Post-Migration Challenges among Bhutanese-Nepali Refugees in Columbus, Ohio

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Chapter One: Statement of the Problem

Introduction

In 2018, 22,491 refugees were resettled in the United States (U.S.), which is the lowest number since the beginning of the resettlement program (Rush, 2018). The number of pending asylum cases at the Department of Homeland Security (DHS) at the end of fiscal year (FY) 2018 was approximately 320,000 (U.S. Department of State, 2018). According to the 1951 Convention Relating to the Status of Refugees, a refugee "is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UN General Assembly, 1951). The main emphasis is *protection from political or other forms of persecution* (UN General Assembly, 1951). Not only must refugees leave behind their family and homes, they face many hardships once they arrive at their new country.

According to the U.S. Department of State (2017), 92,500 Bhutanese-Nepali refugees have been resettled in the U.S. since late 2007 and in 2017, 3,500 Bhutanese-Nepali refugees were admitted into the U.S. (U.S. Department of State, 2017). Approximately, 15,000 Bhutanese-Nepali live in Columbus, Ohio, making the city the second largest urban area where Bhutanese-Nepali refugees have been resettled, behind Atlanta, GA (Office of Refugee Resettlement, 2019). As this population continues to increase in the U.S., it is critical to have a better understanding of the needs of this community (BNCC, 2017). The majority of research on the Bhutanese-Nepali refugees has been related to mental health. There is a paucity of literature on the social needs and difficulties post-migration among Bhutanese-Nepali refugees. The purpose of this study was to examine the perceived social

support, family resources, post-migration living difficulties, and the association between social support, family resources, and post-migration living difficulties among Bhutanese-Nepali refugees living in Columbus, OH.

Study Aims

This study was a secondary analysis of a parent study that assessed the community needs of the Bhutanese-Nepali refugee community in Columbus, OH. The parent study examined the cultural, social, and health needs of the Bhutanese-Nepali adults aged 18 year and older. Research questions specifically addressed in this study included:

1. What is the perceived social support of Bhutanese-Nepali refugees?
2. What are post-migration living difficulties among Bhutanese-Nepali refugees?
3. What is the association between perceived social support, family resources, and post-migration living difficulties among Bhutanese-Nepali refugees?

Chapter Two: Review of the Literature

Bhutanese-Nepali refugees are from Bhutan. The nation of Bhutan is located in the Eastern Himalayas in Southern Asia. Bhutan borders China and India, which separates Bhutan from Nepal. In the 1980's, Bhutan had three major ethnic groups: the Ngalongs, the Sharchhops, and the Lhotshampas (Hutt, 1996). The Lhotshampas are Bhutanese people of Nepali-descent who are also known as the Nepali-Bhutanese (Hutt, 1996). The Lhotshampa people are Southern Bhutanese with Nepali ancestry (BBC, 2010). The Lhotshampa sought equality for their contributions to society and to the economy of Bhutan (Rizal, 2004). Bhutan's ruling elite, the Drukpa, saw the Lhotshampas as a threat to their rule and created the policy of "One nation, one people," which led to the oppression and expulsion of the Lhotshampa and other ethnic groups through ethnic cleansing (Rizal, 2004). This was called the "Bhutanization," which eliminated

many cultural, linguistic, and religious traditions of the Lhotshampas (BBC, 2010). The Drukpa regime began to eliminate their citizenship rights, confiscate property, and shut down businesses to eliminate the Lhotshampas (COR, 2007). Many Lhotshampas were forced to leave Bhutan due to persecution, torture, expulsion and other human rights violations (Khanal, 1998). The refugees who fled Bhutan made up one-sixth of Bhutan's population and half the of the Nepali-Bhutanese population (Hutt, 1996). Many Lhotshampas ultimately settled in refugee camps in Nepal, but others stayed in Assam and West Bengal, which they had to cross in order to reach Nepal (Khanal, 1998).

The Bhutanese-Nepali community in Columbus is a diverse community represented by different religions, languages, and sub-cultural groups (BNCC, 2017). An estimated 80,000 Bhutanese-Nepali refugees resettled in the U.S. and over 15,000 Bhutanese-Nepali refugees have been resettled in Columbus, OH through refugee resettlement programs and through secondary migration (BNCC, 2017). Refugees are at risk for mental health disorders, such as depression and post-traumatic stress disorder (PTSD), due to the traumatic experiences that many have endured (Kue, Pyakurel, & Yotebeing, 2016). A better understanding of Bhutanese culture and historical experiences is necessary to understand how these experiences impact their post-migration experiences.

Cultural and Historical Background

The Bhutanese-Nepali culture is diverse and is comprised of various religions, languages, and beliefs. Most Bhutanese refugees are Hindu, a religion practiced widely throughout Bhutan, Nepal, and India (CDC, 2014). Many refugees are bilingual, speaking Nepali and Dzongkha, the Bhutanese language (CDC, 2014). Some of the younger members of the community were first exposed to English while in the refugee camps in Nepal (CDC, 2014). Many of the Bhutanese-

Nepali refugees are born into a caste system, though it has been declining after resettlement in the U.S., but majority still follow this system (CDC, 2014). The typical Bhutanese household is multigenerational, including grandparents, parents, children, especially sons and their wives, and sometimes may extend to aunts and uncles (CDC, 2014). This population values the cultural tradition of respecting one's elders and the children often take care of their older relatives (CDC, 2014). Overall, the Bhutanese-Nepali community is close-knit and they value familial relationships (CDC, 2014).

Health

Health Status

The general health of Bhutanese-Nepali refugees is good with mortality and acute malnutrition rates far below the emergency threshold, which is a crude mortality rate of one per 10,000 per day (CDC, 2014; World Health Organization, 2019). Many refugees in the camps in Nepal had access to routine vaccines. Upon arrival to the U.S., refugees were subject to pre-departure and post-arrival medical screenings (CDC, 2014). Some of the common diagnoses in refugees were vitamin B12 deficiency and anemia (CDC, 2014). In a study of refugees in Columbus, OH, the majority of participants self-reported having very good health with few reporting poor health (Kue et al., 2016). The most common self-reported diagnoses were hypertension, high cholesterol, and diabetes (Kue et al., 2016). The most prevalent health issues found in this population are mental health disorders including, depression, anxiety, PTSD, and suicidal ideation (Schick et al., 2016).

Mental Health Status

Refugees that flee political conflicts, similar to the Bhutanese-Nepali population, often experience a significant level of physical and mental health symptoms (Kue et al., 2016). The

majority of the research on the Bhutanese-Nepali refugees has focused on the high suicide rate in this population (CDC, 2012). A study by the CDC (2012) showed that the suicide rate for the Bhutanese-Nepali refugees is double the rate for the general U.S. population, 24.4/100,000 vs. 12.4/100,000, respectively. Contributing factors to the high suicide rate include socio-psychological factors, such as not being able to provide for their family, a lack of social support, and being diagnosed with mental health problems such as, anxiety, depression, and distress (CDC, 2012). There are many factors that contribute to the presence or absence of suicidal ideation within this population. One study on Bhutanese-Nepali refugees resettled in Arizona, Georgia, New York, and Texas, found that those who reported suicidal ideation were 2.7 times more likely to perceive themselves as a burden and twice as likely to report a lack of belongingness than those who did not report suicidal ideation (Ellis et al., 2015). While current research is focused on high suicide rates, research is lacking in describing the challenges faced by the Bhutanese-Nepali community in areas of health, social, and cultural needs (Kue et al., 2016).

A study of the Bhutanese-Nepali refugee population in Ohio, found that the most commonly diagnosed mental health conditions were depression, followed by schizophrenia and anxiety, and many refugees also had a family member with a mental health condition (Adhikari, Yotebieng, Acharya, & Kirsch, 2015). The study also found that the most common symptoms of a mental health disorder were trouble sleeping, difficulty concentrating, and recurrent nightmares, which when present, can negatively affect their life and ability to be successful after resettlement (Adhikari et al., 2015). Bhutanese-Nepali refugees reported a high level of exposure to trauma and a low rate of self-identified mental health disorders; thus, the actual levels of inadequate mental health treatment may have been underreported (Adhikari et al., 2015).

Health Seeking Behavior

The health seeking behaviors of the Bhutanese-Nepali refugees are unique to their culture and often begin with seeking guidance from a family member or neighbor, a home remedy, or a traditional healer and outside medical advice is only sought if the first line treatment did not work (CDC, 2014; Yun et al., 2016). It is uncommon to seek medical advice outside of the Bhutanese community unless they are critically ill or injured. The lack of health insurance, not knowing where to go to obtain affordable healthcare, low English proficiency, and/or limited literacy skills further exacerbates poor health seeking behaviors (CDC, 2014; Yun et al., 2016). Many refugees also seek help through family and friends, such as their children, a family member, or a neighbor, who often times does everything for them, therefore many never learn how to schedule appointments or navigate insurance systems independently (Yun et al., 2016).

Post-Migration Challenges

Refugees face multiple post-migration challenges, the severity of which may depend on the events they experienced pre-migration, and availability, accessibility, affordability, and acceptability of services and support (Edward & Hines-Martin, 2015; Schick et al., 2016). Post-migration, refugees face many challenges including language barriers, financial austerity, healthcare problems, lack of access to basic resources, separation from family, unemployment, and discrimination, which contribute to their level of psychological distress, the prevalence of mental disorders, and the higher unemployment rates (Edward & Hines-Martin, 2015; Li, Liddell, & Nickerson, 2016; Schick et al., 2016). There is a high prevalence of trauma related mental health disorders among refugees, some of which are Post Traumatic Stress Disorder (PTSD), anxiety, and depression (Schick et al., 2016). These stressors can negatively affect their mental health and their ability to acculturate into society (Schick et al., 2016). Once refugees

become residents in their host country, they are often expected to quickly acculturate into society, such as to become proficient in the language and have financial independence (Schick et al., 2016). For those dealing with mental health issues, it can be extremely difficult, and many are unable to meet those expectations (Schick et al., 2016).

Refugees also have difficulties accessing appropriate medical services due to a lack of trust of medical providers, the stigma of mental health disorders, and a lack of knowledge about mental health disorders or treatment options (Edward & Hines-Martin, 2015; Schick et al., 2016). In a Swiss study, researchers found that many healthcare providers diagnose refugees based on the common symptoms and manifestations the rest of the population present with instead of taking into account the refugees unique past experiences (Maier, Schmidt, & Mueller, 2019). This caused many mental health disorders to go undiagnosed among refugees (Maier et al., 2019).

Refugees are not only at risk for mental health disorders, but also other post migration difficulties such as challenges with employment. For example, educational degrees and some job qualifications from their home county, such as certification exams, occupational training, or credentials, may not be recognized in the U.S., which can make finding suitable employment difficult (Krahn, Derwing, Mulder, & Wilkinson, 2000; Li, Liddell, & Nickerson, 2016). According to a study by the Center of Migration Studies, the unemployment rate among refugees in the U.S. was 5.9% in 2016, compared to the 4.6% unemployment rate among U.S. born people (BLS, 2017; Kerwin, 2018). Many refugees are also frequently employed in positions below their qualification or skill level (Li et al., 2016). The majority of foreign-born people were more likely to be employed in the service industry and less likely to be in the management or professional occupations (BLS, 2017). Foreign-born people earned a median weekly wage of

$155 less than U.S. born people, due to many factors such as education level, occupation, industry and geographic location (BLS, 2017). Fleeing their home country and adjusting to an unfamiliar environment can cause social challenges for refugees such as family separation, worries about families back home, social isolation, and a loss of social identity (Li et al., 2016).

Social Support

Social support entails networks of people and services that individuals have relationships with, such as family, friends, and co-workers (Kue et al., 2016). Those with a strong social support system are able to better cope when faced with stressful circumstances such as immigration and resettlement, employment, ability to meet basic needs, and physical and emotional health (Stewart et al., 2010). Social support from one's own community is also an important protective factor against mental health difficulties (Li et al., 2016). There is typically an increased need for social support especially to help cope with immigration and resettlement challenges refugees and immigrants face (Stewart et al., 2010).

One study among Chinese immigrants and Somali refugees in Canada identified social support as creating a peace of mind, alleviating stress, and decreasing isolation and loneliness, but many of the participants reported that they faced unhelpful social support due to barriers such as eligibility restrictions to specific services (Stewart et al., 2010). This study found that the two different cultural populations (Chinese and Somali) identified and viewed social support differently (Stewart et al., 2010). The Chinese immigrants identified social support as formal support from the government or informal support from friends and family, but since formal support was lacking in China, they expected to get the majority of their support from family and friends (Stewart et al., 2010). The Somali refugees tied social support to their religion believing that it came from God. They see social support as helping someone, usually in terms of

psychological, moral, or financial support, but social support in their host country means someone who helps provide the necessities such as health, housing, or employment, not psychological or moral support (Stewart et al., 2010). While their definition of social support is different, both populations felt that the presence of social support allowed them to overcome obstacles in the immigration process, helped them find a sense of community, and positively impacted their physical and mental health (Stewart et al., 2010).

Across all cultures, one of the most common sources of social support is from family members who often provide support in the form of child care, housing, and financial aid (Hynie, Crooks, & Barragan, 2011). One study on immigrant and refugee women found that the most helpful form of social support is from people of the same culture, or co-ethnic support (Hynie et al., 2011). Co-ethnic support ensures that the support provided is culturally sensitive and appropriate; this type of support allows the members of the community to help each other when facing challenges (Hynie et al., 2011). This study highlighted the importance of supporting practices and preferences of immigrants and refugees that help them build a sense of community and support (Hynie et al., 2011).

Social factors that are important for refugee mental health and well-being include perceived discrimination and changes in social/gender roles associated with displacement and resettlement (Li et al., 2016). Changes in socioeconomic status can lead to shifting gender roles, such as the male head of household no longer being the sole breadwinner. This change in gender roles can lead to increased strain on interpersonal difficulties in families, which has been related to domestic violence (Li et al., 2016).

There is little research available on Bhutanese-Nepali refugees' social support. A study on Bhutanese-Nepali refugees in Columbus, OH found that refugees reported having a strong

support system, such as having someone to rely on in times of need and having close relationships that provided them with a sense of emotional security and well-being (Adhikari et al., 2015). A study among the Bhutanese refugee community examined the impact of peer-led community health workshops, which used culturally sensitive and multidimensional intervention topics, including stress, acculturation, mental health, nutrition, and community in order to address gaps in support and create health promotion interventions in this population (Im & Rosenberg, 2016). The study found that the workshops had a positive effect to their "health knowledge and competency in access to proper health resources [and]…change in health behaviors and coping" (Im & Rosenberg, 2016, p. 511).

Family Resources

Family resources include factors such as the socioeconomic status, income, education, and the members' perceptions of available resources across a range of areas, including money, basic needs, and time for self and family (Van Horn, Bellis, & Snyder, 2001). The availability of resources to the refugee population is important in determining the families' ability to adapt to stressors and transitions (Kue et al., 2016). There is little data available on the lack of resources to the Bhutanese-Nepali refugee population.

Education is another resource that can affect refugee children. Limited or a lack of education among refugee parents negatively affected their children's education due to not being able to advocate for their child, access opportunities to academics, or even help their children with their academics (Vang & Trieu, 2014). Finally, some refugees have limited access to stable housing, which can lead to a decreased continuity of community relationships and a lack of safety (Li et al., 2016).

Project Background

In this study, we conducted a secondary data analysis of the parent study that assessed the community health needs of Bhutanese-Nepali refugee adults in Columbus, OH. The project background and methods are as follows.

In order to gain a better perspective of the community health issues, a community-engaged research approach was used in which researchers and community members worked together to address community health concerns (Kue et al., 2016). A community health needs assessment was created with members of the Bhutanese Community of Columbus (BNCC) and the Refugee Women in Action (RWIA) organizations (Kue et al., 2016). Two bilingual and bicultural interviewers from the Bhutanese-Nepali community administered the needs assessment face-to-face with participants (Kue et al., 2016 The community needs assessment included questions on healthcare practices, cancer knowledge and screening behavior, tobacco use, mental health issues and preferences for mental health services, social support, family resources, and barriers to health and social services and resources (Kue et al., 2016).

Methods

Parent Study – Bhutanese Nepali Community Needs Assessment

The purpose of the Bhutanese-Nepalese community needs assessment (parent study) was to identify community health priorities, specifically health, social, and cultural needs, of the Bhutanese-Nepali refugee community in Columbus.

Study Setting and Population

This study was conducted in North Columbus within a one-mile radius of the Morse Road and Karl Road intersection, which is where the majority of the Bhutanese-Nepali refugees resides. The eligibility criteria included participants who self-identified as Bhutanese-Nepali, were aged 18 years and older, and lived in Columbus, OH.

Recruitment and Procedures

In partnership with the BNCC and RIWA, a cultural community advisory board (CCAB) was created to determine Bhutanese-Nepali community health priorities and guide the study to ensure cultural appropriateness. The CCAB also helped identify bilingual and bicultural interviewers and potential places to recruit.

The parent study received approval from The Ohio State University Institutional Review Board (IRB) (Kue et al., 2016). Once participants were recruited and eligibility was confirmed, the interviewer obtained consent before any data was collected. The study obtained a waiver of documentation of informed consent. The waiver of documentation of informed consent was requested due to the only document linking the participant to the research being the consent document, the research presented less than minimal risk of harm to the participants and did not involve any procedures where written consent was required outside the study, and having a bilingual witness present for the non-English speaking participants could have impacted the participants' confidentiality (Kue et al., 2016).

Bilingual and bicultural interviewers administered the community health needs assessment questionnaire. The questionnaire was administered in English, Nepali, or both depending on the participant's preference (Kue et al., 2016). The questionnaire was completed in the participants' homes or in private rooms in community locations (Kue et al., 2016). Each participant received a $5.00 cash compensation for participating in the study (Kue et al., 2016).

Measures

Sociodemographic questions included standard demographic questions, such as age, gender, birthplace, religion, language, etc.

The Post-Migration Living Difficulties Questionnaire (PMLDQ) was used to assess the post-migration difficulties faced by the Bhutanese-Nepali refugees (Aragona, Pucci, Mazzetti, & Geraci, 2012). The PMLDQ is a self-evaluated questionnaire used to determine unfavorable experiences that are typical of migration (Aragona et al., 2012). This scale consists of 24 post-migration living difficulties (PMLD) questions, and the recipients indicate the extent of the problems they faced on a five-point scale from "no problem at all" to "a very serious problem" (Aragona et al., 2012). Based on recommendations from the CCAB, this study's PMLD questions were reduced to a three-point scale from "no problem" to "somewhat of a problem" to a "serious problem" in order to obtain more accurate results and decrease potential confusion between "serious problem" and "very serious problem." The CCAB also recommended that the number of PMLD questions the participants answer be reduced from the PMLDQ's 24 questions to 19 questions as some of the questions are no longer relevant to the population since they have already been resettled. The questions removed dealt with the immigration process such as application processing, interactions with immigration officials, and being in detention (Aragona et al., 2012).

The Multidimensional Scale of Perceived Social Support (MPSS) was used to determine the social support of the Bhutanese-Nepali refugees (Zimet, Dahlem, Zimet, & Farley, 1988). This scale is a subjective assessment of the adequacy of social support from family, friends, and a significant other (Zimet et al., 1988). MPSS is psychometrically sound and has good internal and test-retest reliability, factorial validity, and adequate construct validity (Zimet et al., 1988). MPSS contains questions that address the relationship of social popularity, respect, and areas that are directly related to perceived social support with family, friends, and a significant other (Zimet et al., 1988). The questions in the MPSS are rated on a five-point Likert scale from

"strongly disagree" to "strongly agree" (Zimet et al., 1988). Based on recommendations from the CCAB, this study limited the scale to three response categories including "disagree," "neutral," and "agree" in order to minimize potential confusion between Likert-type answer choices such as "strongly agree" and "somewhat agree."

To assess the extent of family resources of the Bhutanese-Nepali refugee participants the Family Resource Scale (FRS) was used (Van Horn et al., 2001). The FRS helps to determine whether a participant feels they have adequate resources to meet the needs of their family (Van Horn et al., 2001). The FRS has three main categories – basics, money, and time (Van Horn et al., 2001). Similar to the scales above, the FRS included 30 questions in which participants rated their response on a five-point Likert scale that ranged from "not at all adequate" to "almost always adequate" or "does not apply" (Van Horn et al., 2001). For the purposes of this study, the original FRS five-point scale was reduced to a three-point scale that included the choices, "not at all enough", "sometimes enough", and "usually enough" as well as "does not apply" in order to simplify the answer choices for the participants.

Data Analysis

SPSS version 24 was used to analyze the data. Frequencies and means were run for all sociodemographic data, PMLD, social support, and family resources. T-tests were run to compare PMLD, social support, and family resources to age (grouped 18-34 years and 35-55+), sex, education (grouped none-high school or GED and some college to graduate degree), and time spent in refugee camps (19+ years). The T-tests for PMLD data were run analyzing the top five questions answered a somewhat-serious problem, which were access to counseling services, not enough government help with welfare (unemployment benefits, financial help), communication difficulties/language difficulties, being unable to find work, and difficulty

adjusting to the weather/climate. The family resource questions were categorized into family resource necessities, family resource services, and family monetary resources. The questions for each category are divided in Table 3.

Results

Participants

This cross-sectional study surveyed 201 participants in 2015. Participant demographic characteristics are shown in Table 1. Per enrollment criteria, all participants reported Bhutanese-Nepali ethnicity, were over the age of 18, and lived in Columbus, OH. Nearly half of the participants were male (51.7%), between the ages of 18-34 years (49.2%), and spent more than 20 years in a refugee camp (50.8%). The majority had less than a high school education and were Hindu. More than half of the participants were employed full-time (54%) and had Medicare or Medicaid for health insurance (76.3%).

Table 1. *Participant characteristics (n=201)*

Characteristics	%	n
Sex		
Male	51.7	104
Female	48.3	97
Age		
18-24 years	18.9	38
25-34 years	30.3	61
35-44 years	23.4	47
45-54 years	14.9	30
55+ years	12.4	25
Country of Birth		
Bhutan	87.6	176
Nepal	10.4	21
Time in Refugee Camp		
0-19 years	49.2	96
20+ years	50.8	101
Education		
No school	14.6	29
Grade school (K-8)	18.6	37
Some high school	15.1	30
High school grad or GED	17.6	35
Some college or technical school	15.1	30
College graduate	12.6	25
Graduate degree	6.5	13
Religion		
Hindu	82.7	162
Christian	8.2	16
Buddhist	5.1	10
Health Insurance		
No health insurance	4.5	9
Self-pay	4	8
Through work (spouse's or own)	12.6	25
Medicare/Medicaid	76.3	151
Other	2.5	5
Total Family Income		
Less than $15,000	43.1	84
$15,001-$30,000	34.9	68
$30,001-$50,000	16.9	33
$50,001-$75,000	2.6	5
More than $75,000	0.5	1
Don't know or prefer not to answer	2.1	4
Employment		
Full-time	54	107
Not working	34.3	68

Post-Migration Living Difficulties (PMLD)

PMLD experienced by participants are presented in Table 2. More than half the participants (54.2%) reported communication and language difficulties were a somewhat to serious problem. Participants felt they had a somewhat to serious problem adjusting to the weather and climate (40.3%), and 39.9% of participants reported that being able to find work was a somewhat to serious problem. Fear of being sent home (83.5%), being unable to practice your religion (81.3%), poor access to traditional foods (79.4%), and discrimination because of language, color, religion, etc. (74.7%) were reported as the least challenging experiences post-migration.

Table 2. *Post-migration living difficulties (PMLD) frequencies*

PMLD Question	No problem %(n)	Somewhat of a problem %(n)	Serious Problem % (n)
Getting treatment for health problems	66.8 (131)	23.5 (46)	9.7 (19)
Access to emergency medical care	68.9 (135)	21.9 (43)	9.2 (18)
Access to long term medical care (family doctor, Primary Care Physician)	66 (128)	22.7 (44)	11.3 (22)
Access to dental care	63.9 (124)	21.1 (41)	14.9 (29)
Access to counseling services	63.2 (120)	25.8 (49)	11.1 (21)
Not enough government help with welfare (unemployment benefits, financial help)	60.6 (117)	28 (54)	11.4 (22)
Not enough help with welfare from charities (social services, Red Cross, Salvation Army)	63.7 (123)	28 (54)	8.3 (16)
Communication difficulties/ language difficulties	45.8 (87)	23.7 (45)	30.5 (58)
Discrimination (because of language, color, religion, etc.)	74.7 (145)	17.5 (34)	7.7 (15)
Being unable to find work	60.1 (116)	20.2 (39)	19.7 (38)
Bad working conditions	71.4 (137)	15.6 (30)	13 (25)
Separation from family	69.2 (135)	15.4 (30)	15.4 (30)
Worries about family back home	65.3 (126)	21.2 (41)	13.5 (26)
Unable to return home to family in an emergency	71.8 (140)	15.4 (30)	12.8 (25)
Loneliness and boredom	69.1 (132)	17.8 (34)	13.1 (25)
Poor access to traditional foods	79.4 (154)	11.3 (22)	9.3 (18)
Fears of being sent home	83.5 (162)	8.8 (17)	7.7 (15)
Being unable to practice your religion	81.3 (157)	9.3 (18)	9.3 (18)
Difficulty adjusting to the weather/climate	59.7 (117)	27 (53)	13.3 (26)

Family Resources

Family resources are presented in Table 3. Over half of the participants reported to having not at all to sometimes enough money to buy things for family (55.6%), money to save (68%), and travel or vacation (65.6%). The majority of participants reported they usually have enough resources for two meals a day (88.8%), a house or apartment (86.9%), money to buy necessities (68.5%), time to get sleep (87.8%), dependable transportation (66.3%), dental care for family (69.6%), money to pay bills (70.9%), and time for family to be together (77.6%).

Table 3. *Family resources frequencies*

To what extent does your family have the following?	Not at all Enough %(n)	Sometimes Enough %(n)	Usually Enough %(n)	Does Not Apply %(n)
Resource Necessities				
Food for 2 meals a day	3 (6)	6.1 (12)	88.8 (175)	2 (4)
House or apartment	3.7 (7)	6.3 (12)	86.9 (166)	
Money to buy necessities	6.1 (12)	24.9 (49)	68.5 (135)	0.5 (1)
Enough clothes for your family	3.6 (7)	19.3 (38)	76.1 (150)	1 (42)
Heat for your house or apartment	3.6 (7)	8.3 (16)	86.5 (167)	1.6 (3)
Indoor plumbing/water	3 (6)	5.1 (10)	87.8 (173)	4.1 (8)
Time to get enough sleep or rest	5.6 (11)	11.2 (22)	82.7 (163)	0.5 (1)
Furniture for your home or apartment	6.1 (12)	12.6 (25)	79.8 (158)	1.5 (3)
Telephone or access to phone	3.6 (7)	11.4 (22)	82.4 (159)	2.6 (5)
Resource Services				
Public assistance (SSI, AFDC, Medicaid, etc.)	5.7 (11)	18.2 (35)	64.1 (123)	12 (23)
Dependable transportation (own car or provided by others)	16.6 (32)	14.5 (28)	66.3 (128)	2.6 (5)
Child care/day care for your child(ren)	9.3 (18)	4.1 (8)	46.6 (90)	39.9 (77)
Dental care for your family	8.9 (17)	20.4 (39)	69.6 (133)	1 (2)
Monetary Resources				
Money to pay monthly bills	5.1 (10)	22.4 (44)	70.9 (139)	1.5 (3)
Toys for your child(ren)	5.2 (10)	16.7 (32)	49 (94)	29.2 (56)
Money to buy things for self	12.4 (24)	29.5 (57)	57 (110)	1 (2)
Money to buy things for family	18.9 (37)	36.7 (72)	41.8 (82)	2.6 (5)
Money to save	39.6 (78)	28.4 (56)	29.9 (59)	2 (4)
Travel/vacation	33.8 (67)	31.8 (63)	30.3 (60)	4 (8)
Time for Self and Family				
Time to be by yourself	6.6 (13)	16.2 (32)	75.6 (149)	1.5 (3)
Time for family to be together	3.6 (7)	17.2 (33)	77.6 (149)	1.6 (3)
Time to exercise	10.9 (21)	18.8 (36)	66.7 (128)	3.6 (7)

Social Support

Table 4 shows the participants' perceived social support. The majority of participants reported their family really tries to help them (86.3%), they get the emotional support they need from their family (83.3%), and their family is willing to help them make decisions (85.3%).

Table 4. *Social support frequencies*

Question	Disagree %(n)	Neutral %(n)	Agree %(n)
There is a special person who is around when I am in need.	4 (8)	21.6 (43)	74.4 (148)
There is a special person with whom I can share my joys and sorrows.	3.5 (7)	13.6 (27)	82.9 (165)
My family really tries to help me.	4.1 (8)	9.6 (19)	86.3 (170)
I get the emotional help and support I need from my family.	4 (8)	12.6 (25)	83.3 (165)
I have a special person who is a real source of comfort to me.	5.6 (11)	16.3 (32)	78.1 (153)
My friends really try to help me.	6.1 (12)	25.8 (51)	68.2 (135)
I can count on my friends when things go wrong.	9.8 (19)	29 (56)	61.1 (118)
I can talk about my problems with my family.	4 (8)	14.1 (28)	81.8 (162)
I have friends with whom I can share my joys and sorrows.	7.2 (14)	22.7 (44)	70.1 (136)
There is a special person in my life who cares about my feelings.	7.6 (15)	14.7 (29)	77.7 (153)
My family is willing to help me make decisions.	2.5 (5)	12.2 (24)	85.3 (168)
I can talk about my problems with my friends.	7.6 (15)	25.4 (50)	67 (132)

T-Test Results

Independent samples t-tests were run to compare different demographic data with monetary resources, PMLD, and social support in order to determine areas lacking support for the Bhutanese-Nepali refugees (see Table 5). An independent samples t-test indicated that monetary resources were significantly higher for 18-34-year-olds (M = 2.51, SD = 0.52) than for 35-55+ years old (M = 2.30, SD = 0.60), [t(197)= 2.54, p=0.012]. Monetary resources were also significantly higher in those with at least some college or a graduate degree (M = 2.59, SD = 0.53) than in those with no education to a high school graduate/GED (M = 2.31, SD = 0.57), [t(196)= -3.35, p= 0.001]. PMLD was significantly higher in those with no education to a high school graduate/GED (M = 1.71, SD = 0.57) than with at least some college or a graduate degree (M = 1.43, SD = 0.54), [t(194)= 3.38, p= 0.001]. Interestingly, PMLD was significantly higher in those who lived in a refugee camp for 10-19 years (M = 1.73, SD = 0.56) than those who lived in a refugee camp for 20+ years (M= 1.49, SD = 0.56), [t(192)= 2.97, p= 0.003]. There was no significant difference found between men and women and family resource necessities, services, and monetary resources, social support, and PMLD; between time spent in a refugee camp and family resource services and monetary resources and social support; and between age and education with PMLD, social support, or family resource services and necessities.

Table 5. *Independent samples t-test results*

Characteristic	Score Mean (SD)	*t*	*df*
Monetary resources			
18-35 years	2.51 (0.52)	2.54*	197
35-55+ years	2.30 (0.60)		
Monetary resources			
No education-high school/GED	2.31 (0.57)	-3.27**	196
Some college-graduate degree	2.59 (0.53)		
PMLD			
No education-high school/GED	1.71 (0.57)	3.32**	194
Some college-graduate degree	1.43 (0.54)		
PMLD			
10-19 years in refugee camp	1.73 (0.56)	2.97**	192
20+ years in refugee camp	1.49 (0.56)		

Note: SD = standard deviation; *df* = degrees of freedom.
*$p < .05$, **$p < .005$.

Discussion

This study examined the perceived social support, PMLD, and family resources among Bhutanese-Nepali refugees in Columbus, OH using data from a community health needs assessment. The results of this study provide greater insight into the cultural, social, and heath needs of Bhutanese-Nepali refugees who recently resettled in Columbus. The most commonly reported PMLD was communication and language difficulties, followed by difficulty finding work and insufficient government help with welfare. These findings indicate that communication and language barriers can add stress in resettlement, especially in a society where immigrants are expected to quickly learn, understand, and speak English upon arrival (Schick et al., 2016). Barriers to communication and language can also limit employment opportunities for Bhutanese-Nepali refugees. Their difficulty in finding employment may be due to different obstacles, such as a language barrier and a lack of education (the majority of participants reported having a grade school-high school grad/GED level education). Another barrier to finding employment may be due to a gap in their employment history or lack of experience due to the amount of time many spent in refugee camps (50% spent 20+ years prior to immigration). Their lack of education and decades spent in a refugee camp may limit their skills needed to find employment in the U.S. In terms of family resources, many reported they did not have enough money to save or enough money for travel/vacation or to buy things for family. A lack of family resources may also increase their feelings of stress, which can potentially impact many aspects of their daily lives and their ability to create a stable life.

Despite these challenges, participants in this study reported that they have strong social support, which may ease some of the burdens of resettlement (Stewart et al., 2010). It was

surprising that this population, despite all their hardships, maintain a strong social support system within their community and families. A study on the Bhutanese-Nepali refugees in Ohio found that they had strong social support among their family and friends, especially in times of need (Adhikari et al., 2015). These findings are important because it allows us to determine how to best support them in their resettlement. For example, by taking into account how some cultures define a family unit, it may be beneficial to attempt to resettle extended family members, not just the nuclear family since many refugees rely on their family for survival (UNHCR, 2001). Keeping extended families together can increase well-being and is essential for successful resettlement and integration (UNHCR, 2001). The Bhutanese-Nepali family unit consists of not only the nuclear family but also the extended family; by resettling the nuclear and extended family together, it may increase their feelings of support. It will also help determine how to best support Bhutanese-Nepali refugees in their resettlement by outlining specific areas that are lacking in support, such as, monetary resources and PMLD. Since refugees are given support for only 30-90 days after arrival, it is important to be able to efficiently target resources to the areas that are lacking support (Cepla, 2019). Further research should examine how to foster their strong social support system and decrease any PMLD and family resource difficulties in the process. Since they feel they have a strong social support system, it is crucial to maintain and strengthen that support while providing resources to decrease other areas of difficulty.

There were significant differences found between family resources in terms of monetary resources and age. This finding indicated that those aged 18-34 years and employed had more monetary resources than those aged 35-55 years. This finding suggests that a need for financial or employment services to help support the older age groups as they arrive and resettle. There are social service agencies in Columbus that provide assistance to recently resettled refugees such as

the Community Refugee and Immigration Services (CRIS), a non-profit organization that serves the refugee population in Central Ohio (Community Refugee and Immigration Services, 2017). CRIS offers an older refugee and immigrant program for individuals over 60 years old residing in Franklin County (Community Refugee and Immigration Services, 2017). Examples of the services CRIS provides for older refugees and immigrants include, U.S. citizenship classes and tutoring, assistance with social security issues, referrals to medical and dental clinics, and resources for doctors, driving schools, grocery stores in the area (Community Refugee and Immigration Services, 2017). Another service available is the Ohio Refugee Services Program that offers medical assistance if not eligible for Medicaid, and refugee social services including acculturation, English as a Second Language (ESL), employment training, job payment, transportation, childcare, and translation/interpreter services (Ohio Department of Job and Family Services, 2018). The Jewish Family Services (JFS), in Columbus, Ohio, also offers support to refugees who have been in the U.S. for five years or less (Jewish Family Services, 2014). JFS provides job-readiness and interview training, job application and placement assistance, and resume preparation (Jewish Family Services, 2014). Barriers to accessing these resources may include a lack of knowledge of the existence of the services available, and with cuts in funding, many of these agencies are not able to support as many refugees and some had to close their doors altogether. It is important to ensure the refugees are aware of these resources and how to access them. It is also important to have adequate funding in order to provide resources for a longer period of time since it is difficult to become self-sufficient in 30-90 days upon arrival (Cepla, 2019).

There was a significant difference between family resources in terms of monetary resources and education (which indicates that those with some college education or higher had

more monetary resources). There was also a significant difference found between PMLD and education, which indicates that those with less education reported greater PMLD. Finally, there was an unexpected significant difference found between PMLD and time spent in a refugee camp, which indicates that those who were in a refugee camp for 20+ years reported less PMLD than those who were in the refugee camps for less than 20 years. Those who have at most a high school degree/GED degree have greater monetary resource challenges and PMLD. Those who are 35 and older also have greater monetary resource challenges. These findings are important because they can indicate areas of further research and potential services that could be provided for the areas in need, such as those with less education and those who are older than 35 years. There is research available on the Bhutanese-Nepali refugees' mental health disorders, but this study points to other areas of need. If the refugees' age, education level, and time spent in a refugee camp prior to resettlement are taken into account, then those at risk of these difficulties may be able to obtain additional resources and support upon arrival. Further research should explore the differences found between age and family resources, education and family resources, PMLD and education, and PMLD and time spent in refugee camps to determine the cause of these significant differences. This inquiry could determine specific areas of difference between the participant's age and education levels in these areas to determine patterns between the challenges faced.

The majority of research available on the Bhutanese refugee population examines mental health issues and suicide rates. Contributing factors to the population's high suicide rate may include not being able to provide for their family and a lack of social support (CDC, 2012). Interestingly, this study found that the majority of participants felt they did not have enough money to buy things for their family, save, or travel, but they also felt they had strong social

support. Studies have found that post-migration, refugees typically face various challenges from language barriers to unemployment, which may contribute to mental health issues and unemployment rates (Edward & Hines, 2015; Li, Liddell, & Nickerson, 2016; Schick et al., 2016). This study did find higher rates of language difficulties being a significant problem for the Bhutanese-Nepali refugees. Another study also found evidence that the Bhutanese-Nepali refugees in Columbus, OH have a strong social support system (Adhikari et al., 2015). A strong social support system can benefit those recently resettled by reducing loneliness, suicidal ideation, and adverse psychological effects of stress, which can enhance their mental health (Ao et al., 2016; Stewart et al., 2010). A strong social support system can also help facilitate employment, their ability to meet basic needs, and increase their sense of belonging in their host county (Liamputtong & Kurban, 2018; Stewart et al., 2010).

Strengths and Limitations

This study had several strengths. The community health needs assessment was created to gain a better understanding of cultural, social, and health needs of the Bhutanese-Nepali community. The community health needs assessment was also created with guidance from a cultural community advisory board. This board assisted in developing culturally appropriate methods and materials (e.g., questionnaire). In addition, bilingual and bicultural field staff recruited and administered the needs assessment questionnaire.

While this study had many strengths, there were also limitations. The small sample size and convenience sample limits generalizability of the findings. Response bias may be a limitation in the study due to the data being self-reported. Another limitation may be selection bias since the majority of the participants were recruited from a local refugee resettlement

agency. Those who resettled through different agencies or moved to Columbus after resettling elsewhere first may not be represented in this sample.

Conclusions

To our knowledge, this is one of the first studies to examine the PMLD, family resources, and social support in the Bhutanese-Nepali refugees. This study is important because looking at PMLD, family resources, and social support can help determine a families' ability to adapt to stressors and transitions to life in the U.S. As new refugees resettle in the U.S., it is imperative to help them acculturate and thrive in their new country. This study also highlights issues in this population that need further research.

Future studies should examine ways to help refugees maintain strong social networks in their communities in order to lessen or eliminate post-migration challenges. As the U.S. continues to receive refugees from around the world, it is critical to be aware of the needs of these individuals and their families in order to help minimize stressors and help them become successful, contributing members of society.

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