

An Overview of the Unique Mental Health Challenges Facing the Bhutanese Refugee Population

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The Lhotsampas (or “People of the South”) are an ethnically Nepali, Nepalese-speaking group of people that had lived peaceably in Bhutan until the 1980s. At their height this group consisted of over 100,000 people, and made up over one sixth of the Bhutanese population. In the late 80s and early 90s the ruling Druk majority in Bhutan as well as the king began to fear the Lhotsampas would begin to overrun the ruling majority and dilute the Dzongkha-speaking, largely Buddhist Druk majority. In this context, young educated Lhotsampas too started pro-democracy movements fighting for equal rights and inclusion in the democratic process. In response to this, a cultural campaign called “One country, one people” was born which intended to re-Bhutanize the population via institution of a Druk dress code, cracking down on Hindi and non-Buddhist religious practices, and the institution of Dzongkha as the national language. “One country, one people” forcibly attempted to integrate the minority Lhotsampas into the majority culture, however citizenship and equal status were often still denied for this group. Eventually the Lhotsampa people were forced to leave Bhutan and many left in fear of further harassment and torture at the hands of the Bhutanese security forces. A total of 103,000 Lhotsampa left Bhutan for southeastern Nepal, of these roughly 85,000 ended up settling in one of seven UN refugee camps by the end of 1994.

By the early 90s, the migration of the Lhotsampa out of Bhutan had become a massive humanitarian crisis. With the help of the UN, the Center for the Victims of Torture in Katmandu, Nepal as well as several other NGOs, a massive hut-to-hut survey was undertaken to identify survivors of physical torture living in all seven of the refugee camps in Nepal. Ultimately, 2,331 survivors were identified, though the authors of the study note that those who experienced rape may have been less likely to come forward so the numbers may not have fully taken the human toll of this into account. Shrestha et al (1998) in a case control study of 526 torture survivors and 526 matched controls of refugees living in the same camps attempted to further characterize the type of torture experienced as well as the demographics of those who were targeted for physical torture. Seventy six percent of torture victims noted the charges against them to be political, with the vast majority of torture being done by Druk police or soldiers. The torture took place largely in prison (59%) or at home (27%). The mean length of the torture was 21 days with a SD of 79 days. Of note, 45% percent of the torture victims noted one day of torture, however 8%

noted 31-365 days of torture. All of those interviewed experienced physical torture, however 90% also reported torture not involving the body. All in all the mean number of torture techniques experienced was 10 (SD of 7). The most commonly reported torture techniques were severe beatings, threats, humiliation, forced incongruent acts (i.e. forcing a Hindu to eat beef or pork), sleep, nutritional, sensory, health service and hygienic deprivation, hair torture, ear torture and cold torture. The researchers also found that those in the torture group were significantly more likely to have been part of a political group, been literate, and have been physically healthy and a member of a non-Buddhist religion. Van Ommeren et al (2001) also looked at predictors of torture when following up with 810 participants (418 tortured, 392 non-tortured) of Shrestha et al’s study and performed logistical regression analysis of family income in Bhutan, years of schooling, number of childhood traumatic events and mental disease in the family and found among these there were no significant predictors of torture, though family income in Bhutan did approach significance ($P=.09$).

Shrestha et al’s 1998 study used DSM-III R PTSD criteria as well as HSCL-25 depression and anxiety scales to investigate mental health outcomes in their 526 tortured and non-tortured refugees. They found that the tortured group had significantly more PTSD symptoms on each of the DSM-III R’s modalities with the exception of sleep disturbances and recurrent intrusive thoughts. This included distressing dreams, re-experiencing the event, thought avoidance, diminished interest in other activities, personal detachment, hypervigilance and physiological arousal, among others. They also noted significant differences in anxiety (43% vs. 34%) as well as depression (25% vs. 14%) using the HSCL-25. They further investigated demographic differences on symptoms of PTSD, depression and anxiety among torture survivors and found that Buddhist religion predicted lower depression and anxiety, and illiteracy and female sex predicted higher anxiety. Most importantly, they noted the only significant predictor of PTSD among torture survivors was number of torture techniques experienced (OR 1.06 (1.02-1.10)). They also investigated medical complaints and found MSK issues including backache, muscle ache and chest pain to be significantly higher among the torture group as well as increased vegetative complaints (sleep issues, loss of appetite, and loss of sexual desire). Interestingly, the torture group also had significantly higher complaints of diminished hearing and vision.

Working off Shrestha et al's findings, Van Ommeran et al (2001) opted to instead compare the prevalence of ICD-10 R disorders in both the tortured and non-tortured groups, noting that the original study opted to look more at symptoms of disorders rather than diagnosed disorders. Van Ommeran's group looked at specific phobias, affective disorders, GAD, persistent somatoform pain, PTSD and dissociative disorders using the CIDI, noting unlike the DSM, the CIDI was developed for international use. Strikingly, they noted that 3 of 4 tortured refugees had met PTSD criteria at some point in their lives, and 40% had met this in the past year (this was about 8-10 years after the torture had occurred). One half of tortured refugees noted a persistent somatoform pain disorder (compared to 25% of those non-tortured), and 20% of tortured refugees had experienced dissociative disorder in their lives, compared to 5% in the non-tortured population. The rates of somatoform pain disorders and dissociative disorders were similar for lifetime experience and in the past year, suggesting chronicity to these disorders. Of note, significantly higher numbers of those tortured had experienced lifetime anxiety or depression, however these differences largely disappeared in the past year, indicating remission of anxiety and depressive diseases contrasted with chronicity of somatoform and dissociative disorders.

A recurrent theme of the literature regarding PTSD among the Bhutanese refugees is whether PTSD captures the impact of torture among these non-Western groups with very different beliefs regarding mental health. Herman (1993) and others argue the classification "disorders of extreme stress—not otherwise specified" may be more appropriate. The Center for Victims of Torture in Nepal note that many Bhutanese torture survivors experience shame, mistrust, conversion, medically unexplained pain and a feeling of being permanently damaged, constructs that the DSM PTSD criteria do not fully take into account. Further, the trauma model for anxiety, depression and PTSD we may take for granted in the West is not a belief shared worldwide. For example, Young (1995) and others have noted that in Bhutanese and other SE Asians populations, psychiatric problems are not seen as arising from trauma, rather from bad karma, spirits, witchcraft or an angry god. This was explored further by Regmi et al (2004) in a review of mental health practices, beliefs and policy in Nepal. These authors note that while Nepal is very much a multicultural nation, views on mental health are fairly similar across these groups. They note that a peaceful mind is very valued in the Nepali culture, and is associated with spiritual attainment. Further, to become mentally ill is seen as "losing control" of oneself, and can be due to spiritual possession. They further note that while positive mental

health is highly valued and seen as at least equivalent with physical health, there is a strong stigma associated with mental illness such that a man can divorce his wife on the basis of her mental illness. While these authors note that there is beginning to be more awareness of mental health issues in Nepal, most of the rural population continues to view mental illness as a result of poor luck and they often turn to local faith based healers. Further, even among the educated urban population there is no concept of a biological basis to mental illness.

With over 58,000 Bhutanese refugees having resettled in the United States, many issues still remain when confronting this group. Emmelkamp et al (2002) attempted to look more closely at coping strategies used by this group. He distinguished between two ways of describing coping; the first contrasting problem-focused coping and emotion-focused coping strategies (attempts to alleviate emotional distress brought on by the stressor), and the second contrasting approach-based strategies versus avoidance-based strategies. They found that those who had experienced torture exhibited significantly more negative coping mechanisms (tobacco and alcohol abuse, isolation, child abuse, loss of hope, etc). They found negative coping strategies predicted long-term depression, anxiety and somatization. Surprisingly, they did not note that positive coping strategies were protective in this group, but argue that promoting positive coping strategies could also be looked at as a way to protect from the long term effects of negative coping strategies.

The issue of long-term mental health and negative coping strategies is highlighted by a MMWR from July 2013 where the suicides of 16 Bhutanese refugees in the US between 2009 and 2012 are discussed. They report after interviewing 423 Bhutanese refugees in four states in their homes that 4% reported ever having been diagnosed with a mental health disorder, while 19% reported anxiety and 21% reported depression during the interview using DSM-IV criteria. Only 13 reported SI in the past, however 131 reported they had personally known someone who had taken their life. Anxiety, depression, PTSD, and perceived difficulties post-migration (family stress, joblessness, lack of choice, little help from government) were all significant predictors of lifetime SI, however this study was limited by the low numbers reporting lifetime SI.

What is clear from this MMWR is that anxiety and affective disorders are greatly underdiagnosed in the Bhutanese population, but what isn't clear is whether this is due to the diagnosis being missed, or wholly different beliefs regarding mental health discussed earlier in this population. This emphasizes an important point; that clinicians working with this population may need to be on high alert for symptoms of depression, anxiety and PTSD, but they should also recognize that

somatization, dissociation and negative coping strategies may underlie deeper psychological distress. They too must be approached in a culturally sensitive way including working with this population to help understand why they feel they are experiencing psychiatric symptoms. Clinicians can help by promoting the replacement of negative coping strategies with more healthy coping strategies. They can also provide social support and realize that this refugee population may understand their distress in a wholly different way than their other patients.

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