

# Characterization of Bhutanese Refugee Mental Health and Its Sociocultural Contexts

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## Abstract

Since 2006, over 86,000 Bhutanese refugees have resettled in the United States, primarily from Nepalese refugee camps. These refugees belong to the Lhotshampa ethnic group, which faced systemic persecution by the Bhutanese government in the 1990s, driven by policies aimed at excluding and denationalizing ethnic and religious minorities. The majority of these refugees arrived between 2008 and 2012, after enduring years of displacement and trauma in Nepal. Their journeys are marked by historical traumas—including forced displacement, separation from family, and escape from genocide and torture. These past experiences are compounded by the challenges associated with resettlement, such as acculturation and the struggle to access basic needs like social services and employment. As a result, many Bhutanese refugees experience significant mental health challenges that demand attention, particularly, high rates of suicide. Furthermore, particular risk factors such as role played in the family have been found to be associated with higher risk of mental health struggles in this population. This paper also outlines the care that these refugees received throughout many years in Nepalese camps. Religious and cultural conceptions of mental health among the Bhutanese refugees are also discussed, as well as intra-group differences. Cultural stigma surrounding mental health significantly reduce mental health services utilization, particularly for Bhutanese refugees, who often view well-being through a collectivist lens. Community-generated solutions hold promise for enhancing mental health service provision and overall well-being in refugee populations.

## Introduction

Since 2006, over 86,000 Bhutanese refugees have resettled in the United States, primarily from Nepalese refugee camps. These refugees belong to the Lhotshampa ethnic group, which faced systemic persecution by the Bhutanese government in the 1990s, driven by policies aimed at excluding and denationalizing ethnic and religious minorities. The majority of these refugees arrived between 2008 and 2012, after enduring years of displacement and trauma in Nepal. Their journeys are marked by historical traumas—including forced displacement, separation from family, and escape from genocide and torture. These past experiences are compounded by the challenges associated with resettlement, such as acculturation and the struggle to access basic needs like social services and employment.<sup>1</sup> As a result, many

Bhutanese refugees experience significant mental health challenges that demand attention.

## Common Mental Health Issues

Bhutanese refugees face a range of mental health challenges, with notably high prevalence rates of depression, anxiety, substance misuse, and post-traumatic stress disorder (PTSD). Recent studies indicate that approximately 21% of Bhutanese refugees experience depression, 19% report symptoms of anxiety, 4.5% are diagnosed with PTSD, and 3% experience suicidal ideation.<sup>2</sup> These figures starkly contrast with the general U.S. population, where the prevalence of depression and anxiety ranges from 7% to 10%.<sup>3</sup> The distressing experiences associated with displacement, coupled with the stressors of resettlement—such as sociocultural isolation,

language barriers, and economic hardship—are closely linked to these mental health conditions.

Suicide is a particularly concerning issue among Bhutanese refugees, with high rates of both attempts and completions. From 2004 to the present, the Bhutanese refugee camps in Nepal recorded 67 certified suicides and 64 certified attempts, alongside 53 uncertified cases. In the years following resettlement, reports have documented 12 cases of suicide among Bhutanese refugees, although these data are considered incomplete, especially regarding attempts.<sup>2</sup>

Trends in suicide rates reveal a decline from 2004 to 2007, likely due to the beginning of resettlement opportunities, which may have provided temporary relief. However, the burdens associated with the resettlement registration process may have led to underreported vulnerabilities, including suicide. Notably, most suicides among Bhutanese refugees occur via hanging, highlighting the urgency for timely mental health interventions both in camps and resettlement contexts.<sup>2</sup>

While the majority of known suicide cases have occurred in the U.S., there is no significant variation in suicide rates based on resettlement destination within the country.<sup>4</sup> This underscores the critical need for culturally sensitive mental health resources tailored to the unique experiences of Bhutanese refugees.

### **Risk Factors**

The mental health of Bhutanese refugees is profoundly affected by the disruption of their communities due to their flight from Bhutan. Many families were separated or left behind, leading to a significant decline in socioeconomic status. Having lived in a state of suspension for over two decades, refugees face numerous

protection challenges and were often prohibited from working legally in Nepal, resulting in a devaluation of their professional skills and social roles. Despite these hardships, Bhutanese refugees demonstrated resilience by reconstructing new community ties and ethno-cultural identities during their time in Nepal, actively engaging in camp services and community life. However, the geographical fragmentation resulting from the resettlement process impacts individual and group identities, particularly concerning suicide.<sup>4</sup>

Family conflicts and the erosion of traditional family support systems further exacerbate mental health issues. The expectation for married sons to care for elderly family members has diminished, correlating with increased depression among parents when anticipated support from the eldest son declines.<sup>4</sup>

Post-migration difficulties also contribute to mental health challenges, including language barriers, concerns for families left behind, separation from loved ones, lack of social support, financial instability, and challenges in maintaining cultural and religious traditions. Additionally, limited access to healthcare and inadequate assistance from charitable organizations or government programs further increase family conflict and undermine community structures.<sup>1</sup>

Economic stress, primarily stemming from challenges in securing employment, is a pressing issue. Refugees often arrive with pre-existing difficulties and navigate resettlement environments that stigmatize their status.<sup>1</sup> Research indicates that individuals in refugee camps who have experienced gender-based violence or belong to families with multiple unmet basic needs as defined by the United Nations High Commissioner for Refugees (UNHCR) are at a higher risk of suicide.

Additionally, older individuals (mean age 41.9) and those with a family history of mental illness are also particularly vulnerable, though the data remain inconclusive.<sup>4</sup>

Interestingly, younger refugees in the U.S. tend to have a higher incidence of suicide compared to those in camps. Among individuals under 40, excessive responsibilities placed on non-traditional providers within families—especially women separated from their families—are associated with increased risks.<sup>4</sup>

Additionally, refugees with untreated mental disorders, particularly depression and bipolar disorder, those who abuse alcohol, and individuals with a family history of suicide are at significant risk. Impulsivity, consistent with evidence from Asia, also contributes to suicide risk. Interviews reveal that family conflicts, perceived excessive responsibilities towards family, and feelings of shame for failing to meet these obligations are prevalent risk factors. While suicide is a familiar concept within the population, it is rarely discussed openly among family members or peers, highlighting the need for tailored awareness initiatives.<sup>4</sup>

Studies have indicated that Bhutanese refugees are significantly concerned about economic hardship, particularly the inability to afford basic necessities<sup>1</sup>. Acculturative stressors, such as language barriers, complicate interactions between parents and school personnel, resulting in academic struggles for children. These financial and social stressors disrupt family life and contribute to heightened risks of depression and suicidal ideation.<sup>3</sup>

Additionally, a cross-sectional survey of 386 adult Bhutanese refugees identified several factors associated with depression symptoms. The study revealed that 26% of women reported symptoms of depression compared to 16% of

men ( $p = 0.0097$ ). Higher odds of experiencing depression were linked to being a family provider, self-reported poor health, and literacy difficulties in Nepali among men (OR 4.6, 3.9, and 4.3, respectively); similarly, poor health and literacy challenges in Nepali were associated with increased depression symptoms among women (OR 7.6 and 2.6, respectively).<sup>3</sup>

### **Care Provided in Camps**

In 2010, reports of high incidences of suicide among Bhutanese refugees prompted the attention of humanitarian organizations and governmental bodies. The anecdotal nature of these reports underscored the need for a detailed investigation. In January 2011, the International Organization for Migration (IOM), in collaboration with UNHCR and the Bureau of Population, Refugees, and Migration (PRM), conducted an assessment to evaluate the psychosocial well-being and suicide risk factors among Bhutanese refugees in both Nepal and the United States.<sup>1</sup>

#### *Mental Health and Psychosocial Support Services*

**In the Camps:** For over two decades, basic services such as healthcare, education, and nutrition had been available, with notable community participation. Participatory methods, including democratic representation, had preserved cultural relevance in service delivery. However, there were concerns over declining service quality attributed to the resettlement process, as many organizations faced staffing challenges when skilled workers left for resettlement opportunities. Consequently, the hiring and training of new staff often resulted in decreased service competency.

**In the Resettlement Process:** Identifiable gaps existed in the provision of basic services. While

UNHCR staff had received some training in counseling techniques, comprehensive training on psychosocial needs during resettlement was urgently needed. Information about the resettlement process was disseminated through various channels, including mobile counseling teams and participatory sessions, but misunderstandings about application processes often led to distress among refugees.

In the United States: Resettled refugees receive basic services such as shelter and health referrals for a limited duration, contrasting sharply with the stable support systems experienced in Nepal. Language barriers further complicate the communication of rights and responsibilities, with many refugees unaware of available services, complicating their journey toward self-sufficiency.

#### *Community and Family Support*

In the Camps: Community leaders and places of worship contributed significantly to social cohesion, while organizations like Caritas facilitated child-friendly spaces and educational activities. The Transcultural Psychosocial Organization (TPO) operated community support programs, with psychosocial workers providing psycho-educational support and basic family mediation. However, the adequacy of training for these workers raised concerns about their capacity to effectively support vulnerable populations.

In the Resettlement Process: The transition from camp life disrupted established community networks, leading to family separations, particularly affecting women. Ritualizing the departure process and creating symbolic closure could have helped mitigate emotional distress. Cultural orientation classes addressed psychosocial issues but often lacked a holistic approach to emotional management.

In the United States: Limitations in assessing community and family support structures hinder a thorough understanding of how these networks function for resettled refugees.

#### *Focused Non-Specialized Services*

In the Camps: Focused mental health and psychosocial support (MHPS) services had been largely absent. Although TPO assigned trained counselors to the camps in 2009, poor recognition and utilization within the population undermined their effectiveness. Outreach efforts were insufficient, and the problem-based approach to counseling may not have effectively addressed the complexities of individual situations.

In the Resettlement Process: The lack of acknowledgment for services provided in the camps further compounded challenges faced by Bhutanese refugees in the U.S. The transition disrupted family structures, complicating relationships as individuals adjust to the new sociocultural contexts. Limited opportunities for integration may contribute to a decline in mental health.

In the United States: The gap between mental health needs and available services necessitates coordinated efforts among various agencies. Most refugees cannot access culturally competent mental health resources or meaningful support.

#### **Conceptions of Mental Health**

A survey of 40 Bhutanese refugees conducted in partnership with a community-based ethnic organization revealed that nearly 97.5% of respondents regard mental health as important.<sup>1</sup> However, there remains a significant lack of awareness and cultural disbelief surrounding mental health issues. The younger Bhutanese

demographic appears to have a more nuanced understanding, fostering recognition and acceptance of mental health concerns, which positively impacts the broader community. As one survey participant noted, “People do have mental health issues, but there is a lack of awareness. They are not open to discussing these issues. I feel that more young Bhutanese members are starting to be aware of mental health issues—it’s progressing.”<sup>1</sup>

Respondents associated mental health with various domains, including emotional (87.5%), social (82.5%), physical (67.5%), spiritual (60%), and clinical attributes (42.5%). Despite these associations, focus group discussions (FGDs) revealed a lack of a common understanding of mental health within the Bhutanese community. Many participants shared that mental health symptoms are often normalized due to prolonged exposure, with one participant describing mental health as “unexpressed”, whereby emotions often go unexpressed.<sup>1</sup> Interestingly, while 32.5% reported no mental health symptoms, nearly 55% experienced minimal anxiety, and significant percentages reported varying levels of depression. These findings suggest a complex relationship between reported symptoms and the community's reluctance to discuss mental health issues openly.

The cultural context plays a critical role in the expression of mental health. Bhutanese refugees often adhere to a collectivist culture that prioritizes communal experiences over individual ones. As a result, personal feelings and emotional expression are often sidelined, especially in the wake of their collective trauma from political violence and discrimination. This historical experience has led to a pervasive cultural stigma surrounding mental health, further compounded by fear of labeling and social isolation. Participants in the aforementioned study noted that men, in

particular, face societal pressure to conform to traditional notions of strength, rendering them unable to express vulnerability or seek help.<sup>1</sup>

FGD participants identified several coping mechanisms that enhance mental well-being, primarily rooted in community support. Survey findings indicated that support-seeking behavior is often limited to family and friends. Common practices include discussing feelings with peers, accepting help from relatives, and finding solace in spiritual practices, such as yoga and communal rituals. Temples and sacred sites serve as vital healing spaces, reinforcing the interconnectedness of mind, body, and spirit in Bhutanese culture. Traditional rituals, like "Graha Shanti" (a pre-wedding ceremony) and collective prayer sessions, strengthen communal bonds and promote emotional healing.<sup>1</sup>

Younger participants highlighted the transformative role of technology and social media in sharing mental health experiences and seeking support, especially in the absence of culturally competent mental health professionals. Platforms like Facebook, TikTok, and private messaging apps have become vital tools for discussing mental health issues and fostering a sense of community.<sup>1</sup>

In discussing the community's challenges, participants acknowledged negative coping strategies, such as alcohol and substance use, that often emerge from cultural stigma and suppressed emotions. These maladaptive behaviors can lead to severe consequences, including rising suicide rates. Interestingly, while older generations may view suicide as a sin, younger individuals increasingly perceive it as a response to overwhelming social pressures. Factors like impulsivity, family conflict, and social shame are highlighted as risk factors, emphasizing the need for preventive discussions surrounding suicide in the community.<sup>4</sup>

In summary, the Bhutanese community's understanding of mental health is shaped by cultural beliefs, collective experiences, and generational shifts in perception. While there is a growing awareness of mental health issues among younger members, barriers such as stigma, limited expression, and lack of access to culturally relevant resources continue to challenge their well-being.

### **Barriers and Facilitators of Mental Health Service Utilization**

Soukenik's study highlights various barriers and facilitators to accessing mental health services (MHS) among resettled Bhutanese refugees in the USA.<sup>5</sup> The findings underscore community-generated solutions to address MHS challenges, which can inform current service provision and delivery efforts. Consistent with prior research, barriers such as social, cultural, linguistic, and economic factors, along with transportation issues and gaps in health system structures, hinder mental health utilization in the Bhutanese refugee population. Cultural stigma surrounding mental health, along with fears of being labelled or isolated, significantly reduce MHS utilization. This is particularly relevant for Bhutanese refugees, who often view well-being through a collectivist lens.<sup>1,5</sup>

Distrust within the Bhutanese community regarding MHS can stem from concerns about confidentiality, especially when local interpreters are involved. Refugees fear that breaches of confidentiality could lead to community stigma<sup>1</sup>. Additionally, perceived cultural and linguistic mismatches between service providers and the Bhutanese population exacerbate this distrust, discouraging service utilization. At the provider level, it is essential to acknowledge the unique experiences of this population and adjust standard practices to foster trust and provide culturally sensitive care.<sup>1</sup>

The findings also reveal the local Community-Based Educational Organization (CBEO) as a vital community entity, although it faces structural challenges due to the isolation of small non-profit organizations from larger agencies.<sup>1</sup> Enhancing multi-sectoral collaborations with larger agencies and academic partnerships could help overcome funding limitations and improve service capacity. Community-generated strategies such as holistic case management, peer-led information sharing by Bhutanese leaders, and diversifying the mental health workforce can enhance service access and utilization.

A case management approach focusing on social and cultural determinants of health may assist refugees in navigating their new environment. Employing a hierarchy of needs framework, which addresses foundational needs like employment and housing, may help mitigate mental health stressors. Furthermore, understanding the role of case managers in delivering holistic MHS is crucial for effective social work practice. However, Western interventions focused primarily on trauma may not align with Bhutanese cultural perspectives.<sup>5</sup>

Despite the professional focus on cultural competence within social work, disparities in service experiences for minority populations indicate a gap between ethical standards and the realities of care.<sup>1</sup> The historical context of refugees' experiences and the power dynamics inherent in provider-client relationships must be acknowledged to improve mental health outcomes. Fear of authority and the formal demeanor of mental health workers can hinder engagement, while Western terminology in therapeutic contexts may evoke negative associations based on past experiences.<sup>1</sup>

Maleku's research points to a persistent lack of trust in MHS as a significant barrier to utilization within the Bhutanese community.

This distrust is often linked to discrimination based on race, language, legal status, and cultural beliefs.<sup>1</sup> Recognizing the complexities of refugees' experiences and the structural factors that exacerbate mental health challenges is essential for effective service delivery. Engaging with community strengths and lived experiences, along with disaggregating socio-demographic characteristics, is critical for visibility and targeted service responses.

While these findings provide valuable insights, caution should be exercised in generalizing them due to the small sample size in the Maleku study, potential respondent bias, and challenges in communication and interpretation. Nevertheless, community-generated solutions hold promise for enhancing mental health service provision and overall well-being in refugee populations. Among refugees, stigma significantly shapes perceptions of mental illness, and the fear of bringing shame to themselves and their families remains a primary reason for avoiding mental health services.<sup>1</sup> Traditional healthcare approaches among Bhutanese refugees often rely on home remedies, seeking medical treatment only when

issues persist, which presents challenges within the U.S. healthcare system.<sup>1</sup>

Additionally, studies among Bhutanese refugees indicate that idioms related to psychological trauma encompass complex interactions between the heart, mind, and body, with somatic expressions contributing to mental health stigma.<sup>1</sup> Evidence for "Nepali-Bhutanese syndrome," a form of somatization, remains anecdotal in the United States.<sup>1</sup>

## Conclusion

The mental health challenges facing Bhutanese refugees are deeply rooted in their history of trauma and displacement, exacerbated by the complexities of resettlement. Understanding the sociocultural contexts that shape their experiences is essential for developing effective interventions and support systems. Continued research and targeted mental health resources are vital to address the unique needs of this population, fostering resilience and promoting well-being among Bhutanese refugees in their new homes.

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