

Community Strategies for Healing War Trauma: The Bhutanese Refugee Experience

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I can't think of another country where people know less about the situation that the refugees left. What people know about Bhutan is a utopia, Shangri-la, kind of thing. But I don't think people look at it as a country where one-sixth of the population was ethnically cleansed.

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Goal of Project

The goal of my senior capstone project for the social work major at St. Olaf College was to carry out a research project benefitting the Healing in Partnership (HIP) program of the Center for Victims of Torture (CVT). I focused my research in two areas: (1) the mental health effects of war trauma and refugee resettlement with emphasis on the situation and culture of Bhutanese refugees in the Twin Cities; and (2) the strategies CVT can employ to effectively share knowledge of mental health treatment across cultures and in a community setting.

In this report, I will follow the outline listed below to summarize and present my findings, taken primarily from an extensive literature review and observations of a HIP psycho-education support group for Bhutanese women in the Twin Cities.

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A note on information:

The knowledge I share in this paper is drawn from published materials and observations of a psycho-education support group of Bhutanese women. During my research, I noted several instances where data and information varied between sources. In this paper, I attempt to provide the most accurate information possible but discrepancies may exist. Additionally, I am not Bhutanese or a refugee; the majority of this paper is my interpretation of primary and secondary sources which should be taken into consideration when using this information.

A note on terminology:

Within this paper, there are references to both the Lhotshampa ethnic group and Bhutanese refugees. Of the Bhutanese refugees resettled in Minnesota, 98% are of the Lhotshampa ethnicity (Center for Victims of Torture [CVT], 2010). Thus, when references are made to Bhutanese refugees, it can be understood that the vast majority are Lhotshampa people, but other ethnicities are represented. Where possible, the term “Lhotshampa” has been used to indicate information pertaining specifically to the ethnic group, rather than Bhutanese refugees as a whole.

A note on religion:

Throughout this paper I devote much space to discussion of Hinduism and the cultural implications of the religion. Of the Bhutanese refugees resettled in Minnesota, 60% identify as Hindu (Center for Victims of Torture [CVT], 2010). Although there is significant overlap between the Hindu worldview and the general culture of Bhutanese refugees, I am aware that this information is not specifically relevant for approximately 40% of refugees. Wherever possible, I have indicated if the concept discussed is characteristic of Hinduism or is a more generalized cultural observation. Additionally, many of the sources I accessed to write portions of this paper pertaining to religion did not differentiate between Hinduism as practiced in India, Nepal or Bhutan. Although the broad picture may still be accurate, there are generalizations made and information used from this paper should take this into consideration.

History and Culture of Bhutanese Refugees

Demographic Information

Bhutan is a small country in the foothills of the Himalayas, landlocked between China and India. Spanning a territory approximately half the size of the state of Indiana, Bhutan ranks 164th in the world for population size. The total population predicted for July 2011 is 708,427 people. Bhutan has a small economy with the majority of occupations in the agriculture and forestry sectors. The GDP of the country, considered in terms of purchasing power parity was \$3.526 billion in 2010, ranking the country 169th in the world (Central Intelligence Agency, 2011).

Within the Bhutanese population, there are ten major ethnic groups. Three main ethnic groups are the Ngalung (western Bhutan), the Sharchop (eastern Bhutan), and the Lhotshampa (southern Bhutan). Three similar groups combine to form the majority group of Bhutan, known as the Druk: the Ngalung, the Sharchop and the Bhutanese of the central region are the three subgroups of the Druk. The Druk hold much of the power in the country (Schäppi, 2005).

The national language of Bhutan is Dzongkha, the traditional language of the Ngalung. The Druk generally speak Dzongkha and identify as Buddhist, specifically practicing Lamaistic or Tibetan Buddhism, a form associated with Mahayana Buddhism. Outside the Druk majority, the next largest ethnic group is the Lhotshampa. The Lhotshampa are ethnic Nepali, living primarily in the southern regions of Bhutan and practicing Hinduism; the term “Lhotshampa” means “people from the south” in Dzongkha. The 1988 national census found that 48% of the total Bhutanese population was Buddhist, 45% Lhotshampa Nepali and 7% “other” (United Nations High Commissioner for Refugees [UNHCR], 2006).

History and Ethnic Cleansing of the Lhotshampa People

Lhotshampa migration to Bhutan occurred primarily between 1875-1940 when the Lhotshampa people were invited by the Bhutanese government to come as migrant workers, clearing the jungle of southern Bhutan. The government granted citizenship to these Lhotshampa immigrants through the Nationality Law of 1958; citizenship requirements were ownership of land and 10 years of residency (Sokoloff, 2005). As part of this process, all new citizens were given a land tax receipt and the Lhotshampa began to grow in population and power, some occupying positions within the government. Despite living in Bhutan for a few generations, the Lhotshampa retained much of their Nepali culture and language (CVT, 2010).

After a nationwide census in 1980 the government became concerned with the increasing size and influence of the Lhotshampa. These concerns manifested in policies and actions occurring primarily in the 1980's and early 1990's that have since been classified as ethnic cleansing by international humanitarian organizations (UNHCR, 2006).

The first action the Bhutanese government took against the Lhotshampa people was the passage of the Bhutan Marriage Act. This act revoked citizenship from non-national women married to Bhutanese men. In 1985, the National Assembly passed the Citizenship Act which created three channels to obtain Bhutanese citizenship: citizenship by birth, citizenship by registration and citizenship by naturalization.

Dictated by the terms of the Citizenship Act, citizenship by birth was restricted to those children born to two parents with Bhutanese citizenship. Citizenship by registration was restricted to those who could prove they had been in the country prior to December 31, 1958. Acceptable forms of proof were the land tax receipts issued in 1958 or equivalent documentation; after providing documentation, names were entered into a census registrar. Citizenship by naturalization required continuous residence in the country for 20 years (shortened to 15 years for dependents of government employees), proficiency in the Dzongkha language and knowledge of

the history and culture of Bhutan (Sokoloff, 2005). The Citizenship Act of 1985 also implemented a policy stating that individuals emigrating from the country would forfeit their Bhutanese citizenship.

When the act went into effect in 1988, the government instituted a special regional census in southern Bhutan, primarily Lhotshampa territory. Despite efforts to maintain citizenship by registration via production of land tax receipts granted in 1958, the citizenship of many Lhotshampas was revoked. There are multiple reports of rejection and/or confiscation of land tax receipts and other valid documentation when Lhotshampa people produced these necessary proofs (International Organization of Migration – Nepal [IOM Nepal], 2008; Immigrant and Refugee Board of Canada, 2008).

As another component of this special census, the government began a procedure of classifying the Lhotshampa into seven categories, identified as F1-F7. The categories are as follows (Working Group on the Universal Periodic Review, 2009):

- F1: Genuine Bhutanese
- F2: Returned migrants
- F3: People not available during the census
- F4: Non-national woman married to Bhutanese man
- F5: Non-national man married to Bhutanese woman
- F6: Children legally adopted
- F7: Non-nationals – migrants and illegal settlers

Many Lhotshampas who had previously been considered citizens were re-classified as non-nationals in the F7 category. Human Rights Watch described the granting of citizenship as both “selective” and “arbitrary” (Human Rights Watch, 2007, p.17).

In 1989, King Jigme Singey Wangchuk proposed a policy referred to as “One Bhutan, One People”. This policy is based on the premise that the small size of Bhutan is unable to support the cultural diversity created by the Lhotshampa and stems from a fear of losing traditional Buddhist values and culture. This policy required all people to follow the rules of driglam namzah, the code of cultural traditions and etiquette for the Druk majority (Zilk, 2007). The scope of driglam namzah included restrictions on clothing and language, leading to an elimination of the Nepali language from the schools (IOM Nepal, 2008). During this period there were also incidences of forced intermarriage between Hindus and Buddhists (CVT, 2010).

As the government initiated and carried out these discriminatory policies, public unrest increased. Criticism of the government policies was stifled, often in harsh manners. Tek Nath Rizal, a member of the Royal Advisory Council, petitioned the king to amend discriminatory portions of the Citizenship Act of 1985 and expressed displeasure with the treatment of the Lhotshampa people during the special census of 1988. Rizal was subsequently removed from the Royal Advisory Council and jailed for three days. After his release, he fled to Nepal, where he was arrested and extradited to Bhutan in 1989. He was imprisoned for ten years, until his release in December of 1999 (Bhutanese Refugee Support Group, 2001).

Resentment among the Lhotshampa over their discriminatory treatment culminated in September and October of 1990. Public riots erupted in the southern districts of Bhutan against government policies and in support of democratization. In response, the government closed 76 of the 114 schools in the southern region and classified all who had taken part in the demonstrations “anti-nationals”. The government also imprisoned several thousand demonstrators and tortured at least two thousand of the Lhotshampa inmates (Bhutanese Refugee Support Group, 2001). On August 17th, 1990 the Home Ministry issued a circular stating that people leaving the country to assist and work with the declared “anti-nationals” would forfeit their Bhutanese citizenship (Gazmere, 2011).

During the imprisonment of those involved in the demonstrations of 1990, various human rights abuses occurred within the Samtse State Jail and other jails holding political prisoners. Many of the inmates demonstrated a deterioration of health, both physical and mental (Working Group on the Universal Periodic Review, 2009). Access to jails was severely restricted and relatives were not given information on locations of the prisoners. The majority of prisoners were never brought to trial and as of 2009, 200 political prisoners are still incarcerated (Working Group on the Universal Periodic Review, 2009). Within the prison system, all prisoners were forced to attend Buddhist prayers and eat meat despite the Hindu belief in vegetarianism, an action classified as a form of torture called “forced incongruent actions” (Van Ommeren et al., 2001).

Other human rights abuses documented in Bhutan throughout this time period include restrictions on freedom of religion and information, refusal to recognize minority groups, criminalization of homosexuality and restrictions on movement through the country due to checkpoints (Working Group on the Universal Periodic Review, 2000).

After the demonstrations and unrest of the early 1990's, the government of Bhutan required all citizens to apply annually for a No Objection Certificate (NOC), also referred to as a Security Clearance Certificate (SCC). People involved in the pro-democracy demonstrations have extreme difficulty obtaining these documents (Immigrant and Refugee Board of Canada, 2008). Additionally, anyone associated with a person deemed an “anti-national”, a classification given to participants in the demonstrations and to individuals living in refugee camps outside the country, is considered guilty by association and has serious difficulty obtaining these certificates (Working Group on the Universal Periodic Review, 2009).

This policy of being found guilty by association is problematic as these certificates are authorized by the Bhutanese police and are essential for obtaining travel documents, jobs and enrollment in schools. The impact of these certificates was felt heavily in the schools and exclusion of Lhotshampa children from the education system by means of NOC's was widespread; in some cases, schools in the southern region stayed open solely to serve children of northern Bhutanese settled in the south (Working Group on the Universal Periodic Review, 2009).

Additionally, the government restricted the use of Nepali in schools and there are documented cases of humiliation of children who spoke Nepali in school (Bhutanese Refugee Support Group, 2001). The requirement of a NOC for school enrollment has since been revoked, but parents are still required to provide their marriage certificate, biometric ID card number and a birth certificate for their child. These remaining requirements continue to limit the ability of Lhotshampa children to enroll in schools.

In 1991, the National Assembly passed a resolution to evict any citizens deemed “anti-nationals”. This resolution was accompanied with a violent crackdown on the Lhotshampa people. Public figures and leaders were arrested, detained and tortured. As the culmination of this ill-treatment, these individuals were forced to sign voluntary migration forms and were evicted from the country (Bhutanese Refugee Support Group, 2001).

After the violence of 1991, the Lhotshampa began to leave the country out of fear of mistreatment by the government and due to forced eviction. Many of those evicted during were forced to sign voluntary migration forms. Stated reasons the Lhotshampa left during this period include whole family punishment for the alleged actions of one member, forced eviction as a condition for release of a jailed relative and forced eviction after refusal to cooperate with government demands to give access to a family member accused of being “anti-national” (Bhutanese Refugee Support Group, 2001). Although numbers vary between sources, approximately 103,000 Lhotshampa people have fled Bhutan to refugee camps in southeast Nepal since the exodus began in 1991 (UNHCR, 2006).

In Bhutan, the oppression of the Lhotshampa people continues. In 1997, the National Assembly passed a resolution to remove all relatives of people classified as “anti-nationals” from government jobs (Bhutanese Refugee Support Group, 2001). A 2005 census counted 81,976 non-nationals still residing in Bhutan, many of whom are Lhotshampa people, where they remain subject to various human rights abuses including denial of access to education and health services along with violations of their rights to hold property, work and travel (Working Group on the Universal Periodic Review, 2009).

The status of the Lhotshampa refugees in Nepal remains unclear. Many have expressed a desire to return to Bhutan but the Bhutanese government refuses to grant citizenship. Despite this refusal, refugees have made various attempts over the years to return home. These attempts to return to Bhutan have often been dangerous, as evidenced by an expedition of 15,000 refugees attempting to cross into India from Nepal. During clashes with the Indian Border Patrol, 3 refugees were killed and 100 wounded (Zilk, 2007). No attempts to return to Bhutan have been successful; since the evictions began, there have not been any cases of refugee repatriation (Working Group on the Universal Periodic Review, 2009). Diplomatic talks between Nepal and Bhutan over the status of the refugees began in 1993 but have yet to produce a durable solution (UNHCR, 2006).

Brief Cultural and Religious Overview of Bhutanese Refugees

The culture of the Bhutanese refugees draws heavily from both the Nepalese customs and the Hindu religion. Hinduism especially has a significant impact on the culture of the refugees and informs their social structure, death rituals, worship and perspectives on physical health and mental illness.

The social structure of the Bhutanese refugees takes the form of a caste system. In the entirety of the refugee camps, there are 64 total castes (IOM Nepal, 2008). The refugee camps have banned the use of the caste system, but the system still informs many social interactions. Along with the caste system, death rituals are informed by religious practices. Hindu refugees practice cremation while Buddhists bury the dead. The death is marked by a thirteen day mourning period (IOM Nepal, 2008).

The Bhutanese culture is collectivist and discourages focusing on the self as an individual. The external focus of the culture can be tied back to core values and ideas of Hinduism, including the importance of interdependence. The Hindu worldview conceptualizes the individual as an intrinsic part of a greater whole; harmonious connection within this larger order is the basis of wellness. This principle of interdependence and connection is solidified in the Hindu conception of dharma, which is “unseen, metaphysical moral order that permeates the universe” (Hodge, 2004, p.28). The emphasis on connection with the larger social order means that “ordering society and personal conduct to correspond with the design of the universe is one's duty and brings integrity, harmony and balance both societally and personally” (Hodge, 2004, p.28). Thus, individual well-being is achieved through communal well-being.

Additionally, one way a Hindu can transcend this world and escape the cycle of reincarnation (liberation referred to as *moksha*) is through avoidance of accumulating karma throughout their life. Focus on the self is problematic for a Hindu because “egocentricity results in the accumulation of karma and emphasizes separateness, which in turn inhibits union with the [divine]” (Hodge, 2004, p.24). Thus, selflessness and focus on the community is consistent with the interdependent nature of the Hindu worldview while offering a path to *moksha*.

This selflessness causes an aversion to behaviors perceived as aggressive as well as an observation from a Western mental health perspective that Bhutanese refugees may have an “underdeveloped ego” (Neubauer & Spector, 2007; Hodge, 2004). When discussing this with people from outside their culture, the refugees may

refer to this aversion as “shyness”. Along with this practice of selflessness, the Bhutanese value sharing and working for the betterment of the community. In traditional Bhutanese culture there is a focus on day-to-day living, without much emphasis on future planning (Neubauer & Spector, 2007). The Bhutanese, especially the Lhotshampa women, are creative people who value education.

From a cultural perspective, this selflessness means there is often strong community and social support within the Bhutanese community. The importance of the family is paramount, both because it offers community and because of the religious significance of various rituals and religious practices that occur at a family level. The importance of family is evidenced by a study in which Hindu participants were asked which cultural value was the most important to them. More than 60% of respondents chose “family”, creating a response rate three times higher than any of the other value options (Hodge, 2004).

Followers of the Hindu religion do recognize concepts of mental illness and may be willing to talk about it although there is a tendency to externalize the idea and attribute it to forces outside the individual. (IOM Nepal, 2008). Due to the importance of family, it is not uncommon for family members to be admitted along with a mentally ill relative to the only psychiatric clinic in the capital city of Thimpu (Neubauer & Spector, 2007). These values of the Hindu religion, family and interconnectedness form the basis of Bhutanese culture.

Mental Effects of the Bhutanese Refugee Situation

Protracted Refugee Situations

Overview of Protracted Refugee Situations

A protracted refugee situation is defined by the United Nations (UN) as 25,000 or more people displaced from their homes and living for 5 or more years in a developing nation. The majority of refugee situations across the globe are defined as protracted situations, affecting more than 5.5 million refugees in 33 distinct situations in 2004 (UNHCR, 2006). As the number of distinct protracted situations has increased over the past decades, so has the average length of stay. In 1993, the average refugee situation took nine years to resolve. By 2004, that number had increased to 17 years (UNHCR, 2006, 109).

Protracted refugee situations arise due to a combination of “prevailing conditions in the country of origin, the policy responses of the country of asylum and lack of sufficient donor engagement” (UNHCR, 2006, 109). Generally there are three possible durable solutions for any refugee situation: repatriation to the country of origin, integration into the local community in the country of asylum or resettlement to a third country. In protracted situations, none of those three options are available, resulting in long stays in refugee camps.

Protracted refugee situations are problematic at multiple levels for a variety of reasons. On the level of the individual refugee, protracted situations have detrimental effects for the mental health of refugees, which will be thoroughly discussed later in this section. These mental health effects can impact the success of any eventual resettlement; past mental health challenges are frequently exacerbated by life in a new country.

Community stressors also arise, generally occurring when host communities feel refugees receive preferential treatment from humanitarian organizations or that the presence of refugees increases crime. Limited donor support for the host community can cause instability and discrimination as refugees are perceived as a burden competing for resources with the communities. These stressors limit the effectiveness of community integration as a durable solution, due to long-standing negative biases against the refugees. The impact of these community tensions will be discussed later in this section.

On a regional scale, protracted situations tend to destabilize regional diplomatic relationships as countries struggle to find durable solutions. The UN states these situations are “no less dangerous sources of instability than other more conventional security threats” and uses the example of Rwanda as a situation where “it was widely recognized that the failure of the international community to find a lasting solution for the Rwandan refugees from the 1960's was a key factor behind the events that led to the genocide in 1994” (UNHCR, 2006, 118). This regional instability and breakdown of international diplomatic talks reduces the likelihood that a sustainable solution can be found through repatriation.

To resolve protracted refugee situations, the UN recommends a collaborative approach, involving actors from the peace and security sector (UN Security Council, African Union, South Asian Association for Regional Cooperation, etc.), the development sector (UN Development Programme, World Bank, etc.) and humanitarian agencies (UNHCR, UN Office for the Coordination of Humanitarian Affairs) working together to achieve a sustainable solution. Coordination between these sectors to “place the problem within a historical and political context, to address the root causes of refugee movements, to support national capacity-building and [encourage] sustained donor involvement” is one way these situations can be resolved.

The UN definition of protracted refugee situations clearly fits the situation of the Bhutanese, who have now been in exile in Nepal for twenty years, with an estimated total population of over 100,000. As mentioned earlier, one of the main challenges in resolving the Bhutanese situation is the failure to reach a regional solution despite 15 rounds of diplomatic talks between Nepal and Bhutan, spanning over a decade.

Success seemed close in 2001 when Bhutan agreed to repatriate refugees who were verified as genuine Bhutanese citizens. However, in the process of verifying citizenship status in one of the camps, the Joint Verification Team found that 70% had left voluntarily and thus forfeited their citizenship and that 2.8% were involved in criminal activities, including children ranging from 18 months to 8 years old (Bhutanese Refugee Support Group, 2001). The verification team was composed entirely of representatives from the Bhutanese and Nepali governments and was widely criticized for exclusion of international organizations and discriminatory practices (UNHCR, 2006). Despite this beginning attempt to verify nationality, Bhutan never allowed any of the refugees to be repatriated.

In 2003, UNHCR proposed a solution of integration into the local communities which was rejected by the government of Nepal. At the time, Nepal supported repatriation to Bhutan as the preferred durable solution. UNHCR did not consider repatriation a viable option due to fear of setting a precedent of excusing ethnic cleansing. After 16 years of failed solutions, UNHCR began resettlement proceedings in 2007 despite opposition from within the refugee population (IOM Nepal, 2008).

Specific Solutions for Bhutanese Refugees

When resettlement discussions began in 2006, seven nations agreed to take refugees. The United States accepted resettlement of 60,000 refugees while Australia, Canada, Norway, the Netherlands, New Zealand and Denmark each accepted resettlement of 10,000 refugees (Shrestha, 2008). During the initial proposal of resettlement as a durable solution for the Bhutanese, there was unrest within the refugee camps. Most of this discontent was because resettlement effectively ended the hopes of repatriation, the desired solution for many of the refugees (Shrestha, 2008; Zilk, 2007). This discontent turned into violence in 2007 as members of the Bhutanese Communist Party within the camps attacked refugees who supported resettlement (Whelpton, 2007).

Due to the violence and misinformation about resettlement as a non-voluntary action, the UN set specific objectives to increase education about various options available to the refugees while reiterating resettlement as a voluntary option. At the end of 2010, over 20,000 refugees had left the camps for resettlement while 78,000 refugees had expressed interest. As many as 16,000 more people are set to be resettled during 2011 and referrals for resettlement have a 99% acceptance rate (UNHCR, 2010, 2011). As of 2011, the camps have a total population of 75,000 refugees. As refugees continue to be resettled, the UN has tentative plans to close two of the seven total camps, potentially in late 2011 (UNHCR, 2011).

Impact of Refugee Camps on Individuals and Communities

Logistical Overview of Nepalese Refugee Camps

Currently, refugees are living in seven camps run by the United Nations High Commissioner for Refugees (UNHCR). These camps are located in the Jhapa district of southeastern Nepal near the town of Damak. The seven camps are Beldangi 1, Beldangi 2, Beldangi Extension, Sanischare, Goldhap, Khudunabari and Timai.

Within the camps, the average family size is four and the population aged 0-2 years old is equivalent to those aged 65 and above, a distribution that is fairly unusual in refugee camp settings (IOM Nepal, 2008, 7). The governance structure of the camps is a democratic model; the sector heads report to the Camp Secretary at meetings of the Camp Management Committee. Camp governance positions are open to women and people from all castes.

Free education within the camps is provided through tenth grade. After tenth grade, refugees are required to pay a portion of the tuition although those who are able may choose to attend a boarding school in Nepal or India. Some children and young adults are able to leave the camps to attend university. The educational style

used in schools is rote memorization. Within the school system, children are taught English and Dzongkha. Adult refugees are restricted from working but there are some opportunities for education through vocational courses, driving courses and English lessons.

Health care is available to the refugees, managed by the Association of Medical Doctors of Asia. The quality of medical services available is reported by the International Organization of Migration (IOM) to be superior relative to other refugee situations and women have access to family planning choices (IOM Nepal, 2008). However, reduction of services due to funding limitations has had a detrimental impact on the quality and variety of services provided.

Mental health is addressed in the camps as doctors have noticed elevated rates of depression/anxiety and the suicide rate is four times higher than that of the surrounding community (IOM Nepal, 2008). Food portions are provided every 15 days and allows each person a daily ration of 400 grams of rice, 60 grams of lentils, 25 grams of vegetable oil, 20 grams of sugar, 7.5 grams of salt, 35 grams of a wheat/corn/soya blend and 100 grams of seasonal vegetables (IOM Nepal, 2008). Water access is limited but is considered good relative to other refugee situations. The Camp Governance Committee has responsibility for food distribution, health care programming and dispute resolution, among other tasks. There have been instances reported of sector heads distributing food unequally to benefit themselves.

Refugee Camps and Physical Health

Although the IOM perceives the health services available as better than those available elsewhere, the repetitive diet within the camps, devoid of eggs and dairy product, combined with reduction of needed health services and complete absence of dental services creates medical issues for the refugees (International Rescue Committee [IRC], 2009; CVT, 2010). Malnutrition and vitamin deficiency, primarily of vitamins A, B12 and calcium, are common complaints. Deficiency of vitamin B12 is especially concerning because low levels of the vitamin are associated with impaired functioning of the nervous system, a dementia-like state and anemia (Walker et al., 2011). Other common medical conditions include: tuberculosis, dysentery, malaria, measles and respiratory illnesses. Additionally, many refugees only use medical services in emergencies and do not access preventative services (IRC, 2009).

Along with inadequate medical services, mental health services are lacking despite the demonstrated need for mental health care. Physical safety is an on-going concern for women and girls. There are many reports of rape and gender violence within the camps; in 2010, UNHCR documented a need to “prevent and respond to sexual and gender-based violence in the camps” (UNHCR, 2010).

Refugee Camps and Mental Health

Due to trauma experiences in Bhutan and/or the prolonged stay in Nepalese refugee camps, many of the Bhutanese refugees have mental health concerns. The detrimental effects on mental health are an area of concern for protracted refugee situations. In these situations, refugees live in a state of limbo. This presents mental health concerns because while “their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile” (UNHCR, 2006). Restrictions on working, present in the Nepalese camps, increase feelings of dependency, force refugees to live in poverty and, in long-term situations, violates terms of the 1951 UN Refugee Convention guaranteeing freedoms to “move and seek wage-earning employment” (UNHCR, 2006).

Globally, refugees and immigrants have reported that “lack of meaningful work is undermining [their] sense of well-being”, a sentiment that corresponds directly with the Bhutanese experience (Dossa, 2002). Long-term dependency impacts the mental health of refugees and may lead to additional challenges when refugees are resettled. This growing phenomenon of refugees living in limbo with restrictions on the ability to be productive is referred to as “refugee warehousing”, a phenomenon that frequently causes feelings of despair

and hopelessness while denying refugees the opportunity to make positive contributions to their host communities through engagement in the region.

Regional insecurity also contributes to violence in and around the camps which adds additional stressors to the refugee situation. UNHCR reports that political instability around the camps interrupts some of the activities of the camps, including limiting access to resettlement interviews in the town of Damak (UNHCR 2010; Gazmere, 2011). Political instability in Nepal stems from actions of the Maoists' People's Liberation Army (PLA), an armed wing of the Communist Party of Nepal. Although tensions between the Nepali government and the PLA had improved marginally by 2007, there is now growing tensions within the PLA, especially in the southern Tarai region of Nepal. This discontent has been expressed through assassination campaigns and violence in the region. The refugee camps are located in the extreme southeast corner of the country and proximity to the instability can cause refugees to feel unsafe in the camps as well as affecting the movement of partner organizations and the delivery of needed supplies (CVT, 2010; UNHCR, 2011).

The political instability has reportedly spread inside the camps, further affecting mental health. In 2007, the Nepalese government attributed a bombing in the town of Phuentsholing to an armed faction of the Bhutan Communist Party, a refugee-based political party (Whelpton, 2007). The stress of living near a volatile political situation with violence occurring both inside the camps and in surrounding areas presents additional stressors on mental health, especially when the refugees are living in the situations for up to twenty years.

Refugee Camps and Host Communities

The interactions between the Bhutanese refugees and their host communities are strained and there is little integration into the communities. Local residents express dissatisfaction with their presence and feel refugees “drive down wages, depress prices in the food markets by selling their food rations, and contribute to crime and prostitution (UNHCR, 2006). Additionally, residents view refugees as harmful to the environment and UNHCR has observed feelings of resentment within the local residents due to the perceived superiority of the services available for refugees within the camps (UNHCR, 2010; Gazmere, 2011).

Community tensions are evident in the refusal of Nepal to integrate refugees into local communities when UNHCR suggested this as a durable solution in 2003. In general, the lack of integration into the host community prevents the Bhutanese from making positive contributions to the local economy, increases fear within the host community and facilitates discriminatory beliefs and actions against the refugees.

Nepalese Refugee Camp Programs and Budget Shortfalls

The Nepalese refugee camps, administered by UNHCR, offer a variety of services and programs that rely on funding from both the organization and donor governments, with an average annual budget of \$20 million USD (UNHCR, 2006). There are concerns over funding shortfalls which “threaten to erode the quality of service provision in the camps in Nepal and to undermine the confidence of the refugees that their rights will continue to be protected” (Bhutanese Refugee Support Group, 2001). Currently, UNHCR is facing a 20-40% funding shortfall that will affect 2011 camp programming in the following ways (UNHCR, 2010, 2011):

- Shortage of medication
- End of referrals to medical specialists
- Irregular and limited maintenance of roads/infrastructure allowing access to the camps
- End of semi-permanent shelter construction for vulnerable families
- End of information campaign about durable solutions
- Reduction of poverty-alleviation programming
- Inability to complete planned improvements to host communities

- Inability to repair/maintain schools and classrooms

Program goals for 2011 include a continued focus on sexual and gender-based violence in the camps, expanded vocational trainings, services for unaccompanied child refugees and expansion of psychosocial services. On a broader scale, UNHCR will continue seeking new durable solutions and will maintain a focus on the issue of statelessness, although funding shortfalls will limit their ability to implement this programming (UNHCR, 2011).

Bhutanese Acculturation in the United States

Bhutanese Challenges in the United States

In fiscal year 2009, 13,317 Bhutanese refugees arrived in the United States (U.S. Dept. of Health and Human Services, 2009). The total Bhutanese population in Minnesota at the end of fiscal year 2009 was 202 people (Minnesota Dept. of Health, 2010). This number will continue to grow; in 2005, the Bhutanese were not included in the “other” category of the percentage breakdown of primary refugee arrivals for the state. In 2009, the Bhutanese had their own category and accounted for 8% of the total refugee arrivals (Minnesota Dept. of Health, 2009). Although the growing number of Bhutanese refugees increases the possibility of social support and community building, significant challenges remain for the Bhutanese as they adjust to life in the United States.

As discussed earlier, issues of mental health present difficulties when Bhutanese people seek mental health services from a provider who is unaware of their cultural values and norms. Similar challenges exist within the U.S. medical system. For many newly arrived refugees, the medical system is complex and difficult to navigate due to the language barrier, lack of familiarity with preventative health, limited information on insurance, low-cost providers and a lack of understanding of patient rights, especially the right to an interpreter. Specifically within the Bhutanese population, the tendency to use health services only in emergency situation can lead to higher medical costs when a visit is eventually made to a doctor or hospital.

The vegetarian diet of many Bhutanese may present some situational challenges, especially with regards to children's school lunches (CVT, 2010). The school system is significantly different than schools in the refugee camps and some parents may be uncomfortable or unfamiliar with being active in the child's education and interacting with teachers. Understanding and utilizing transportation may present challenges, as can the shift in climate from southern Nepal to Minnesota.

Religious concerns about resettlement to the United States for refugees identifying as Hindu include finding access to a Hindu temple and maintaining traditional death rituals and cremation (IOM Nepal, 2008). Some of the more significant religious rituals of Hinduism require a Brahman priest and because they “are not a preferred immigration category in the eyes of immigration officials, there is a substantial shortage of qualified individuals to perform certain rituals” (Hodge, 2004).

Resettlement to the United States may cause value conflicts as they adapt to life in the individualistic American culture. Resettlement can also cause family stress with regards to religion as children who grow up in the United States may absorb new cultural values while parents maintain traditional beliefs. Family stress can occur due to a changing power dynamics as children learn English faster and adapt more quickly to the United States. Parents may find themselves becoming dependent on their children, which fundamentally changes the family power structure (CVT, 2010). Remnants of the caste system may also limit the opportunities for socialization with Bhutanese living close by as people from different castes may be uncomfortable visiting or socializing with those from a different caste. Along with these specific cultural and religious challenges, Bhutanese refugees in the United States may also face discrimination or racial profiling.

Although resettlement provides some measure of relief from concerns of physical insecurity, this new freedom may also allow the first opportunity for surfacing of emotions that had previously buried under the stress of survival (Fabri, 1999). Compounding the already difficult process of cultural adaptation is grief over loss of relatives, culture and home (Fabri, 1999). New arrivals frequently follow a four stage model of cultural adaption: honeymoon period, culture shock, adjustment and integration. The honeymoon stage is characterized by idealization of the new country and optimism, which can be a psychological coping mechanism for refugees facing the extreme stresses of resettlement. When this initial stage wears off, many refugees feel that successful integration into the United States is extremely difficult or impossible to achieve; this stage is referred to as culture shock. The adjustment phase is characterized by a realistic attitude about life in a new culture. This may eventually become integration, when the refugee is able to feel a sense of belonging in the United States while successfully maintaining connections to their home culture, a state referred to as biculturalism (Atkins, Birman, Sample, Brod & Silver, 1999).

Strengths of the Bhutanese Refugees and Culture

Although there are significant challenges facing the Bhutanese refugees during resettlement in the United States, the culture is rich and full of strengths refugees can draw on as they begin in a new country. Many of these strengths come from religious beliefs.

During the bereavement process, most Eastern religions attribute “suffering to the root problem of anger and offer rituals that assist people suffering from post-traumatic stress and the loss of loved ones” (Kissman & Maurer, 2002, p.39). Hindu and Buddhist worldviews promote conceptions of life and death as parts of the same process which may comfort refugees whose family members have died. Specifically within the Hindu faith, belief in reincarnation may be helpful in reduction of death anxiety. Within the Bhagavad Gita there are descriptions of the soul being able to transcend psychological pain and in doing so creating empathy and personal growth (Kissman & Maurer, 2002). These factors can help Hindu Bhutanese refugees cope with the extreme losses of the ethnic cleansing.

The effectiveness of faith as a means of coping with stressors is also clear. Faith is helpful in these situations because “it is not stress itself but hopelessness and despair, the perception that the stress is inescapable, that there is nothing a person can do to prevent it, that is associated with immune system suppression and illness” (Kissman & Maurer, 2002, p.38). Within the Hindu faith, the acknowledgement of mental illness is a strength, although individuals may be reluctant to discuss the issue in personal or internalized terms. Individuals may be willing to share their stories and experiences provided they can communicate the experiences in an impersonal manner, potentially using stories or figures from mythology to share their experience. Using stories of others allows the individual to maintain the desired external focus while managing to share some personal emotions.

The Bhutanese culture and the Hindu religion are both focused on the present (Kissman & Maurer, 2002; Schäppi, 2005). Heightening this focus through meditation or similar exercises can be helpful because “energy is power; when it is spent on resentment about the past or worries about the future, the results are energy depletion and feelings of powerlessness” (Kissman & Maurer, 2002, p.27). Meditation offers a chance to focus on the present moment while finding acceptance of powerful emotions, including feelings of stress. Meditation has also been shown to be effectively used in recovering from various health issues, including depression and substance abuse (Hodge, 2004). Ritual expressions of faith may serve as antidotes to anxiety and reaffirm an individual's place within the larger order of the universe, reviving the crucial sense of interconnectedness. Thus, religious Bhutanese refugees who follow a religion may find it helpful as they cope with the stress of resettlement and past trauma.

Although the interconnectedness of the Bhutanese culture may cause difficulties in accessing Western mental health services, the powerful support of the collectivist community is a key strength of the culture. Group therapy can be effective in “healing [feelings of] separation and isolation from others that [has] led to

depression, substance abuse and other 'dispirited' conditions" (Kissman & Maurer, 2002, p.41). Group interventions are effective due to their communal nature, provided the groups follow Hindu patterns of "other-centeredness" and do not become isolated from the larger community (Hodge, 2004, p.35). Especially because the Hindu worldview equates wellness with harmonious functioning of the larger community, interventions that focus on a broader scale than individual therapy may be most effective.

Mental Health and Bhutanese Refugees

Overview of Mental Health and the Refugee Experience

It is clear the events many Bhutanese refugees lived through have powerful mental health implications. Some refugees experienced torture, defined in the UN Convention on Torture as "any act by which severe pain or suffering, whether physical or mental is intentionally inflicted....intimidating or coercing...for any reason based on discrimination of any kind...by or at the instigation of or with the consent or acquiescence of a public official or another person acting in an official capacity" (United Nations, 1984). When a government uses torture against their own citizens the goals include destroying the cohesion of a community, creating an atmosphere of fear and apathy and eliminating leaders.

Although many Bhutanese refugees did not experience torture while in Bhutan, the majority experienced some form of trauma either during the ethnic cleansing, while fleeing the country and/or during internment in Nepal. Trauma is defined as events which "overwhelm the ordinary systems of care that give people a sense of control, connection and meaning. Herman stated that "traumatic events are extraordinary, not because they occur rarely, but because they overwhelm the ordinary human adaptations to life...[t]hey confront human beings with the extremities of helplessness and terror and evoke the responses of catastrophe" (1992). Trauma events include deprivation of food, unsanitary living conditions, lack of health care, witnessing violent actions, witnessing death, rape or threatened rape, disappearances and forced displacement and separation of family (CVT, 2005). Common elements among all trauma experiences are the powerlessness of the victim, the unpredictable nature of the event and the life-threatening consequences. After a trauma experience, a victim may develop mental disorders, including depression, anxiety or post-traumatic stress disorder (PTSD). Some common symptoms of anxiety, depression and PTSD are listed below.

Anxiety

- Heart pounding
- Excessive sweating
- Numbness/tingling of the body
- Difficulty breathing
- Feelings of dread

Depression

- Crying
- Hopelessness
- Helplessness
- Isolating behaviors
- Poor focus
- Guilt
- Appetite issues
- Death idealization
- Trouble sleeping

PTSD

- Depression
- Avoidance of triggering situations
- Inability to control thoughts/memories
- Exaggerated startle responses
- Flashbacks
- Nightmares
- Trouble sleeping
- Memory problems
- Flat affect
- Hyperarousal

Some Bhutanese refugees may also exhibit physical symptoms of exposure to war trauma including scars, musculoskeletal pain, hearing loss, dental problems, headaches, shaking or sweating at night (CVT, 2005). Although some refugees may find solace in their faith, others may have trouble maintaining

religious or spiritual beliefs. New questioning the existence of a divine power is another stressor affecting mental health.

Along with individual consequences of torture and/or trauma experiences, these actions have repercussions for families and communities. On a family level, torture and trauma can reduce or eliminate social support, cause a stressful change in the family dynamics and split families among generational or ethnic characteristics. Additionally, if parents have experienced trauma or torture, the mental effects may be passed to their children. Research in a Mexican refugee camp found that female refugee children whose mothers were struggling with trauma-related mental disorders had more mental health issues than their male peers, suggesting that girls, who spent more time at home with their mothers, absorbed some of the residual mental effects of trauma (Miller & Rasco, 2004).

At the community level, these actions create climates of fear and distrust, leading to a general sense of apathy, isolation, helplessness and hostility. Other community effects of prolonged torture/ trauma include unsafe conditions for women and girls through increased rates of sexual violence along with changes to community life by “unwanted 'children of rape,' and the stigmatization of rape survivors who may be viewed as undesirable marriage partners” (Miller & Rasco, 2004, p.11). Effects on community functioning also include creation of orphans or children with detained parents as well as normalization of violence as a means of conflict resolution.

Within the sphere of refugee mental health there are frequent references to “stressors”. Stressors are defined as discrete events that burden individuals past their capacity to cope with them. Refugees typically experience three distinct forms of stress: migration stress, acculturative stress and traumatic stress (Adkins et al., 1999).

- *Migration stress* is the specific stress caused by an unpredicted, forced displacement from a refugee's home to a country of asylum or resettlement. In migration stress, refugees are forced to confront many of the typical life stressors (death of a relative or friend, moving, loss of employment, etc.) simultaneously without “the usual coping resources, such as family, friends, surrounding community, etc., which people would ordinarily rely on to help them cope with stress” (Adkins et al., 1999, p.8).
- *Acculturative stress* is the often subtle stress of adapting to life in a new culture and country. This stress is escalated by refugee beliefs that “life in a new country...will be basically pretty much the same, except in a new language” (Adkins et al., 1999, p.8). When reality does not match expectations, acculturative stress increases. Changed school and health systems, new jobs, urban/rural differences, changed social supports and the difficulties of day-to-day functioning in a new culture and language are all examples of acculturative stress.
- *Traumatic stress* refers specifically to stress caused by traumatic events, including natural disasters and human actions. Traumatic stress has effects on an individual's psychological, social and physical functioning and responses to stress vary between people. There is some thought that stress caused by “accidents and natural disasters is experienced as less traumatic than injury that results from willful acts by other human beings, such as torture” (Adkins et al., 1999, p.9). PTSD is most frequently linked with experiences of traumatic stress.

Another conception of refugee stress divides experiences into two categories, instead of three: pre-displacement violent experiences and post-displacement adjustment experiences, also called

displacement-related stressors (Miller & Rasco, 2004). Addendums to this model include pre-displacement violence unconnected with the refugee situation and post-displacement stress following the exile from the country that is not directly related to the displacement. Despite the differing organizational styles, both models categorize the same stress events.

Research studies focusing on the mental health of refugees have taken place with a variety of refugee populations, mostly examining rates of PTSD within the community. Researchers have examined Cambodian youth (50% exhibiting symptoms of PTSD), Vietnamese male torture survivors (90% exhibiting symptoms of PTSD), Central American adults (68%) and Sierra Leonian refugees (49%) (Miller & Rasco, 2004, p.8-10). It is clear that torture, trauma and stress related to the refugee experience negatively impact the health of individuals, families and communities in many ways.

Incidences of Mental Disorders Among Bhutanese Refugees

There have been some research studies focusing on the Bhutanese refugees in Nepal, mostly examining relationships between torture experiences and mental disorders (Nepal, 2005). One of the more recent examinations of the mental health of Bhutanese refugees was published in 2001 and examined 810 refugee participants, both tortured and non-tortured. The study found that “tortured and non-tortured refugee groups were similar in terms of age, sex, marital status, employment status, years of schooling, early separation, childhood trauma and mental illness in the family” (Van Ommeren et al., 2001, p.478). The only association between torture and a demographic characteristic was between the male gender and torture. Additionally, the researchers found that around 75% of tortured refugees had symptoms of PTSD, making it the most frequent mental effect of torture and trauma (Van Ommeren et al., 2001, p.479). Researchers also found that women were at a higher risk for the development of mental disorders and that 56% of non-tortured refugees had a lifetime disorder. For refugees who experienced torture, 97.1% experienced severe beatings, 89% were threatened, 79.2% experienced humiliation and 66.3% experienced forced incongruent acts (Van Ommeren et al., 2001, p.478).

The research article concludes by stating that “the high rates of disorder in the Bhutanese refugee community argue for the presence of quality mental health services [which] are not typically present in refugee camps” (Van Ommeren et al., 2001, p.481). A challenge in performing traditional, clinical therapy with Bhutanese refugees is past experience with this form of treatment. Bhutan did not develop a Westernized mental health policy until 1997, after the period when the majority of the refugees left the country, so there is generally little previous experience with clinical therapy (WHO, 2006).

Mental Health and Bhutanese Culture

As discussed previously in this paper, the Bhutanese culture is collectivist and family-focused. For these reasons, utilizing traditional Westernized mental health interventions to work with the Bhutanese can be difficult as it may not take into account cultural differences in the perceptions and handling of mental health issues. Cultural differences that may impact provision of mental health services include differing perspectives on the use of traditional healers, inclusion of religious views in understandings of mental illness and the collectivist worldview (Miller & Rasco, 2004; Hodge, 2004).

Because of the comprehensive nature of Hinduism as religion and lifestyle, understanding Bhutanese perspectives on mental health necessitates an understanding of Hindu perspectives on mental health. As discussed previously in this paper, Hinduism promotes a universal order in which each individual is intrinsically linked to other individuals, to the community and to the divine power through the ordering principles of *dharma*. One area where Bhutanese refugees may have trouble with clinical psychiatry is with the idea of the self as an object that can be understood independent of its external connections

(Navsaria & Peterson, 2007). This self-centered approach is incompatible with the traditional Hindu perspective on mental illness, which attributes the disorder to external forces acting on the individual, again emphasizing the connection between the individual and their surroundings (Navsaria & Peterson, 2007). In keeping with the theme of connectedness, Hindus tend to view health as a holistic conception of mind, body and spirit. As part of the externalization of Hindu practices, there is a tendency to focus more on the physical and concrete behaviors than on the internal emotional processes (Navsaria & Peterson, 2007). All of these factors present some degree of difficulty for work within a medicalized and internally focused mental health system.

Mental Health Implications of Denial of Citizenship

Many of the mental health concerns of the Bhutanese refugees come from experiences of trauma and/or the protracted refugee situation. Another source of mental distress concerns their status as stateless people. Because the government of Bhutan included a provision within the 1985 Citizenship Act, stating that people who emigrated from the country would forfeit their citizenship, the Bhutanese living in Nepal are not recognized as citizens of Bhutan nor have they been allowed to seek Nepalese citizenship through naturalization. Along with the emigration clause in the 1985 Act, the government of Bhutan maintains that refugees were not forced to sign the voluntary migration forms and thus, they voluntarily forfeited citizenship. The refusal of any government to claim the refugees as citizens renders them stateless, which has far-ranging implications including vulnerability to human rights abuses and associated detrimental effects on mental health. Globally, there are 9 million stateless people, spanning the Asian continent and extending into sub-Saharan Africa and Eastern Europe (Sokoloff, 2005).

Governments revoke or deny citizenship for a variety of reasons including fear of a specific group challenging a newly emerging government, fear of change to established structures, association of a specific ethnic group with a former enemy of the government or blaming a specific group for “an ailing social, political or economic system” which the government uses to “reinforce national unity and mobilize support for the country's leadership” (Sokoloff, 2005, p.21).

Whatever the reason is, the aim of denial of citizenship is disempowerment in the political process. Citizenship can be understood as entitling the citizen to three rights: the right to permanent residence in the country and to travel freely outside of it, the right to domestic and foreign protection and the right to individual freedoms, sometimes referred to as the empowerment rights (Sokoloff, 2005). Empowerment rights include the right to vote, hold political office, have economic rights, etc. Put simply, citizenship is the “right to have rights” (Brouwer, 2003).

Governments manage to deny citizenship to people rightfully entitled to it through legal norms, including language, ancestry, residency/income requirements and discriminatory election laws. Administrative harassment, as exemplified by the difficulty in obtaining certain required documentation in Bhutan such as the land tax receipts and NOC's, is “an effective means of discouraging people from regularizing their situation or claiming their rights” and is another mechanism of denial (Sokoloff, 2005, 25).

Statelessness affects the individual, community and region. On an individual level, statelessness leaves people incredibly vulnerable to human rights abuses. They are routinely denied the “right to life; the right to privacy; equality before the courts and tribunals; freedom of opinion and religion; and retention of language, culture, and tradition” (Sokoloff, 2005, p.14). The disempowerment of stateless people leaves them unable to voice their concerns because stateless “individuals and communities become in effect non-entities, which then can be manipulated as seen appropriate by the state” (Sokoloff, 2005,

p.15). The ethnic cleansing of the Lhotshampa effectively denied the population of all the rights listed above.

Along with the denial of these basic human rights, guaranteed to all humans under the Universal Declaration of Human Rights, stateless people frequently face economic insecurity. This insecurity often manifests as inability to access monetary services, such as credit and bank services, inability to own or lease land or travel freely. Stateless people can be taxed arbitrarily and have little protection from exploitative labor practices. The expulsion of Lhotshampa workers from jobs, presence of travel checkpoints and the redistribution of lands owned by Lhotshampa people all indicate economic exploitation.

There are concerns over access to health services for stateless people, due to the fact that many such services are operated by the government. Additionally denial of citizenship has detrimental effects on mental health including depression, violence, suicide and increased emotional tension in the community. In the case of the Bhutanese refugees, it can be seen that “the mental health of many Lhotshampa men living in the refugee camps of South East Nepal has degraded over the past ten years and alcoholism, domestic violence and suicide are not uncommon” (Sokoloff, 2005, p.17). Limited access to education in Bhutan denied children of their fundamental right to public education and limited their opportunity for personal betterment and empowerment through education.

Denial of citizenship is a particular problem for groups that already suffer some discrimination, especially women, children and older adults. Women and children more frequently run the risk of rape, sexual exploitation and trafficking while older adults face physical health challenges and decreased economic opportunities. Especially when combined with the detrimental effects of refugee warehousing, it is clear the denial of citizenship for the Lhotshampa people has had negative effects on the mental health of individuals.

Aside from individual consequences, systemic denial of citizenship has a serious impact on surrounding communities. Economic exploitation of stateless people can create tension and hostility. Because “social exclusion breeds desperation, violence and crime...trafficking in women, sexual exploitation, addiction to drugs or alcohol are frequent occurrences....and erode the social and cultural fabric of both communities” (Sokoloff, 2005, p.20). If the government decides to disinvest in areas heavily populated by non-citizens, full citizens living in the region are also affected which increases tension, social unrest and instability. Under the right conditions, groups denied citizenship may rise up with political protests or acts of violence, as happened in Bhutan with the demonstrations of 1990. This internal instability is a common result of denial of citizenship and further erodes the cohesion and strength of the community.

On a regional level, denial of citizenship frequently creates refugees as people flee the human rights abuses of their own government. When stateless refugees become part of a protracted refugee situation, regional instability increases. This is discussed earlier in this paper and is exemplified by the situation of Bhutanese refugees and the regional tensions caused by their lack of integration into host communities. On both a community and regional level, the negative effects of denial of citizenship can be traced through a process beginning with denial of citizenship, followed by marginalization, leading to exclusion and eventually reaching conflict levels (Sokoloff, 2005). In this way, denial of citizenship represents a threat to human security, at an individual, community and regional level.

Part of the challenge of stateless people is their disempowerment in the political process and lack of options to appeal when their rights are violated. This disempowerment is echoed up to an international

level due to the lack of a binding international charter on statelessness. The issue was first addressed with the 1954 Convention relating to the Status of Stateless Persons, which standardized minimum treatment of stateless people by their country of residence. In 1961, the Convention was updated with a requirement for “signatory states...to provide mechanisms for persons born on their territory to acquire nationality” (Sokoloff, 2005, p.26). The majority of nations have not signed on to these conventions: as of October 2010, 65 states were parties to the 1954 Convention, while 37 states were parties to the 1961 Convention (UNHCR, 2001). The closest international organizations have come to laying out a comprehensive groundwork for issues of citizenship is the 1997 European Convention on Nationality which codifies all major components of citizenship including retention, loss and recovery.

A UN report offers a concise summary of the challenges created by denial of citizenship:

Denial of citizenship constitutes a severe threat to people's basic rights and freedoms. It breeds social exclusion and destitution, creates tensions between communities and paves the way to violent internal and international conflicts. It affects directly the security and the quality of life of both non-citizens and surrounding communities. The consequences on populations are devastating and long-lasting. A pivotal effect of the denial of citizenship on communities is the loss of empowerment. People's inability to take their lives in their own hands through political and social participation crystallizes their and their children's condition into a permanent state of dependence and insecurity. (Sokoloff, 2005, p.29)

Critique of Current Refugee Mental Health Service Provision

Despite the well-documented need for culturally competent mental health services, the current system of mental health as practiced by Western organizations is currently unable to meet this need. There are three main areas in which refugee mental health services are lacking: (1) limited access to any type of mental health service, Western or otherwise;(2) under-utilization of available Western mental health services due to cultural differences; and (3) inability of traditional, clinic-based services to address displacement-related stressors [defined earlier in this paper as stressors relating to displacement and cultural adaptation in countries of resettlement] (Miller & Rasco, 2004, p.2).

Lack of access to mental health services is caused by scarcity of mental health professionals in conflict zones and refugee camps along with cost barriers to mental health services in the countries of resettlement. Although there are many mental health clinics in countries of resettlement that work specifically with refugee populations, reducing the language and cost barriers, these operations are frequently small and underfunded, making it difficult for them to work with a significant number of refugees (Miller & Rasco, 2004).

As discussed earlier in this paper, cultural differences in perceptions of mental health affect usage of mental health services; refugees may not view Western mental health as an effective means of resolving mental illness and mental diagnosis may cause a heavy burden of stigma for the refugee.

Displacement-related stressors may be understood to include challenges such as the loss of social support, isolation, lack of meaningful employment, changed role within country of resettlement and challenges of cultural adaptation. Although these issues may not appear to be mental health issues, they have been significantly associated with “levels of self-reported depression and anxiety” (Miller & Rasco, 2004, 15). These results have been replicated in multiple other studies when these stressors were found to be associated with anxiety, depression and in some cases, aggressive behavior (UNHCR, 2006).

A Guatemalan woman in a refugee camp in Chiapas, Mexico illustrated the power of displacement-related stressors when she stated: “I cry because of what we suffer *here*” (Miller & Rasco, 2004, p.18). Displacement-related stressors are issues of mental health and it is clear that failure to address these stressors represents a deficiency in the refugee mental health system.

Previous research into the field of refugee mental health has looked primarily at rates of PTSD within refugee population. However, it has been noted that results from these studies, which primarily occur in countries of resettlement, may not be generalizable to the 70% of refugees living in developing countries due to the significant difference in living conditions and security concerns (Van Ommeren et al., 2002). Additionally, the heavy focus on PTSD is problematic due to several limitations of PTSD as cross-cultural diagnosis. The main points of the critique of PTSD are outlined below (Miller & Rasco, 2004, p.46):

- Does not take into consideration ongoing traumatic stress
- Generalizing the full range of traumatic events into a single diagnosis
- Insufficient explanation of the entirety of ways in which trauma can impact a person (for example, disregarding spiritual impact)
- Pessimistic outlook on the functioning of individuals with PTSD
- Medicalization of a normal response to traumatic experiences
- Limitation in use for children due to adult-centered diagnostic criteria
- Cultural variations in stress expression are not included
- Individualizes effects of trauma

In Nepalese refugee camps, somatoform pain disorders occur with high frequency (Van Ommeren, 2002). In the single psychiatric clinic within Bhutan, 50% of the “presenting psychiatric problems show up as somatized symptomatology such as headaches, tingling sensations, or burning feelings” (Neubauer & Spector, 2007, p.11, 2007). One explanation for the prevalence of somatoform disorders is the lack of appropriate outlets to express strong emotions which may result in somatization or manifestation of these unresolved emotions in physical responses (Neubauer & Spector, 2007).

Another explanation for the somatization of mental illness is found in the Hindu religion. Followers of Hinduism view health as a combination of mind, body and spirit, without differentiation between “‘feeling bad’ and emotionally ‘feeling bad’” (Navsaria & Peterson, 2007, p.166). Thus, the diagnosis of somatization, or manifesting mental distress through physical symptoms, may be irrelevant for Hindus who do not differentiate between mental and physical functioning.

An Ecological Model of Community Psychology for Refugee Mental Health Service Provision

The critiques of the current mental health system listed above illustrate some of the challenges refugees face in access and appropriateness of clinical therapy as a solution to mental health needs. A new perspective is needed on this issue. One answer may be found in the developing field of community psychology.

Community psychology is characterized by its ecological approach to mental health, demonstrated by its focus on collaboration, empowerment and building on strengths present in the community. The community model grew out of the field of public health and focuses on “collaborative endeavors in which community members contribute their expertise and play essential roles in the intervention process; individual treatment...supplemented or replaced by communal rituals and activities; and...a new focus on identifying and developing community strengths and resources that can promote healing

and adaption” (Miller & Rasco, 2004, p.4).

Utilizing community members as collaborative partners in the process allows practitioners the chance to learn from their clients, an act of empowerment, and prioritizes their input to ensure that community interventions are both desired and effective. This could indicate a change in assessment methods from quantitative to a more qualitative approach. Additionally, allowing the community to define their own needs and working together on these organically generated challenges is an important component of the ecological model which believes “mental health interventions are most likely to be successful when they address those stressors that participants identify as most significantly impacting their psychological well-being” (Miller & Rasco, 2004, p.38).

The focus on the community as a collective entity fits well with many refugee cultures that promote a more collectivist worldview than the United States. Violence and war trauma have a detrimental effect on communities and one of the explicit goals of torture is disrupting community life. A community approach to mental health is an opportunity to approach the problems on the level at which the disruption happens. Taking mental health out of the clinic and into the community makes it more accessible, more consistent with collectivist worldviews and may decrease the stigma of receiving services by presenting it in non-traditional manners.

It has been suggested that a mental health framework for refugee mental health should have two broad aims. First, it should seek to relieve psychological distress and address coping and adaptation within the community (Miller & Rasco, 2004). Second, coping and adaptation work should happen at a community level as interventions to promote rebuilding of social support networks or other community-focused activities.

Despite the ecological framework’s emphasis on group and community level work, it does not seek to discount the value of individual therapy as a complement to these larger interventions. Individual therapy is a powerful tool in healing trauma and should continue to be utilized within the ecological framework. To effectively address mental health problems relating to coping and adaptation, change can be effected on multiple levels.

As discussed earlier, displacement-related stressors have direct impacts on mental health; by focusing on external, rather than internal, changes to these situations, practitioners can work within an ecological framework. This can happen through changing problematic situations in some way, creating new settings when possible and/or increasing the coping capacity of the individual. These interventions are able to occur at the macro, local and individual level which creates awareness of the ecological nature of struggles with adaptation and coping. Additionally, work at a preventative level is consistent with an ecological model. For refugees with experiences of war trauma, prevention may simply mean the development of stronger social support in the country of resettlement in an effort to avoid or minimize the effects of PTSD (Miller & Rasco, 2004, p.39).

In summary, the six principles of ecological community psychology, as identified by Kenneth Miller and Lisa Rasco, are listed below (2004).

1. Ecological interventions seek to alter problematic settings, create alternative settings that are better suited to people's needs and capacities, or enhance people's capacity to adapt effectively to existing settings.
2. Ecological interventions should address problems that are of concern to community members.

Intervention priorities should reflect the priorities of the community.

3. Whenever possible, prevention should be prioritized over treatment. This does not negate an important role for treatment, it simply regards individual treatment as one tool in the arsenal of intervention responses.
4. Local values and beliefs regarding psychological well-being and distress should be incorporated into the design, implementation, and evaluation of community-based interventions.
5. Whenever possible, ecological interventions should be integrated into existing community settings and activities, in order to enhance participation in and long-term sustainability of the interventions.
6. Capacity building, rather than the direct provisions of services by mental health professionals, should be an intervention priority in all communities.

Taking into consideration the ideals of ecological community psychology, it is possible to create mental health interventions that work at the community level to address a broad range of displacement related stressors in a culturally relevant manner.

Community Based Mental Health Interventions

As illustrated in the previous section, traditional mental health interventions are frequently ineffective with refugee populations for a variety of reasons. In this section, dance therapy and mental health interventions within English as a Second Language (ESL) classrooms are discussed as mechanisms to increase access and effectiveness of refugee mental health interventions.

Dance Therapy

Overview of Dance Therapy

Dance therapy is one way to incorporate mental health in a new setting. Dance is a human phenomenon understood across cultures that provides for self-expression, social expression and reconnection with the community (S. Bauer, personal communication, May 2, 2011). Dance therapy is defined as:

The use of expressive movement and dance as a vehicle through which an individual can engage in the process of personal integration and growth. It is founded on the principle that there is a relationship between motion and emotion and that by exploring...movement people experience the possibility of becoming more securely balanced yet increasingly spontaneous and adaptable...through movement and dance each person's inner world becomes tangible, individuals share much of their personal symbolism and in dancing together relationships become visible. (Payne, 1992, p.4)

Dance therapists approach work from a set of seven guiding beliefs about the nature of movement. These seven principles are:

- Clarification: Movement as another way to understand how strong emotions affect the individual
- Access to the unconscious: Unlike speech, movement does not require an intellectual process which allows individual expression to move closer to unconscious processes and reactions
- Kinesthetic memory: The body remembers actions, including acts of violence, in a different manner than conscious memory
- Simultaneity: Movement can express multiple ideas simultaneously, a process difficult to achieve in speech
- Transmutation: Movement allows for easy shifts between contrasting emotions (anger to joy, sorrow to comfort, etc.)
- Catharsis: Movement allows for tension release and expression of strong emotion
- Integration: Expression through movement allows for expression and acceptance of emotions, resulting in integration

Although dance therapy may be effective with some populations, it may be counter-productive in others, including those from cultures that are uncomfortable with physical touch or body movement. For cross-cultural use, it is important that therapists do not attempt to imitate or prescribe the culture of the dancers. Instead, therapists should engage individuals as cultural experts and develop together a curriculum that is culturally relevant and appropriate. Therapists should be aware that what works with one population will likely need significant adaptations before it can be effectively used with another population.

Beneficial Characteristics of Dance and Movement

Many dances include elements of ritual performance, which can alleviate anxiety, as well as incorporation of music, which allows for further emotional expression. The freedom of dance as a medium for self-expression links it to the concept of “play”, as it permits dancers to leave the “real world” for a moment and create something separate in a safe environment (Payne, 1992). In this manner, dance therapy offers the opportunity to recreate real emotions in this separate, safe environment and in doing so, to understand these emotions in a different way.

Along with the exploration of dance therapy as a means for understanding emotions, it can also provide the simple benefit of release of strong emotions or tensions held within the body. Even if the dancers are uncomfortable with large, angry dance patterns, the basic action of making a fist and then releasing it allows the individual to feel the tension leaving the body. This symbolic action of “letting go” of negative emotions can be quite powerful (S. Saterstrom, personal communication, May 9, 2011). Dancers may be willing to express strong emotions that would be difficult to talk about through the medium of movement due to the historical nature of dance as an “approved channel for abreaction” (Siegel, 1984, p.18). Additionally, dance offers a chance for an individual to explore and develop a deeper understanding of their body which allows for inner focus without requiring self-centered conversation that may be difficult for some cultures.

Dance therapy in groups can emphasize the connectedness of all dancers and allow the individual to feel the connectedness between members of the group (referred to as *synchrony* in the field of dance therapy), especially if movements are passed around the group via mirroring of other dancers or a leader. In group dances, a leader is not a necessity which can allow for a more egalitarian process. Dance therapists and group leaders can choose to mirror the actions of an individual dancer, giving them the role of the leader in the group. Seeing an individual movement echoed around the group can be an empowering process for this leader. This learning and mirroring process also illustrates the connection between all members of the group and the connection of the individual to a larger whole. If the dance therapist incorporates traditional movements, or allows dancers to teach the therapist and the other dancers about possible traditional movements to include, the dance process can then be used as a mechanism for honoring culture and emphasizing connection between the individual, the group and the larger culture.

The mental health benefits of dance therapy are based in the idea that the body and mind are not separate entities. Physical activity as a way to address mental health is more consistent with the Hindu/Bhutanese worldview than the traditional clinical model, which may make dance therapy an effective complement to individual or group work. In the specific case of the Bhutanese refugees, the high rates of psychosomatic disorders makes dance therapy a potentially useful intervention because it works to reunite the psyche and soma and reconcile their dichotomous treatment in modern mental health. Dance therapy allows for expression and understanding of emotions in a non-verbal manner which is particularly important for populations with limited English proficiency or cultures that discourage talking about the individual. Dance may give these populations a chance to express themselves differently and in a more familiar medium, allowing for feelings of competency and enjoyment that may be difficult to create with traditional talk therapy.

These specific characteristics of dance therapy as reinforcement of interconnectedness, as empowerment and as a cultural celebration make it an appropriate mental health intervention for the Bhutanese refugee population, given the specific challenges of lacking social supports and the mental effects of refugee warehousing, statelessness and ethnic cleansing.

Specific Techniques and Suggestions for Dance Therapy

Dance therapy is a flexible field and can be incorporated into individual or group settings in many ways. For populations that may be hesitant to embrace dance, movement can be incorporated in very basic ways. For example, the activity of clenching and releasing a fist as described above is one way movement can be brought into traditional therapies. Other suggestions include mimicking the movements of traditional games, cooking motions, child care activities or specific cultural dances (S. Bauer, personal communication, May 2, 2011).

Music is an important part of the movement process as it offers the dancers something to draw on as they recreate their emotions in movement. If the dance form is outside the cultural norms of the population, using traditional music may increase comfort and familiarity with the activities. Similarly, in cultures where self-expression and individual activity is limited, moving in groups may help individuals feel more comfortable with the activities. Including children in the activities may help older dancers feel comfortable as they can mimic the more free movements of the children. This also gives the activity a sense of play and may be especially appropriate for cultures with a strong emphasis on family.

To offer a general framework, a dance therapy session may begin with a warm-up to encourage individuals to become comfortable in the environment and with other group members. An unstructured warm-up allows the therapist a chance to gauge the energy level of the group and adjust any structured activities as necessary (Payne, 1992). In populations that are comfortable with movement and dance as a means of self-expression, an improvisation period can allow the therapist to observe individual dancers and the emotions conveyed through their movement. Populations that are less comfortable with dance therapy may want to use a cultural dance or a smaller activity, as described earlier, to incorporate movement and allow for some emotional expression and release. The closing of the session often includes a relaxation period that allows individuals to focus on their own thoughts and body followed by a sharing time when individuals are invited to share any thoughts or observations they have about the experience (Payne, 1992).

A thorough overview of specific techniques used in dance therapy is offered by Payne (1992). Techniques listed are touch, mirroring, exaggeration, improvisation and organized movement sequences. Therapeutic touch can offer either comfort or provocation; both manners of touch may be used in a therapy session along with variations in the quality of touch. Mirroring creates a “movement dialogue” and often leads to improvisation or self-reflection on the movement. Exaggeration helps establish a starting point for a motion and then allows individuals to carry the movement where they wish. Improvisation connects dance back to play and can be an effective addition to exaggeration with confident individuals. Organized movement sequences allow individuals to make a statement with their movements and offers a way to summarize a session of movement.

A session structure similar to the moving meditation experience offered by Professor of Dance Sheryl Saterstrom at St. Olaf College in Northfield, MN, may offer another set of techniques for populations that are more reluctant to participate in free improvisation. These half hour sessions are divided into three discrete ten minute sections: warm-up, finding symmetry and breath focus. Calm music is played throughout the session.

During the warm-up period, dancers are encouraged to move in whatever way they would like, from stretching exercises to vigorous physical activity. If improvisation is not working for the group, a session of following the leader can be used.

In the second period, finding symmetry, the focus is on finding balance and symmetry within the body. This may include activities like placing both hands on both shoulders and feeling the balance or imbalance between the two sides. This process can move from the top of the head down to the feet; popular points on the body to feel the symmetry are the top of the head, the jaw, shoulders, the back, hips and legs. When an imbalance is felt, the dancer can make necessary adjustments to bring the body back into symmetry with the understanding that the body is changeable and can be taken out of imbalanced conditions.

As an adaptation for populations that discourage self-touch or individual activities, this work may be performed with a partner, as appropriate. Additional adaptations may include bringing in a symmetrical picture or object, including cultural images. Asking dancers to sit quietly and focus on the symmetry of the object and then incorporate small symmetrical movements into this reflective time may be more comfortable for some populations. If possible, food, scented items or music may be used as the dancers can inhale with both nostrils or hear with both ears and then feel the symmetry flow down through the rest of the body.

The third stage has individuals sit or lay in a comfortable position and focus on their breath. The concentration on inhaling and exhaling can mimic the feeling of tension release created by the clenching and releasing of the fist. This focus on the breath is something that should be present throughout the previous two stages as well as it enhances awareness of rhythms of the body and provides a centering basis for reflection.

Mental Health in the ESL Classroom

Another way mental health can be incorporated in a non-traditional setting is through inclusion in the curriculum of English as a Second Language (ESL) classrooms. Inclusion of mental health in the classroom can provide an alternative to the traditional model of mental health in a clinic and can help meet the refugees where they are in the process of healing trauma.

Challenges of the Current System

There is a sentiment in some refugee communities of not wanting to talk to a doctor, or anyone else perceived as “official”, about issues of mental health due to fear of losing refugee status or being forced to leave the country (University of Minnesota, 2010). Many refugees, such as the Bhutanese, come from countries and backgrounds where issues of mental health were not discussed in institutional settings and discussions of mental health carried a heavy stigma. Additionally, many refugees perceive that doctors do not have time to talk to them about issues of mental health and if they do discuss issues of mental health with a doctor, they may be reluctant to take medication because it is not perceived as a “long term solution” to the problem (Dossa, 2002). Additionally, as discussed earlier in this paper, traditional mental health therapy relies almost exclusively on work with pre-displacement stressors and neglects the impact of displacement-related stressors.

Refugees arrive in the United States with a host of challenges. Many are in mourning for losses of homes, family and friends, struggling with survivor guilt, utilizing coping mechanisms born out of necessity (ex. extreme distrust of others), struggling with changing family dynamics or realizing their expectations do not match the reality of life in the United States. Language barriers prevent many from seeking help and a weakened social network presents additional challenges.

ESL as an Effective Mental Health Intervention

The ESL classroom is an appropriate place to begin addressing some of these issues for a variety of reasons. The classroom is a safer space, focused on cooperative learning and skill development. The understanding that the students are still learning English can make it a lower-stress environment and teachers are aware and respectful of cultural differences. For some refugees who are relatively isolated, the ESL classroom may be their greatest source of social support and connections can form across cultures as students communicate and recognize commonalities of their experiences.

The ESL classroom is explicitly concerned with helping refugees adapt to life in the United States by providing them the tools of communication and literacy in English. The development of these skills is empowering and helps alleviate displacement-related stressors. For refugees such as the Bhutanese, who experienced long stays in refugee camps, developing the language and communication skills necessary for employment can help with many of the challenges associated with twenty years of being unable to work. Even without inclusion of specific mental health activities, ESL instruction can help improve the mental health of refugees by strengthening their capacities to live in a new environment. For many, the process of learning and gaining new skills may be helpful in counteracting the powerlessness of war trauma and refugee warehousing. A characteristic of successful mental health interventions is willingness to start where the consumer is – including mental health discussions and health literacy activities in the ESL classroom allows refugees to focus on learning the survival skills necessary for life in a new culture while simultaneously giving them crucial information and allowing a safe space for discussions of past experiences and emotions.

ESL education can help address some of these challenges by providing a safe space for expression of strong emotions without fear of losing refugee status, working in a cooperative learning environment and enhancing coping skills for life in the United States. Performing this work in a setting that is not stigmatized and working at a group and community level allows for a more effective intervention with refugee populations.

For students who do not have a mental disorder at the time of the class, ESL curriculum can work at a preventative level by enhancing awareness of healthy lifestyles, developing coping and adaptive skills and increasing student self-esteem (Cohon, Lucey, Paul & Penning, 1986). Because all newly arrived refugees are required to attend ESL classes, this can be an excellent avenue for prevention work. A list of preventative strategies of mental health is outlined by Cohon et al. This list includes promotion of mental health (enhancement of self-esteem, developing feelings of success, cultural pride, security and support) and enhancement of coping skills (skills to modify situations, skills to change the meaning of events and skills to manage stress).

The importance of preventing mental illness is outlined in the following diagrams from Cohon et al. (1986):

Migration (Resettlement) → Stress → Illness (physical/psychological)

Primary prevention → Increased coping capacities and self-esteem → Decreased stress

Decreased stress → Decreased risk for illness → Greater chance of achieving self-sufficiency

ESL classrooms are effective spaces for mental health interventions because they are supportive and safe environments focused on empowerment by means of facilitating development of social support networks, increasing capacities to cope with displacement-related stressors and developing the skills necessary for employment and self-sufficiency in the United States.

Limitations

The incorporation of mental health into an ESL classroom can create challenges for ESL teachers. One problem that can arise is the teacher being put into the role of a therapist. This puts undue strain on the mental health of the teacher and can have negative consequences for the health of the student if the teacher attempts to take on this role. It is important to clarify with students that the teacher is not a therapist. ESL teachers can be invaluable in helping develop coping skills, language instruction and a safe classroom environment but are not providers of mental health services (Adkins et al., 1999).

The teacher needs to maintain contacts within the wider community to be able to effectively refer students to other professionals if a serious mental health issue emerges in class. Failure to respect the boundaries of professional competence can result in vicarious trauma for the teacher and negatively impact the health of the student.

General Techniques

At the end of this section is an annotated bibliography (Appendix I) with specific health literacy resources and classroom activities. For the most effective presentation of these activities and materials there are certain general considerations that should be taken into consideration.

There are two main ways that ESL classrooms can incorporate discussions of mental health in the classroom. The first is by improving health literacy of students, defined as “the ability to use English to solve health-related problems at a proficiency level that enables one to achieve one’s health goals, and develop health knowledge and potential” (Singleton, 2002, p.3). Health literacy empowers individuals to interact with the medical system by providing information and education on all issues of health, including mental health. The complexity of the United States health care system and the lack of distinction between physical and mental problems in the perspective of some refugee cultures makes discussion of health literacy a crucial part of any ESL mental health intervention.

The second way ESL classrooms can incorporate discussions of mental health is through direct discussion of mental health concepts and potentially personal experiences. When combined with health literacy, these class discussions can help refugees connect mental health concepts to their own situation and utilize newly acquired skills to access needed services.

ESL classrooms should be safe and welcoming spaces for students. ESL teachers can create this environment by treating all students with respect and understanding cultural differences. ESL teachers need to recognize the students were not always refugees, that all have strengths and the ability to contribute to the classroom environment. In many refugee cultures, as in the Bhutanese culture, direct communication can be taken as aggressive so indirect communication may be a preferable choice whenever possible.

In a pilot program at the Spring Institute, a curriculum was designed specifically for survivors of tortures. Accommodations to the classroom setting included increased time for socializing, incorporation of celebrations and relaxation activities, long breaks to allow students to eat together, a student informed

curriculum and a slower classroom pace (Spring Institute & Rocky Mountain Survivor's Center, n.d.). Flexibility in class participation during potentially triggering discussions of mental health is also recommended. A strong curriculum will offer students a choice of how much to participate without making them feel obligated to join in; teachers can clarify with students that it is acceptable if they do not feel like participating fully in these discussions and some teachers may choose to create a "quiet corner" students can use if they feel unable to participate in a specific discussion (Isserlis, 2000). It should be noted that classroom discussions of personal traumatic experiences are discouraged due to the lack of a therapist in the classroom to help with what may be a challenging sharing process and/or the impact a personal story may have on other students with similar experiences.

Performing a needs assessment and allowing student input on future topics empowers students and helps create a more effective curriculum. Inclusion of art and music activities in the classroom can provide opportunities for stress relief and increase the student's language learning capabilities. Teachers can employ active listening techniques which have the dual purpose of allowing students to check their comprehension as well as increasing the sensation that the words they are saying are being heard, an empowering experience.

To help facilitate discussions of mental health in the classroom it may be best to approach the issue using picture stories or cartoons depicting common mental health issues. In this approach, students respond to prompts from the teacher and work together to either construct an understanding of what is happening in the picture story or decide what advice they would give the characters. This approach is referred to as the Language Experience Approach, which allows students to use their own language to work cooperatively and determine what is happening in the pictures (Singleton, 2002). With the Language Experience Approach, pre-teaching vocabulary can help with the student response. This approach is consistent with a mental health intervention because allows the student to be the authority on the events of the story and frequently gives insights to how students view issues of health and mental health.

Additionally, de-personalizing discussions of mental health has two impacts: reduction of stigma and/or shame associated with sharing personal experiences and increased cultural competency for those cultures that discourage discussion of internal processes and prefer to focus on external people and concepts. For students with low literacy levels, picture stories make the discussion accessible and can lessen stress as they are more universally understood.

Other helpful activities include those that teach students how to ask questions and advocate for themselves in the culture of the United States. For many refugees, lack of language skills and cultural norms may limit their willingness to ask questions of service providers outside of the ESL classroom. Increasing these capabilities within the ESL setting further empowers students to advocate for themselves in the broader US culture and increases coping skills. Additionally, many pre-displacement stressors such as war trauma are associated with a loss of control; incorporating activities that give students a sense of control over their lives (for example, goal planning) is one way to address issues of mental health without explicit discussion of the topic (Adkins et al., 1999).

Some suggested topics for mental health in the ESL classroom include: the doctor's office, safe housing, school in the United States, parent/child relationships, adult relationships, recreational activities, shopping for healthy foods, conflict resolution and remembering the past, native country and family and friends (Adkins et al., 1999, 20). Specific ESL activities are discussed in the following section.

Appendix I

Annotated Bibliography - ESL Activities & Resources

Health/Mental Health Education

Crossing Cultures: Five Simple Steps to Improve Health by Improving Communication ***Center for International Health***

This 13 minute video offers a technique to use when working with people from different cultures in a medical setting. Although the presentation is specifically geared towards the medical profession, the technique can be used in any situation where cultural differences arise. The technique outlined is called LEARN, which stands for Listening (asking questions of the patient, asking for their input, etc.), Explain (explaining the Western medical ideas), Acknowledge (recognize the differences in opinion), Recommend (recommend treatment actions) and Negotiate (work to find a compromise together).

Access information:

A copy of the DVD is available from:

<http://www.minnesotamovie.com/freecountrymedia.html>

Culture, Health and Literacy: A Guide to Health Education Materials for Adults with Limited English Skills ***World Education***

This document is an annotated bibliography of health literacy resources available, designed specifically with limited proficiency English adults in mind. The topics covered include specific health issues, advocacy, cross-cultural communication and patient's rights. Many of the sources are available for free download and many list multiple languages. There are no Nepali specific resources, but many of the English resources indicate they would be appropriate for adults learning English.

Access information:

The document is available for download from:

<http://www.healthliteracy.worlded.org/docs/culture/index.html>

Easy-to-Read Health Materials ***MedlinePlus***

Medline Plus offers a significant selection of brochures and information on various health topics. Each resource focuses on a specific disease, condition or prevention measure and is defined as "easy-to-read". The brochures were not designed specifically with ESL students in mind, but the level of English may be appropriate for some students. The brochure on PTSD is included in Appendix III and will give a general sense of the level of English needed to understand these resources. The specificity and range of the brochures could be very useful if students have questions about a specific condition or disease.

Access information:

All brochures are available for download from:

http://www.nlm.nih.gov/medlineplus/all_easytoread.html

A hard copy of the PTSD brochure is included in Appendix III

***Health Guide for Refugees in Minnesota
Minnesota Department of Health***

This 99 page booklet offers a comprehensive overview of every aspect of the health care system, specifically targeting newly arrived refugees to Minnesota. Specific topics include paying for health care, preventative health care, dental care, mental health and patient rights. A glossary is included as well as suggestions on questions for health care providers. The handbook is written in English, which may limit its effectiveness for newly arrived refugees as the language is quite technical at times.

Access information:

The booklet is available for download from:

<http://www.health.state.mn.us/divs/idepc/refugee/hcp/healthguideeng.pdf>

***Navigating the Health Care System Video
Emergency & Community Health Outreach (ECHO)***

This 30 minute video offers an overview of how the United State healthcare system functions. Topics covered include insurance (benefits, costs and coverage) and forms of health care provision (hospital, primary care, specialist, urgent care). Other topics addressed are how to get insurance, what to bring to appointments and the importance of preventative health. The video is aimed at an audience of immigrants and refugees and the speakers use basic terminology. The DVD is available in English, Spanish, Hmong and Somali.

Access information:

The DVD is available for streaming and purchase from:

<http://www.echominnesota.org/library/navigating-health-care-system>

***Staying Healthy: An English Learner's Guide to Health Care and Healthy Living
Florida Literacy Coalition, Inc.***

The Staying Healthy handbook is a 104 page educational book, written for adults with limited English proficiency. The information is divided into six chapters titled "Health Care", "Your Doctor", "Medicines", "Nutrition", "Chronic Diseases" and "Staying Healthy". At the end of the handbook is a glossary of technical words with a pronunciation guide. All chapters and the glossary are available for individual download. The handbook has two addendums, on the topics of "Stress" and "Women's Health". The workbooks are visually appealing and use lots of graphics. Accompanying the student books are teacher handbooks that walk through each chapter and allow adaptations for students with different language capabilities.

Access information:

All student workbooks and teacher handbooks are available for download from:

http://www.floridaliteracy.org/literacy_resources_teacher_tutor_health_literacy.html

***Women's Mental Health: What It Means to You
US Dept. of Health and Human Services***

This 22 page booklet offers a comprehensive overview of various issues of mental health. Topics covered include self-care, suicide prevention, eating disorders and menopause. Information is given on prevention activities and a resource list is included at the end. The level of English will likely be too

demanding for some ESL students, but the summary sections offers a list of common symptoms of mental health issues that is clearly written and easier to understand.

Access information:

The booklet is available for download from:

<http://store.samhsa.gov/shin/content//OWH09-CONSUMER/OWH09-CONSUMER.pdf>

A hard copy of the booklet is included in Appendix III

ESL Activities

ABC's for Tutors: 26 Teaching Tips

Shirley Brod, Spring Institute for International Studies

This list of 26 general teaching tips for ESL tutors provides a variety of suggestions on effective teaching. Tips range from specific activities to guidelines for classroom conduct. This could be helpful for an inexperienced tutor or for generating new activities and ideas to incorporate into the classroom.

Access information:

The list is available for download from:

<http://www.springinstitute.org/Files/26tips1.pdf>

A hard copy of the list is included in Appendix III

Applications

Barbara Sample, Spring Institute for International Studies

This is a full lesson plan focusing on improving employment skills. The lesson focuses specifically on the process of filling out an application by familiarizing students with common application vocabulary and practicing filling out the required information.

Access information:

The lesson is available for download from:

<http://www.springinstitute.org/Files/app108.pdf>

A hard copy of the lesson is included in Appendix III

Cultural Adjustment, Mental Health and the ESL Experience

Spring Institute for International Studies

This packet gives a comprehensive overview of general mental health interventions in the ESL setting and concludes with a section detailing specific activities designed to address issues of mental health. Topics include culture shock, goal setting, active listening practice, memory activities and journaling. A full curriculum is provided, with objectives and procedures listed.

Access information:

The packet is available for download from:

<http://www.springinstitute.org/Files/culturaladjustmentmentalhealthandeshl.pdf>

A hard copy of the activity section is included in Appendix III

Egal Shidad: Mental Health***Partnership between Confederation of Somali Community of MN, ECHO Minnesota, KFAI Community Radio, St. Paul Neighborhood Network***

This curriculum is designed for use specifically within an ESL classroom of Somali students and covers issues of mental health and the United States healthcare system through a video and accompanying workbook. Although the explicit focus on Somali culture and language may present challenges in using the material with other populations, the curriculum offers a strong set of chapters on depression, listening to mental health providers, mental health dialogs, finding help, following advice and mental health vocabulary. This written curriculum may be transferrable to other populations, although the accompanying video, produced in Somali with English subtitles, will have limited usage outside the Somali population. The vocabulary sections (broken down by level of English competency) and the activities for each section could prove to be very useful.

Access information:

The complete curriculum is available for download from:

<http://www.echominnesota.org/library/egal-shidad-stories-somali-health>

Egal Shidad: Raising Our Children***Partnership between Confederation of Somali Community of MN, ECHO Minnesota, KFAI Community Radio, St. Paul Neighborhood Network***

This second curriculum with the Egal Shidad program covers topics of parent-child relationships and how to strength communication across generations. Vocabulary lists, worksheets and activities are included with this curriculum. Vocabulary focuses on healthy communication styles, family relationships and interactions between adults. There is discussion of parent-teacher conferences and how to ask questions. The same limitations apply with this second curriculum as with the mental health curriculum. The Egal Shidad program is produced specifically for Somalis and the accompanying video will not be useful outside of this population. However, the vocabulary and activities focused on family relationships may be easily modified to reach a broader population of English language learners.

Access information:

The complete curriculum is available for download from:

<http://www.echominnesota.org/library/egal-shidad-stories-somali-health>

ESL As A Mental Health Intervention***Spring Institute and Rocky Mountain Survivor's Center***

This PowerPoint presentation focuses primarily on outlining general characteristics of an ESL-based mental health intervention. Near the end of the presentation are discussions of specific activities, including several about health literacy. Activities include a worksheet to use for checking comprehension of medicine labels, recognizing important sounds (train, fire truck, smoke alarm, car horn) and understanding voicemail messages.

Access information:

The presentation is available for download from:

<http://www.healtorture.org/files/files/0709WebinarPPT.pdf>

A hard copy of the slides is included in Appendix III

***Health Literacy Materials and Instruction Guide
Literacy Information and Communication System***

This health literacy curriculum is designed especially for students with limited English proficiency and includes 18 extensive sections. Each section sets out basic vocabulary, graphic descriptions and definitions and activities. Each closes with an explanation of the English learning opportunities of the section and offers specific activities to promote language acquisition. The curriculum covers a range of topics from an overview of the health system to prevention to procedures and medications. Mental health is not explicitly addressed. There are two levels of the curriculum available, depending on the English ability of the student.

Access information:

The full curriculum is available for download from:
<http://lincs.ed.gov/health/health-begin>

***Is That All There Is?
Spring Institute for International Studies***

This lesson seeks to familiarize students with language necessary for work in a hotel housekeeping setting as well as preparing them for the United States work culture with discussion of time and personnel management. Activities and vocabulary are provided with this curriculum.

Access information:

The full curriculum is available for download from:
<http://www.springinstitute.org/Files/scansall.pdf>
A hard copy of the lesson is included in Appendix III

***Life Book Trainer's Guide
International Organization of Migration - Nepal***

This handout is designed to teach trainers to guide refugees through the Life Book exercise. The Life Book is designed to be completed prior to resettlement so it may have limited application with resettled refugees but some of the activities still apply. Examples of activities included in the Life Book are development of a tree of life, discussion of favorite places in the country of origin and country of resettlement, cultural values and plans for the future.

Access information:

The guide is available for download from:
http://www.cal.org/co/email_discussion/Attachments/2010_05_11-IOM_Nepal_LifeBook_Trainer_Guide.pdf

A hard copy of the handout is included in Appendix III

***The Medical Simulation: A Confidence Building Tool for Refugee Students
Phanat Nikhom Refugee Camp***

This lesson plan provides students the opportunity to role play various components of interactions with the medical system, including making an appointment, talking to the doctor and paying for their

appointment. The simulation is designed to give students greater confidence in talking to doctors and managing the health care system.

Access information:

The curriculum is available for download from:

<http://www.eric.ed.gov/PDFS/ED254099.pdf>

A hard copy of the lesson is included in Appendix III

Picture Stories For Adult ESL Health Literacy
Kate Singleton, Fairfax County Public Schools

This set of 8 lessons about topics of health literacy are titled “Emergency”, “Doctor’s Appointment”, “Stressed Out”, “What Should She Do?”, “Depressed”, “The Right Dose”, “What Happened to My Body” and “Snack Attack”. Each discussion topic has an accompanying picture story and teacher guidelines. The preferred methodology for using these pictures is to prompt discussion about the chosen topic by allowing students to discuss the actions of people in the cartoons rather than disclosing their personal experiences. This may make students more comfortable addressing issues of mental health and serve as a strong starting point for classroom discussions about sensitive topics.

Access information:

Discussion topics and accompanying picture stories are available for download from:

http://www.cal.org/caela/esl_resources/Health/healthindex.html

A hard copy of these materials is included in Appendix III

Preventive Mental Health in the ESL Classroom: A Handbook for Teachers
J. Donald Cohon, Moira Lucey, Michael Paul, Joan Penning

This handbook for teachers offers a comprehensive argument for inclusion of mental health into the ESL classroom as a preventive measure. The beginning section of the handbook offers psychological theory and an overview of challenges facing refugees. The second half focuses on implementation for classroom use with discussion of how to alter existing curriculum for use as a prevention tactic and offering specific activities.

Access information:

The handbook is available for purchase from:

<http://www.amazon.com>

A hard copy of the section on classroom implementation and specific activities is included in

Appendix III

Silk-Screening: Task-Based Learning in a Basic Job Skills Lesson
Galang Refugee Processing Center

This lesson plan focuses on developing language ability and understanding the measurement system in the United States. Students are given basic instructions and have the chance to practice measuring and responding to questions about their activities. Many materials are required for this lesson, which may limit its effectiveness, but it provides a basis for development of skills that may transfer to employment.

Access information:

The lesson is available for download from:

<http://www.eric.ed.gov/PDFS/ED254099.pdf>

A hard copy of the lesson plan is included in Appendix III

Stress and Relaxation/Functional Complaints
Mental Health of Refugees, World Health Organization

These two units are taken from the larger handbook, *Mental Health of Refugees*. Designed to be used by people working with refugees, these units offer background information on mental issues and give suggestions for techniques and activities to reduce stress and anxiety as well as ways to handle somatized mental disorders.

Access information:

The complete handbook is available for download from:

<http://whqlibdoc.who.int/hq/1996/a49374.pdf>

A hard copy of the two units is included in Appendix III

Resources in Nepali

A Guide to Your Refugee Health Assessment
Minnesota Department of Health

This brochure explains important information about the refugee health assessment procedure. It explains the purpose of the assessment as well as giving information about what to bring, where to go and provides referral phone numbers for more questions. This brochure is available in Nepali, as well as several other languages.

Access information:

The brochure is available for download from:

<http://www.health.state.mn.us/divs/idepc/refugee/hlthmat.html>

A hard copy of the Nepali brochure is included in Appendix III

Food Safety Handout
World Health Organization

This one page handout covers the basics of food safety with five key points to remember. The food safety information is geared towards Western style cooking, which may make this a useful resource for refugees recently arriving to the United States

Access information:

The brochure is available for download from:

http://www.who.int/foodsafety/publications/consumer/en/5keys_nepali.pdf

A hard copy of the brochure is included in Appendix III

Healthy Refugee Toolkit
US Committee for Refugees and Immigrants

This toolkit covers a variety of health issues and is available in Nepali. Topics covered in Nepali include communicable diseases (Hepatitis B), environmental health (lead poisoning), nutrition (vitamin D and calcium) and mental health, among others. More information is available in English.

Access information:

All brochures are available for download from:

<http://www.refugees.org/resources/for-refugees--immigrants/health/healthy-living-toolkit/>

A hard copy of the Nepali mental health topics (Adjusting to a New Culture, Substance Abuse, Stress Management) is included in Appendix III

Nepali Health Topics
Healthy Roads Media

This collection of Nepali language health education materials focuses primarily on HIV/AIDS information, including prevention, transmission and symptoms. An additional handout focuses on infant/child health. All information is available as either a printed handout or a video. The site is difficult to navigate as it lacks English markers, but offers a significant amount of information in the Nepali language.

Access information:

All handouts are available for download from:

<http://www.healthyroadsmedia.org/nepali/index.htm>

A hard copy of the Nepali infant/child health handout is included in Appendix III

Refugee Health Resources
Refugee Health Information Network

The refugee health resources provided in this searchable database provide an effective starting point for searches on health information in multiple languages. There are 34 resources available in Nepali, with much of the information focusing on vaccinations and minor illnesses. The UN Universal Declaration of Human Rights is included, as is a series titled “Refugee Family Strengthening Programs – Relationship Enhancement Workbook” that covers topics like “Remembering What’s Good”, “Problem Solving Steps” and “Ways to Manage Stress and Anger”.

Access information:

All handouts are available for download from:

<http://www.rhin.org/Default.aspx>

A hard copy of “Remembering What’s Good” and “Ways to Manage Stress and Anger” is included in Appendix III

Vaccine Information Statements
Immunization Action Coalition

Available for download from this website are six vaccination information sheets, translated from information provided by the Center for Disease Control. Resources are available for the chickenpox, Hepatitis B, measles/mumps/rubella, polio and tetanus/diphtheria/pertussis vaccinations.

Access information:

All information sheets are available for download from:

http://www.immunize.org/vis/vis_nepali.asp

Additional Resources

Adult ESL Resources

Center for Adult English Language Acquisition

http://www.cal.org/caela/esl_resources/bibliographies.html

and

http://www.cal.org/CAELA/esl_resources/

- List of resources for instructors of adult ESL

Easy-to-Read Health Materials

MedlinePlus

http://www.nlm.nih.gov/medlineplus/all_easytoread.html

- List of publications and informational brochures on a wide variety of health topics

ELT Publications Library

Spring Institute for Intercultural Learning

<http://www.spring-institute.org/?action=publications>

- List of resources for instructors of ESL, including curriculum and guidelines

Health Education Materials for Refugees

Minnesota Department of Health

<http://www.health.state.mn.us/divs/idepc/refugee/hlthmat.html>

- List of health education resources specifically for refugees in Minnesota, multiple languages

Overseas Toolkit Lesson Plans

Cultural Orientation Resource Center

<http://www.cal.org/co/overseas/toolkit/index.html>

- List of resources to prepare refugees for resettlement and the United States, English only

Outreach Activities and Resources

U.S. Department of Health and Human Services

<http://sis.nlm.nih.gov/outreach/multicultural.html#a3>

- List of culturally specific health resources, multiple languages available (little Nepali information)

Patient Education

EthnoMed

<http://ethnomed.org/patient-education>

- List of health education resources, multiple languages

Publications Ordering

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/home>

- Collection of publications focusing on mental health and substance abuse

Refugee Health Resources

Refugee Health Information Network

<http://www.rhin.org/Default.aspx>

- Collection of translated health documents, multiple languages

Resource Guides and Publications

The Cross Cultural Health Care Program

<http://www.xculture.org/>

- List of multilingual resources, most requiring purchase, including Nepali/English medical glossary and links to other relevant sites.

Translation Library

Exchange: Translations and Resources

<http://www.health-exchange.net/>

- Collection of 4,000+ translated health-related resources. Requires membership to access

Appendix II

Annotated Bibliography – Bhutanese Experience & Refugee Mental Health

Adkins, M.A., Birman, D., Sample, B., Brod, S., & Silver, S. (1999). *Cultural adjustment, mental health and ESL.*

This handout, produced by the Spring Institute, provides a guide for ESL teachers who wish to incorporate more knowledge of mental health into their classroom setting. The handout lists various reasons why ESL classrooms are often the places that issues of mental health/stress related to resettlement are addressed including the idea of the classroom as a safe space and the comfort of a classroom as opposed to a clinical setting.

In the beginning, an explanation is provided of the various forms of mental health ESL teachers are likely to encounter. The authors discuss typical stress experienced during the resettlement process, theories of acculturation, stages of cultural adaptation and the role of social support throughout resettlement. In the second segment of the handout, the authors give more detail about the connection between ESL and mental health discussion, including an overview of the role of English capabilities as a tool for employment and cultural adjustment. The handout concludes with eight activities that may be helpful in teaching language skills and allowing students an opportunity to discuss feelings, improve emotional communication and find some form of closure for places and people they have left behind.

Hard copy included in Appendix III

Bhutan. (2005). In *Mental health atlas 2005.*

WHO offers a comprehensive summary of the state of mental health services in Bhutan in 2005. Although the majority of refugees were not present in the country in 2005, the article gives an understanding of the cultural perceptions of mental health that many of the refugees may hold. Notably, although mental health is considered a part of the primary health care system there is little reporting of mental illness, no legislation in place and no programs for special care.

Hard copy included in Appendix IV

Bhutanese Refugee Support Group, Ireland and UK. (2001). *NGO response to initial state party report: Bhutan – under the Convention of the Rights of the Child.*

This report provides the response to the report by the Kingdom of Bhutan on the country's progress in adhering to the standards set down by the Convention of the Rights of the Child, which Bhutan ratified in 1990. The various NGOs involved in the production of this report begin with a thorough history of the cultural genocide and refugee situation of the Lhotshampa and uses the Bhutanese refugee children to illustrate various ways in which Bhutan has failed to adhere to standards set by the CRC. The report argues that Bhutan has fallen short with regards to non-discrimination.

There are strict limitations on Bhutanese citizenship and the majority of the refugee children, born in refugee camps to parents whose nationality is denied by Bhutan are stateless children. Bhutan and Nepal have a long-standing agreement on the need to determine the citizenship status of the refugees living in Nepal but have failed to make any kind of progress in these deliberations. The report offers a comprehensive summary of many of the issues within Bhutan and the refugee situation in Nepal, focusing mostly on the issue of denial of citizenship.

Hard copy included in Appendix IV

Cohon, J. D., Lucey, M., Paul, M., & Penning, J. L. (1986). *Primary prevention and the promotion of mental health in the ESL classroom*. New York: American Council for Nationalities Service.

This handbook provides an overview of a framework for inclusion of mental health in the ESL classroom. It begins with a discussion of the various stressors refugees and immigrants face in their resettlement and moves to an explanation of a framework for primary prevention which is based on the premise that stress-related illness is preventable if intervention is provided early enough in the resettlement process. The framework is explained in full, and the main point is the importance of identification of stressors in refugee's lives through information provided by the students themselves. Once these stressors have been identified, specific activities can be designed to reduce the stress of the experience and enhance coping skills and acculturation. Specific activities are given as examples.

Portions of text included in Appendix III

Dossa, P. (2002). Narrative mediation of conventional and new "mental health" paradigms: Reading the stories of immigrant Iranian women. *Medical Anthropology Quarterly*, 16(3), 341-359.

This article is an explanation of a research ethnography carried out in Canada with Iranian immigrant women. The author sought to understand how storytelling may be an avenue with which to effect change in populations at risk. The introductory pages are focused on offering a critique of society as a whole with regards to immigrant women, specifically looking at the issue of the veil for Muslim women. The importance of storytelling and the terminology of "emotional well-being" as opposed to "mental health" were two of the more relevant topics covered in this article. The author argues to connect mental health or emotional well-being in settings outside of a clinic and encourages the use of storytelling as a mechanism for producing knowledge.

Fabri, M. (1999). *Understanding refugee mental health concerns*.

This article is a very brief summary of many challenges facing refugees. The author moves from the hopes and initial excitement of resettlement to the disappointment when life is not easy in the United States. Emotions which have been locked up due to the day-to-day survival nature of fleeing the home country and existing in refugee camps may have the first opportunity to surface once refugees are in the safety of resettlement. The changed surroundings (urban – rural, rural – urban) may present a challenge as can symptoms of PTSD, including flashbacks. The article calls for specialized programming for refugee mental health as this is a topic that requires extreme cultural sensitivity.

Hard copy included in Appendix IV

Hodge, D. R. (2004). Working with Hindu clients in a spiritually sensitive manner. *Social Work*, 49(1), 27-38.

This article offers an overview and a general framework for service providers working with clients from the Hindu faith. The author discusses the importance of community, the idea of dharma as a sacred ordering of the universe, the family as an important spiritual concept, the caste system, rebirth and karma. The reality of life for Hindus in the United States is discussed, including demographics and challenges. The most discussed challenges are lack of access to Brahman priests as well as value conflicts with the larger society. Recommendations for practitioners working with Hindu clients include an understanding of the orientation towards the other, the functionality of indirect communication styles and the potency of group interventions.

Hard copy included in Appendix IV

Horsman, J. (1997). *“But I’m not a therapist”*: Furthering discussion about literacy work with survivors of trauma.

This paper discusses only literacy work in the sense of United States citizens learning to read their native language. For the most part, it is not useful for the purposes of this project although a definition of trauma is provided that may prove useful.

International Organization of Migration - Nepal. (2008). *The Bhutanese refugees in Nepal: A tool for settlement workers and sponsors.*

This handout, prepared by the International Organization of Migration (IOM) is aimed at Canadian workers and sponsors who are about to begin receiving Bhutanese refugees. Thus, it is a useful document for overviews of cultural practices, highlighting significant differences between Western and Bhutanese lifestyles and giving a general history of the Lhotshampa people. Topics covered include: religion, the caste system, birth/wedding/death rituals, life in the refugee camps (including housing, food, water, education and health care), language, employment histories and the camp governance structure. There is no mention in this article of the violence, exploitation and disempowerment commonly discussed in other articles. The cultural information presented is useful but should also be taken with the natural consideration that culture is difficult to summarize in a short document.

Hard copy included in Appendix IV

International Rescue Committee. (2009). *The health of refugees from Bhutan.*

The article summarizes the major health concerns of Bhutanese refugees. These health issues are identified as:

- Malnutrition (Vitamin A, Anemia specifically)
- Mental Health concerns (related to trauma experiences of murder, torture, physical and sexual violence)
- Dental/oral health

The article discusses specific challenges refugees will face as they transition to the United States including a misconception of medical services as emergency rather than preventative measures. Education is needed about the services now available and about effective self-care. Nutritional concerns are necessary due to long stays in refugee camps and a high prevalence of vegetarian lifestyles. The US healthcare system will likely be overwhelming due to cultural and language barriers and the complex system of insurance.

Hard copy included in Appendix IV

Isserlis, J. (2000). *Trauma and the adult English language learner.*

This brief article offers an overview of the impacts of trauma on adult language learners. The introduction offers a brief definition of trauma and its effects on the ability of students to acquire a new language. The article mostly discusses trauma in terms of domestic violence and offers concrete suggestions for ways ESL instructors can make the classroom a safe space to share about past or current trauma experiences.

Hard copy included in Appendix IV

Kissman, K., & Maurer, L. (2002). East meets west: Therapeutic aspects of spirituality in health, mental health and addiction recovery. *International Social Work, 45(1), 35-42.*

This article examines the impact of spirituality on social work treatments for substance abuse, mental health and bereavement. Specifically, the authors relate spirituality and mental health via discussions of traditional healing, energy transmission and belief in the connection between the self and a higher power. The article argues for inclusion of more Eastern religions and incorporation of ideas such as meditation, holistic thinking and non-attachment. Group work may be found to be beneficial for spiritual work as well as an improved focus on treatments that lower stress through both Western and Eastern spiritual techniques.

Hard copy included in Appendix IV

Lucey, M., Chaffee, M., Terry, D., Le Marbre, J., Stone, B., & Wiencek, D. (2000). *Mental health and the ESL classroom: A guide for teachers working with refugees.*

This handbook, produced by the International Institute of Boston, covers a range of topics on the impact of mental health in the ESL classroom. The handbook is directed towards teachers and opens with a general statement of some of the mental health challenges refugees bring to classrooms. Other discussions include reasons why the ESL classroom is a helpful space for mental health challenges, how the ESL teacher can fit within the greater system of refugee resettlement, frameworks for developing a curriculum focused on student empowerment and a discussion of the importance of needs assessments.

Hard copy included in Appendix IV

Miller, K. E., & Rasco, L. M. (2004). An ecological framework for addressing the mental health needs of refugee communities. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 1-64).

This chapter provides an overview of the emerging concepts of ecological frameworks and community psychology as methods for addressing mental health needs of refugees in countries of origin, refugee camps and countries of resettlement. The authors begin with a thorough overview of the limitations of the current mental health system available for refugees focusing on three main points: the lack of access to mental health services in all settings, the cultural irrelevance of clinical mental health treatment and the limitations of clinic-based services in addressing the multitude of needs aside from past trauma that affect mental health (displacement-related stressors).

The article then gives examples from specific refugees to illustrate the two main stressors: experiences of trauma/war violence and displacement-related stressors. Other factors which are not explored in the same depth include pre-displacement experiences not directly related to war trauma and psychosocial stressors which occur immediately following movement to a third country. The chapter concludes with an outline of the ecological model of community psychology.

Hard copy included in Appendix IV

Navsaria, N., & Peterson, S. (2007). Finding a voice in *shakti*: A therapeutic approach for Hindu Indian women, *Women & Therapy, 30(3), 161-175.*

This article examines the concept of *shakti* as a means for Hindu women to explore any issues of mental health in a therapeutic setting. The authors begin the article with an overview of the importance of religion in therapy work, especially a religion such as Hinduism which has an all-encompassing nature.

The model proposed in this article focuses on *shaki*, defined as “the feminine power derived from goddesses”. Cultural implications for practice including role of women, immigration and understandings of illness are presented and examined. There is also discussion of various Hindu religious practices and how they may offer a healing effect to clients. The article talks exclusively about Indian Hinduism.

Hard copy included in Appendix IV

Nepal. (2005). In *Mental health atlas 2005*.

WHO offers a comprehensive summary of the state of mental health services in Nepal in 2005, with much of the information in the “Epidemiology” section focusing on research carried out with Bhutanese refugees. There are multiple studies summarized that may be examined further, mostly focusing on the mental health and trauma experiences of refugees in camps. Nepal has NGO's functioning within the country in mental health with special programs for refugee populations. Other notable aspects of Nepali mental health the inclusion at the primary level of health care, but all professionals are located in urban/semi-urban settings. Additionally, the government has established a national non-communicable disease prevention and control committee with an included focus on mental health.

Hard copy included in Appendix IV

Neubauer, R. & Spector, R. Two American mental health professionals meet with the only psychiatrist in Bhutan. (2007, September). *Greater Washington Society for Clinical Social Work*.

This article was written by two authors, both mental health workers (LCSW, LICSW & LMFT), after a visit to Bhutan where they spent an afternoon with Dr. Chenchu Dorji, the only practicing psychiatrist in Bhutan as of Sept. 2007. The article gives useful information on the isolationist history of the kingdom as well as an overview of the mental health system currently functioning in Bhutan. The authors address some cultural considerations which may have mental health implications, including the cultural view that change and assertiveness are negative qualities. There is brief discussion about traditional healing mechanisms as well as information on family structure, sexuality and alcoholism. Although the article provides a solid overview of the mental health system in Bhutan, the limitations of the article are obvious. The information may be useful as cultural notes but appears to be based on a single afternoon with Dr. Dorji.

Hard copy included in Appendix IV

Payne, N. (Ed.). (1992). *Dance movement therapy: Theory and practice*. New York: Tavistock and Routledge.

This book of dance therapy theory and practice techniques gives a picture of the varied uses of dance therapy, as well as an argument for its effectiveness in treating mental disorders. The author focuses on dance therapy as a way to reduce isolation and anxiety by connection with a group through synchronized, calming movement. Along with this connectedness, dance therapy offers a chance to explore the individual as part of a greater whole, a concept consistent with the Bhutanese worldview. Seven characteristics of dance therapy are outlined and case studies are given of successful dance therapy interventions.

Portions of text included in Appendix IV

Shrestha, M. (2008). First of 60,000 refugees from Bhutan arrive in U.S. *CNN International*.

The article offers a basic overview of the initiation of the resettlement process of Bhutanese refugees. The article gives a synopsis of the ethnic cleansing and the conditions causing migration. CNN identifies various United States resettlement locations as New York City, Chicago, Syracuse and St. Louis. Additional discussion points include the divide in the refugee community over whether to resettle and the elections ending over 100 years of royal rule.

Hard copy included in Appendix IV

Siegel, E. V. (1984). *Dance-movement therapy: Mirror of our selves. The psychoanalytic approach*. New York: Human Sciences Press.

This book offers an explanation and overview of dance therapy as a tool to explore issues of mental health. The author writes from a psychoanalytic perspective and devotes much time to discussion of the connection between the mind and body. Dance therapy is explored as an alternative to a framework that differentiates between psychological and biological functioning – this holistic view of the functioning of the whole person is consistent with the cultural views of the Bhutanese and the author's arguments strengthen the idea of dance therapy as an appropriate intervention with this population.

Singleton, K. (2002). *Health literacy and adult English language learners*.

This article examines the importance and challenges of health literacy with ESL students. Health literacy is defined as “the ability to use English to solve health-related problems at a proficiency level that enables on to achieve one's health goals and develop health knowledge and potential”. Although the article focuses mainly on health as a general topic, issues of mental health are examined briefly. Reasons are given why students may struggle with the US health care system, challenges facing the ESL instructors are discussed and a specific activity is given as an example of how to incorporate health literacy within the ESL setting.

Hard copy included in Appendix IV

Sokoloff, C. (2005). *Denial of citizenship: A challenge to human security*. United Nations Office for the Coordination of Humanitarian Affairs.

This report offers an overview of the effects of statelessness and denial of citizenship as a challenge to human security. The report estimates that 9 million people throughout the world are denied citizenship with the largest groups in Central, South and Southeast Asia, sub-Saharan Africa and Eastern Europe. Discussion includes reasons governments prevent groups from obtaining citizenship, common mechanisms used for denial of citizenship and the impact of this denial.

Selected case studies are examined including the Rohingyas of Burma, the Banyarwanda of Democratic Republic of Congo, Bihari of Bangladesh and the Lhotshampas of Bhutan. In the case study of the Lhotshampa people, the authors trace the history of the denial of citizenship and ethnic cleansing focusing on the Nationality Law and Citizenship Act of 1985.

Hard copy included in Appendix IV

United Nations High Commissioner for Refugees. (2006). Protracted refugee situations: The search for practical solutions (chapter 5). In *The state of the world's refugees 2006: Human displacement in the new millennium* (pp. 105-197).

This article, produced as part of the report on the state of the world's refugees examines protracted refugee situations, the effect of these situations on refugees, communities and countries and examines key steps necessary to develop sustainable solutions. Protracted refugee situations now account for the majority of all refugee situations worldwide, making this a pressing global problem.

In a discussion of the causes of protracted situations, the report identifies three key factors: prevailing conditions in the country of origin, policy responses of the country of asylum and lack of sufficient donor engagement. The report is clear on the idea that protracted situations have underlying political causes and thus, the solutions must come from both humanitarian and political organizations. The international community is identified as crucially important to the development of solutions, specifically the engagement of the peace and security sector, development sector and humanitarian agencies.

The report discusses some of the consequences of protracted refugee situations, highlighting the importance of finding sustainable resolutions. Identified consequences include human rights abuses and political/security implications. The report specifically addresses some of the concerns of the Lhotshampa people as a case study.

Hard copy included in Appendix IV

United Nations High Commissioner for Refugees (2010). Nepal: UNHCR global appeal 2010-2011.

The Global Appeal document offers an update on the conditions in Nepal and plans for the future. UNHCR has identified the majority of refugees in Nepal as Bhutanese with a smaller number of Tibetans, undocumented asylum seekers and other Nepalese who are considered stateless due to lack of citizenship documents. Additionally, there are questions of various psycho-social issues, divorce and custody needs prior to resettlement and sexual violence within the camps.

UNHCR identifies various goals for Nepal, including ensuring standards of protection for all refugees/asylum-seekers, reduction of statelessness, improvement of nutritional, water, shelter and sanitation services and provision of assistance to individual urban refugees. Additionally, UNHCR puts a focus on creation of projects to develop capacities of Bhutanese refugees while benefiting host communities. This may indicate a current tension between host communities and refugee camps although the authors do not go into much detail on the relationship between refugee camps and the host communities.

Hard copy included in Appendix IV

United Nations High Commissioner for Refugees. (2011). Nepal. UNHCR global appeal 2011 update.

This updated global appeal augments the information provided in the appeal from 2010-2011 with an update. New information includes heightened discussion of the political situation in Nepal as general elections are scheduled to take place in late 2011, provided a new constitution can be announced by May 2011. Regional political instability continues to present a problem for the operations of UNHCR.

The updated numbers provided by UNHCR show there are 73,300 Bhutanese refugees living in the seven UNHCR refugee camps in eastern Nepal. The resettlement process is underway and there is a proposed

consolidation and closure of two of the camps in 2011. Within the camps, UNHCR is working to expand vocational and capacity building activities as well as expanding psychosocial services offered in the camps. UNHCR is continuing to work with the government of Nepal to reduce statelessness.

Hard copy included in Appendix IV

Van Ommeren, M., de Jong, J. T. V. M., Sharma, B., Komproe, I., Thapa, S., & Cardeña, E. (2001). Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Archives of General Psychiatry, 58, 475-482.*

The goal of this study was to examine the effects of torture on a sample of Bhutanese refugees in Nepalese refugee camps. The researchers sought to identify any demographic characteristics that were correlated with specific torture experiences, as well as gaining an understanding of the effects of torture experiences in terms of mental health. Additionally, they explored the impact demographics had on reporting of torture experiences.

Findings indicated that female refugees who had experienced torture were at a comparatively higher risk than male survivors for most psychiatric disorders, which the researchers note may be partially due to the separate stress of being a women in a Southeast Asian culture. However, researchers found that within this population, torture occurred across demographic groups. Additionally, more than half of the non-tortured refugees reported a lifetime psychiatric disorder. The research also indicated that the only demographic characteristic correlated with reporting of torture experiences was the male gender. Final notations of the researchers include a relation between unexplained somatic complaints and PTSD as well as the obvious need for more quality mental health services, frequently unavailable in refugee camps.

Hard copy included in Appendix IV

Whelpton, J. (2008). Nepal and Bhutan in 2007: Seeking an elusive consensus. *Asian Survey, 48(1), 184-190.*

This article offers a brief overview of the general situations in the Nepal and Bhutan in 2007. In the section focusing on Nepal, much of the time is spent discussing the political instability from the Maoist political party due to the emerging group interests based on ethnic and regional lines. Several factions operating in the Tarai region (southern Nepal) have increased use of violent behavior including assassinations of civil servants.

The Bhutan section focuses on the changing political structure of the country, moving from a monarchy to a more democratic system. The GDP of the country is growing at a faster rate than in previous years, largely credited to hydroelectric power industries. There is a brief discussion about the instabilities caused by the protracted refugee situation, especially with regards to the refugee-based Bhutanese Communist Party and violence aimed at people expressing interest and support of resettlement as a solution to the refugee situation.

Hard copy included in Appendix IV

Working Group on the Universal Periodic Review. (2009). *Compilation prepared by the Office of the High Commissioner for Human Rights, in accordance with paragraph 15(b) of the annex to human rights council resolution 5/1 - Bhutan.*

This summary presented in 2009 reports on various issues of human rights in Bhutan. The reporting stakeholders include: Bhutanese Refugee Support Group, European Centre for Law and Justice, Global Human Rights Defence, Global Initiative to End all Corporal Punishment of Children, International GLBT Organizations and Society for Threatened People.

Issues covered in the report include abuses against women (sexual abuse, trafficking, domestic/labor exploitation, violence, limited work), categorization of the Lhotshampa (seven categories F1 – F7), difficulties of citizenship for Lhotshampa refugees, denial of services for F7 persons, discrimination (against persons related to anyone deemed anti-national), political prisoners, media censorship, corporal punishment, regulations against same-sex relationships, freedom of movement. Additional human rights concerns include freedom of religion, restrictions on access to information, limitations on human rights organizations, limiting of active political parties, lack of access to education, mistreatment of indigenous people and refugees/migrants.

Hard copy included in Appendix IV

World Health Organization. (2006). *WHO– AIMS report on mental health system in Bhutan.*

This official report, written by both the WHO and the Ministry of Health of Bhutan evaluates the present state of mental health in Bhutan and assess the areas of growth necessary in the 10th Five Year Plan of the country (2007-2012). The report offers a comprehensive look at the mental health system as it stood in 2006. Measurements are made in six domains: Policy and Legislative Framework, Mental Health Services, Mental Health in Primary Health Care, Human Resources, Public Education and Links with Other Sectors and Monitoring and Research.

There are very few trained mental health professionals, either doctors or nurses in the country, and the primary care of mental health patients is performed by workers without specialized training in mental health care. The policy sector of the mental health system is similarly lacking. Bhutan lacks separate legislation for mental health, an emergency preparedness plan, a human rights review body and sufficient treatment facilities for the growing demand for services. The report is helpful in describing the home culture of mental health in Bhutan.

Hard copy included in Appendix IV

Appendix III

Resources – ESL Education Materials & Curricula

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 - *US Department of Health and Human Services*

ESL Activities

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 - *Spring Institute for International Studies*
- Applications
 - *Spring Institute for International Studies*
- Cultural Adjustment, Mental Health and the ESL Experience
 - *Spring Institute for International Studies*
- ESL as a Mental Health Intervention
 - *Spring Institute for International Studies & Rocky Mountain Survivor’s Center*
- Is That All There Is?
 - *Spring Institute for International Studies*
- Life Book Trainer’s Guide
 - *IOM Nepal*
- The Medical Simulation: A Confidence Building Tool for Refugee Students
 - *Phanat Nikhom Refugee Camp*
- Silk-Screening: Task-Based Learning in a Basic Job Skills Lesson
 - *Galang Refugee Processing Center*
- Picture Stories for Adult ESL Health Literacy
 - *Fairfax County Public Schools*
- Preventive Mental Health in the ESL Classroom: A Handbook for Teachers [Excerpt]
 - *Cohon, Lucey, Paul, Penning*
- Stress and Relaxation/Functional Complaints
 - *World Health Organization*

Resources in Nepali

- A Guide to Your Refugee Health Assessment
 - *Minnesota Department of Health*
- Food Safety Handout
 - *World Health Organization*
- Healthy Refugee Toolkit [Adjusting to a New Culture, Substance Abuse, Stress Management]
 - *US Committee for Refugees and Immigrants*
- Infant/Child Health
 - *Healthy Roads Media*
- Refugee Health Resources [Remembering What’s Good, Ways to Manage Stress and Anger]
 - *Refugee Health Information Network*

Appendix IV

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- Nepal: UNHCR Global Appeal 2010-2011
 - *UNHCR*
- Nepal: UNHCR Global Appeal 2011 Update
 - *UNHCR*

- Psychiatric Disorders Among Tortured Bhutanese Refugees in Nepal
 - *Van Ommeren, et al.*
- Nepal and Bhutan in 2007: Seeking an Elusive Consensus
 - *Whelpton, J.*
- Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1 – Bhutan
 - *Working Group on Universal Periodic Review*
- WHO-AIMS Report on Mental Health System in Bhutan
 - *World Health Organization*

Complete Reference List

- Adkins, M.A., Birman, D., Sample, B., Brod, S., & Silver, S. (1999). *Cultural adjustment, mental health and ESL*. Retrieved from Spring Institute for Intercultural Learning website: <http://www.springinstitute.org/?action=publications>
- Brod, S. (1998). *ABC's for tutors: 26 teaching tips*. Retrieved from Spring Institute for Intercultural Learning website: <http://www.springinstitute.org/Files/26tips1.pdf>
- Brouwer, A. (2003). *Statelessness in Canadian context: A discussion paper*. Retrieved from UNHCR website: <http://www.unhcr.org/40629ffc7.pdf>
- Bhutan. (2005). In *Mental health atlas 2005*. Retrieved from http://www.who.int/mental_health/evidence/mhatlas05/en/index.html
- Bhutanese Refugee Support Group, Ireland and UK. (2001). *NGO response to initial state party report: Bhutan – under the Convention of the Rights of the Child*. Retrieved from www.crin.org/docs/resources/treaties/crc.27/Bhutan.doc
- Center for Victims of Torture. (2005). *Working with war survivors* [PowerPoint slides]. St. Paul, Minnesota
- Center for Victims of Torture. (2004). *Helping to heal the wounds of war* [PowerPoint slides]. St. Paul, Minnesota
- Center for Victims of Torture. (2010). *Bhutanese in Minnesota fact sheet*. St. Paul, Minnesota
- Central Intelligence Agency. (2011). Bhutan. In *The World Fact Book*. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/>
- Cohon, J. D., Lucey, M., Paul, M., & Penning, J. L. (1986). *Primary prevention and the promotion of mental health in the ESL classroom*. New York: American Council for Nationalities Service.
- Dossa, P. (2002). Narrative mediation of conventional and new “mental health” paradigms: Reading the stories of immigrant Iranian women. *Medical Anthropology Quarterly*, 16(3), 341-359. Retrieved from <http://www.jstor.org/stable/25487771>
- Erikson, E. (1998). *Is that all there is?: Allocating time and staff*. Retrieved from Spring Institute for International Studies website: <http://www.springinstitute.org/Files/scansall.pdf>
- Emergency & Community Health Outreach. (2010). Egal Shidad: Mental health. In *Egal Shidad: Stories of Somali health*. Retrieved from <http://www.echominnesota.org/library/egal-shidad-stories-somali-health>.
- Emergency & Community Health Outreach. (2010). Egal Shidad: Raising our children. In *Egal Shidad: Stories of Somali health*. Retrieved from <http://www.echominnesota.org/library/egal-shidad-stories-somali-health>
- Emergency & Community Health Outreach. (Producer). (2010). *Navigating the health care system* [DVD]. Retrieved from <http://www.echominnesota.org/library/navigating-health-care-system>

- Enterprise Community Partners, Inc. (2006). *Resources for English as a second language (ESL) programs*. Retrieved from Enterprise Community Partners website: http://www.enterprisecommunity.org/resources/tutorials/resident_services/adult_education.asp
- Fabri, M. (1999). *Understanding refugee mental health concerns*. Retrieved from ERIC database. (ED 435208).
- Florida Literacy Council. (2010). *Coping with stress*. Retrieved from http://www.floridaliteracy.org/literacy_resources_teacher_tutor_health_literacy.html
- Florida Literacy Council. (2010). *Women's health*. Retrieved from http://www.floridaliteracy.org/literacy_resources_teacher_tutor_health_literacy.html
- Florida Literacy Council. (2010). *Staying healthy: A learner's guide to health care and healthy living*. Retrieved from http://www.floridaliteracy.org/literacy_resources_teacher_tutor_health_literacy.html
- Gazmere, J. (2011). Background. *Bhutanese Association in South Australia*. Retrieved from <http://www.bhutanese.org.au>
- HealthPartners Center for International Health. (Producer). (2008). *Crossing cultures: Five simple steps to improve health by improving communication* [DVD]. Available from <http://www.minnesotamovie.com/freecountrymedia.html>
- Healthy Roads Media. (2003). *Infancy* [Nepali]. Retrieved from <http://www.healthyroadsmedia.org/nepali/index.htm>
- Herman, J. (1992). *Trauma and recovery: The aftermath of violence –from domestic abuse to political terror*. New York: Basic Books.
- Hodge, D. R. (2004). Working with Hindu clients in a spiritually sensitive manner. *Social Work*, 49(1), 27-38. Retrieved from ERIC database. (ED 695975).
- Horsman, J. (1997). "But I'm not a therapist": *Furthering discussion about literacy work with survivors of trauma*. Retrieved from National Adult Literacy Database: <http://www.nald.ca/>
- International Organization of Migration - Nepal. (2008). *The Bhutanese refugees in Nepal: A tool for settlement workers and sponsors*. Retrieved from http://www.peianc.com/sitefiles/File/resources/cultural_profiles/Bhutanese-Refugees-in-Nepal.pdf
- International Organization of Migration Nepal. (2010). *Life book trainer's guide*. Retrieved from http://www.cal.org/co/email_discussion/Attachments/2010_05_11-IOM_Nepal_LifeBook_Trainer_Guide.pdf
- International Rescue Committee. (2009). *The health of refugees from Bhutan*. Retrieved from http://www.cal.org/co/email_discussion/Attachments/IRC-Bhutanese_Health_FactSheet.pdf

- Immigrant and Refugee Board of Canada (2008). *Bhutan: Whether Bhutanese Citizens of Nepalese origin face restrictions in obtaining passports or travelling abroad*. Retrieved from <http://unhcr.org/refworld>
- Immunization Action Coalition. (2010). *Nepali-language vaccine information statements*. Retrieved from http://www.immunize.org/vis/vis_nepali.asp
- Isserlis, J. (2000). *Trauma and the adult English language learner*. Retrieved from ERIC database. (ED444397).
- Kissman, K., & Maurer, L. (2002). East meets west: Therapeutic aspects of spirituality in health, mental health and addiction recovery. *International Social Work, 45*(1), 35-42. Retrieved from <http://isw.sagepub.com/content/45/1/35>
- Literacy Information and Communication System. (2002). *Research-based health literacy materials and instruction guide: Beginning ABE and ESL levels*. Retrieved from <http://lincs.ed.gov/health/health-begin>
- Lucey, M., Chaffee, M., Terry, D., Le Marbre, J., Stone, B., & Wiencek, D. (2000). *Mental health and the ESL classroom: A guide for teachers working with refugees*. Retrieved from ERIC database. (ED467256).
- Mariman, E., & Stephens, K. (1985). Silk screening: Task-based learning in a basic job skills lesson. *Passage: A journal of refugee education, 1*(1), 46-51. Retrieved from ERIC database. (ED 254099)
- McKinney, J. & Kurtz-Rossi, S. (2000). *Culture, health and literacy: A guide to health education materials for adults with limited English literacy skills*. Retrieved from World Education website at: <http://www.healthliteracy.worlded.org/docs/culture/index.html>
- MedLinePlus. (2011). *Easy-to-read health materials*. Retrieved from http://www.nlm.nih.gov/medlineplus/all_easytoread.html
- Miller, K. E., & Rasco, L. M. (2004). An ecological framework for addressing the mental health needs of refugee communities. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 1-64). Retrieved from http://drkenmiller.org/Ken_Miller_Ph.D./CV.html
- Minnesota Department of Health. (2009). *Primary refugee arrivals to Minnesota by initial country of resettlement and country of origin*. Retrieved from <http://www.health.state.mn.us/divs/idepc/refugee/stats/index.html#arrival>
- Minnesota Department of Health (2010). *Cumulative arrivals*. Retrieved from <http://www.health.state.mn.us/divs/idepc/refugee/stats/index.html#arrival>
- Minnesota Department of Health, Refugee Health Program. (2009). *A guide to your refugee health assessment [Nepali]*. Retrieved from <http://www.health.state.mn.us/divs/idepc/refugee/hlthmat.html>

- Minnesota Department of Health, Refugee Health Program. (n.d.). *Health guide for refugees in Minnesota*. Retrieved from <http://www.health.state.mn.us/divs/idepc/refugee/hcp/healthguideeng.pdf>
- Munnell, K. (1985). The medical simulation: A confidence-building tool for refugee students. *Passage: A journal of refugee education*, 1(1), 13-17. Retrieved from ERIC database. (ED 254099).
- Navsaria, N., & Peterson, S. (2007). Finding a voice in *shakti*: A therapeutic approach for Hindu Indian women, *Women & Therapy*, 30(3), 161-175. Retrieved from http://dx.doi.org/10.1300/J015v30n03_12
- Neubauer, R. & Spector, R. Two American mental health professionals meet with the only psychiatrist in Bhutan. (2007, September). *Greater Washington Society for Clinical Social Work*. Retrieved from <http://www.gwscsw.org/pdf/newsletter/07/0709.pdf>
- Nepal. (2005). In *Mental health atlas 2005*. Retrieved from http://www.who.int/mental_health/evidence/mhatlas05/en/index.html
- Payne, N. (Ed.). (1992). *Dance movement therapy: Theory and practice*. New York: Tavistock and Routledge.
- Refugee Health information Network. (n.d). *Examples of remembering what's good* [Nepali]. Retrieved from <http://www.rhin.org/Default.aspx>
- Refugee Health information Network. (n.d). *Ways to manage stress and anger* [Nepali]. Retrieved from <http://www.rhin.org/Default.aspx>
- Sample, B. (1998). *Applications*. Retrieved from Spring Institute for International Studies website: <http://www.springinstitute.org/Files/appl08.pdf>
- Schäppi, D. (2005). *Cultural plurality, national identity and consensus in Bhutan*. Center for Comparative and International Studies, University of Zurich, Zurich, Switzerland.
- Sharma, B. K., & Adhikary, A. (2009). *Adjusting to the American way of life: Tips for visitors, students and immigrants from Nepal*. Retrieved from Association of Nepalese in Midwest America website: www.anmausa.org/downloads/anmahandbook.pdf
- Shrestha, M. (2008). First of 60,000 refugees from Bhutan arrive in U.S. *CNN International*. Retrieved from <http://edition.cnn.com>
- Siegel, E. V. (1984). *Dance-movement therapy: Mirror of our selves. The psychoanalytic approach*. New York: Human Sciences Press.
- Singleton, K. (2002). *Health literacy and adult English language learners*. Retrieved from ERIC database. (ED465309).
- Singleton, K. (2003). *Picture stories for adult ESL health literacy*. Retrieved from Center for Adult English

- Language Acquisition website: http://www.cal.org/caela/esl_resources/
- Sokoloff, C. (2005). *Denial of citizenship: A challenge to human security*. Retrieved from United Nations Office for the Coordination of Humanitarian Affairs website: <http://www.ochaonline.un.org/>
- Spring Institute and Rocky Mountain Survivor's Center. (n.d.) *ESL as a mental health intervention* [PowerPoint slides]. Retrieved from <http://www.healtorture.org/webinars?id=34>
- United Nations. (1948). *Universal declaration of human rights*. Retrieved from <http://www2.ohchr.org/english/law/>
- United Nations. (1951). *Convention relating to the status of refugees*. Retrieved from <http://www2.ohchr.org/english/law/>
- United Nations. (1954). *Convention relating to the status of stateless persons*. Retrieved from <http://www2.ohchr.org/english/law/>
- United Nations. (1961). *Convention on the reduction of statelessness*. Retrieved from <http://www2.ohchr.org/english/law/>
- United Nations. (1989). *Convention on the rights of the child*. Retrieved from <http://www2.ohchr.org/english/law/>
- United Nations High Commissioner for Refugees. (2001). *UN conventions on statelessness*. Retrieved from United Nations High Commissioner for Refugees website: <http://www.unhcr.org/pages/4a2535c3d.html>
- United Nations High Commissioner for Refugees. (2006). Protracted refugee situations: The search for practical solutions (chapter 5). In *The state of the world's refugees 2006: Human displacement in the new millennium* (pp. 105-197). Retrieved from <http://www.unhcr.org/4a4dc1a89.html>
- United Nations High Commissioner for Refugees. (2010). Nepal. In *UNHCR global appeal 2010-2011*. Retrieved from <http://www.unhcr.org/4b03d32b9.html>
- United Nations High Commissioner for Refugees. (2011). Nepal. *UNHCR global appeal 2011 update*. Retrieved from <http://www.unhcr.org/4cd96ec19.html>
- U.S. Committee for Refugees and Immigrants. (n.d.). *How to manage stress* [Nepali]. Retrieved from <http://www.refugees.org/resources/for-refugees--immigrants/health/healthy-living-toolkit/nepali.html>
- U.S. Committee for Refugees and Immigrants. (n.d.). *Drugs and alcohol abuse* [Nepali]. Retrieved from <http://www.refugees.org/resources/for-refugees--immigrants/health/healthy-living-toolkit/nepali.html>
- U.S. Committee for Refugees and Immigrants. (n.d.). *Adjusting to a new culture* [Nepali]. Retrieved from <http://www.refugees.org/resources/for-refugees--immigrants/health/healthy-living-toolkit/nepali.html>

- U. S. Department of Health and Human Services, Office of Refugee Resettlement. (2009). *Fiscal year 2009 refugee arrivals*. Retrieved from <http://www.acf.hhs.gov/programs/orr/data/>
- U.S. Department of Health and Human Services, Office on Women's Health. (2009). *Women's mental health: What it means to you*. Retrieved from <http://store.samhsa.gov/shin/content//OWH09-CONSUMER/OWH09-CONSUMER.pdf>
- University of Minnesota, School of Social Work. (2010). *Developing culturally informed mental health screening for Minnesota's refugees* [PowerPoint slides]. Retrieved from Minnesota Department of Health website: <http://www.health.state.mn.us/divs/idepc/refugee/metrotf/mtgarchive.html#jan12>
- Van Ommeren, M., de Jong, J. T. V. M., Sharma, B., Komproe, I., Thapa, S., & Cardeña, E. (2001). Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Archives of General Psychiatry*, 58, 475-482. Retrieved from <http://archpsyc.ama-assn.org/cgi/reprint/58/5/475.pdf>
- Walker, P. F., O'Fallon, A., Nelson, K., Mamo, B., Dicker, S., Chute, S., Lynfield, R...Foltz, J. L. (2011, March). Vitamin B12 deficiency in resettled Bhutanese refugees – United States, 2008-2011. *Morbidity and Mortality Weekly Report*. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6011a4.htm>
- Whelpton, J. (2008). Nepal and Bhutan in 2007: Seeking an elusive consensus. *Asian Survey*, 48(1), 184-190. Retrieved from <http://www.jstor.org/stable/10.1525/as.2008.48.1.184>
- Working Group on the Universal Periodic Review. (2009). *Compilation prepared by the Office of the High Commissioner for Human Rights, in accordance with paragraph 15(b) of the annex to human rights council resolution 5/1 - Bhutan*. Retrieved from http://ap.ohchr.org/documents/alldocs.aspx?doc_id=16241
- World Health Organization. (2011). *Five keys to safer food* [Nepali]. Retrieved from http://www.who.int/foodsafety/publications/consumer/en/5keys_nepali.pdf
- World Health Organization. (1996). Stress and relaxation. In *Mental health of refugees* (unit 2). Retrieved from <http://whqlibdoc.who.int/hq/1996/a49374.pdf>
- World Health Organization. (1996). Functional complaints. In *Mental health of refugees* (unit 3). Retrieved from <http://whqlibdoc.who.int/hq/1996/a49374.pdf>
- World Health Organization. (2006). *WHO– AIMS report on mental health system in Bhutan*. Retrieved from http://www.searo.who.int/LinkFiles/Mental_Health_Resources_WHO-AIMS_Report_MHS_Bhu.pdf
- Yuen, L. (2009). *From Bhutan to Minnesota: Their journey is not over*. St Paul, Minnesota: Minnesota Public Radio. Retrieved from <http://minnesota.publicradio.org/display/web/2009/01/27/bhutan/>
- Zilk, C. (2007). Plight of the Lhotshampas. *Human Rights House Foundation*. Retrieved from <http://www.humanrightshouse.org>