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# Perceptions Toward Mental Illness and Seeking Psychological Help among Bhutanese Refugees Resettled in the U.S.

**Hannah MacDowell, MPH, MSW, LSW**[a], **Sudarshan Pyakurel, MA**[b], **Jhuma Acharya**[b,c], **Dianne Morrison-Beedy, PhD, RN, FNAP, FAANP, FAAN**[d], **Jennifer Kue, PhD**[d]

[a]College of Social Work/College of Public Health, The Ohio State University, Columbus, OH

[b]Bhutanese Community of Central Ohio, Columbus, OH

[c]Community Refugee and Immigration Services, Columbus, OH

[d]College of Nursing, The Ohio State University, Columbus, OH

## Abstract

This study examined perceptions toward mental health and seeking psychological care among Bhutanese refugees in a large Midwestern U.S. city. Bhutanese adults ($n$ = 201) completed a community health needs assessment. Survey questions addressed beliefs toward mental health and seeking psychological care. Perceptions toward mental illness and receiving psychological help were generally negative among participants. Over 71% believed others would look unfavorably on a person who sought out a counselor. Participants who had less than a high school education, were 35 years and older, and lived in refugee camps for more than 20 years had significantly greater negative beliefs toward mental illness. Over one-third (34.8%) of participants reported access to counseling services as being somewhat of a problem or a serious problem. These findings may inform future research and interventions aimed at improving mental health among Bhutanese refugees.

## Background

As of 2016, approximately 85,000 Bhutanese refugees were resettled in the United States (U.S.) (White House Initiative on Asian Americans and Pacific Islanders, 2016, March 11). In 2012, they were the leading population resettled in the U.S. with 15,021 individuals arriving that year (Office of Refugee Resettlement, 2015). Refugees may experience trauma from war or displacement, and post-migration difficulties that may put them at substantially higher risk for mental health disorders, including depression, post-traumatic stress disorder (PTSD), and anxiety (Bogic, Njoku, & Priebe, 2015; Vonnahme, Lankau, Ao, Shetty, & Cardozo, 2015). Despite being at increased risk for mental health concerns, refugees often encounter barriers that prevent or deter them from obtaining care, including stigma surrounding mental health diagnoses and treatment, seeking mental health services not being a perceived norm in their country of origin, differing cultural practices, and lack of information about mental health services (Saechao et al., 2012). A study with Bhutanese, Karen, Oromo, and Somali first-generation refugees in the U.S. found barriers that may be unique to these more recently resettled refugees in the U.S., including a history of political repression, fear, the belief that talking will not help, lack of knowledge about mental health,

avoidance of symptoms, shame, and cultural norms (Shannon, Wieling, Simmelink-McCleary, & Becher, 2015).

Historical context is essential when examining issues of mental health with Bhutanese refugees. In the early 19th century, a small group of people from eastern Nepal immigrated to Bhutan, known as Lhotsampas ("People of the South") (COR, 2007; Maxyn, 2010). They retained their Nepali language, culture, and religion for five generations, and functioned autonomously apart from the Druk Buddhist majority in Bhutan. Many Lhotsampas were able to gain citizenship when Bhutan passed a new nationality law in 1958 (Ridderbos, 2007). In the 1980s, Bhutan's majority became concerned with growth of the Lhotsampas population and implemented policies to unify the country under the Druk culture. Lhotsampas' protest of what was called *Bhutanization* was met with force from the government, through mass arrests, torture of protesters, destruction of property, and expulsion from the country (Ridderbos, 2007). Over 100,000 Lhotsampas fled to refugee camps in Nepal. Despite this being their ethnic country, the Nepali government did not allow Bhutanese refugees to relocate or work within the country. Unable to return to Bhutan or integrate into Nepal, many Bhutanese refugees have lived for the last two decades in refugee camps in Nepal (COR, 2007). In 2008, Bhutanese refugees were resettled to third countries including the U.S.

### Bhutanese refugees and mental health

Mental health among the Bhutanese community has come into focus in the past decade after high rates of suicide were identified both within-refugee camps in Nepal, and after resettlement in the U.S. between 2004 and 2010, the rate of suicide in the refugee camps was 20.76 per 100,000 (Schininà, Sharma, Gorbacheva, & Kumar Mishra, 2011). The suicide rate among Bhutanese refugees in the U.S. between 2009 and 2012 was 20.3 per 100,000 (Ao et al., 2012), compared to 12.4 per 100,000 for the general U.S. population (Centers for Disease Control and Prevention, 2013). Studies have also found high rates of mental illness symptomatology among Bhutanese refugees in the U.S. (Ao et al., 2012). However, despite research suggesting a high prevalence of mental illness and an alarming incidence of suicide among this population, self-reports of mental health diagnoses and thoughts of suicide are discrepantly low. This suggests an under-diagnosis of mental disorders in this population and a reluctance to disclose mental health concerns (Ao et al., 2012).

A better understanding of Bhutanese refugees' perceptions of mental illness and toward seeking psychological care is essential for developing culturally responsive interventions to address the high rate of suicide in this population, and ensure those in need of mental health services are able to access services. This study aimed to explore Bhutanese refugee beliefs toward mental illness and perceptions toward seeking psychological care.

## Methods

A community health needs assessment was conducted with a convenience sample of Bhutanese adults in a large Midwestern city. Throughout the study, a nine-member Cultural Community Advisory Board (CCAB) worked with our research team to ensure cultural sensitivity and protection of participants. The CCAB consisted of Bhutanese community

leaders such as director of a local Bhutanese community-based organization, a case manager, community organizers, and individuals who work with refugee families. Details about the methods are presented elsewhere Kue, Pyakurel, & Yotebeing, 2016. This study was approved by The Ohio State University Institutional Review Board.

## Participants

Bhutanese refugees, 18 years and older, who lived in Columbus, Ohio were eligible for the study. Community estimates of Bhutanese refugees in Columbus is approximately 20,000. In 2015, the primary arrival of refugees to Ohio directly from Nepal was 1,038 (Office of Refugee Resettlement, 2015); however, Columbus has experienced an influx of Bhutanese through secondary and tertiary migrations from states such as Texas, Arizona, and Georgia.

## Data collection

Bilingual and bicultural Nepali-speaking interviewers recruited and administered the community health needs assessment. The questionnaire examined different topics including the use of health care services, disease diagnoses, cancer screening, mental health, and post-migration living difficulties. For this study, we assessed perceptions toward mental illness and seeking mental health care. The questionnaire was written in English, and interviews were conducted in Nepali, English, or both. The interviews were conducted in participants' homes or in private rooms at community locations and took approximately 15–40 minutes to complete. Participants received $5.00 cash for taking part in the study.

## Measures

The Belief toward Mental Illness Scale (BMI) was used to assess stigma associated with mental illness (Hirai & Clum, 2000). The original BMI had 21 items with three subscales (dangerousness, poor interpersonal, and social skills, and incurability) and used a 6-point Likert scale of completely disagree (0) to completely agree (5) (score range 0–105), with a higher score indicating more negative beliefs toward mental illness. The dangerousness subscale (5-items) was excluded in this study, bringing the revised BMI to 16 items. The response categories were modified to binary categories, disagree (0) and agree (1), which made the possible score range 0–16, where a higher score suggested more negative mental illness beliefs. The decision to exclude the dangerous subscale and condense the response categories were made after extensive discussions with the study's CCAB who felt that the questionnaire needed to be simplified for limited English speakers to understand. For this reason, certain words and phrasings were adjusted, such as "psychological disorder" was replaced with "mental illness."

Stigma associated with receiving psychological treatment was assessed using the Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya, Good, & Sherrod, 2000). The original SSRPH has 5 items and uses a 4-point Likert scale of strongly disagree (0) to strongly agree (3) (score range 0–15). The revised SSRPH in this study also followed the advisory board's recommendation to adjust the response to a dichotomous category of disagree (0) and agree (1), and used all 5 items. Therefore, scores could range from 0 to 5, with higher scores predicting more negative perceptions toward seeking psychological care. We also replaced the term "psychologist" with "mental health counselor."

Standard demographic questions assessed participants' social and health status such as gender, age, marital status, education, income, religion, health insurance, time spent in a refugee camp, and age when participants came to the U.S. The results of these questions are described in Table 1.

### Data analysis

Data were analyzed using the SPSS version 23 (IBM Corp., 2015). Descriptive statistics were used to describe sample sociodemographic characteristics, BMI, and SSRPH items. Differences between-group BMI and SSRPH total score means were tested using two-sample t-tests. Pearson chisquare tests were used to examine associations between access to counseling being a problem and other categorical variables.

## Results

More than half of the participants were male (51.7%) and between the ages of 25 and 44 years of age (53.7%) (Table 1). The majority were born in Bhutan (87.6%) and half of the participants had lived in a refugee camp for 20 years or more (50.8%). Most of the participants were Hindu and married.

### Beliefs toward mental illness

More than half of the participants (57.7%) reported feeling embarrassed by the term "mental illness" (see Table 2). The majority of participants believed that mental illness can reoccur (79.6%) and that people who have had treatment for mental illness would need treatment in the future (81.1%). The vast majority of participants believed that the behavior of people with mental illness is unpredictable, and 61.7% agreed that there is no cure for mental illness.

### Perceptions toward seeking psychological care

More than half of the participants (55.2%) believed that it is shameful to see a mental health counselor and is a sign of weakness (52.2%) (see Table 3). Nearly, three quarters of the participants (71.1%) believed that others would look unfavorably on a person if they knew that he/she sought out a mental health counselor. Only 17.9% ($n$ = 36) believed that a person should hide information that he/she has seen a mental health counselor.

### Demographic factors associated with mental health stigma

The total average BMI score for all participants who completed the entire scale was 10.96 (SD = 4.52) (Table 4), which suggests the participants in this study tended to have more negative beliefs toward mental illness. Significant differences were found between the mean total scores of the BMI for age, education, religion, length of time spent in refugee camp, and age when the participant came to the U.S. Participants ages 18–34 had significantly lower BMI scores (M = 9.73, $SD$ = 4.51) than those 35 and older (M = 12.17, $SD$ = 4.20), $p$<.0005. Those with less than a high school degree had significantly higher BMI scores (M = 11.81, $SD$ = 4.42) than those with high school degrees or higher (M = 10.19, S = 4.49), $p$=.019. Those who lived in refugee camps 20 years or more and who were 30 years or older when they arrived in the U.S. also had significantly higher BMI scores. In addition,

participants who reported access to counseling as being a problem since coming to the U.S. had significantly lower BMI scores.

When conducting the same between-mean comparisons for the SSRPH, the same trends seen in the BMI were found, except country of birth was also significant (Table 5). Participants who were 35 years and older had significantly higher SSRPH scores (M = 2.8, *SD* = 1.4) than those 18–34 years (M = 2.3, *SD* = 1.5), *p*=.013, and those with less than a high school degree had significantly higher scores (M = 2.9, *SD*= 1.4) than those with a high school degree or higher (M = 2.3, *SD*= 1.5), *p*=.005. Participants who lived in refugee camps 20 years or more and those who were 30 years and older when they came to the U.S. had significantly higher SSPH scores.

### Accessing counseling services

Over one-third (34.8%) of participants reported access to counseling services as being somewhat of a problem or a serious problem (see Table 6). Participants who reported challenges with reading, speaking, and writing English were more likely to report access to counseling as being problematic. Those 55 years and older had the highest proportion of participants reporting access to counseling being a problem (not significant), followed by those 45–54 years, and 35–44 years.

## Discussion

The results of this study provide insight into beliefs toward mental illness and perceptions toward seeking psychological care among Bhutanese refugees resettled in the U.S. These results describe generally negative perceptions toward mental illness and seeking psychological care among Bhutanese refugees in this study. Most participants also viewed seeking mental health services as a weakness and shameful, and reported that others would view those seeking care unfavorably and with dislike. Interestingly, only 17.9% of participants agreed that a person should hide that they see a mental health counselor. It is unclear whether this discrepancy from the rest of the SSRPH items is due to the way this question was asked or understood, or whether participants actually thought a person should be open about their psychological care despite strong mental health stigma in this community.

Certain subgroups within the sample endorsed negative mental health perceptions more than others. Those who were older, had less education, lived longer in the refugee camps, and immigrated to the U.S. when they were older had significantly more negative beliefs toward mental illness and seeking psychological help. This is consistent with other research that found more negative beliefs toward mental illness and seeking mental health care among older age groups, but the results are limited in generalizability due to differing samples (e.g., mostly Caucasian, lower age range) (Hirai & Clum, 2000; Rojas-Vilches, Negy, & Reig-Ferrer, 2011; Segal, Coolidge, Mincic, & O'Riley, 2005). However, one study with Puerto Rican and Cuban American young adults and their parents found that increased acculturation in the U.S. was associated with more positive attitudes toward mental illness and seeking help (Rojas-Vilches et al., 2011). Further research to examine whether

perceptions and stigma impact access to care and barriers to care among Bhutanese refugees is warranted.

In addition, over one-third of the sample described access to counseling as being somewhat of a problem or a serious problem. Ability to read, speak, and write English was associated with describing access to counseling as a problem; those with lower reported English abilities reported access to counseling as a problem at significantly higher proportions. While age was not significantly associated with reporting access to counseling as a problem, participants 45 years and older indicated this more frequently than other age groups. Further investigation into the relationship between age, language barriers, and access to counseling would be helpful in ensuring that older members of this community are able to access effective mental health care.

Participants who reported access to counseling being somewhat or a serious problem also had significantly less negative attitudes toward mental illness and seeking psychological help. While this finding may be a tenuous relationship for interpretation because it is cross-sectional and does not demonstrate temporality, it may provide further insight into the mechanism of attitudes toward mental health and seeking care in this population. Those who have had a personal experience in trying to find mental health services for either themselves or others might tend to have less negative perceptions compared with those who have not. Or conversely, having less negative perceptions of mental illness and seeking psychological care might align with noticing barriers to counseling in instances where it is needed. Those who have negative perceptions toward mental illness and seeking care might not view counseling as a relevant resource and thus not view access to it as a problem, regardless of its availability. Further research in this area is warranted.

Nurses have a unique opportunity to engage Bhutanese refugees regarding mental health, particularly through screening in community health centers where many refugees seek health care. The U.S. Preventive Services Task Force (USPSTF) recommends screening adults and youth ages 12–18 for depression, with processes to allow for “accurate diagnosis, effective treatment, and appropriate follow-up” (USPSTF, 2016a,b). These guidelines have informed quality of care performance measures that the Health Resources & Services Administration (HRSA) requires its funded health centers to report (HRSA, 2017). Screening for depression in primary care settings can help identify mental health concerns and connect patients with relevant services and resources, which can be especially helpful for individuals who would not normally seek out mental health care.

The participants in this study who indicated more trouble with speaking, writing, and reading English were more likely to report access to counseling as being a problem. Nurses can play important roles by being able to screen and engage Bhutanese patients regarding mental health needs, but should ensure their practices have interpretation services available either with in-person interpreters or virtual (video, phone) interpreters to communicate with patients if needed (Murray, Elmer, & Elkhair, 2018). Care should be taken to speak directly with the patient through an external interpreter rather than through a family member (Hadziabdic & Hjelm, 2013).

Screening tools should also be available in Nepali. The Patient Health Questionnaire is translated in Nepali and has a 2-item depression screener as well as a 9-item screen, which could be administered to those with positive PHQ-2s (Kroenke, Spitzer, & Williams, 2003; Kroenke, Spitzer, Williams, & Löwe, 2010). However, these tools have not been validated with Bhutanese refugees relocated in the U.S. A study found that first screening patients in Nepal with cultural idioms for distress (asking about "heart-mind problems" then whether these impaired functioning), and if they screen positive for those then administering the translated PHQ-9 led to a reduction in false positives and 88% sensitivity (Kohrt, Luitel, Acharya, & Jordans, 2016). This may be a promising approach for engaging with Bhutanese refugees in the U.S.

Participating in cultural humility trainings and education regarding the history of Bhutanese refugees and culture, preferably through Bhutanese educators, would be helpful for nurses in knowing more about the culture and history of this population. This study found that participants 55 years and older were most likely to report access to counseling as a problem and to have more challenges reading, speaking, and writing English. A qualitative study with Bhutanese refugees in the U.S. age 50 years and older revealed challenges that could contribute to mental health in this population, including separation from family members in Nepal, post-migration cultural tensions, language barriers, isolation and loneliness, and citizenship worries (Gautam, Mawn, & Beehler, 2018). The participants in the study described not knowing how to attain citizenship and expressed concerns about learning English as part of this process. The authors recommended nurses become familiar with the migration challenges of older Bhutanese refugees and refer to culturally relevant mental health services (2018). In addition to using interpreting services, interdisciplinary teams may be beneficial in responding to these systemic stressors; social workers or caseworkers could assist older Bhutanese refugees in navigating the path to citizenship and other post-migration stressors.

Furthermore, even if screening and discussing mental health care options with Bhutanese patients goes perfectly, they may not find traditional Western mental health services helpful. Nurses and other medical providers would benefit from becoming familiar with culturally appropriate services in their communities. For example, in the area where our study took place, the local Bhutanese community organization has implemented several initiatives to address mental health. They have collaborated with local mental health organizations and providers to offer yoga for women with anxiety and depression and in-home therapy with a counselor who has worked extensively with the community. Discussing services and resources that may be more culturally relevant for patients may increase follow-through on mental health referrals and, in turn, better health outcomes.

A number of community-engaged efforts aimed at improving mental health with Bhutanese refugees have been documented. A pilot study of mental health first aid training for Bhutanese refugee community leaders in the U.S. found significant improvements in ability to identify depression in a community member, likelihood of encouraging that person to seek psychological help, confidence in providing mental health assistance, and attitudes regarding the helpfulness of mental health care in pre and post-test comparisons (Subedi et al., 2015). Another study with the Bhutanese refugee in the U.S. demonstrated collaboration

with peer-led community health workshops (CHW) improved health behavior knowledge, awareness, and skills, as well as actual reported changes in health behaviors and perceived changes in health, including subjective mental well-being (Im & Rosenberg, 2016). Strengthened community social capital was reported and participants described the CHW as providing a group that had been missing for them since resettlement. The culturally relevant group space where participants and peerleaders spoke in Nepali allowed for social closeness to develop within the group, which facilitated discussion of sensitive topics, including mental health (Mitschke, Praetorius, Kelly, Small, & Kim, 2017).

Similarly, a qualitative study interviewing refugees (including Bhutanese) resettled in the Southwest U.S. regarding their experiences in group mental health psychoeducation courses found that participants preferred a group setting over individual counseling and refugees wanted to participate in the development of future courses and interventions (Mitschke et al., 2017). Another study used mixed methods to measure outcomes of a community garden for primarily Bhutanese and Karen refugees in Minnesota, and focus groups revealed that some participants found the garden to help with depression symptoms and improve overall mental well-being (Hartwig & Mason, 2016). These interventions highlight the need for community participation in continued research and development of programming to improve mental health.

The successful recruitment and enrollment of participants in this study was in part due to engaging Bhutanese community leaders in the research process and hiring bilingual/bicultural interviewers who could easily converse with individuals in the community. Although there are strengths, this study is not without limitations. Our small sample size and the use of convenience sampling limits the generalizability of the study findings to Bhutanese in the U.S. The responses reported in this article may not be representative of those who were resettled through other agencies or moved to the area via secondary migration. We also chose to not translate the questionnaire into Nepali due to limited funding and timing, and relied on bilingual interviewers to appropriately translate questions. Even though interviewers were thoroughly trained and practiced asking questions before data collection, by not translating the questionnaire, this does introduce bias as interviewers may have asked questions differently in the field. Furthermore, the reduced response categories in both the BMI and SSRPH scales may have obscured potential variability in responses. We also relied on self-reported data, which can lend itself to response bias. Selection bias may have also been a limiting factor as we recruited the majority of participants from a local refugee resettlement agency.

## Conclusions

Findings from this study provide insight into beliefs about mental health stigma and perceptions related to seeking psychological care among Bhutanese refugees in the U.S. Health care providers should be aware of Bhutanese refugees' beliefs and perceptions toward mental illness to better understand how to address and treat the mental health disparity facing this community. Continued research into beliefs regarding mental health and culturally responsive interventions and treatment is needed to improve mental well-being among the Bhutanese.

Bhutanese refugees are at greater risk for poor mental health and suicide compared to the general U.S. populations. Future research should explore mental health stigma, barriers, and facilitators to accessing mental health services and resources among this population. Inquiry into the relationship between perceptions toward mental health (including perceptions toward psychological treatment) and actual help-seeking behaviors, as well as mental illness symptomatology and diagnoses would be valuable in extending the results described in this study. The measures used that assessed mental health and care-seeking perceptions may also be useful in interventions involving psychoeducation or mental health advocacy campaigns to evaluate changes in beliefs.

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**Table 1.**

Participant characteristics.

| Variable | Male n (%) (N = 104) | Female n (%) (N = 97) | Total n (%) (N = 201) |
|---|---|---|---|
| Age | | | |
| 18–24 years | 17 (16.3) | 21 (21.6) | 38 (18.9) |
| 25–34 years | 33 (31.7) | 28 (28.9) | 61 (30.3) |
| 35–44 years | 21 (20.2) | 26 (26.8) | 47 (23.4) |
| 45–54 years | 16 (15.4) | 14 (14.4) | 30 (14.9) |
| 55+ years | 17 (16.3) | 8 (8.2) | 25 (12.4) |
| Country of birth | | | |
| Bhutan | 95 (91.3) | 81 (83.5) | 176 (87.6) |
| Nepal | 9 (8.7) | 12 (12.4) | 21 (10.4) |
| India | 0 (0.0) | 4 (4.1) | 4 (2.0) |
| Time in refugee camp | | | |
| 0–19 years | 51 (49.5) | 47 (49.0) | 98 (49.2) |
| 20+ years | 52 (50.5) | 49 (51.0) | 101 (50.8) |
| Age when came to U.S. | | | |
| 1–10 years | 2 (1.9) | 3 (3.2) | 5 (2.5) |
| 11–19 years | 14 (13.6) | 13 (13.7) | 27 (13.6) |
| 20–29 years | 29 (28.2) | 30 (31.6) | 59 (29.8) |
| 30–39 years | 26 (25.2) | 25 (26.3) | 51 (25.8) |
| 40–49 years | 14 (13.6) | 15 (15.8) | 29 (14.6) |
| 50+ years | 18 (17.5) | 9 (9.5) | 27 (13.6) |
| Education | | | |
| No school | 16 (15.4) | 13 (13.7) | 29 (14.6) |
| Grade school (K-8) | 18 (17.3) | 19 (20.0) | 37 (18.6) |
| Some high school | 15 (14.4) | 15 (15.8) | 30 (15.1) |
| High school grad or GED | 15 (14.4) | 20 (21.1) | 35 (17.6) |
| Some college or technical school | 14 (13.5) | 16 (16.8) | 30 (15.1) |
| College graduate | 15 (14.4) | 10 (10.5) | 25 (12.6) |
| Graduate degree | 11 (10.6) | 2 (2.1) | 13 (6.5) |

| Variable | Male n (%) (N = 104) | Female n (%) (N = 97) | Total n (%) (N = 201) |
|---|---|---|---|
| Total Family Income | | | |
| Less than $15,000 | 42 (41.2) | 42 (45.2) | 84 (43.1) |
| $15,001–30,000 | 41 (40.2) | 27 (29.0) | 68 (34.9) |
| $30,001–50,000 | 13 (12.7) | 20 (21.5) | 33 (16.9) |
| $50,001–75,000 | 5 (4.9) | 0 (0.0) | 5 (2.6) |
| More than $75,000 | 1 (1.0) | 0 (0.0) | 1 (0.5) |
| Don’t know or prefer not to answer | 0 (0.0) | 4 (4.3) | 4 (2.1) |
| Employment | | | |
| Full-time | 63 (61.2) | 44 (46.3) | 107 (54.0) |
| Part-time | 7 (6.8) | 16 (16.8) | 23 (11.6) |
| Not working | 33 (32.0) | 35 (36.8) | 68 (34.3) |
| Religion | | | |
| Hindu | 88 (86.3) | 74 (78.7) | 162 (82.7) |
| Buddhist | 3 (2.9) | 7 (7.4) | 10 (5.1) |
| Kirat | 2 (2.0) | 3 (3.2) | 5 (2.6) |
| Christian | 6 (5.9) | 10 (10.6) | 16 (8.2) |
| No religion | 3 (2.9) | 0 (0.0) | 3 (1.5) |
| Marital status | | | |
| Married | 80 (76.9) | 78 (81.3) | 158 (79.0) |
| Single | 18 (17.3) | 12 (12.5) | 30 (15.0) |
| Divorced/separated | 1 (1.0) | 3 (3.1) | 4 (2.0) |
| Widowed | 3 (2.9) | 3 (3.1) | 6 (3.0) |
| Not married, living with partner | 2 (1.9) | 0 (0.0) | 2 (1.0) |
| Number of children | | | |
| No children | 21 (20.2) | 13 (13.4) | 34 (16.9) |
| 1–2 | 47 (45.2) | 38 (39.2) | 85 (42.3) |
| 3–5 | 27 (26.0) | 42 (43.3) | 69 (34.3) |
| 6+ | 9 (8.7) | 4 (4.1) | 13 (6.5) |
| Health status | | | |
| Excellent | 17 (16.3) | 3 (3.1) | 20 (10.0) |
| Very good | 38 (36.5) | 25 (25.8) | 63 (31.3) |

| Variable | Male n (%) (N = 104) | Female n (%) (N = 97) | Total n (%) (N = 201) |
|---|---|---|---|
| Good | 36 (34.6) | 51 (52.6) | 87 (43.3) |
| Fair | 9 (8.7) | 9 (9.3) | 18 (9.0) |
| Poor | 4 (3.8) | 9 (9.3) | 13 (6.5) |
| Health insurance | | | |
| None | 7 (6.7) | 2 (2.1) | 9 (4.5) |
| Self-pay | 5 (4.8) | 3 (3.2) | 8 (4.0) |
| Through work (spouse's or own) | 11 (10.6) | 14 (14.9) | 25 (12.6) |
| Medicare/Medicaid | 79 (76.0) | 72 (76.6) | 151 (76.3) |
| Other | 2 (1.9) | 3 (3.2) | 5 (2.5) |

**Table 2.**

Beliefs toward mental illness.

| Item | % Agree (*n*) |
|---|---|
| *Poor social and interpersonal skills* | |
| The term “mental illness” makes me feel embarrassed | 57.7 (116) |
| A person with a mental illness should have a job with minor responsibilities | 71.6 (144) |
| I am afraid of what my boss, friends, and others would think if I were diagnosed as having a mental illness | 61.2 (123) |
| It might be difficult for mentally ill people to follow social rules such as being on time or keeping promises | 76.6 (154) |
| I would be embarrassed if people knew that I dated a person who once received psychological treatment | 55.2 (111) |
| A person with a mental illness is less likely to be a good parent | 57.2 (115) |
| I would feel embarrassed if a person in my family became mentally ill | 54.7 (110) |
| Mentally ill people are unlikely to be able to live by themselves because they are not responsible | 67.2 (135) |
| Most people would not want to be friends with a mentally ill person | 67.2 (135) |
| I would not rely on the work of a mentally ill person assigned to my work team | 61.2 (123) |
| *Incurability* | |
| Mental illnesses will reoccur/come back | 79.6 (160) |
| Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life | 65.7 (132) |
| People who have once received mental illness treatment are likely to need additional treatment in their future | 81.1 (163) |
| I do not believe that mental illness is ever completely cured | 65.2 (131) |
| The behavior of people who have mental illnesses is unpredictable | 78.6 (158) |
| Mental illness is unlikely to be cured even with treatment | 61.7 (124) |

Note: Item responses adjusted to Agree/Disagree.

**Table 3.**

Stigma scale for receiving psychological help.

| Item | % Agree (n) |
|---|---|
| Seeing a mental health counselor for emotional or personal problems is seen by others as shameful. | 55.2 (111) |
| It is a sign of personal weakness or inadequacy to see a mental health counselor | 52.2 (105) |
| People will see a person in a less favorable way if they know that he/she has seen a mental health counselor | 71.1 (143) |
| A person should hide that he/she has seen a mental health counselor | 17.9 (36) |
| People tend to dislike those who are receiving professional psychological help | 54.7 (110) |

Note: Item responses adjusted to Agree/Disagree.

**Table 4.**

Between mean comparisons of beliefs toward Mental Illness scale.

| | N | Mean | SD | p-value (2-sided) |
|---|---|---|---|---|
| Total | 170 | 10.96 | 4.52 | |
| Age | | | | |
| 18–34 years | 84 | 9.7 | 4.5 | <.005 |
| 35+ years | 86 | 12.2 | 4.2 | |
| Gender | | | | |
| Male | 88 | 10.85 | 4.35 | .738 |
| Female | 82 | 11.09 | 4.71 | |
| Marital status | | | | |
| Married | 131 | 11.20 | 4.70 | .217 |
| Other | 39 | 10.20 | 3.80 | |
| Education | | | | |
| None through some high school | 81 | 11.8 | 4.4 | .019 |
| High school grad through grad degree | 89 | 10.2 | 4.5 | |
| Religion | | | | |
| Hindu | 136 | 10.51 | 4.60 | .001 |
| Other | 31 | 13.40 | 2.90 | |
| Country of birth | | | | |
| Bhutan | 147 | 10.90 | 4.60 | .628 |
| Nepal, India, or Other | 23 | 11.39 | 4.02 | |
| Time in refugee camp | | | | |
| 0–19 years | 86 | 9.42 | 4.10 | <.005 |
| 20+ years | 84 | 12.55 | 4.39 | |
| Age when came to U.S. | | | | |
| 1–29 years | 76 | 9.54 | 4.40 | <.005 |
| 30+ years | 92 | 12.32 | 4.12 | |
| Access to counseling | | | | |
| No problem | 109 | 11.96 | 4.25 | <.005 |
| Somewhat or serious problem | 53 | 8.77 | 4.24 | |

Note: Possible total score of 0–16.

**Table 5.**

Between means comparisons of Stigma Scale for Receiving Psychological Help.

| | N | Mean | SD | p-value (2-sided) |
|---|---|---|---|---|
| Total | 197 | 2.54 | 1.51 | |
| Age | | | | |
| 18–34 years | 97 | 2.3 | 1.5 | .013 |
| 35+ years | 100 | 2.8 | 1.4 | |
| Gender | | | | |
| Male | 102 | 2.47 | 1.51 | .52 |
| Female | 95 | 2.61 | 1.50 | |
| Marital status | | | | |
| Married | 156 | 2.49 | 1.52 | .498 |
| Other | 40 | 2.70 | 1.50 | |
| Education | | | | |
| None through some high school | 94 | 2.9 | 1.4 | .005 |
| High school grad through grad degree | 101 | 2.3 | 1.5 | |
| Religion | | | | |
| Hindu | 158 | 2.42 | 1.49 | .005 |
| Other | 34 | 3.21 | 1.30 | |
| Country of birth | | | | |
| Bhutan | 174 | 2.46 | 1.54 | .045 |
| Nepal, India, or Other | 23 | 3.13 | 1.10 | |
| Time in refugee camp | | | | |
| 0–19 years | 95 | 2.21 | 1.50 | .003 |
| 20+ years | 100 | 2.84 | 1.46 | |
| Age when came to U.S. | | | | |
| 1–29 years | 89 | 2.13 | 1.48 | .001 |
| 30+ years | 105 | 2.88 | 1.44 | |
| Access to counseling | | | | |
| No problem | 120 | 2.67 | 1.39 | .086 |
| Somewhat or serious problem | 66 | 2.27 | 1.65 | |

Note: Possible total score of 0–5.

**Table 6.**

Difficulty accessing counseling services since immigrating to the U.S.

| | No problem n (%) | Somewhat or Serious Problem n (%) | Total n | Pearson chi-square p-value |
|---|---|---|---|---|
| Total | 120 (59.7) | 70 (34.8) | 190 | |
| Gender | | | | |
| Male | 66 (65.3) | 35 (34.7) | 101 | .505 |
| Female | 54 (60.7) | 35 (39.3) | 89 | |
| Age | | | | |
| 18–24 years | 23 (63.9) | 13 (36.1) | 36 | .409 |
| 25–34 years | 33 (58.9) | 23 (41.1) | 56 | |
| 35–44 years | 35 (74.5) | 12 (25.5) | 47 | |
| 45–54 years | 17 (58.6) | 12 (41.4) | 29 | |
| 55+ years | 12 (54.5) | 10 (45.5) | 22 | |
| Read English | | | | |
| Not at all | 16 (48.5) | 17 (51.5) | 33 | .054 |
| Not too well | 26 (57.8) | 19 (42.2) | 45 | |
| Well | 77 (70.0) | 33 (30.0) | 110 | |
| Speak English | | | | |
| Not at all | 15 (48.4) | 16 (51.6) | 31 | .043 |
| Not too well | 30 (56.6) | 23 (43.4) | 53 | |
| Well | 74 (70.5) | 31 (29.5) | 105 | |
| Write English | | | | |
| Not at all | 16 (45.7) | 19 (54.3) | 35 | .036 |
| Not too well | 28 (62.2) | 17 (37.8) | 45 | |
| Well | 76 (69.7) | 33 (30.3) | 109 | |