoughts can only be understood in the context of their past experiences, there was legitimate evidence to link the suicidal actions among the settled refugees to their horrible history of pre- migration stressors". P16 spoke of the effect of separation as a contributor to suicide: "This is what has led to these people—they are not able to tolerate the amount of pressure, the amount of stress, and that makes them decide to end their life."

In summary, participants reported that the negative effects of pre-migration trauma on mental health and well-being were compounded by post-migration stressors. Those stressors included culture shock, the language barrier, isolation, inability to find employment, and family separation. Participants perceived those stressors as contributing to elevated rates of suicide, depression, and anxiety in the Bhutanese refugee community. The following two themes indicate the protective factors and treatments that participants perceived as necessary to mitigate the

negative effects of pre-migration trauma and post-migration stressors on post-migration mental health and well-being.

Research Question 2. RQ2 was: What supports do Bhutanese refugees in Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) perceive as effective or potentially effective in alleviating ongoing effects of pre-migration traumas on their post-migration mental health and well-being? Two of the themes identified during data analysis were relevant to addressing this question: (Theme 5) post-migration protective factors included a strong Bhutanese community, and (Theme 6) greater availability of culturally competent treatment is needed to address trauma. The following subsections are presentations of these themes.

Theme 5: Post-Migration Protective Factors Included a Strong Bhutanese Community

Thirteen participants contributed to this theme, and no participants provided discrepant data indicating that the Bhutanese refugee community was not strong or that it was not a protective factor. This theme contributed to addressing the research question by indicating that the strong Bhutanese refugee community provided effective support in alleviating the ongoing effects of pre-migration traumas on their post-migration mental health and well-being. Participants cited cultural activities and social support, community, and temples of worship, and gaining education in the U.S. as protective factors associated with a strong Bhutanese refugee community.

Cultural activities and social supports ranged from festivals to gatherings of fellow Bhutanese refugees. P4 said of gatherings of Bhutanese refugees that they helped to alleviate isolation, particularly among the elderly: “Having frequent social gatherings, religious gatherings, interaction programs, socializing programs is significant to our elderly folks in regard to avoiding social trauma, loneliness, things like that.” P7 described community cultural activities as effective supports for addressing isolation and trauma:

> For the people who are feeling isolated and traumatized, it's very good to be in a community situation where you can share music, culture, dance . . . it will help us to share our suffering. And when we know that other person also knows the suffering like you, you start feeling better, you are not alone, and that will help you to heal better.

P10 highlighted the importance of traditional culture to Bhutanese refugees: "Wherever we live, our religion, culture, festivals, costumes are dearer than life." P10 added that cultural activities were effective in improving well-being for members of his community:

> We have been working for our religion and culture while respecting all other religions . . . Its positive impact has been seen in the community. We have started Nepali and Sanskrit language classes. We are also starting Nepali instrumental classes soon.

P18 was working to transmit the Nepali language to second-generation refugees: "We are working hard to establish Nepali language teaching facility, at least virtually, in the U.S.A. and Canada. So far, we have taught around 200 students from the U.S. and Canada virtually." P18 stated that transmitting the language enhanced well-being for refugees and their descendants: "Once they learn the language [Nepali], I hope they may not forget their culture, and they'll be happy forever, culturally, you know, they don't lose their identity."

Seven participants cited community and temples of worship as significant protective factors associated with the strong Bhutanese refugee community. P1 spoke of being able to worship in a temple dedicated to her religion, close to her place of residence in the U.S., contributed to her well-being:

> When I go to the temple, I can burn incense, visit the Idols of God, worship it and offer something in the name of God. After doing so, a kind of peace is found in the mind. I am happy that society has built a temple here.

P10 spoke of how the preservation of their Hindu religion was closely associated with Bhutanese refugees' expulsion from Bhutan: "We, the Bhutanese of Nepali origin, have been expelled from the country for not giving up our Hindu religion and culture." P19 associated traditional worship and the construction of temples with the flourishing of the community and its culture: "As our community moves forward in a positive direction, we are now able to run our religious organizations and temples with confidence . . . Our community is becoming more collective and constructive. Now it is expanding." P20 stated that he belonged to a Hindu organization dedicated to serving members of his community: "We like-minded people in the community got together and opened a nonprofit organization to serve the people who were in need of help in different aspects like religion, social, culture, and language." The help that P20's organization provided included instruction in English for elderly people, classes in the Nepali language for young people, as well as religious and cultural activities to alleviate trauma among first-generation refugees.

Six participants referenced obtaining education in the U.S. as a protective factor. In a representative response, P4 discussed how education was associated with the strong Bhutanese community, and particularly with the values of the student's family:

> Some youths are self-aware that they should go to college, but it comes from the family, and it comes from the environment of the family. If you have a good father, if you have a good mother who motivates you to go to college, who shows you the right path, that kid is more likely to follow their direction.

P16 corroborated P4's response in explaining education as a value associated with Bhutanese culture even before resettlement in the U.S. made education more widely available to members of the community: "Back in the [Bhutanese] society, even though we didn't have the chance for education, our community had high respect for education. The awareness of the need

for education was there." P15 stated that education was a protective factor because it enabled Bhutanese refugees to integrate successfully into U.S. society: "We work sincerely, we upgrade ourselves, learn, go to school, go to college, even take ESL classes . . . [and] our people are so successful now."

In summary, participants cited several protective factors that were effective as supports in alleviating the negative impacts of pre-migration trauma and post-migration stressors on Bhutanese refugees' mental health and well-being. These factors were associated with the strength and values of the Bhutanese community. The protective factors included cultural activities and social supports, community, and temples of worship, and obtaining education in the U.S. The participants described these protective factors as effective in alleviating the effects of trauma, isolation, and, in the case of education, the language barrier and the difficulty of obtaining employment. While this theme addressed existing supports that participants described as effective, the following theme addresses supports participants described as potentially effective in alleviating negative impacts on Bhutanese refugees' mental health and well-being.

Theme 6: Greater Availability of Culturally Competent Treatment Is Needed to Address Trauma

Seventeen participants contributed to this theme, and no participants provided discrepant data. This theme contributed to addressing the research question by indicating that culturally competent treatment was perceived as a potentially effective support in alleviating the ongoing effects of pre-migration traumas on Bhutanese refugees' post-migration mental health and well-being. Participants expressed that culturally competent care would need to have several components to be optimally effective. First, it would require culturally competent practitioners who understood the traumas of the refugee population. Second, it would require mental health education to overcome cultural barriers to seeking mental health treatment. Third, it would

require community partnerships to ensure the availability of culturally competent mental health resources.

Participants believed the language barrier was a significant factor in preventing Bhutanese refugees from receiving appropriate treatment, but they regarded providers' lack of understanding of their community's collective experience as a more significant barrier. Thus, participants believed that the availability of practitioners who understood their community's collective experience was a higher priority than the availability of providers who spoke Nepali. P3 expressed the perception that it would be sufficient to have a single cultural liaison in doctors' offices: "The services need to be made culturally appropriate. That doesn't mean that everybody has to speak Nepali. No, [but] at least there has to be some cultural liaisons in each facility where [refugees] go." P3 clarified that what service providers needed to understand was the nature of the traumas the refugees had suffered:

> People were kicked out of the country. They were not allowed to take anything. Their relatives were killed at gunpoint. People were raped in public, and many of the adults were taken to prison and never came back. That is still living in the cells of the human bodies that were evicted from Bhutan. So, the service providers need to understand that first. Unless that is being addressed, no matter what you do is not going to be successful, because people are living with that trauma.

P14 concurred that doctor wishing to serve the Bhutanese refugee community should be culturally competent so that they understood the community's collective experiences: "If I want to be a doctor in America, I should understand the attitude of the people. I have to understand what type of people, what they feel for? What will make them happy? Why are these people not happy"?

P17 said that the perception that mental illness among Bhutanese refugees needed to be understood in terms of their collective and individual experiences, rather than in terms of standard definitions:

> The word depression, in a broad spectrum, may be defined differently here in the U.S., may be defined differently in Australia or Canada or anywhere else. That can be the combination of what you call local situations, or maybe an imbalance of some chemical in the mind. But the type of depression a Bhutanese refugee has is related to the trauma of the past. And that needs to be understood differently.

Although participants believed that it was more important for providers to understand their collective and individual experiences than for providers to speak Nepali, they expressed that the language barrier was a significant obstacle to getting appropriate treatment for some members of their community. P6 expressed that even the best treatment would be ineffective if the patient and doctor were unable to understand each other: “Even if you go to a psychiatrist who is a highly qualified or topmost psychiatrist in the areas, but he doesn't understand what you say, and you don't understand what they say, even though translation, that [treatment] doesn't matter.” Participants emphasized that in the absence of cultural competence, translators were not sufficient to help Bhutanese refugees and U.S. doctors understand one another. P6 articulated this perception:

> They [refugees] have to say all about their trauma, all about the torture, all about their mental [health] issues . . . But whenever you have to tell your things, if you cannot directly convey to the doctor, probably it's not conveyed, because the translator, they are qualified, but I don't know how qualified they are in terms of our population when they [refugees] have a trauma when they have a mental health [concern]. So, things get lost [in translation] there.

Bhutanese refugees who needed mental health care also faced the barrier that admitting a mental health issue was not permitted in their culture. P4 stated, “Mental health is considered as a taboo in our community. It's very true . . . So, because of that taboo, I think people haven't been able to get the treatment they should be getting.” P5 corroborated P4’s response, “Suicide and mental health are considered taboo or a stigma in our community.” P6 reported a lack of distinction in the culture between mental health issues and insanity: “Our elder folks don't know what mental health basically is . . . it is a cultural kind of thing. They don't want to talk about their mental health. If you talk about mental health, you are crazy.” P18 corroborated P6’s perception in describing refugees’ fear of being seen by other members of their community to seek mental health care: “If someone sees you visiting a counselor, then other people in the community, they think you are totally crazy.” P6 also expressed that the taboo against mental health issues in the older generation prevented members of the younger generation from seeking treatment as well: “If you start having anxiety, depression, your parents will not understand if you say, ‘Hey, I'm depressed’ . . . So, from that standpoint, the kids are thinking, ‘Oh, no, I won’t talk about that.’” Participants noted that mental health education was needed to overcome the taboo against mental health issues so that members of the community could seek treatment without fear of stigmatization. P7 stated his belief that mental health education should equate mental health issues to physical health issues, as legitimate concerns that should prompt the sufferer to seek appropriate care:

> If you are feeling sad, and you are feeling like crying, and you don't want to live, that's a very serious situation, you should seek help . . . So, what I would like to tell the people is let's normalize the situation, it is like getting help for any other physical health condition. Mental health conditions are also part of our life.

P8 recommended seminars to deliver mental health education to members of the community who lacked it: “We should involve those uneducated people in training seminars, have a resource for them, and provide mental health awareness.” P13 corroborated P7’s perception that mental health should be treated like physical health and that education was needed to achieve this change of perspective in the community: “If we are able to educate the people that mental health is as important as physical health, and it should be treated in the same manner as physical health, then people should be able to speak for themselves openly.”

The third potentially effective means of delivering culturally competent care that participants cited comprised partnerships between organizations in the Bhutanese refugee community and organizations in the broader community that offered mental health care. P4 pointed out that effective partnership already existed to give refugees access to a suicide hotline, but that more such partnerships should be implemented to address mental health and well-being in the community:

> We have taken a good initiative to reach out to the Dauphin County mental health coordinator, suicide prevention hotlines, things like that. They are working very closely with our community. And I think involving and having a frequent dialogue between the community and local officials would give us an idea of what to do next.

P6 corroborated P4’s perception that additional community partnerships were needed to develop and deliver culturally competent care: “We need to partner with the local health groups . . . Our community needs to partner with them to come up with those kinds of programs which will directly benefit these stressed [Bhutanese refugee] people.” P7 recommended liaising with other immigrant groups that were more experienced in living and succeeding in U.S. society: “We have to get help from other like-minded communities who understand our culture. We can

get help from the Indian community and other communities who are Nepali who are willing to help us."

The study suggested that Bhutanese refugees by now are four generations. The first-generation elder Bhutanese, the second generations who were in the schools and colleges in Bhutan and came to the refugee camps. Third generations are those who were kids in Bhutan and came to the refugee camps with their parents and who were born in the camps. This group is still the students in U.S. Among these four generations the first generation are in depression and sadness and has experienced some loss of social status and increased vulnerability in the post-resettlement context, but individuals in this group are still largely catered to by their younger relatives and actively served through community-based programs. The working generation, on the other hand, has limited access to the professional jobs and force to work in the factories in spite of their higher education and experiences tremendous distress associated with the responsibilities of resettled life, including an increase in the number of dependents and a decrease in the quality of employment available to them. Third generations who came as children and the fourth generations who were born in the aftermath of resettlement in U.S however are doing good by many if not by all. There is a huge generational gap in this community.

The finding of this study not only highlighted the innumerable complexities; like the language barrier, unemployment, inability to find jobs, and the problems of adjustment faced by the elderly Bhutanese including the high rate of suicide among them, but also try to find the difference between the younger generation's ways of living, integrational strategies, and coping with the new realities and their success stories who arrive as children and grow up in this country. A decade later, Bhutanese refugee youths resettled in U.S reveal a story of resilience, brotherhood, and community building, to ensure a balanced life in the U.S. While they assimilate structurally by participating in American institutions and American life, culturally and socially

they have retained an element of nostalgia in recreating aspects of their homeland in their new home, which gives something to the different generations of Bhutanese youth to hold onto, in a land far from home.

This study found that the younger Bhutanese resettled in the US integrate better than the first-generation elderly Bhutanese refugees. Refugee children who came as adolescent are now adult and refugee children who were born in US after their parents came are now adolescent, who are in many regards similar to their U.S.-born neighbors, with similar rates of labor force participation, post-secondary education, and homeownership, despite challenges stemming from backgrounds of living in refugee camps, sparse educational opportunities, and overall impoverished environments. The large majority have improved or acquired English language skills after being in the country for several years and have become naturalized U.S. citizens at the early points of eligibility. In the long run, all attain varied levels of integration, and success.

There is also the question of the Bhutanese youth and the effects of a western/American life on them. On the flip side, there are many success stories of the refugees. Many Bhutanese refugees of second generations are very successful. Many are running larger businesses, some received good scholarships and funding for the higher education, some were elected to the District Councils, the children are being successful in school and carving out successful careers, the middle aged are settling down in jobs and successful businesses. While elderly Bhutanese refugees and some youths as well are still facing several pre-migration stressors and mental health issues, many more Bhutanese youths have overcome the odds and cultural barriers and have made a success of their lives in the United States and already became the positive contributors in the society.

In summary, participants expressed the perception that culturally competent mental health care had great potential to be effective in alleviating the negative effects of pre-migration trauma

on Bhutanese refugees' post-migration mental health and well-being. Participants emphasized that services like translation and healthcare liaisons were needed, but that the highest priority was to ensure that existing providers, translators, and other persons involved in mental health care be culturally competent in understanding the collective and individual traumas of Bhutanese refugees. Mental health education within the refugee community was needed to overcome the stigmatization of mental health issues and help-seeking for those issues, participants added. Partnerships with community organizations also needed to be increased and expanded to develop and deliver culturally competent care, participants said.

Summary

Two research questions were used to guide this study. RQ1 was: How do Bhutanese refugees in Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) describe their post-migration mental health and well-being? Four themes were used to address this question. RQ1 theme 1 was: ethnic persecution prior to displacement was traumatizing. The participants reported suffering from social trauma in the form of ethnic persecution, as well as witnessing or suffering interpersonal violence trauma ranging from the murder of relatives to rape, arrest, abduction, torture, exile, seizure of property and livelihoods, and revocation of citizenship with denial of basic human rights.

RQ1 theme 2 was: living conditions in refugee camps were traumatizing. Participants and their families were forced into exile in the refugee camps to escape atrocities. In the camps, conditions were also traumatizing. Separation from family members without any information on their well-being or whereabouts was traumatic, as was the deprivation of basic necessities and the resulting severe malnutrition, illness, and frequent deaths. Violence was also pervasive in the anarchic conditions of the camps, including fighting that sometimes led to murder, looting of fellow refugees' property, and sexual violence against women and girls.

RQ1 theme 3 was: pre-migration traumas caused post-migration mental illness in some refugees. Participants perceived pre-migration trauma as negatively impacting the mental health and well-being of Bhutanese refugees in four major ways. First, pre-migration trauma impacted post-migration mental health through PTSD, depression, and anxiety. Second, pre-migration deprivation in the refugee camps contributed to chronic health conditions such as diabetes and high blood pressure, as well as through cancer. Pre-migration trauma was also perceived as contributing to post-migration substance abuse, as well as to an elevated rate of post-migration suicide in the Bhutanese refugee community. However, most participants argued that while pre-migration trauma was the most significant contributor to negative effects on post-migration mental health and well-being, the living conditions refugees experienced in the U.S. also contributed.

RQ1 theme 4 was: post-migration stressors compounded pre-migration trauma. Participants reported that the negative effects of pre-migration trauma on mental health and well-being were compounded by post-migration stressors. Those stressors included culture shock, the language barrier, isolation, inability to find employment, and family separation. Participants perceived those stressors as contributing to elevated rates of suicide, depression, and anxiety in the Bhutanese refugee community.

RQ2 was: What supports do Bhutanese refugees in Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) perceive as effective or potentially effective in alleviating ongoing effects of pre-migration traumas on their post-migration mental health and well-being? Two themes were used to address this question. The first RQ2 theme was: post-migration protective factors included a strong Bhutanese community. Participants cited several protective factors that were effective as supports in alleviating the negative impacts of pre-migration trauma and post-migration stressors on Bhutanese refugees' mental health and well-being. These

protective factors included cultural activities and social supports, community and temples of worship, and obtaining education in the U.S. The participants described these protective factors as effective in alleviating the effects of trauma, isolation, and, in the case of education, the language barrier as well as the difficulty of obtaining employment.

The second RQ2 theme was: greater availability of culturally competent treatment is needed to address trauma. Participants expressed the perception that culturally competent mental health care had great potential to be effective in ameliorating the negative effects of pre-migration trauma on Bhutanese refugees' post-migration mental health and well-being. Participants emphasized that services such as translation and healthcare liaisons were needed but added that the highest priority was to ensure that existing providers, translators, and other persons involved in mental health care be culturally competent in understanding the collective and individual traumas of Bhutanese refugees. Mental health education within the refugee community was needed to overcome the stigmatization of mental health issues and help-seeking for those issues. Partnerships with community organizations also needed to be increased and expanded to develop and deliver culturally competent care, participants said. Chapter 5 includes the conclusions drawn from these findings.

Chapter 5

Discussion, Conclusion, and Recommendations

The purpose of this generic qualitative inquiry was to explore how Bhutanese refugees resettled in Northeast Pennsylvania perceive the effects of pre-migration traumas including stress and suicidal ideation on their post-migration mental health and well-being. Three mental health problems, post-traumatic stress disorder (PTSD), anxiety and depression, and self-esteem provided a clear understanding of the risk factors, influence, and potential solutions to the research problem identified. In this chapter, a summary of the research findings is presented, discussed, and interpreted. The chapter ends with recommendations for stakeholders and future researchers.

Interpretation of Study Findings

Research Question 1. RQ1 was: How do Bhutanese refugees in Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) describe their post-migration mental health and well-being? Four of the themes identified during data analysis were used to address this question. The four RQ1 themes were: (Theme 1) ethnic oppression prior to displacement was traumatizing, (Theme 2) living conditions in refugee camps were traumatizing, (Theme 3) pre-migration traumas caused post-migration mental illness in some refugees, and (Theme 4) post-migration stressors compounded pre-migration trauma. The following subsections are presentations of these themes.

Theme 1: Ethnic Persecution Prior to Displacement Was Traumatizing

The findings of this study indicate that ethnic persecution prior to displacement was traumatizing thus affecting individuals' mental health. The participants indicated that the ethnic persecution before their displacement to the refugee camp in Nepal included social and

interpersonal violence traumas. In line with this study, Ellis et al. (2019) stated that torture plays an important role in the development of PTSD, anxiety, and depression among Bhutanese refugees. Since the 1990s, a large population of southern Bhutan has moved into the Northeastern Pennsylvania countries. These refugees were moved by the government in fear of harassment and torture by the security forces of the country. According to Hagaman et al. (2016), ethnic persecution is linked to high levels of traumatic experiences and psychiatric sequelae among refugees seeking help in healthcare centers. Refugees who experience ethnic persecution prior to their displacement to the refugee camp report symptoms of PTSD, depression, and anxiety. In terms of food, shelter, and health, many refugees in Northeastern Pennsylvania face uncertainties, which is why chances of facing acculturation and asylum status are high.

Social traumas have also affected the mental health of Bhutanese refugees in Northeastern Pennsylvania. Refugees have experienced extremely stressful events due to religious or political oppression, migration, and war. In agreement with this study, Jackson et al. (2016) stated Bhutanese refugees experienced imprisonment, malnutrition, torture, fear, physical assault, loss of property, and loss of livelihood before being forced to flee. During the process, the refugees are separated from their families and friends and endure extremely harsh environmental conditions. According to the findings of this study, torture is the severe form of social trauma that refugees experience, which ranges from 3% to 63% depending on the historical event and group. Among the Bhutanese refugees, torture is the main predictor of medical and mental illness in the refugee camp (Kim & Till, 2015). A large percentage of Bhutanese refugees have experienced social trauma such as torture hence have significant challenges for emotional and physical healing, which must be carefully assessed and healed. “When refugees resettle to a host country, which is most often in a place that is not of the

refugee's choosing, the refugee must adapt to a new place and language under uncertain circumstances and with uncertain futures" (Kim et al., 2017, p. 185).

Theme 2: Living Conditions in Refugee Camps Were Traumatizing

The findings of this study indicate that living conditions in refugee camps affected the mental health of the Bhutanese refugees in Northeastern Pennsylvania. The conditions were traumatizing, which forced the refugees to leave Bhutan from fear of death, torture, arrest, rape, and other interpersonal violence traumas. Additional traumas were associated with family separation, lack of basic necessities, and violence in the camps. According to Kingston and Stam (2017), living conditions in refugee camps are appalling, with substandard housing, poor infrastructure, and lack of enough water and sanitation, which jeopardizes the health of the refugees at risk. The Bhutanese refugees live in refugee camps permanently due to political and religious issues. The international organizations providing aid in camps should recognize that camps that were meant to provide temporary settlement for refugees have now become permanent. Some of the challenges that face Bhutanese refugees in camps include lack of affordable housing, communication, and language barriers, disrupted education, financial difficulties, separation from families, mental health issues, and discrimination.

Separation from families takes on different forms. Many children among the Bhutanese refugees have been separated from their parents who have to relocate in search of work. As noted by Ellis et al. (2019), over 70, 000 Bhutanese refugee families live without their fathers and many children are separated from both parents. The impact of family separation is that it has destroyed the family structure both emotionally and economically. Due to interrupted preventive healthcare, families, especially children, have experienced psychological trauma, which impedes their development. Thus, there is a need for international organizations to create

awareness on tangible steps to promote change in the lives of vulnerable children in refugee camps.

This study also established that a lot of the trauma associated with life in the refugee camps for Bhutanese refugees is a consequence of chronic deprivation. Basic necessities such as clean water, nutritious food, and medical care were lacking. Listo (2018) noted:

The provision of adequate sanitation services is crucial to prevent communicable diseases and epidemics while ensuring good health and dignity. Though the importance of having adequate latrines is well documented, still 30% of refugee camps do not have adequate waste disposal services or latrines (p. 173).

Listo (2018) mentioned the camps in eastern Nepal that provided sanitation facilities had 1.6 cholera cases per every 1000 people and those that did not provide such facilities were almost three times greater. It is important to provide adequate resources in the refugee camps for the refugees to curb diseases and epidemics. In countries such as Kenya, sharing of latrine by more than three households was found to be a risk factor in the spread of cholera. Refugees can be aware of the dangers associated with dirty and contaminated water and food by promoting cleanliness and sufficient sanitation facilities.

Another challenge facing refugees in camps is the lack of proper health services. Bhutanese refugees have experienced different challenges such as lack of shelter, exposure to insecurity and physical violence, overcrowded camps, insufficient access to quality food, lack of immunity to local diseases, and emotional stress. However, the biggest challenge is to ensure every refugee has access to healthcare services. There is a lack of information regarding the available healthcare services. According to Lumley et al. (2018), refugees have the right to quality healthcare services as resident communities. How these services are pursued depends on

specific factors such as whether the refugees are living in enclosed or remote camps, availability of national health services, and the most pressing health services.

Theme 3: Pre-Migration Traumas Caused Post-Migration Mental Illness in Some Refugees

Pre-migration traumas might cause post-migration mental illness in Bhutanese refugees. This study found that the incidence of substance abuse was elevated in the Bhutanese refugee population, in part as a consequence of pre-migration trauma. Families, especially children, are more vulnerable to the unpredictable, traumatizing environment of immigration detention. The majority of Bhutanese refugees do not have opportunities for education and safe play and experience parental distress and an undermining of the parental role, which increases the risk of children experiencing poor developmental psychopathology. The key principle of refugee camp operation is that all operations are based on equality and protection. All refugees should have equal access to services and also contribute to their living conditions and own protection.

The findings of this study have indicated that pre-migration trauma has a negative impact on the mental health of the refugees. Exposure to pre-migration trauma is a strong predictor of PTSD, depression, major depressive disorder (MDD), and long-term psychological dysfunction. Despite the increased cases of mental health cases among the Bhutanese refugees, the level of mental health services usage remains low. However, Lumley et al. (2018) noted post-migration stressors have more impact as compared to pre-migration trauma. Exposure to pre-migration trauma affects mental health by triggering post-migration stressors. Neglecting the relationship between pre- and post-migration traumas will limit the understanding of the source of traumas for refugees. This study postulates that the disruptive nature of traumatic events affects the beliefs of refugees regarding the benevolence of the world and justice. Increased exposure to pre-migration trauma results in higher levels of perceived discrimination among the refugee, which in turn leads to high levels of psychological distress.

This study suggests that mental health issues such as depression and PTSD are common among Bhutanese refugees that have experienced traumatizing events. Pre-migration trauma was associated with a negative impact on post-migration mental health. Because Bhutanese refugees experience many traumatic events, they are at greater risks of developing PTSD. Some of the traumatic events include political persecution, torture, starvation, and criminal victimization.

The increased rates of chronic health conditions among Bhutanese refugees are caused by three main factors, which include an improved ability to diagnose the conditions in the United States, the wide availability of cheap, unhealthy foods in the U.S., and poor conditions in the refugee camps. Unsanitary conditions in refugee camps caused by overcrowding and lack of clean water and food storage can result in an increased risk of chronic health conditions. According to Ellis et al. (2019), many refugees across the US have faced challenges such as overcrowding, poor living conditions, and food insecurity, which has caused respiratory problems, the spread of infections, and gastrointestinal illnesses. Access to clean water and quality food is the solution for mitigating these chronic health issues in refugee camps.

Theme 4: Post Compounded Pre-Migration Trauma

Different post-migration stressors are harmful to the mental health of Bhutanese refugees. The stressors include culture shock, the language barrier, post-migration family separation, an inability to find work in the U.S., and isolation. In high-income countries, post-migration stressors include poor social integration, financial difficulties, and discrimination. McCleary et al. (2019) opined that the effects of post-migration stressors are gender specific. “These stressors have been shown to not only have strong negative direct effects on mental health, but also to mediate and moderate the adverse effects of other stressors associated with the refugee experience, including pre-migration trauma exposure” (McCleary et al., 2019, p. 45).

Bhutanese refugees are linguistically and ethnically a minority group in Bhutan, who were forced to move to Nepal. Human service organizations such as schools, social services agencies, health centers, and community-based organizations play a key role in mediating migration. These organizations provide important services including education, health, language access, and financial services that help protect and maintain the well-being of communities. This study postulates that Bhutanese refugees face many barriers such as the provision of mental health services and impediments related to language. Cultural factors are embedded in preconceived notions of mental health and how symptoms are portrayed, creating internalized and silenced symptoms due to shame. The Bhutanese refugees have fear of speaking out as they will be viewed as crazy. The stigma and privacy concerns regarding mental health and gender hierarchy together with family pressures from cultural barriers result in fear of seeking help. Among older Bhutanese refugees, language barriers were identified as one of the biggest stressors thus limiting service access. There is a belief that service providers will not understand their culture, which often keeps them from seeking mental health services.

Research Question 2. RQ2 was: What supports do Bhutanese refugees in Northeastern Pennsylvania (i.e., Dauphin and Lackawanna counties) perceive as effective or potentially effective in alleviating ongoing effects of pre-migration traumas on their post-migration mental health and well-being? Two of the themes identified during data analysis were relevant to addressing this question. The RQ2 themes were: (Theme 5) post-migration protective factors included a strong Bhutanese community, and (Theme 6) greater availability of culturally competent treatment is needed to address trauma. The following subsections are presentations of these themes.

Theme 5: Post-Migration Protective Factors Included a Strong Bhutanese Community

The protective factors that can help the refugees overcome the effects of pre-migration trauma include cultural activities and social support, community, and temples of worship, and gaining education in the U.S. Protective factors are related to positive outcomes, which help refugees improve access to mental health services and education. Protective factors are drawn from several domains such as age, social support, self-esteem, belonging, maintenance of cultural identity, and innovative social care services. According to Sriram (2019), focusing on protective and resilience factors is a crucial long-term goal for improving the mental health and general well-being of Bhutanese refugees. To effectively settle these refugees, policies and approaches must be incorporated within a positive socially inclusive society. The local culture has to be accommodative. By focusing on cultural values, healthcare providers in refugee camps adopt a resilience-focused approach.

For Bhutanese refugees, positive cultural activities and social supports ranged from festivals to gatherings. The refugees need to feel included and valued. According to Sheikh and Anderson (2018), having a good mental and physical health helps refugees prevent themselves from vulnerabilities. Good academic background and professional skills may help the migrant in the integration into the host country. During the pre-migration phase, having adequate psychological resources help prevent psychological distress during the migration phase. As highlighted in this study, migration may bring positive outcomes such as self-affirmation, the adoption skills, personal growth, and learning new social values. In such cases, the mental health of the refugees is excellent and satisfactory. In line with this study, Rinker and Khadka (2018) argued social support plays an important role in the maintenance of good mental health. “An adequate social support, a co-ethnic presence, and expression of low expressed emotion are protective factors against alcohol use behaviors and mental disorders. It is predictive of greater

happiness and less depression" (Rinker & Khadka, 2018, p.31). Making social networks broader will ensure that immigrants are integrated and accepted in the new country. Low perceived discrimination and high perceived social support in the host country are the keys of successful integration and good mental health.

Theme 6: Greater Availability of Culturally Competent Treatment Is Needed to Address Trauma

Culturally competent treatment is perceived as a potentially effective support in alleviating the ongoing effects of pre-migration traumas on Bhutanese refugees' post-migration mental health and well-being. A culturally competent treatment should have several factors to be considered effective, including culturally competent practitioners who understand the traumas of the refugee population, mental health education to overcome cultural barriers to seeking mental health treatment, and community partnerships to ensure the availability of culturally competent mental health resources. The development of culturally responsive clinical skills is vital to the effectiveness of behavioral health services. Concordantly, Brown et al. (2019) suggested the development of culturally responsive skills can help Bhutanese refugees improve their engagement in treatment services.

Healthcare providers in the Bhutanese refugee community should be culturally competent to understand the traumas and needs of the refugees. As stipulated by Ellis et al. (2019), doctors in refugee camps who understand the needs and challenges that refugees face tend to provide effective treatment services. Culturally responsive organizational strategies and clinical services can help mitigate organizational risk and provide cost-effective treatment.

Implications of Study Findings

The findings of this study have contributed to the understanding of how Bhutanese refugees resettled in Northeast Pennsylvania perceive the effects of pre-migration traumas

including stress and suicidal ideation on their post-migration mental health and well-being. For Bhutanese refugees, the findings of this study have indicated protective factors that can help the refugees overcome the effects of pre-migration trauma include cultural activities and social support, community, and temples of worship, and gaining education in the U.S. Protective factors are related to positive outcomes, which help refugees improve access to mental health services and education. Greater availability of culturally competent treatment is needed to address trauma. Culturally competent treatment is perceived as a potentially effective support in alleviating the ongoing effects of pre-migration traumas on Bhutanese refugees' post-migration mental health and well-being.

Office of Refugee Resettlement (ORR), US Department of Health and Human Services, PA Department of Health should involve culturally competent experts from refugee population while making policies, health requirements, emergency preparedness strategies for greater availability of culturally competent treatments to address traumas of the refugees. PA Department of Health should establish effective systems, if not in place already, to track refugees' mental health conditions, suicidal Ideations, and other health complications. Refugee resettlement agencies like Diocese of Scranton; Catholic Social Services of Scranton should give orientation to the newly arrived refugees about the day-to-day life adjustments, transformational changes, way of living in the new environment, and safety and wellness.

This study provides information about the pre-settlement hopes, expectations, and experiences of the Bhutanese refugees. This study can be a useful tool for Public Welfare, Resettlement Agencies, Case Workers, Service Providers, Employers, Hospitals, Schools, Universities, Business Owners, Donors, and many more in the city of Scranton and Harrisburg, Pennsylvania. The information provided here is intended to help resettlement agencies, clinicians, and providers understand the cultural background and mental health issues of

Bhutanese refugees in US. Bhutanese refugees are not only the burden but also the huge contributors to the local communities in Lackawanna and Dauphin counties in particular and throughout US in general. The faster the refugees can integrate into the labor force, the faster they can become productive members of society.

Bhutanese refugees contribute to the economy in many ways in Lackawanna and Dauphin counties. Bhutanese refugees have made a substantial contribution to the economy, and social and cultural values that have molded Pennsylvanian society and impart vitality and multiculturalism into US. They have assisted in the expanding of consumer markets for local goods, opening new businesses, groceries, health care, services orientated businesses, they brought skills needed by the American Labor Market which has created employment and filling empty employment places. Bhutanese have contributed to the development and expansion of small businesses, which are the cornerstone for the US economy. Refugees have had a great impact in the increase of demand for infrastructure through the spending by refugees on food, clothing, electrical appliances, and housing. Refugees pay taxes, fill critical labor gaps at a time when many businesses are facing labor shortages.

The US Government should be committed to a just, inclusive, and socially cohesive society where everyone can participate in the opportunities that Americans offer and where government services are responsive to the needs of Americans from culturally and linguistically diverse backgrounds. After decades Bhutanese refugees are given every opportunity to participate in and contribute to local community and its social, economic, and cultural life. Refugees from all backgrounds are also entitled to receive equitable access to government services. The Government should strengthen its access and equity policies to ensure that government programs and services are responsive to the needs of refugee's culturally and linguistically diverse communities. The local government of Scranton and Harrisburg should increase the funding and

resources to refugee empowerment and training programs, local grants to the community organizations, local business, and social programs. The city of Scranton and the city of Harrisburg would be benefited if refugees' populations are received, resettled, and empowered.

Limitations of Study Findings

Limitations are potential weaknesses of a study that may be beyond the researcher's control or other factors that may impose restrictions that can affect the study design, findings, or conclusion (Theofanidis et al., 2019). Limitations include the potential for participant and researcher bias to distort the findings in the study. Participant responses that are biased by conditions unrelated to the phenomenon of interest, and researcher biases and preconceptions related to the study topic and population, may weaken the credibility, dependability, and confirmability of the results. A member-checking procedure were used to allow participants to review and, if necessary, correct their responses. Interviewing multiple participants and identifying emergent themes common to all or most participants' experiences have also minimized the influence of participant bias on the data. The researcher was aware and remained mindful of his biases and preconceptions during data collection and analysis to minimize the potential influence of researcher bias on the results. By remaining mindful of biases, the researcher consciously worked to suspend them and thereby minimize their influence on the study results. Including direct quotes in the presentation of results as evidence for all emergent themes allows readers to independently confirm the findings.

Another limitation of the study was that there were a limited number of participants in this study. This limitation was caused by the time-consuming and intensive nature of qualitative data collection. There are benefits to having fewer participants in a study, as more attention can be paid to the individual experiences and perceptions gathered in this study (Yin, 2017). However, generalizability will not be achieved without a statistically significant sample size.

Therefore, the limited sample size in this study might limit the data interpretation to the experience of individuals. However, the researcher has tried to ensure the transferability of results by collecting thick, rich data from each participant and by collecting data until data saturation is reached (Yin, 2017). Generally, saturation was reached with 20 participants.

Recommendations for Future Studies

This study has established that ethnic persecution prior to displacement of the Bhutanese refugees was traumatizing thus affecting individuals' mental health. This study explored how Bhutanese refugees in Northeastern, Pennsylvania perceives the effects of pre-migration traumas on their post-migration mental health and well-being using a small sample size of 15 individuals. The researcher, therefore, recommends for future researchers to explore the same research problem using a larger sample size in order to increase the generalizability of the research findings to a larger population. The findings of these future studies will be compared with the results of this study to determine the credibility and generalizability of this study. This study used a qualitative approach; therefore, future researchers should explore the same research problem using a quantitative approach and survey research design and compare the findings. During the study, two areas emerged that require further research in future. These areas include how pre-migration stressors create post-migration issues such as suicide and anxiety and how lack of good academic background affects refugees' integration into the host culture.

As refugees are particular types of immigrants, arriving under different circumstances and with different benefits, it is of the utmost importance to study them as a unique population. They are population with rare resilience and courage that deserves further attention from their host country. Therefore, future researchers can further explore the same research problem using a larger sample size The findings discussed provide valuable information about the resettlement experience but demand further verification and testing. Future researchers should explore the

same research problem using a quantitative approach in order to understand the traumas and needs of the refugees, healthcare providers in the Bhutanese refugee community should be culturally competent. As stipulated by Ellis et al. (2019), doctors in refugee camps who understand the needs and challenges that refugees face tend to provide effective treatment services. Providers have to integrate the refugees' needs and the cultural values in the host country. All stakeholders who are dealing with refugee populations should consider refugees' past refugee life and assist them with appropriate tools and resources. Therefore, the government must allocate more resources to refugee communities to improve living conditions of the refugees.

Conclusion

This generic qualitative inquiry explored how Bhutanese refugees in Northeastern, Pennsylvania perceives the effects of pre-migration traumas on their post-migration mental health and well-being. The research questions used were: a) How do Bhutanese refugees in the Northeastern Pennsylvania i.e., Dauphin and Lackawanna counties describe their post-migration mental health and well-being? and b) What supports do Bhutanese refugees in the Northeastern Pennsylvania i.e., Dauphin and Lackawanna counties perceive as effective or potentially effective in alleviating ongoing effects of pre-migration traumas on their post-migration mental health and well-being? A sample size of 20 individuals were used.

The participants stated that ethnic persecution prior to displacement of Bhutanese refugees was traumatizing thus affecting individuals' mental health. Participants reported that the poor conditions in refugee camps affected the mental health of the Bhutanese refugees in Northeastern Pennsylvania. For Bhutanese refugees the findings of this study have indicated protective factors that can help the refugees overcome effects of pre-migration trauma include

cultural activities, social support, community involvement, places for worship, delivering appropriate health care, providing culturally competent treatment, and gaining education in the United States.

The methodological approach used was qualitative inquiry, where respondents share their individual experiences. The findings from this research provide evidence that contributes to addressing the mental health needs of Nepali-speaking Bhutanese refugees in the United States. One of the participants shared that despite the fact that ethnic persecution prior to displacement of the first-generation Bhutanese was traumatizing and affected the individuals' mental health, younger generations demonstrated a high degree of familiarity with American culture and want to become further connected. Their community involvement shows the degree to which they have successfully integrated. It was facilitated by schools, colleges, workplaces, social bridges, social bonds, social links, and feeling of safety and security. Protective factors are related to positive outcomes, which help refugees improve access to mental health services and education.

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APPENDIX A

IRB Approval Letter

MARYWOOD UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Immaculata Hall, 2300 Adams Avenue, Scranton, PA 18509

DATE:	August 17, 2021
TO:	Narad Pokhrel
FROM:	Marywood University Institutional Review Board
STUDY TITLE:	[1790195-4] *Ongoing Effects of Pre-migration Traumas on the Mental Health of Bhutanese Refugees in the United States: A Qualitative Inquiry*
MUIRB #:	2021-004
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVED

APPROVAL DATE: August 17, 20 21

NEXT REPORT DUE DATE: August 17, 2022

REVIEW TYPE: Expedited Review - 45 CFR 46.110
EXPEDITED REVIEW TYPE: 6 and 7

PLEASE READ THIS LETTER CAREFULLY IN ITS ENTIRETY.

IT CONTAINS IMPORTANT INFORMATION ABOUT YOUR RESEARCH PROPOSAL AND YOUR RESPONSIBILITIES AS AN INVESTIGATOR. THE IRB IS REQUIRED BY FEDERAL LAW TO REPORT ALL SERIOUS OR CONTINUING NONCOMPLIANCE WITH THESE REQUIREMENTS TO FEDERAL AGENCIES.

Thank you for your submission of Amendment/Modification materials for this research study. Marywood University's Institutional Review Board has **APPROVED** your submission. This

approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the study and assurance of participant understanding, followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant to receive a copy of the signed consent document.

We have applied the IRB's approval stamp to your final informed consent form (Translated and English versions) and flyer, which have been uploaded with this letter. The stamp must appear on all versions which will be given to subjects.
Please be aware that all research records must be retained by the researcher for a minimum of three years after IRB closure of the project.

Please also note that:

- **A CLOSURE REPORT FORM is due upon completion. If not closed by August 17, 2022, a CHECK-IN REPORT FORM will be required by that date instead.**
- Any REVISION to the protocol must be submitted to and approved by the IRB prior to initiation.
- All DEVIATIONS from the described protocol, UNANTICIPATED PROBLEMS or SERIOUS ADVERSE EVENTS must be reported immediately to this office.
- All NON-COMPLIANCE issues or COMPLAINTS regarding this study must be reported to this office.

The appropriate forms for any of the reports mentioned above may be found on the IRB's website or in the Forms Library at IRBNet.

If you have any questions, please contact the IRB at 570-348-6211, x. 2418 or irbhelp@marywood.edu. Include your study title and MU IRB number in all correspondence with this office.

Thank you and good luck with your research!

APPENDIX B

Informed Consent Form

Title: Ongoing Effects of Pre-migration Traumas on the Mental Health of Bhutanese Refugees in the United States: A Qualitative Inquiry

Principal Investigator (PI): Narad Pokhrel Student at Marywood University
Principal Investigator Contact Information: Phone: 6149430728 and email: npokhrel@m.marywood.edu
Research Advisor: Alan M. Levine, PhD Professor at Marywood University
Research Advisor Contact Information: 570-348-6290, Email: levine@marywood.edu

Invitation for a Research Study

You are invited to participate in a research study about the effects of pre-migration traumas on the mental health of Bhutanese refugees in the United States. You were chosen because you are a first-generation adult Bhutanese refugee living in the Scranton, Harrisburg, or Pennsylvania area. This population is Nepali Speaking Bhutanese who fled the ethnic persecution and violence in their home country. Any age over 18 years can volunteer for the study. You may or may not have experienced interpersonal violence trauma. Based on the refugee status most have experienced social and historical traumas.

Purpose – About the Study

The purpose of this study is to explore how Bhutanese refugees in Northeast Pennsylvania perceive the effects of pre-migration traumas on their post-migration mental health and well-being. The researcher is seeking around 15 – 25 participants.

Procedures - What You Will Do

Once it is determined you are eligible to participate in the study, the researcher will arrange a one-on-one interview. Interviews will be conducted at a time chosen by you to ensure you can give unhurried responses to the interview questions without distractions of other obligations. Interviews will be conducted in a private place of your choice or in the researcher's office in Harrisburg or Scranton. This is to ensure you are comfortable and that you have access to immediate supports if needed. If the COVID -19 pandemic has not subsided beforehand, the interviews will take place on the internet using Zoom. If you do not have access to a smartphone or computer capable of using Zoom, the interview will take place over the phone. Before the interview, the researcher will email or mail you an informed consent form to be signed and sent back to the researcher. Interviews will be audio-recorded and will be transcribed by the researcher. Then the transcribed document will be given back to you to review to make sure it is accurate.

Risks and Benefits

The risks are no greater than the risks in daily life or activities. However, you may feel some emotional discomfort. This is a list of counselling centers from Scranton and Harrisburg areas.

1. Scranton Counselling Center Address: 329 Cherry Street Scranton, PA 18505 Phone: 570.348.6100
2. Family Enrichment Center, P.C, Address: 541 Wyoming Ave, Scranton, PA 18509, Phone: (570) 342- 4665, Toll Free: (877) 437-8808, Fax (570) 342-5024, Email: Famrch@aol.com
3. Integrative Counseling Services, PC, Address: 4309 Linglestown Rd Suite 214, Harrisburg, PA 17112 Phone: (717) 412-4908
4. Mental Health Associates in Pa, Address: 1414 N Cameron St C, Harrisburg, PA 17103, Phone: (717) 346-0549
5. Covenant Counseling Services, Address: 2459 Walnut St, Harrisburg, PA 17103, Phone: (717)695- 2006

Confidentiality

If the interview takes place over Zoom it will be audio recorded. If the interview takes place over the phone, it will also be audio recorded. All records of this study will be kept private. The information of this study may be used in a written or oral report and any information that may identify you will be deleted. Only the researcher will have access to the research records. All of the records about this study will be kept in a locked drawer or in a password-protected file. Records will be kept for 3 years after closure. Then they will be destroyed professionally (e.g., deleted, shredded, etc.). The data collected for this study will not be used in any other future research studies even if identifiers are removed. No web-based action is perfectly secure. However, reasonable efforts will be made to protect your transmission from third-party access. This applies if you are interviewed through Zoom.

Taking Part is Voluntary

Participation in the study will be entirely voluntary. You may withdraw at any time. You do not have to answer any question you do not want to answer. You do not need a reason. If you decide to withdraw, please inform the researcher that you no longer want to participate in the study. The researcher will destroy all information related to you if you decide to withdraw. This will not affect your relationship with Marywood University. Your decision whether or not to participate will not affect your current or future relationship with the researcher. There will be no negative consequences for withdrawing from the study. There will be no incentives for participating in this study. However, the results may help healthcare workers to provide better, culturally sensitive, trauma-informed care to Bhutanese refugees in the United States.

Contacts and Questions

If you have questions about this study at any time, contact the principal investigator at 6149430728 or email at npokhrel@m.marywood.edu or his advisor at 570-348-6290 or email at: levine@marywood.edu.

If you have questions related to the rights of research participants or research-related injuries (where applicable), please contact the Institutional Review Board at (570) 961-4782 or irbhelp@marywood.edu.

You will be given a copy of this form to keep for your records.

APPROVED BY
MARYWOOD UNIVERSITY'S IRB
08/17/20
No expiration dates

Statement of Consent

By signing this document:

- You understand what the study involves.
- You have asked questions if you had them.
- You agree to participate in the study.

_____

Printed Name of Subject or Legally Authorized Representative

_____ _____

Signature of Subject or Legally Authorized Representative Date

Narad Pokhrel _____ Printed

Name of Authorized Person Obtaining Informed Consent

Date

_____ _____

Signature of Authorized Person Obtaining Informed Consent Date

APPENDIX C

Demographic Questions

1. Did you come from Bhutan?
2. Did your family migrant with you or did you come alone and how old were you at that time? Were you a child, adolescent, or adult?
3. Are you born in the Bhutanese refugee camp in Nepal?
4. Did you come to USA from Bhutanese refugee camp or elsewhere? If yes, What camp?
5. Did you migrate to another camp before migrating to USA?
6. Did you come to Harrisburg or Scranton directly from Nepal or did you move from other cities?
7. Are you living in the Bhutanese communities or live away from them?
8. Did you come to USA between 2008-2018? If not, when?

APPENDIX D
Interview Protocol

Title of Study: Ongoing Effects of Pre-migration Traumas on the Mental Health of Bhutanese Refugees in the United States: A Qualitative Inquiry

Brief reorientation of the topic: I am interested to learn about your experiences while living in Bhutan, your journey when you left Bhutan, your life in the refugee camps in Nepal, and how you have adapted to life here in the United States. I am aware of the difficulties of living in Bhutan, as that is where I am from too. I also know about the psychosocial supports available to the Bhutanese people who have migrated to the United States. I want to talk with you and others who have migrated from Bhutan to understand some of the traumas you have suffered. I would like to know how the traumas you suffered in Bhutan before you migrated affect you now. I am interested in how Bhutanese refugees in Northeast Pennsylvania perceive the effects of pre-migration traumas on their post-migration mental health and well-being. I am interested in things like your particular stories of the violence you many have suffered or witnessed, how that violence affected you then, and how it affects you now. I am also interested in what your journey was like when you left Bhutan and the experiences in the camps you stayed in. Also, I would like to know how long you lived in the camps and how you are coping now. I am doing this because I want the people from Bhutan to be understood better and for their voices to be heard so that the psychosocial support services here in the United States can provide better services for the people from Bhutan. The stories about your experiences are important for people here in the United States to grasp to build sensitivity about the people from Bhutan and the culture of Bhutan. At any time, you feel uncomfortable answering a question, please let me know that you would rather not answer. You can end this interview at any time. Also, if you do not understand a question, please ask for clarification, and I will explain. Do you have any questions or comments at this point?

Interview Questions

1. Where were you born? Where were you raised? Did you live in a refugee camp (if so, when, and where?)? What can you tell me about your childhood experiences? What were your experiences within the Bhutanese community? What are/were your family experiences?

2. Did you belong to any groups (religious, social, political)? Did you have any medical, or mental health needs/issues? How do you sleep?

3. What can you tell me about your social life? Schooling? Refugee camp experiences? Did you witness/experience any violence at any time during your experiences? What can you tell me about your move from the refugee camp? What were your experiences and feelings moving to a new country? Do you identify any needs you have?

4. How do you think the challenges and conditions in refugee camps influence the mental health and well-being of Bhutanese refugees?

5. How do you think pre-migration stressors may have contributed to negative feelings and/or any mental health concerns in post-migration living?

6. Is there anything else you would like to share with me before we stop?

APPENDIX E
Research Studies Participation Letter

Name: _____

Address: _____

Subject: Requesting your valuable Participation in the Research Studies

Date: _____

Dear Mr./ Mrs.

Namaste

With due respect and humble submission, I would like to request for your valuable time and intellect in my study. I am one of the PhD students at Marywood University and completing my dissertation on: Ongoing Effects of Pre-migration Traumas on the Mental Health of Bhutanese Refugees in the United States: A Qualitative inquiry. It is determined that you are eligible to participate in the study. Interviews will be conducted at a time chosen by you to ensure you can give unhurried responses to the interview questions without distractions of other obligations. Interviews will be conducted in a private place of your choice or in my office at 3865 Seattle Slew Dr, Harrisburg, pa 17112. It will take one and half hours to complete the interview. This is to ensure that all recordings of this study will be kept private and very confidential.

I have attached the approval letter and flyer for your information and Informed Consent Form for you to complete and return before the interview. Professional interview protocols will be pursued in the interview process. Interview (Data collection process) will begin from 1st of September through 30th of October 2021. If you are interested, please reply to my email with date and time with your availability within the above time frame.

If you have any questions and concerns, feel free to contact me at: npokhrel@m.marywood.edu or call me at 614-943-0728.

I shall be obliged if you kindly consider my case sympathetically.

Thank you

Narad Pokhrel

PhD Student

Marywood University

Scranton Pennsylvania, USA

APPENDIX F

Sight Authorization Request letters

NEOLY HOME CARE, LLC

1730 PITTSTON AVENUE, BLOCK B, SCRANTON, PA 18505

Email: neolyhomecare.pa@gmail.com**. Phone: 570-880-7428, Fax: 570-880-7396**

August 3, 2021

Re: Ongoing Effects of Pre-migration Traumas on the Mental Health of Bhutanese Refugees in the United States: A Qualitative Inquiry

Dear Mrs. Loftus

Institutional Review Board or Exempt Review Committee

Marywood University, Scranton Pennsylvania

This letter confirms that as an authorized representative of Neoly Home Care, LLC (1730 Pittston Ave, Block B, Scranton, PA 18505). I am aware of Narad Pokhrel's (the principal investigator) research project and protocol.

I will allow Narad Pokhrel (the principal investigator) to post flyers to a bulletin board at my business.

However, I understand that research activities may commence only after the principal investigator (Narad Pokhrel) provides evidence of final approval from Marywood University's IRB or ERC for the proposed project.

If you have any questions, please contact me at knkafley@gmail.com or by phone at 570-800-9439

Sincerely,

Kedar Kafley

City Administrator

Neoly Home Care, LLC

BEST OF ASIAN

NEPALI- INDIAN GROCERY STORE

2035 LINGLESTOWN RD, HARRISBURG, PA 17110

PHONE: 717-693-8180

August 3, 2021

Re: Ongoing Effects of Pre-migration Traumas on the Mental Health of Bhutanese Refugees in the United States: A Qualitative Inquiry

Dear Mrs. Loftus

Institutional Review Board or Exempt Review Committee

Marywood University, Scranton Pennsylvania

This letter confirms that as an authorized representative of Nepali- Indian Grocery Store (2035 Linglestown Rd, Harrisburg, Pa 17110) I am aware of Narad Pokharel's (the principal investigator) research project and protocol.

I will allow Narad Pokhrel (the principal investigator) to post flyers to a bulletin board at my business.

However, I understand that research activities may commence only after the principal investigator (Narad Pokhrel) provides evidence of final approval from Marywood University's IRB or ERC for the proposed project.

If you have any questions, please contact me at 717-693-8180.

Sincerely,

Meg R. Khadka

Owner/ Proprietor

Best Of Asian Nepali- Indian Grocery Store

APPENDIX G

Research Participants Needed

A study is being conducted about Bhutanese refugees' experiences of pre-migration stressors and their influence on post-migration health. It is needed to tailor culturally sensitive, trauma-informed interventions and resources to optimally serve this population. Benefits may include a better understanding of how the Bhutanese refugees can be more mentally healthy and, consequently, more productive members of the society. If you decide to participate, you will be interviewed for about one hour at a private place of your choice at a time that will work for both you and the researcher.

Principal Investigator

Narad Pokhrel

PhD Student

Marywood University.

Phone: 6149430728

Email:
npokhrel@m.marywood.edu

Eligibility:

- ✓Bhutanese Refugees
- ✓Age 18 and above
- ✓English not needed

Please take one and call me if you are interested.

6149430728 npokhrel@m.marywood.edu
6149430728 npokhrel@m.marywood.edu
6149430728 npokhrel@m.marywood.edu
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