DEPRESSION IN REFUGEE POPULATIONS: A ROLE FOR COMMUNITY-BASED MENTAL HEALTH INTERVENTIONS?

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Depression in refugee populations:
A role for community-based mental health interventions?

by
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Abstract

Refugees face a variety of challenges both before and after resettlement, including increased psychological distress. The purpose of this research is to determine the prevalence of depression in the Bhutanese refugee community in Buffalo, New York and to suggest intervention strategies. The research was done in two parts. In the first study, facilitated through Jericho Road Community Health Center, the Patient Health Questionnaire (PHQ-9) was administered to 100 Bhutanese refugees and 100 American-born, English speakers. Results reveal that the American-born, English-speaking participants had significantly higher scores on the PHQ-9 than the Bhutanese refugees, contrary to expectations. The second study used a focus group to explore the discrepancy between the results of Study 1 and the published literature on depression in refugee populations. The focus group discussion indicated that the Bhutanese refugees in Buffalo are indeed suffering from mental distress as a result of daily stressors, but that this distress does not likely meet the DSM-IV diagnostic criteria for depression. The results of both studies are discussed in the context of community psychology and the treatment needs of Bhutanese refugees, including suggestions for how to better meet these needs and improve their psychological well-being.

Depression in refugee populations: A role for community-based mental health interventions?

The United Nations High Commissioner of Refugees (UNHCR) defines a refugee as someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his [or her] nationality, and is unable to, or owing to such fear, is unwilling to avail himself [or herself] of the protection of that country" (UNHCR, 2013). At the beginning of 2013, there were 10.4 million refugees of concern to UNHCR worldwide. One long-term solution to this crisis is resettlement, meaning migration from a country where refugees were seeking protection to a third country where they are granted permanent residence. In 2012, 69,252 refugees were resettled to a third country, of which 53,053 came to the United States (UNHCR, 2013).

Mental Health of Refugee Populations

Refugees face a variety of challenges both before and after resettlement, including psychological distress. The World Health Organization (WHO) reports that between one-third and one-half of all refugees and internally displaced people have some type of mental distress, with post-traumatic stress disorder (PTSD) and depression being the most common diagnoses within this population (WHO, 2001). The rate of depression varies among studies. Fazel, Wheeler, and Danesh (2005) reviewed the prevalence of mental illness within refugee populations. Of the twenty studies selected for analysis, they reported an overall prevalence of 9% for PTSD and 5% for major depression, but these results varied dramatically among the chosen studies. Emily Keyes (2000) also did an

integrative review of studies about refugee mental health. Of the 58 articles she found using a keyword search, 12 met inclusion criteria. She found that in every population studied, there was at least one mental disorder present, again finding PTSD and depression to be the most common.

Kroll, Yusuf, and Fujiwara (2011) report that over half of the Somali female refugees in a particular mental health clinic in Minneapolis suffer from both depression and PTSD. Even higher percentages were found in research done by Jamil, Farrah, Hakim-Larson, Kafaji, Abdulkhaleq, and Hammad (2007) in which 80 percent of Iraqi refugees in their sample had dealt with extreme anxiety and/or depression. Barnes (2001) implemented a mental health screening into the health examination program already in place at a clinic and found that whether interviewed at the clinic or at home, the refugees had a significantly higher rate of depression than the general population. While these examples show tremendous variation in percentages, they agree that refugee populations face high rates of mental illness, depression in particular.

There are also differences within refugee populations in regards to who is most at risk for mental illness. A meta-analysis by Porter and Haslam (2005) offers insight into some of these risk factors. They reported that females tend to suffer from mental illness more often than males, those from rural areas more than those from urban areas, adults more than children, and the educated more than the uneducated. Post-displacement risk factors included that resettled refugees suffered from mental illness more than those in refugee camps, internally displaced people more than those who have left their home country, and refugees from countries in ongoing conflicts more than those from countries who had experienced past conflicts. These results indicate that social, economic, and

political conditions both before and after displacement are related to mental health outcomes. All refugees are not at equal risk for mental distress and do not experience mental distress in the same way.

Although the prevalence of mental illness varies both among and within refugee populations, the published literature supports the proposition that refugees have a higher rate of mental distress than the general population. There are a variety of possible causes of this problem. First, refugees typically have faced a high level of stress prior to fleeing the country, often including persecution of some kind. Furthermore, the move itself may be traumatic. Refugees may deal with the death of family members, leave behind belongings and family members, or face an unsafe journey. These conditions serve to make the transition to a new place more difficult. Once refugees arrive at a refugee camp or are later resettled, the stresses and trauma are not over. They are entering a new culture and as a result, they often face a language barrier, struggle with finances, and fail to assimilate into their new communities. In addition to these difficulties, most have lost a great deal of social capital and have anxiety over those they have left behind (Kirmayer, 2011; Orley, 1994). This list of stressors is certainly not exhaustive, but it serves to make the point that refugees face many challenges and difficult circumstances that may contribute to the high prevalence of mental health problems within their communities.

Mental Health of Bhutanese Refugees

The Bhutanese refugee population has been receiving particular attention in recent research on refugee mental health, and it is this population that is the focus of the present research. The current refugee crisis surrounds the 35% of the Bhutanese population that is ethnically Nepali (Central Intelligence Agency, 2010; Rizal, 2004). The majority of these

people are Lhotsampa, which literally translates as "people of the South" (Maxym, 2010). Under the rule of Bhutanese King Jigme Singye Wangchuk, their language, dress code, architecture, food, and even religion to some degree were enforced by the government under the "one country, one people" policy (Maxym, 2010; Sinha, 2001; Walcott, 2011). The purpose of the "one country, one people" policy was to promote "national integration, national consciousness, and national identity" (Rizal, 2004, p. 156). This policy, along with economic, social, and cultural factors, led to discrimination and persecution of the Lhotsampa people. Thousands fled Bhutan and entered Nepal, where they lived in refugee camps. Others protested against the oppressive policies and were imprisoned and tortured as a result (Rizal, 2004).

Where do things stand now? As of 2004, there had been 15 rounds of talks between the Bhutanese and Nepalese governments and these talks continue to this day (Rizal, 2004). Talks in 1993 created four official groupings for categorizing the refugees: Bhutanese citizens, Bhutanese who have migrated, non-Bhutanese, and Bhutanese who have committed criminal acts (Rizal, 2004). In 2001, the 12,173 residents of the Khudunabari refugee camp were assessed by a verification team in order to determine how many of them would be permitted to return to Bhutan. The team was composed of both Bhutanese and Nepalese, but no other group was allowed to be involved. The assessment process was completed in 2003, and it was declared that 75% were qualified to return home to Bhutan, but a disagreement between the verification team and the refugees meant that even those in the 75% were not permitted to leave the camps (PhotoVoice, 2010). The above example illustrates the decision reversal that has characterized the Bhutanese refugee crisis thus far.

Resettlement of Bhutanese refugees to third countries began in 2007, when over 100,000 Bhutanese refugees were living in camps in Nepal. Resettlement is a complicated process that involves many stages, including interviews, medical testing, cultural orientation, and the completion of travel itineraries. The United States originally agreed to resettle 60,000 refugees; Canada, Australia, Denmark, the Netherlands, Norway, and New Zealand also offered to take smaller groups (UNHCR, 2007). In Nepal, over 99% of refugees requesting resettlement have been approved, the highest acceptance rate in the world. As of April 2013, approximately 100,000 Bhutanese refugees had been resettled to third countries, 66,134 of whom have come to the United States (UNHCR, 2013). The refugee crisis is ongoing in Bhutan as the number of those fleeing the country and going through resettlement continues to rise, posing major challenges for both the refugees themselves and the countries that are resettling them.

The mental health of Bhutanese refugees has been of particular concern recently due to high rates of suicide reported within the population, rates more than three times the general American population (Kohrt, Maharjan, Timsina,& Griffith, 2012; Refugee Health Technical Assistance Center, 2011). Researchers have responded by investigating the mental health of the Bhutanese refugee population, both in refugee camps in Nepal and after resettlement to third countries. Much of this research has centered around the impact of torture on mental health. A systematic review of the literature on Bhutanese refugee mental health indicated that both tortured and non-tortured refugees experience higher rates of mental distress than the general population, taking forms such as PTSD, anxiety, and depression (Mills, Singh, Roach, & Chong, 2008). The review included studies such as Shrestha et al. (1998), which determined that the experience of torture

was significantly related to these mental illnesses. Van Ommeren et al. (2002) expanded on these findings by adding the factor of somatic symptoms and found that somatization was also significantly related to the presence of PTSD and depression among torture victims.

Recent work has moved beyond researching torture victims and has more specifically focused on the issue of suicide. Both the International Organization for Migration (IOM) and the Centers for Disease Control (CDC) in partnership with the Refugee Health Technical Assistance Center and the Office of Refugee Resettlement recently published reports investigating suicide in the Bhutanese refugee population. The IOM research (Schinina, Sharma, Gorbacheva, & Mishra, 2011) was done in Damak, Nepal. Their team spoke with different groups of people using methods such as family interviews, focus groups, interviews with individuals who had attempted suicide, and interviews with family members of suicide victims. Results from this research revealed that victims of gender-based violence and members of highly vulnerable families are significantly more likely to attempt or commit suicide. This report also included an analysis of 12 suicides of resettled Bhutanese refugees. Researchers found that these suicides were associated with additional responsibility being placed on non-traditional family providers and females being separated from their families or other forms of support.

The IOM report also investigated whether these suicides were connected in any way to mental illness. Interviews with those who had attempted suicide and close family members of suicide victims revealed that nine of the sixteen suicide victims/attempters showed symptoms of untreated mental illness. Of these individuals, 37.5 percent had

symptoms of depression, compared to 8.8 percent in the general refugee camp population. The high rate of suicide (and the probable high rate of mental illness) both in and out of the refugee camps is extremely concerning. The IOM offers several response suggestions such as creating known treatment options, having psychiatrists and psychologists available in the camps, initiating focus group discussions with vulnerable populations, and organizing prevention campaigns.

The report published by the Centers for Disease Control (2012) investigated only the suicides of Bhutanese refugees who had been resettled in the United States. The purpose of their research was to describe the suicides that had happened and determine what factors are related to Bhutanese suicide ideation. The researchers collected data through multiple methods including focus groups, psychological autopsies, and a cross-sectional survey. Focus group discussions dealt with topics such as cultural understanding of mental health and suicide, and in addition to being used as data they were used to assist in creating questions for the other two methods. The psychological autopsies consisted of interviews done with a close contact of the suicide victim to obtain information on the circumstances of the suicide and factors that may have contributed to it. The survey was administered to 579 Bhutanese refugees from all over the country. In addition to questions written specifically for this survey, it included several standardized questionnaires to assess social support and symptoms of depression, anxiety, and post-traumatic stress disorder. Of specific interest are the symptoms of anxiety and depression experienced by the refugees. In the survey, they found that 19% of participants faced anxiety, and 21% dealt with symptoms characteristic of depression. This reveals that although only 4% had been diagnosed with mental illness, there may be undiagnosed

conditions in the community that should be treated. Only one person out of fourteen had sought professional help prior to committing suicide, indicating a possible problem with the availability of mental health services and their use. While the connection between depression and suicide is still inconclusive for Lhotsampa people, the gravity of the problem requires further research.

The present research seeks to determine the prevalence of depression within the Bhutanese refugee community in Buffalo, New York, through both quantitative and qualitative research. In Study 1, a total of 100 Bhutanese refugees and 100 American-born, English-speaking patients at Jericho Road Community Health Center were given the Patient Health Questionnaire (PHQ-9) depression screening. This was done to evaluate the point prevalence of depression in these two groups. Based on the literature cited above, I hypothesized that the Bhutanese refugees would score higher on the PHQ-9 than the American-born, English speakers. The purpose of Study 2 was to investigate the way that Bhutanese refugees understand depression and its symptoms and to determine whether they feel it is affecting their community in a significant way. The answers to these questions were obtained through a focus group discussion.

Study 1

Method

Participants

One hundred Bhutanese refugees and one hundred American-born, English speakers participated in this experiment voluntarily. All were patients at Jericho Road Community Health Center in Buffalo, NY, a non-profit organization whose mission is to

"provide a medical home for refugee and low-income community members in Buffalo, facilitating wellness and self-sufficiency by addressing health, education, and economic barriers" (Jericho Road Community Health Center, 2013). Of the Bhutanese refugee participants, 64 were female and 36 were male. Of the American-born participants, 66 were female and 34 were male. The average age of the Bhutanese refugees was 40.69, while the average age of the Americans was 46.18. The vast majority of Bhutanese refugees were married, with only five widowed, one divorced/separated, and nine who had never been married. The marital statuses of the American-born participants, on the other hand, were more split, with 24 married, 12 widowed, 20 divorced/separated, and 44 who had never been married. The Bhutanese refugees had an average of 3.07 children while the American-born participants had an average of 2.0 children. Bhutanese refugee participants had been in the United States for an average of 1.8 years, with a range from two weeks to five years. All participants gave informed consent and were fully debriefed following the experiment.

Materials

The Patient Health Questionnaire (PHQ-9) depression screening was utilized in this study (Appendix A). It is a ten-question questionnaire in which the participants are asked to respond as to how often they have experienced certain symptoms within the last two weeks. The symptoms and duration criteria included in the PHQ-9 are based on the diagnostic criteria of the DSM-IV. Jericho Road Community Health Center uses both the Patient Health Questionnaire-2 (PHQ-2) and the PHQ-9 regularly at their practice. The International Institute of Buffalo translated the standard English version of the questionnaire into Nepali and it was then back-translated by the two Nepali interpreters at

Jericho Road to confirm accuracy (Appendix B). The same translation process was used for the informed consent form (Appendix C and Appendix D).

Procedure

The PHQ-9 was read aloud to each participant. I read the questions to each American-born, English-speaking participant and one of the two Nepali interpreters read the questions to each Bhutanese refugee participant. They responded orally and I noted their responses on printed copies of the questionnaire. I scored each questionnaire immediately after completion. A copy of each completed questionnaire was later scanned and sent to the patient's primary medical provider so that a doctor would have access to the scores.

After the PHQ-9 was completed, each participant answered a series of demographic questions, also read aloud and recorded in writing. In total, it took between 5 and 10 minutes to assess each participant, and at the close of the session, each participant was debriefed, thanked, and dismissed.

Results

A factorial analysis of variance was conducted to determine the effect of refugee status (Bhutanese refugees vs. American-born participants), sex, and age on PHQ-9 total depression scores, as shown in Table 1. Means and standard deviations for refugee status, sex, and age level are reported in Table 2. There was a significant main effect for refugee status ($F(1,188) = 11.26$, $p = .001$), as Bhutanese refugee participants had significantly lower scores on the PHQ-9 than did American-born participants (Figure 1). This means that the difference was in the opposite direction to what was predicted, because prior

studies on refugee communities led to the hypothesis that the Bhutanese refugees would have higher depression scores than the American-born control group.

Source	Sum of Squares	*df*	Mean Square	*F*	*p*	Partial Eta Squared
Sex	43.731	1	43.731	1.701	0.194	0.009
Age	137.298	2	68.649	2.670	0.072	0.028
Refugee Status	289.397	1	289.397	11.255	0.001	0.056
Sex * Age	0.515	2	0.258	0.010	0.990	0.000
Sex * Refugee Status	32.372	1	32.372	1.259	0.263	0.007
Age * Refugee Status	21.307	2	10.654	0.414	0.661	0.004
Sex * Age * Refugee Status	136.637	2	68.318	2.657	0.073	0.027
Error	4833.894	188	25.712			
Total	11211.000	200				
Corrected Total	5729.955	199				

Table 1: ANOVA Results of PHQ-9 Total Score by Sex, Age, and Refugee Status

		Mean	Standard Deviation	*n*
Sex	Female	4.7429	4.93343	70
	Male	5.5000	5.58549	130
Age	18-29	3.7174	4.78267	46
	30-59	5.5556	5.34410	117
	60 and older	6.1081	5.87265	37
Refugee Status	Bhutanese Refugee	3.5600	4.17864	100
	American-born	6.9100	5.89486	100

Table 2: Means and Standard Deviations for Sex, Age, and Refugee Status

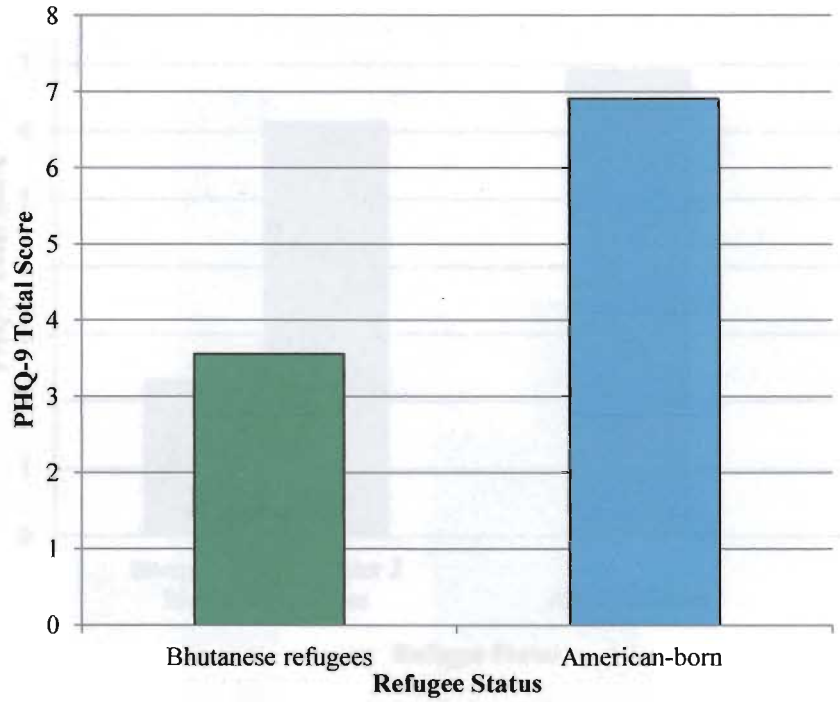

Figure 1: Mean PHQ-9 Total Depression Score by Refugee Status

I also compared the mean PHQ-9 scores obtained by the two interpreters in order to evaluate the consistency of their questionnaire administration. There was a significant difference between the PHQ-9 scores of participants assessed by one interpreter ($M = 2.31$, SD = 3.01) and the PHQ-9 scores of those assessed by the other interpreter ($M = 6.13$, SD = 5.12, $t(97) = 4.65$, $p = .001$). After noting this significant difference, I compared the mean PHQ-9 total scores of the interpreter whose work was associated with higher scores with the mean PHQ-9 total scores of the American-born participants. There was no significant difference between these two groups ($t(130) = .68$, $p = .50$). These results are shown in Figure 2.

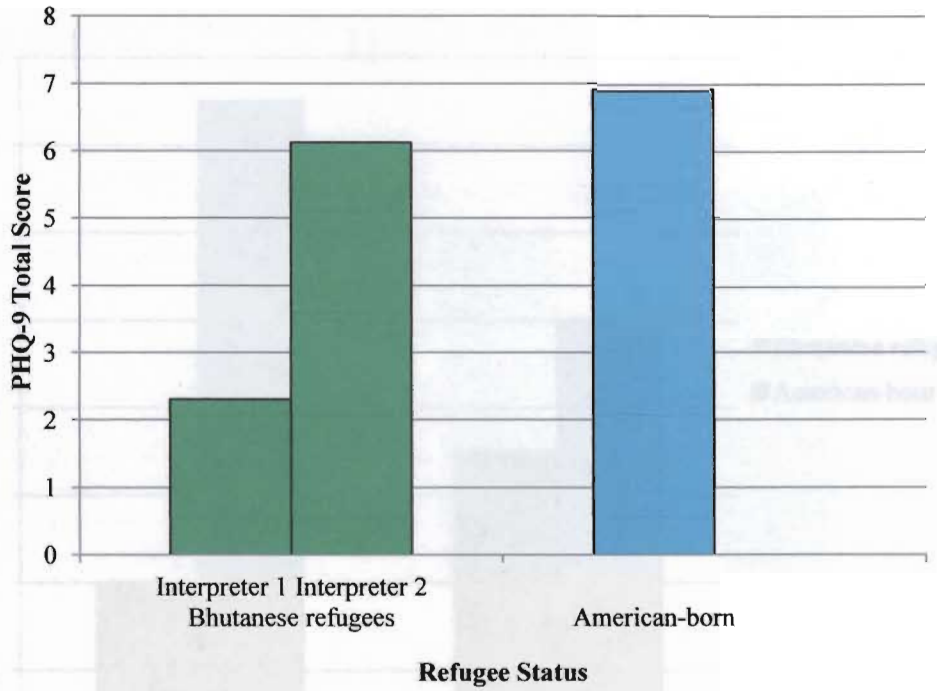

Figure 2: Mean PHQ-9 Total Depression Score by Interpreter and Refugee Status

Since the PHQ-9 total depression score does not by itself indicate depression, I tallied the number of symptoms reported by each participant and then counted the number of Bhutanese refugees and American-born patients who met the DSM-IV criteria for either major or minor depressive disorder. Significantly more American-born participants ($n = 15$) than Bhutanese refugees ($n = 4$) met the DSM-IV criteria for major depressive disorder ($\chi^2 = 6.37, p < .01$). There was no significant difference, however, between the number of Bhutanese refugee ($n = 7$) and American-born ($n = 10$) participants who met the criteria for minor depressive disorder ($\chi^2 = .53, p = .47$). The frequencies for major depressive disorder and minor depressive disorder are shown in Figure 3.

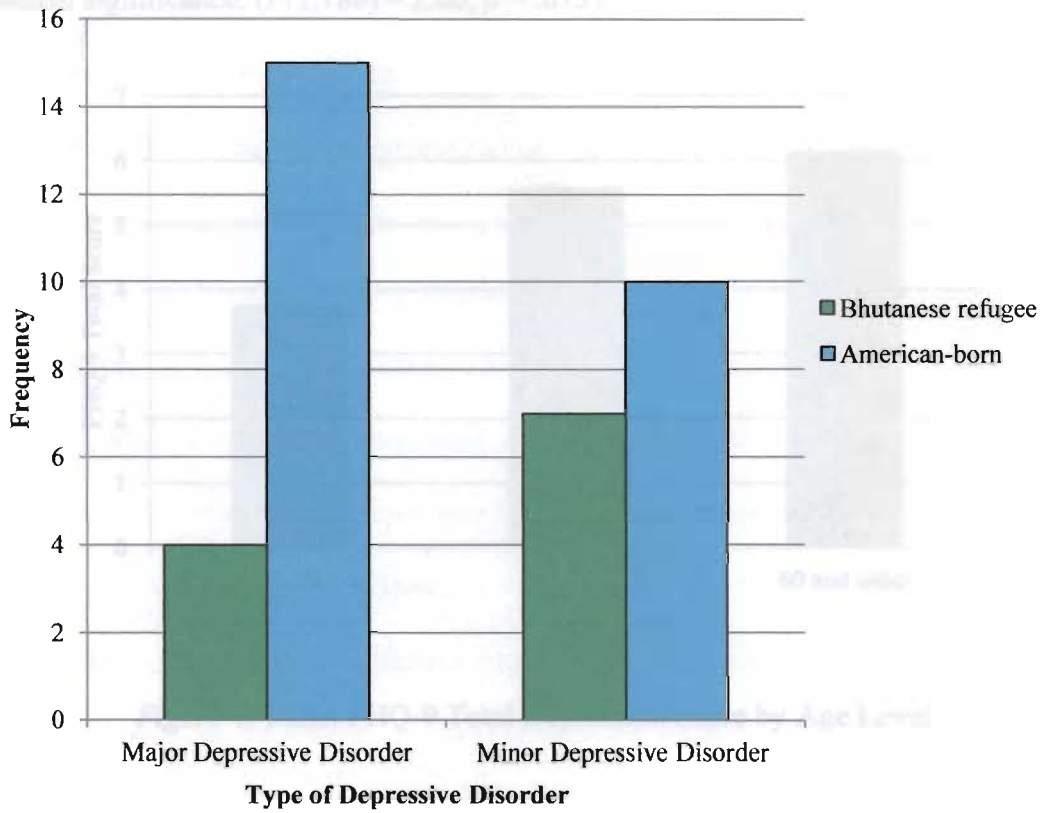

Figure 3: Participants who met DSM-IV Criteria for Depressive Disorders

The DSM-IV indicates that adult females are diagnosed with depression at twice the rate of adult males and that young and middle aged adults are affected more than older adults; I hypothesized that my data would support these demographic trends. However, the main effects for sex and age were not significant. It is worth noting though that when a post hoc comparison was conducted for age groups, the oldest group (participants older than 60) had higher scores on the PHQ-9 than the youngest group (participants 18-29) ($p = .033$). The mean depression scores by age group are presented in Figure 4. The age difference was statistically significant, therefore, but in the direction opposite to the data reported in the DSM-IV. There were no significant interactions,

although the three-way interaction between sex, age, and refugee status approached statistical significance, ($F(2,188) = 2.66$, $p = .073$).

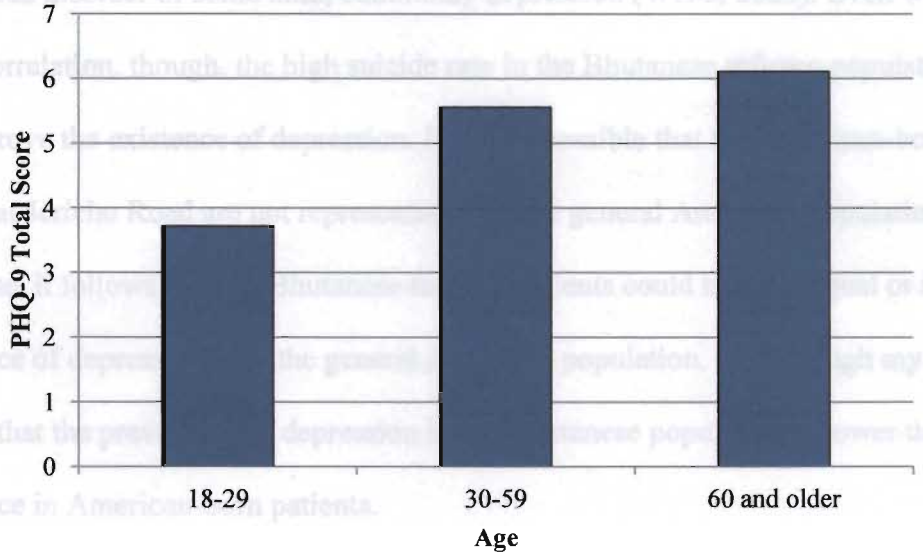

Figure 4: Mean PHQ-9 Total Depression Score by Age Level

Discussion

The Bhutanese refugees did not have significantly higher scores on the PHQ-9 than the American-born, English-speaking patients, in contrast with the published literature on depression within refugee populations. There are many possible reasons for the discrepancy between the results of my research and the published literature that could be investigated through further research. First, the Bhutanese refugee community in Buffalo could indeed be more mentally healthy than the American-born, English-speaking patients who live there. This claim may seem illogical due to the high rate of suicide in the Bhutanese refugee community discussed earlier in the paper (CDC, 2012; Schinina et al., 2011), but it is important to consider the possibility that suicide may not be strongly related to depression in this population. This is not to say that there isn't a

relationship between depression and suicide in the Bhutanese refugee community; after all, at least 80% of suicides in both developing and developed countries are accompanied by a mental disorder of some kind, commonly depression (WHO, 2000). Even with this strong correlation, though, the high suicide rate in the Bhutanese refugee population cannot prove the existence of depression. It is also possible that the American-born patients at Jericho Road are not representative of the general American population. If that is the case, it follows that the Bhutanese refugee patients could have an equal or higher prevalence of depression than the general American population, even though my data indicate that the prevalence of depression in the Bhutanese population is lower than the prevalence in American-born patients.

Second, the Bhutanese refugees may not have been comfortable responding to questions honestly in the setting used in this research. Barnes (2001), for example, reported a 77% refusal rate for refugees screened in a medical clinic, but only a 3% refusal rate for those screened during a home visit, indicating that the home environment may be a better setting for discussions regarding mental health. Very few Bhutanese refugees selected to participate refused, but the setting may have affected their willingness to self-disclose about a sensitive topic.

Third, differences between the two interpreters could have been a factor in the relatively low depression scores in the Bhutanese refugee group. There was a significant difference between the means of the PHQ-9 total depression scores obtained by one interpreter and those obtained by the other. Also interesting is that the significant difference between the means of the PHQ-9 scores of the Bhutanese refugees and the American control group disappears when only comparing the scores of the control group

with the scores of the refugees run by the interpreter whose work is associated with higher scores. The interpreter whose work is associated with higher scores provided explanations or reworded questions when she deemed it to be necessary, a characteristic that may have made the participants who worked with her more comfortable with honest self-disclosure (and thus higher scores) than those who had the other interpreter. Although a causal claim cannot confidently be made in this situation, the significant difference between the scores obtained by the two interpreters emphasizes the importance of detailed training on how to administer the screening to participants. Training would certainly include basic information such as the necessity of confidentiality, execution of the procedure, and importance of consistency, but to minimize differences between interpreters, training should be about more than logistics. More subtle differences in the interpreters' tone of voice, explanations of questions, and style of administering could also affect responses, so training should cover these areas as well. Attention should also be given to the gender of interpreters, as this difference could also have affected results.

A fourth potential reason for the significant differences found in this research being opposite to past studies (and most relevant to the current research) is the possibility that the Patient Health Questionnaire, although translated accurately into Nepali, may not be an accurate measure of depression within Bhutanese refugee culture. It has been widely recognized that depression neither has a singular concept nor presents the same way across all cultures (Durieux-Paillard, Whitaker-Clinch, Bovier, and Eytan, 2006; Halbreich et al., 2007, Kleinman & Good, 1985; Kohrt et al., 2012; Manson, 1995; Marsella, Sartorius, Jablensky, and Fenton, 1985). This is not to deny any neurological, and thus universal, component to the illness of depression, but rather to recognize that

these neurological causes exist within a cultural framework. Keyes (1985) describes this tension, saying that although depression "does entail a representation of the experience of pain rooted in moods found in peoples everywhere, it has practical significance only as an element within a distinctive work of culture" (p. 154).

Conceptualization of Depression in Different Cultures

How, specifically, does the concept of depression and the ways in which it manifests itself vary across cultures? The literature offers numerous examples, only a few of which will be described here. First, the language used to describe depression varies widely. Particularly worth noting is that some people groups do not have a word for depression at all in their language (Halbreich et al., 2007; Kleinman & Good, 1985; Marsella et al., 1985; Ovitt, Larrison, & Nackerud, 2003). Examples include certain groups from Morocco and Tunisia, and some Native American, Native Alaskan, and Southeast Asian cultures (Halbreich et al., 2007; Manson, Shore, & Bloom, 1985; Manson, 1995). This does not mean, however, that similar affect or somatic symptoms are entirely absent. In the case of the Hopi Indians, for example, there are several indigenous illness categories that are related in some way to a concept of depression. These include pathologies that have been translated as worry sickness, unhappiness, heartbroken, drunken-like craziness, and disappointment. None of these corresponds directly to the diagnostic criteria for depression established in the West, but some of them correlate more strongly than others (Manson et al., 1985).

In Western countries, the diagnostic criteria for depression rely heavily on psychological symptoms, while people groups from many non-Western countries often describe more somatic symptoms, including difficulty sleeping, headaches,

stomachaches, and general aches and pains (Halbreich et al., 2007; Marsella et al., 1985). In addition to the strong presence of somatic symptoms, guilt and suicide ideation (and the severity of these symptoms) show tremendous variation across cultures (Durieux-Paillard, Whitaker-Clinch, Bovier, & Eytan, 2006; Marsella et al., 1985). These symptoms are extremely common for depressed people in certain cultures and almost absent in others, yet another piece of evidence of the differences in the way depression presents itself cross-culturally.

The duration of symptoms also varies across cultures. The DSM-IV diagnostic criteria require that the symptoms listed be experienced for at least two weeks in order to indicate major depressive disorder. Certain cultures, however, may have a different cut-off point that would be more appropriate. Returning to the example of the Hopi Indians, it is very common for the Hopi to experience intense sorrow for an extended period of time, meaning that two weeks may be too short a time in order to be comparable in severity to the diagnostic criteria in the DSM-IV (Manson et al., 1985; Manson, 1995). A culture's concept of depression, then, cannot be limited to its symptoms, as it consists of other intersecting and significant factors such as symptom duration.

Noting the evidence that depression concepts seem to vary across cultures, it is important to consider the Bhutanese refugee concept of depression, and their general concept of mental health and illness when doing research with this population. Kohrt and colleagues have done a great deal of research in Nepal, exploring the Nepali mind-body division. They have identified "five elements of self that are central to understanding conceptions of mental health and psychological well-being," (Kohrt & Harper, 2008,

p. 468): *man* (the heart-mind), *dimaag* (the brain-mind), *saato* (the soul), *jiu* (the body), and *ijjat* (social status) (Figure 5).

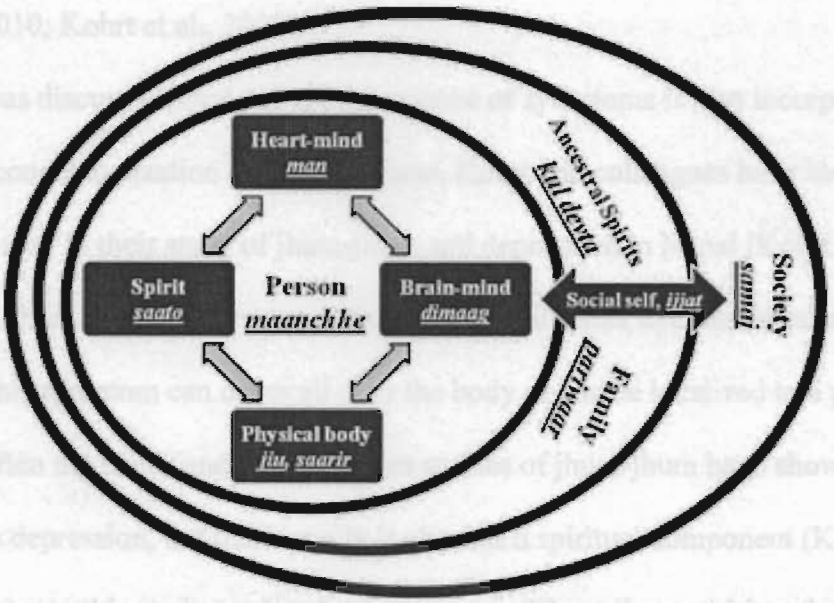

Figure 5: Nepali Mind-Body Division (from Kohrt et al., 2012)

Distinguishing between the heart-mind and the brain-mind is particularly important for the topic of mental illness, specifically depression, and its treatment (Kohrt et al., 2012). The heart-mind is most closely associated with emotion and memory, and as such, disturbances of the heart-mind include things such as sorrow, worry, and anxiety. The brain-mind, on the other hand, is associated with thinking and appropriate behavior. Problems with the brain-mind result in anger, psychosis, and other forms of socially inappropriate actions (Kohrt & Harper, 2008; Kohrt et al., 2012). The heart-mind and brain-mind are related to the other categories of self as well. For example, problems in the heart-mind can lead to physical symptoms in the body or a loss of one's spirit, while problems in the brain-mind can lead to a loss of social status (Kohrt et al., 2012). These categories are important to understand when researching mental illness within the

Bhutanese refugee population because they have implications for the way that mental illness is recognized and treated within their community (Kohrt & Harper, 2008; Kohrt & Hruschka, 2010; Kohrt et al., 2012).

As was discussed previously, the presence of symptoms is also incorporated into the cultural conceptualization of mental illness. Kohrt and colleagues have investigated this topic as well in their study of jhum-jhum and depression in Nepal (Kohrt et al., 2005). Jhum-jhum is a common symptom in Nepal and refers to a numbness and tingling sensation. This symptom can occur all over the body or can be localized to a particular area, most often the hands and feet. Previous studies of jhum-jhum have shown it to be connected to depression, but traditionally it also has a spiritual component (Kohrt, 1999). The researchers in this study explored the presence of jhum-jhum and its relation to both physiological and psychological illness. They used several methods including ethnographic histories, medical exams, and the examination of medical records, thus giving them information on both comorbidity and somatization rather than only one or the other. In two-thirds of the cases of patients struggling with jhum-jhum, the symptom could be attributed to a physical illness such as arthritis, diabetes, or vitamin deficiency. There was no known physiological cause for the other third of participants suffering from jhum-jhum. Practitioners dealing with jhum-jhum, then, should not assume that there is no physical basis for the symptoms, nor should they assume that the patient is only dealing with a physical illness without considering psychological distress (Kohrt, 1999).

The Western conceptualization of depression and the symptoms it causes are not universal. With this in mind, we realize that we cannot "act on an assumption of universality by directly translating our own diagnostic criteria into other languages"

(Kleinman & Good, 1985, p. 5) when there exists such a wide cultural variation in the terminology, symptoms, and duration of depression. In order to evaluate the prevalence of depression within a refugee population, it is important to understand how the specific people group conceptualizes depression and attempt to incorporate that information into the evaluation process.

Use of Mental Health Screenings with Refugee Populations

According to the Centers for Disease Control, the purpose of mental health screenings for refugees is "to identify and triage refugees in need of mental health treatment" (CDC, 2012). They suggest the depression section of the Hopkins Symptom Checklist and the PHQ-9 as suitable depression screening instruments to use with refugee populations. The PHQ-9, which is the screening used in Study 1, has been shown to be reliable and valid in racially and ethnically diverse populations in a primary care setting, including African American, Chinese American, Latino, Thai, and Ethiopian patients (Gelaye et al., 2013; Huang et al., 2005; Lotrakul, Sumrithe, & Saipanish, 2008). The published literature, however, offers differing opinions on the usefulness of these and other screenings with refugee populations and how they should best be used in cross-cultural situations to give the most accurate information about the refugees' mental health.

The importance of mental health screenings in the refugee resettlement process is emphasized by Ovitt, Larrison, and Nackerud (2003) for the very reason mentioned by the CDC: screenings offer a fast and simple way to detect mental health problems within refugee populations. In order to investigate the effectiveness of such screenings, Ovitt et al. administered the Hopkins Symptom Checklist 25 (HSCL-25) to eight Bosnian

refugees, followed by seven questions regarding the comprehensibility and practicality of the screening. All of the refugees felt positively toward the screening, expressing that it took an appropriate amount of time, was easy to understand, and was not an emotionally difficult experience. In addition to these expressions, half of them volunteered the possibility that the screening could help other refugees in similar circumstances. The research done by Ovitt et al. (2003), despite a small sample size, provides an example of refugees responding positively to a standardized, unrevised depression screening, suggesting that this may be a possibility with certain people groups.

While standardized depression screenings can play an important role in determining which refugees need mental health treatment, the use of such instruments can be quite complicated. One reason for this, as Ichikawa, Nakahara, and Wakai (2006) suggest, is that the use of predetermined cut-off points in scoring the scales can lead to inaccurate conclusions about whether the screen is positive or negative. In their work with Afghan refugees in Japan, only 1 in 3 non-cases was correctly identified as a non-case with the HSCL-25. Furthermore, only 3 in 5 refugees who were classified as cases were actual cases after comparing the results to those obtained from an interview based on the DSM-IV diagnostic criteria for depression. It is possible, then, that a similar phenomenon is occurring with data from the PHQ-9 screenings with Bhutanese refugees in Buffalo. Rather than not being conservative enough, perhaps the predetermined cut-off points in the PHQ-9 are too conservative for the Bhutanese refugee population, thereby leading to incorrectly identifying cases as non-cases.

Changing the cut-off points for refugee populations may not be enough, however, particularly if the symptoms described in the questionnaire are not culturally applicable

or if culturally specific symptoms are absent. Durieux-Paillard et al. (2006) asked health professionals with experience working with refugees about the depression section of the Mini International Neuropsychiatric Interview (MINI) and after making a few changes, they sent the reworded version to 14 interpreters who spoke a total of 24 languages. The interpreters pointed out several issues with the questions that the health professionals had not noticed, such as the specificity of the time criteria and the topics of suicide ideation and guilt. Different interpreters, however, expressed different opinions about whether there was a problem with certain questions and if there was a problem, why it was so. For example, thoughts varied dramatically on whether it was appropriate to ask about suicide and if so, how the question should be worded. A few interpreters thought this question was acceptable as is, the Albanian interpreter thought it was appropriate as long as the word "suicide" wasn't used, and the Bulgarian interpreter thought it was appropriate as long as the word "suicide" was used, as opposed to asking if someone wished to be dead. Changing a question to address one problem for a particular culture may therefore create a problem for another culture. Although the researchers did end up with a final version that was successfully tested, their research shows that it is difficult, and perhaps impossible, to adapt a questionnaire in such a way that addresses all of the potential problems for all cultures.

One suggested solution to this problem is to create cross-culturally sensitive depression screenings for specific refugee populations. The Vietnamese Depression Scale (VDS) is an example of this strategy. Kinzie et al. (1982) determined that although depression was a common problem for Vietnamese refugees, existing screenings seemed ineffective in identifying those struggling with it. The criteria included on the screenings,

the inaccuracy of translation, and the direct response styles were seen as specific problems inhibiting the screenings' usefulness. In order to address these problems, a psychiatrist, an anthropologist, and four bilingual Vietnamese people created a preliminary screening that was back-translated; the screening included both patterns of thinking and somatic symptoms commonly expressed by depressed Vietnamese refugees and offered a relatively small range of response choices. This preliminary questionnaire was administered to a clinic group consisting of depressed Vietnamese patients and a 2:1 matched community group consisting of Vietnamese people considered to be mentally healthy, all of whom had already been resettled to America. There was a significant difference between the two groups on every question except three, and fifteen questions accounted for 96% of the variation. The final screening has 18 questions, including both somatic symptoms and feelings and beliefs associated with depression in the Vietnamese population. Dinh, Yamada, and Yee (2009) recently reevaluated this screening and affirmed its structural validity based on a factor analysis and strong internal consistency. It is important to note that several of the criteria on the VDS are not mentioned in the DSM-IV and are not included in a Western concept of depression, such as anger, shame, desperation, and a feeling of going crazy. In creating a depression screening specific to a particular culture, one is therefore able to include criteria that represent the way that culture conceptualizes depression with the hope of more accurately identifying those who need mental health treatment.

While a depression screening specific to each refugee population seems to be an ideal solution, this is not necessarily a viable option. Creating such screenings and testing their reliability and validity is a long and expensive process and depending on the refugee

population, may not be practical. Hollifield et al. (2013) in collaboration with the Pathways to Wellness project, recently proposed an alternative, called the Refugee Health Screener 15 (RHS-15), designed to identify depression, anxiety, and PTSD within refugee populations. An initial questionnaire was translated into four languages through a back-translation process and was then administered to 251 refugees from Bhutan, Burma, and Iraq along with the HSCL-25 and Posttraumatic Symptom Scale-Self Report (PSS-SR). The final version of the RHS-15 was formed based on the results of correlations, t-tests, analysis of variance, discriminant analysis, naïve Bayesian classification, and chi-square. Like other depression screenings, it includes both somatic and psychological symptoms and a Likert scale with descriptions to determine severity of those symptoms, but the RHS-15 also has some unique components. A drawing of a jar ranging from empty to full is included along with the Likert scale and a distress thermometer is drawn at the end to assess overall distress. In addition to an attempt at the symptoms themselves being cross-culturally sensitive, the nature of response takes the patient's refugee status into account. The RHS-15 shows good potential to address the problems inherent in screening refugees for mental health problems and may help to identify those who may be suffering from depression, anxiety, or PTSD and could benefit from further treatment.

While the results from the available research on screening instruments within refugee populations differ, certain conclusions can be drawn by examining the literature as a whole. First, mental health screenings play an important role in meeting the mental health needs of refugees. Primary care centers and resettlement agencies do not have the time or resources to do an in-depth analysis of each refugee's psychological condition, so administering screenings allows them to identify those who need more attention in a

relatively efficient and low-cost way. Second, although beneficial, the process of screening refugees is complicated; the literature suggests multiple reasons for this. Direct translation of a standardized depression screening is rarely, if ever, appropriate due to varied concepts of depression across cultures. Adaptation can help address this problem, but it is difficult to adapt a screening in a way that solves an issue for the general population of refugees. The adaptation problem can be dealt with by creating culturally specific screenings, but this process is time-consuming, expensive, and simply not practical for every refugee culture. Clearly, there is no perfect way to administer depression screenings to refugee populations; in solving one problem, another is almost always created.

Application to Bhutanese Refugee Community in Buffalo

How can these conclusions be applied to the Bhutanese refugee population in Buffalo? First, Jericho Road Community Health Center could evaluate the cultural sensitivity of the PHQ-9 for the Bhutanese people, considering how well it fits with their conceptualization of depression, how accurately it measures their most common symptoms, and whether the response type is comprehensible. If further research indicates that the questionnaire is not appropriate, even if adapted, work could be done to construct a depression screening specific to the Bhutanese refugee population in order to determine a more accurate prevalence rate and better be able to identify those who could benefit from treatment. However, as both of these options require extensive research, it would perhaps be best to first explore the possibility of using the RHS-15 developed by Hollfield et al. (2013). The Bhutanese refugee population was one of the three groups with which this screening was originally tested and considered to be successful, so it

seems fairly likely that the RHS-15 would be appropriate for the Bhutanese refugee population in Buffalo.

As explained above, there are several possible reasons for the discrepancy between the published literature on the prevalence of depression within refugee populations and the results of my research in Buffalo. The likely interaction of these various factors combined with my limited knowledge of the extent to which they affected the results of my quantitative research motivated me to conduct a focus group discussion with the hopes of uncovering information about the Bhutanese refugee conceptualization of depression and the symptoms that it causes. I also explored whether the Bhutanese refugees feel that depression is affecting their community and to what degree. The focus group conversation, then, is intended to help explain the results of the quantitative research.

Study 2

Method

Participants

Focus group participants were recruited by the Nepali interpreters at Jericho Road Community Health Center. There were five Bhutanese refugee participants: four males and one female. All participants gave informed consent and were debriefed and thanked following the study.

Procedure

Both the focus group questions (Appendix E) and responses were translated by one of the two interpreters used in the previous study. The conversation was audio-

recorded for data analysis purposes. The format was semi-structured; I asked at least some form of each question on the list, but allowed the refugees to determine the subject of conversation within the question parameters and to talk about topics of their choice that were often only loosely related to the question. Each time I asked a question or made a comment, my words were translated into Nepali. The responses of the participants, on the other hand, were not always translated individually. Rather, the interpreter would frequently summarize, in English, the discussion held among participants. The conversation lasted for one hour and eighteen minutes.

Results

Much of the focus group conversation was a discussion among the refugees in response to the questions I posed. Any quotations included are written exactly as translated by the interpreter, but may be a paraphrase of the participant's words.

Terminology

At the beginning of the conversation, the interpreter informed me that there are multiple words for depression that mean the same thing. She said that there is one word in particular that is the closest match, but also highlighted that some people without a formal education would not be able to understand it, and it thus required an explanation. She worded it this way:

> We have many words having the same meaning. If I use "depression" only, one word, they will ask me a question, "What is that?"...There are many words in our language for this. There are two, three words, so I have to tell them all. I have to use worried, depression, everything.

Symptoms

Early on in the focus group discussion, I asked the five participants about what symptoms a depressed person has, or how they can tell when a person is depressed. They

mentioned a few things, such as tension, inability to fall asleep, being afraid of things, and forgetfulness. The last two are especially interesting because neither of these symptoms is mentioned on the Patient Health Questionnaire, which is the depression screening I used in the quantitative research described above.

Frustrations

While I did not specifically ask a question about the frustrations that the Bhutanese refugees are feeling during their time of transition and resettlement, this topic came up repeatedly. Of particular concern was the language barrier. They mentioned that not being able to speak or understand English has led to problems in several settings, such as the pharmacy, the bank, and citizenship classes.

Specific examples are as follows:

> He went to ECMC and they asked him, "When you are going to come?" (like making appointment), "Which day is good for you?" they asked him, but he didn't understand anything. And he told date of birth to them and everybody laughed and he was feeling, "What happened to me?"

> They are having problem in the bank also because…he lost his card, he went there to close his account, but they told him, "We don't understand you."

> For the citizenship classes, he is asking that they have to do the test. And who will help us?

Situations such as those described above are extremely frustrating for the refugees, because when they cannot communicate, they feel that they are unable to do anything and unable to function in day to day tasks. Furthermore, when they do try to learn English through English as a Second Language (ESL) classes, they struggle to do so because the teacher doesn't speak their language.

One woman said:

> Teacher doesn't know what is going on with them. She cannot understand them, and they do not understand her, just going to ESL class and sitting down…they are also not learning…both of them, wastes of time. Teacher doesn't know what is going on with the student and the student doesn't know what she is speaking.

Another stated:

> It is useless to go to ESL class without understanding…they need bi-language teacher.

Not only are the Bhutanese refugees struggling in their daily life, but also when they make attempts to address these struggles, they only become more frustrated. These frustrations may not meet the diagnostic criteria for major depressive disorder, but they are severe enough that they are lowering their quality of life.

Prevalence

The participants mentioned that depression is more common among women than men and that it seems to be affecting middle-aged people more than other age groups. They acknowledged that depression is a problem within their population, but considered day-to-day frustrations to be the larger issue, hypothesizing that about half of people are very frustrated and having trouble adjusting. There was, however, concern that maybe in a few years, if these frustrations are not resolved and continue to worsen, that mental health within their community will decline.

Suicide

Due to the frequency of suicide within the Bhutanese refugee community in Buffalo, I asked the focus group participants to identify reasons why they think that people in their community commit suicide. In particular, I was interested in finding

whether suicide is connected in any way to depression. They gave examples of possible situations that lead to suicide: the police separating a husband and wife, leaving the wife at home to care for the children alone, difficulties paying bills, and the woman being unable to find work. Outside of these specific examples, the group seemed to be in consensus that it is general difficulty with daily life that causes someone to commit suicide.

One man stated:

> If I cannot understand, if I cannot do anything, what I am living then? Why to live? I suicide.

It is not necessarily depression that causes someone to commit suicide. Multiple participants expressed the idea that it is general frustration that leads Bhutanese refugees to commit suicide, saying things such as:

> It is not the stress/depression. Maybe some has a depression, but it is the frustrations.

> Most of the things is the frustration…they have a lot of things going on in their life and they will committing suicide.

> To get rid of their problems, they suicide.

While each participant worded it in a slightly different way, it is clear that they are stating that the people who have committed suicide in the Bhutanese refugee community have not typically done so because of depression.

Treatment

I closed the discussion by asking about what treatment methods they thought would be helpful and what support systems are already in place, if any. The first thing

mentioned was staying involved and active in a depressed person's life, referred to by one person as being "engaged":

> We have to find out the way to engage the person who has mental health [problem]...every time engage him or her. Don't give chance to return back to his mind. Talk to them, make them to play...get them involved, every time engaged.

They affirmed that other treatment methods would also be helpful, including one-on-one counseling, group counseling, and talking to someone with whom they are comfortable. The biggest problem, they said, was not being aware of what mental health services are available and how to access them.

One person worded it this way:

> They need somebody who can direct them to go to the support place. They need support, but they don't know who is going to direct them. They need a directing person. The person who can tell them, "We have support place, I can take you there...I will help you...we can go from this way to there."

Both awareness of options and practical assistance in accessing those options is needed within the Bhutanese refugee community. This is not enough, however; they also expressed the need for support within their community.

Someone summed this up in saying:

> They need all. The person who can take there...and they need a person who can speak to them. He is saying that we have our people who can speak [Nepali], but they don't know where we need to go.

In addition to these strategies, a man at the end mentioned that the focus group discussion itself was helpful and that he felt it would be beneficial to hold something similar again. He said:

> They need this type of discussion every three months within a group of people, like ten people, eight people, a group, if they have a frustration like that...if he can come in a group and discuss, they will have some kind of peace...it is helpful to talk with each other, it is comfortable for them.

The Bhutanese refugees not only affirmed a variety of treatment suggestions, but volunteered their own ideas. Others agreed that offering additional focus group conversations would be a safe setting for discussing their frustrations and allow them to express their feelings to people who can relate to them.

Discussion

The Bhutanese refugee community clearly has mental health needs that are not being met; these problems may or may not meet the diagnostic criteria for clinical depression, but they are still legitimate and must be addressed. The main problem is daily stressors such as the inability to communicate, family problems, or financial difficulties. According to the refugees these stressors are causing extreme frustration and, in some cases, are even leading members of their community to commit suicide.

These comments can be better understood by looking at them within the Bhutanese refugee pathological response to distress framework provided by Chase (2012), shown in Figure 6. Her research revealed that the distress caused by life events leads to tension in the heart-mind. The word "tension" came up repeatedly during her interviews as a way to describe general frustration and stress and the refugees in my focus group used the same word when asked about symptoms of depression. Chase goes on to report that prolonged tension in the heart-mind can lead to problems in the brain-mind. My research also supports this idea, as the refugees stated that right now, the mental illness of depression is not a major problem but that if their frustrations and tensions are not addressed, the mental health of their community could decline. The next stage, according to Chase, involves a loss of social status and an increase in physical symptoms. This in turn leads to shame, and at times, can push a person to commit

suicide. The comments that the five focus group participants made seem to fit well with this general progression, again demonstrating the importance of understanding the results in their proper context.

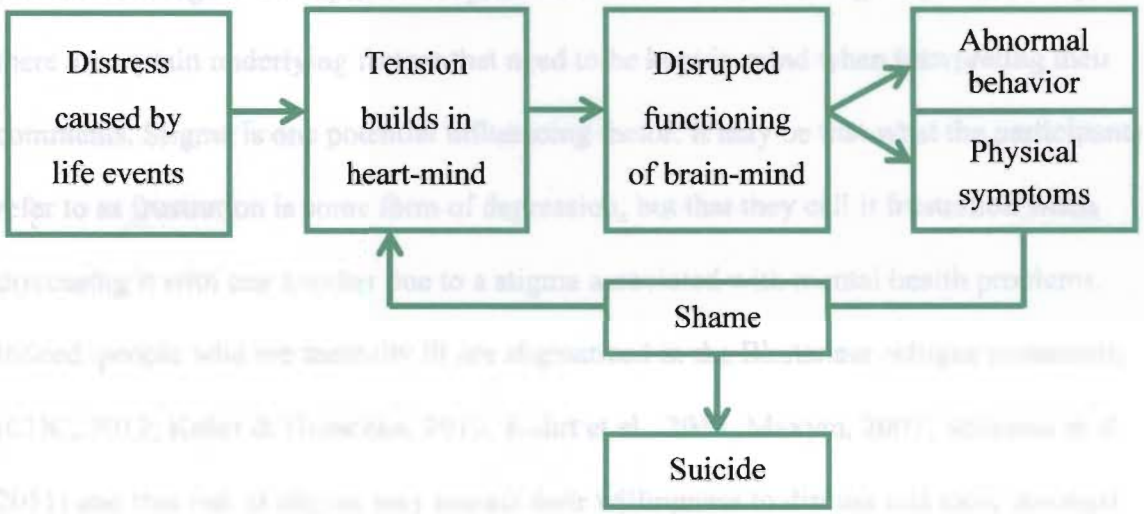

Figure 6: Bhutanese refugee pathological response to distress (adapted from Chase, 2012)

This mental health crisis that the refugees discussed leads me to consider practical implications for how to intervene. Some such suggestions were offered by the refugee participants themselves, as they gave ideas for what treatments they feel would be most helpful. They emphasized the need for support both within and outside of their community and the importance of remaining involved in the lives of those who are experiencing mental distress. The participants in the focus group referred to this method of support as remaining "engaged" or "engaging him or her" and the Bhutanese refugees interviewed by Chase (2012) highlighted this same phenomenon using the same word. Perhaps most interesting, though, was an unprompted comment made at the end of the

conversation suggesting that the focus group be repeated as a form of therapy, an idea that could be followed up on in further research.

The focus group conversation provides helpful insight into the way that the Bhutanese refugees conceptualize depression and how it is affecting their community, but there are certain underlying factors that need to be kept in mind when interpreting their comments. Stigma is one potential influencing factor. It may be that what the participants refer to as frustration is some form of depression, but that they call it frustration when discussing it with one another due to a stigma associated with mental health problems. Indeed, people who are mentally ill are stigmatized in the Bhutanese refugee community (CDC, 2012; Kohrt & Hruschka, 2010; Kohrt et al., 2012, Maxym, 2007; Schinina et al., 2011) and this risk of stigma may impact their willingness to discuss this topic amongst themselves and in the presence of an outsider. Returning to the mind-body divisions discussed earlier (Kohrt & Harper, 2008; Kohrt & Hruschka, 2010; Kohrt et al. 2012), it is clear that stigma is more closely associated with certain elements than others. Disturbances in the heart-mind are relatively common and considered socially acceptable and because of this, Bhutanese refugees and others from Nepali culture are typically very comfortable discussing these problems with one another (Kohrt et al., 2012). Brain-mind problems, though, are highly stigmatized. Part of the stigma comes from the belief that these problems are contagious and permanent. Because of this, people who suffer from them are socially marginalized and rejected, and even family members can suffer from harsh discrimination (Kohrt et al., 2012).

The risk of being stigmatized could have prevented focus group participants from sharing openly about the topic of suicide and depression. Evidence of this idea can be

found in the results of the International Organization for Migration's investigation into suicides within the Bhutanese refugee population (Schinina et al., 2011). People in the general population in the refugee camps and family members of the suicide victims were asked to associate suicide with one or more of the following mind-body categories: heart-mind, brain-mind, social status, spirit/soul, and karma, referencing Kohrt's writing on Nepali ethnopsychology. The answers given by the general population were split fairly evenly, with more people associating suicide with a problem in the heart-mind than any other category (30%). In contrast, the majority of family members of suicide victims attributed suicide to a brain-mind problem (55%), followed by heart-mind, social status, and karma. None of them considered it to be the result of spirit loss. If brain-mind disturbances are highly stigmatized and suicide is associated with a problem in the brain-mind, it follows that the act of suicide is highly stigmatized as well (Kohrt et al., 2012).

Related to the issue of stigma is that of honor and shame. Honor and shame are components of the Bhutanese refugee culture that also likely influence both their comments on depression and the way that they address it when it occurs. In the International Organization for Migration's (Schinina et al., 2011) investigation into suicides within the Bhutanese refugee population, shame was the most common reason given for a family member's suicide—listed in half of the 16 cases. Interviewees commonly attributed the feeling of shame with increased distress over an inability to live up to one's role in the family, a role that is often nontraditional due to the circumstances of resettlement (Schinina et al., 2011). This feeling of shame may also be connected to the concept of *ijjat* (social status). When someone has a brain-mind problem, he or she experiences *bejjat* (loss of status), a shameful condition (Kohrt et al., 2012). The concepts

of stigma and honor/shame were likely salient in the focus group discussion and therefore limit the extent to which the participants' comments can be fully understood. With this said, recognizing the role that these concepts play in the Bhutanese refugee perception of mental illness is very important and can be used in future research.

General Discussion

Community-Based Mental Health Interventions

Rationale for Community-Based Interventions

The widespread mental health problems that refugees are facing demand a response. The response thus far has been primarily in the form of psychotherapy (Miller & Rasco, 2004). Refugees who have experienced past trauma and show signs of post-traumatic stress disorder, depression, or other illnesses are most often referred to counseling at mental health clinics if they are offered treatment at all. This counseling is usually in the traditional model of clinician/client individual psychotherapy and is slightly modified at times to accommodate the apparent mental health needs of refugees. In fact, treatment centers and community clinics have been created for this very purpose (Miller & Rasco, 2004). Stated differently, the mental health treatments familiar to (and very often successful in) the Western world have been offered to refugees experiencing psychological distress of various types.

So yes, there has been a response, but has this response been effective? Evaluation is an important aspect of any intervention, so it is crucial to question whether the treatments that have been used have been successful. Miller and Rasco (2004) recommend three things that should be taken into consideration regarding this reliance on

clinic-based services for refugee communities. First is the accessibility problem. There is a somewhat obvious explanation for this problem for refugees who have yet to be resettled, as mental health professionals are often either not available or are very rare in refugees' countries of origin. Even after resettlement in developed countries, accessibility remains a prominent issue for a variety of reasons, including problems with affordability, communication, and awareness (Tribe, 1999; Asgary & Segar, 2011). When refugees cannot pay for mental health services or express their symptoms, they are prevented from accessing these services, even if they are technically available.

Second, even when mental health treatments are available and barriers to accessibility are removed, refugee communities may not use them. Why, even when experiencing significant psychological distress, would refugees choose not to take advantage of the options available to address this problem? The answer seems to lie primarily in that professional mental health services is itself a foreign concept. The Western model of psychotherapy is rooted in an emphasis on individualism, a reliance on specialized, trained professionals, and use of the medical model. The culture a refugee comes from, typically non-Western, very likely has a dramatically different perspective on mental health and professional helpers. This perspective is rooted in cultural beliefs that may be quite opposite as those mentioned above, such as collectivism, reliance on traditional healers, and religious explanations for many phenomena (Miller & Rasco, 2004). These are generalizations of course, but they serve to illustrate the point that clinic-based services may not be culturally relevant for refugee communities.

A third limitation of clinic-based services for refugee populations is that treatments at mental health clinics specific to refugees tend not to deal with post-

displacement factors and instead focus primarily on past trauma. This pre-displacement trauma certainly needs to be addressed, but research has shown that this is not the only factor contributing the mental illness in refugee populations, and may indeed be secondary. Daily causes of distress also contribute to mental health problems (Kirmayer, 2011; Orley, 1994; Goodkind, 2006; Goodkind, 2005). Treatment, then, would need to address these varied topics more fully in order to meet mental health needs. Furthermore, some research indicates that solely concentrating on past trauma using a psychotherapy model without tackling social, economic, and logistical factors may not only be limited—it may be unproductive and fail to improve refugees' mental health (Kinzie & Fleck, 1987; Pejovic , Jovanovic , & Djurdic , 1997). This is not to say that clinic-based services are useless to meet the needs of refugee populations, but that on their own, they are insufficient. In order to effectively work towards achieving psychological well-being in refugee communities, we must explore alternative interventions that take a more holistic approach.

It is here that the principles central to the field of community psychology can be of great use, as they confront many of the limitations described above. Four in particular are especially relevant, drawn from the work of Rappaport (1977), Rappaport and Seidman (2000), and Nelson and Prilleltensky (2010). First, community psychology emphasizes studying individuals within the contexts in which they find themselves rather than limiting research and treatment to an individual level. Refugee mental health care has traditionally been at an individual level, involving a counselor helping a client to process the trauma experienced. Putting the individual in context by considering community-based treatments can help to address this limitation. Second, in contrast to the

reactive treatment of the medical model, community psychology stresses preventative care. In addition to reacting to refugees' distress, this principle suggests that we should strive to target the root of the problem in order to prevent further distress. Third, research and treatment within the field of community psychology seeks to recognize already existent strengths in addition to recognizing deficits and pathologies. Current mental health treatments focus primarily on existing problems without noting the resiliency strategies already in place within refugee communities. Capitalizing on these and other assets could be practically incorporated into mental health services. Fourth, community psychology encourages participation in research and intervention, in other words, acting with participants rather than participants being passive recipients. Instead of requiring that refugees use the treatment methods already in place in the Western world, refugees should have opportunity to partner with those providing, adapting, and designing the treatments in order to come up with an intervention that would be helpful to their communities and that they can be involved in directly.

These four principles contribute to Prilleltensky and Prilleltensky's (2006) model of promoting well-being. The model has four domains that when put together, claim that wellness is best promoted from a collective, preventative, strengths-based, empowering approach. The goal of mental health interventions within refugee populations should not just be eliminating mental health problems; these interventions can also work towards fostering well-being at multiple levels, including individual, organizational, and community.

While these principles sound appealing and are certainly applicable to the topic at hand, it is legitimate (and indeed necessary) to wonder whether they have practical

implications and if so, what those might be. In order to answer this question, it is important to clarify what defines a community-based health intervention and consider examples of the community-based mental health interventions that have already been implemented with various refugee populations. The term "community-based health intervention" itself needs clarification. To be sure, it can mean different things to different researchers, field workers, and intervention recipients. Revenson and Schiaffino (2000) state five components of community-based interventions. Community-based mental health interventions target an entire population, generate outcomes at a community level, emphasize existing assets, take the cultural context into account, and encourage local ownership to ensure sustainability. While every intervention described in the following pages does not meet every one of these standards, their definition provides a good framework for how the principles of community psychology can be practically implemented into a community-based intervention.

Examples of Community-Based Interventions

In recent years, there has been a move toward more culturally sensitive, strength-based interventions in refugee communities, recommendations that are characteristic of community-based mental health interventions (Murray, Davidson, & Schweitzer, 2010). Williams and Thompson (2011) conducted a literature review on refugee mental health services, limited to community-based interventions. Fourteen studies were selected for systematic review targeting child, adolescent, and/or adult populations, pre- or post-migration. These interventions fell into a variety of categories, including education, play models, creative expression, and group psychotherapy. All except one of the studies in Williams' and Thompson's review had positive, statistically significant results. Perhaps

most significant to the current research are the themes that emerged from this review of community-based interventions, including reliance on refugee participation, availability of interpretation, use of local terminology, and a focus on post-migration stressors. For example, one of the treatments combined assessment, formal therapy, and creative expression through art and dance. In this intervention, translation services were provided, dealing with daily stress was emphasized, and refugees were encouraged to utilize the services they felt would be most helpful. This brief overview of several different community-based interventions indicates the promise that such interventions hold for refugee populations.

Learning and Education Interventions

Goodkind (2005, 2006) implemented a community-based intervention for Hmong refugees that was centered on mutual learning in the form of learning circles and advocacy partnerships. The learning circles involved equal numbers of Hmong refugees and undergraduate students and consisted of a time of cultural exchange and one-on-one paired mutual learning. The advocacy component consisted of the same pair from the learning circles working together to deal with issues that Hmong refugee wanted to address. Goodkind used both quantitative and qualitative measures to evaluate the project's success. The quantitative measure evaluated the refugees' improvement at four different points of the intervention process on five different domains: English proficiency, citizenship knowledge, access to resources, quality of life, and psychological well-being (Goodkind, 2005). English proficiency and citizenship knowledge increased significantly over the course of the intervention and at follow-up. Satisfaction with resources, quality of life, and distress improved during the intervention but the level of

improvement decreased after it ended, although it did not decrease to below the baseline measure. There was no significant change in difficulty accessing resources or in happiness. The quantitative data, then, reveal that the intervention had several significant positive outcomes and did not reveal any significant negative outcomes.

Each participant was also involved in two qualitative interviews in order to provide a more in-depth analysis of certain outcomes and give both the Hmong refugees and undergraduate students the opportunity to share their opinions about the intervention. The participants were interviewed in pairs with their partners from the learning circles and were asked ten open-ended questions about their experiences in the project. Hmong participants reported that they felt that their knowledge, culture, and identity were valued, that their strengths and resiliency were recognized, and that they had experienced notable improvement on several different skills. Although Goodkind acknowledged that there was still some degree of inequality inherent in the partnership, she concluded that the mutual learning approach was a move in the right direction.

This same mutual learning method was adapted and used with a group of African refugees resettled to the United States (Goodkind et al., 2013). The core of the intervention remained the same with its learning circle and advocacy components, but certain aspects of it were changed in order to capitalize on the strengths that the African refugees expressed in qualitative interviews. Adaptations include having the learning circles contain multiple generations (and making the necessary changes to make this possible, such as offering childcare), incorporating traditional dance and song, and changing the topic of certain learning circle sessions to directly deal with issues faced by the African refugees. The approach was successful within this population as well;

participants experienced decreased psychological distress, increased quality of life, increased English proficiency, and increased social support as measured by a variety of standardized scales. Data gathered from qualitative interviews supported and expanded upon the quantitative findings, and refugees expressed overall satisfaction with both their undergraduate partner and the intervention as a whole. The positive outcomes of this style of intervention with multiple refugee communities from different cultures and its attention to many of the principles from community psychology suggest its success as a community-based mental health intervention and its promise for future use with other refugee groups.

Mitschke, Aguirre, and Sharma (2011) also implemented an educational intervention for refugees. Bhutanese refugee women took part in a financial literacy class, the purpose of which was to decrease symptoms of mental illness and increase social support. In addition to the two financial literacy groups, one of which involved a knitting component, there was a control group, meaning that this study addressed some of Goodkind's (2005, 2006) methodological concerns. Classes were held twice a week for 12 weeks and were translated into Nepali by an interpreter so that participants could understand the content clearly. All the women were given a pre-test that included measures of PTSD, measured with the Post-traumatic Stress Disorder Checklist-Civilian screening, and depression, anxiety, and somatization, measured with the Patient Health Questionnaire-Somatic, Anxiety, and Depressive Symptoms Scale. They were then given the same test at the close of the intervention and at a three month follow up. Participants in the two intervention groups experienced significant decreases on all four psychological distress measures while the control group only experienced a slight decrease on PTSD

and depression and increases in anxiety and somatization. Not only was the education beneficial in reducing symptoms of mental illness, but not intervening may mean an increase in mental distress over time.

Group Psychotherapy

One of the more common community-based interventions is group psychotherapy of some variety. Simply adapting individual psychotherapy into a group setting does not in itself make a mental health treatment community-based (as defined by Revenson and Shiaffino (2000) whose criteria are listed earlier), but it is certainly possibly to utilize group counseling as a method for such a treatment. Interventions that use group psychotherapy and specifically identify as being community-based usually emphasize a strength-based approach, adaptations to cultural context, and community or social support.

The Center for Victims of Torture developed a mental health intervention in Guinea to reach out to refugees from Sierra Leone and Liberia (Stepakoff et al., 2006). The main treatment involved group counseling, the goals of which were threefold: offer mental health care to victims of trauma, train refugees to act as group facilitators and counselors, and raise community awareness regarding mental health. Groups typically consisted of 9-10 refugees of the same gender and age group and met for 10 weekly sessions, serving a total of over 4,000 refugees. Each group was led by two refugees training to be paraprofessional counselors and was supervised by a professional clinician. Three stages made up the counseling process. Establishing a feeling of safety was the primary purpose of the first stage, healthy mourning the purpose of the second, and reconnection the purpose of the third. There was a wide range of techniques employed to

meet these purposes and these varied among groups depending on the preferences of the facilitator and group members. Both before, during, and after the treatment, participants were evaluated on standardized measures of psychological well-being, such as posttraumatic stress, somatization, depression, and anxiety, as well as measures of social capital and overall functioning in daily life. The refugees showed significantly lower psychological illness symptoms after the group psychotherapy and experienced a significant increase in social support and functioning. Many of them verbally affirmed these findings, expressing the positive impact that the treatment had had on their daily lives.

Akinsulure-Smith (2012) also implemented a community-based intervention based on group work with African refugee men. Groups of approximately 5 to 8 people met weekly for an hour and a half. The group members were very different on many variables, including country of origin, religion, education level, and family dynamics, but all had experienced some form of trauma and forced migration. The format and content of group meetings were fairly unstructured and addressed whatever the refugees wanted to discuss at that particular time. Conversations frequently dealt with both past-trauma and current difficulties, including navigating the immigration system and frustrations with adjusting to a new culture. At the close of the conversation, each group member had an opportunity to express his response to the session. The members, with permission, were given each other's contact information so that they had opportunity to contact one another outside of formal group sessions to schedule additional group meetings or share a need. The Harvard Trauma Questionnaire and Center for Epidemiological Studies Depression Scale were administered to each group member before treatment and again

six months later; results reveal a significant decrease in depression scores over the six months. The absence of a control group is particularly salient in this study, as the organization also provides other services that the refugees were involved in simultaneously. As such, it is not possible to conclude whether the positive outcomes were the result of the group therapy intervention. Another limitation of this study is that this particular intervention is only available to those who already know English or French. This means that those who only know a local language from their country of origin are unable to participate.

Researchers also implemented a group psychotherapy treatment in Uganda in collaboration with World Vision International (Bolton et al., 2003). This research stands out among the other examples of community-based interventions because it is a randomized, controlled study. A control group is absent from many of the studies on the topic of community-based treatments in refugee populations, primarily because cultural norms made it inappropriate to offer any sort of treatment to certain people in the group and withhold it from others. This common issue is resolved in this study, as all participants were informed that the intervention would be provided to the control group at the end of the study if it was successful. The intervention itself consisted of 16 weekly group sessions led by a local person, each one an hour and a half in length. Groups had eight to ten members, all of whom were of the same sex. During the sessions, the depressive symptoms of the group members were discussed as they offered one another social support and practical ideas for how to improve these symptoms. Baseline measurements indicated that intervention and control groups did not differ significantly on depression scores (measured through the Hopkins Symptom Checklist), or overall

functioning scores (measured through a sex-specific questionnaire about ability to do certain tasks). At the close of the intervention, however, there were significant differences in these scores. The decrease in depression scores and the increase in the functioning scores were significantly greater for the intervention group than the control group. In addition to these findings, the prevalence of depression was significantly higher in the control group than the intervention group, indicating that the intervention was successful in treating depression within this refugee population in Uganda. It should be noted that the control group also showed significant improvement in depressive symptoms and overall functioning, but that this improvement was significantly less than the intervention group.

This group interpersonal psychotherapy treatment in Uganda not only evaluated the success of the intervention immediately after its completion, but returned to evaluate its longer term impact (Bass et al., 2006). The same measurements used to determine the baseline and two-week follow-up results were used at the six-month follow-up. The significant differences present between the control and intervention groups at the two-week follow-up remained six months later. This showed that the significant decrease in depression scores of those who received the intervention was sustained even after six months had passed. It is difficult, though, to determine the cause of these lasting effects. It is of course possible that the short-term group interpersonal psychotherapy itself was helping participants even six months later. On the other hand, the positive impact may have been because certain aspects of the treatment had continued even after the formal intervention had ceased. For example, all of the groups except one had continued to meet together informally. The frequency and purpose of these meetings varied, but some

gathered regularly and offered one another emotional support and guidance. These meetings may have provided sustained benefits for participants in the intervention and kept their depression scores lower than those in the control group. Regardless of the reason, the community-based intervention implemented in this research not only had positive short-term results, but was still effective after six months had passed, indicating the potential for the intervention's long-term success.

The discussion above demonstrates strong potential for the successful use of community-based mental health interventions with refugee populations, but it is also clear that there is a need for further research on this topic. First, future studies should be randomized and controlled, allowing for conclusions to be drawn regarding the effectiveness of the intervention by controlling for other variables. Of course, as Goodkind (2005, 2006) and Bolton et al. (2003) mention, the nature of a control group requires withholding the intervention from a certain subset of the community, a complicated task when the target of the intervention is that entire community. Researchers could address the problems that arise from preventing certain people from receiving treatment by following the strategy used by Bolton et al. (2003) and explaining that the treatment will be provided to the control group after the completion of the study if the intervention is shown to be successful. This would allow for controlled research that is also ethical and culturally appropriate.

The evaluation process would also be improved by testing the reliability and validity of the quantitative measures used to measure psychological distress and overall functioning for the refugee populations participating in the interventions. The cross-cultural validity of such screenings was critiqued earlier in the paper, and that critique

applies here also. Whether calculating prevalence or evaluating interventions, testing the reliability and validity of the measures being used is necessary to avoid coming to false conclusions. Very few of the studies described above included information about testing the reliability and validity of their quantitative measures, even though all of them used some form of quantitative data and many of them used only this methodology. Future research should take this limitation into consideration when assessing the success of mental health interventions within refugee populations, whether or not these interventions are community-based.

In addition to emphasizing the use of reliable and valid quantitative measures, future research should combine quantitative research with qualitative research for a more comprehensive evaluation. This methodology is recommended for cross-cultural research (Ager, 2000; Ahearn, 2000) and was used in some of the studies discussed above, such as the research done by Goodkind (2005, 2006). Qualitative research can be of particular use in this setting because it relies on the subjective experiences of the participants, allowing for a deeper understanding of how the participants perceived the intervention. (Ager, 2000). A combination of these two research methods, then, can "strengthen and deepen the study of refugee health and well-being" (Ahearn, 2000, p. 17), helping to provide direction as researchers and professionals seek to move forward with community-based mental health interventions.

Practical Implications for Jericho Road

Current practices

Jericho Road Community Health Center already strives for community well-being by offering a wide variety of programs targeted to people in multiple demographics, but

their work is not done. To continue to work towards their vision being realized, Jericho Road is currently seeking to expand their mental health services; certain steps have already been taken to better meet the mental health needs of their patients. For example, a psychiatrist and clinical social worker are on staff and work two days each week, allowing primary doctors to refer patients in need of further mental health care to these professionals for counseling.

These changes are of particular relevance to the topic at hand, as they are concerned with how psychological well-being can be better restored within the refugee populations served by Jericho Road. My suggestions for how to foster well-being are based on published literature and the conclusions drawn from my research. The recommendations include changing the mental health screening instrument being used at the medical practice, implementing community-based health interventions, and continuing to consider how to prevent the ongoing issue of the high prevalence of mental health problems.

Recommendations

To evaluate the presence of depression within the Bhutanese refugee population, I believe that Jericho Road Community Health Center should consider using the Refugee Health Screener 15, the particulars of which are detailed in the discussion of Study 1. This screening offers several potential advantages. First, the RHS-15 measures depression, anxiety, and PTSD, eliminating the need for multiple mental health screenings in order to measure the most common disorders faced by refugees. Assessing three mental health concerns in one screening is much more efficient than having a different screening for each illness. Second, the RHS-15 has already been used

successfully with Bhutanese refugees. Rather than needing to do extensive validity and reliability research on a translated mental health screening or construct a culture-specific depression questionnaire, it is possible to use a screening that already exists, has been translated into Nepali, and has been used within the Bhutanese refugee community. Third, the RHS-15 was designed specifically for refugee populations as opposed to being written with Westerners in mind. Its construction is in line with many of the recommendations for quantitative cross-cultural research, such as taking local definitions of concepts into account and considering how certain groups respond to the style and structure of a question (Ahearn, 2000). While certainly not perfect, it is intended to be cross-culturally sensitive, which is a move in the right direction.

In addition to identifying which refugees are in need of mental health treatments, it is important to consider the mental health treatments themselves and what type will be most effective in restoring psychological well-being. It is here that community-based interventions are applicable. A variety of community-based mental health interventions have already been demonstrated to be effective with refugee communities from a variety of countries. Can these interventions, successful elsewhere, be applied to Jericho Road Community Health Center? None of the interventions from the studies discussed in the previous section should be adopted wholesale into another setting, as it is necessary to take the cultural context of both the refugees and the larger organization into account. However, I do believe it is possible for these strategies to be adapted and implemented into the work that Jericho Road is doing in Buffalo and that community-based mental health interventions have the potential to increase psychological well-being among Buffalo's refugee population.

The first recommendation is to run additional focus groups, primarily because this was suggested by a Bhutanese focus group participant in Study 2, a serendipitous finding from the qualitative portion of the present research. One participant requested that a similar thing be done repeatedly. He suggested that a group of 8-10 refugees meet every three months to discuss their daily stressors and voice their frustrations. His comment suggests that the focus group conversation itself was helpful and that running additional focus groups may contribute not only to research, but also contribute to healing for the refugees.

Aside from groups whose main purpose is research, Jericho Road should look into the possibility of groups deliberately intended for psychotherapy. Rather than only providing individual psychotherapy, group psychotherapy could be available as another option for refugee patients with mental health needs, an intervention that seems to have had very positive outcomes when applied to refugee populations. Some of these benefits include a decrease in depression, anxiety, somatization, and trauma symptoms and an increase in social support and overall functioning. In addition to these benefits, group psychotherapy has practical advantages. One professional can meet with several clients at the same time, making it more time and cost effective. Similarly, only one interpreter is needed for several refugees, rather than each refugee requiring separate time with an interpreter. Group psychotherapy then, could be beneficial for both the refugees themselves and the professionals who are serving them.

Group counseling not only has general benefits for refugee populations; it may fit well with coping strategies already used by Bhutanese refugees. Chase (2012) examined psychosocial resilience among Bhutanese refugees using a variety of research methods,

including ethnography, focus groups, semi-structured interviews, and a coping survey. Her research suggests that support groups would address coping principles such as personal growth, controlling negative emotions, increasing social support and expression, and being validated by the community. The focus group participants in my study also indicated that support groups would be helpful and affirmed the value of talking to one another, saying that it leads to "some kind of peace." A Nepali saying describes this well: "*Dukha pokhyo bhane dukha kam hunchha*", translated as "After sharing your pain it becomes less" (Toll, Jordans, Regmi, & Sharma, 2005, p. 322).

Group psychotherapy is not the only possible community-based treatment. Chase (2012) also recommends group learning opportunities such as vocational training, skill-building, and art/drama classes as an intervention style that would be easily adapted for Bhutanese populations. Because the Bhutanese refugees in the focus group repeatedly mentioned daily life frustrations, an adaptation of Goodkind's mutual learning groups has the potential to be an effective intervention. A strength of this intervention is that it intentionally addresses current social and economic factors contributing to distress rather than only dealing with past trauma. Based on the comments made by the focus group participants in the present study, it seems that addressing these post-displacement stressors would be a necessary part of any intervention. The Bhutanese refugees specifically brought up stresses such as the inability to communicate, struggling to learn in ESL classes, worries over taking (and failing) the citizenship test, domestic violence, and difficulty meeting financial needs. It would be best to start with these issues in learning circles, because they are the issues that the refugees consider to be the most salient in their lives. The learning circles could address these topics and the partners

could assist where necessary, working with one another in order to achieve the refugees' goals. I believe that a mutual learning strategy such as this one used with both Hmong and African refugees would likely have similar results if adapted for use with the Bhutanese refugees in Buffalo. This means it would increase not only their practical skills, but improve their overall functioning and decrease their psychological distress.

Any mental health intervention poses certain challenges. It is important to anticipate these challenges as much as possible before implementation. Two in particular stand out in the case of implementing group psychotherapy or a mutual learning strategy at Jericho Road. To start with, cross-cultural work has inherent complications, many of which have already been addressed and include language and cultural differences. In addition to this general difficulty of working with refugee populations, however, is one specific to the Bhutanese refugee community: the caste system. The Lhotsampa have a very complex caste system that has a strong impact on social status. (CDC, 2014, Kohrt, 2008; Maxym, 2010; Ranard, 2007). This division is not typically talked about with outsiders and is not adhered to as strongly after the Bhutanese refugees are resettled in America. However, this does not mean that the caste system is nonexistent or ceases to influence their lives (Maxym, 2010). The extent to which it does so is unclear, so it would be wise to communicate with an interpreter or some other willing key informant before establishing groups for therapy or learning circles. Doing so may help to minimize social division and create a safe, open environment for the refugees to learn and share with one another.

Furthermore, it should be noted that because the refugees report post-migration stressors to be the primary cause of their frustration, perhaps the best intervention would

be to tackle the difficult task of preventing these stressors, rather than just responding to existing mental health problems. It is beyond the scope of the present paper to offer suggestions on how to address the systemic issues that would be part of preventing mental health problems. Prevention is, on the other hand, well within the scope of the field of community psychology, which emphasizes prevention as one important aspect of promoting psychological well-being (Nelson & Prilleltensky, 2010; Prilleltensky & Prilleltensky, 2006). Community psychology, therefore, can not only play a role in treating the depression (and more general mental health concerns) that is already present within the Bhutanese refugee population in Buffalo, but can be of use in the efforts already taken by Jericho Road to prevent it.

Concluding Discussion

Even though the Bhutanese refugees had significantly lower scores on the PHQ-9 than the American-born participants, they are facing significant levels of mental distress, expressing itself in frustration, fear, lack of sleep, anxiety, and at times, suicide. Stated differently, even though the psychological distress faced by the Bhutanese does not appear to meet the DSM-IV diagnostic criteria for depression (and may not even meet the criteria their community has for the mental illness of depression), this distress and its serious consequences are urgent issues that need to be addressed. The conclusions drawn from this research about the mental health needs of Bhutanese refugees are significant and lead to practical implications for how to better meet these needs. Even so, certain limitations in methodology and cultural knowledge restrict understanding and lead to questions that can be explored through further research.

Rather than first doing quantitative research and following up with qualitative research, it would be beneficial to reverse the order of these two approaches. The information that the Bhutanese refugees shared during the focus group would have been useful to know prior to administering the PHQ-9 depression screenings as it provided insight into their concept of depression and the way that they felt it was impacting their community. This method of doing qualitative research before doing quantitative research in refugee populations is well established, particularly when done to clarify concepts in order to inform the selection or development of a quantitative measure (Ahearn, 2000). Several studies have combined these two approaches in this manner, often in the form of running focus groups to help create a more culturally sensitive survey (Ahearn, 2000; Centers for Disease Control, 2012; Hyman, Beiser, Noh, & Vu, 2000). This approach could certainly be used in future research, as there is still a great deal of information to be gathered about depression within the Bhutanese refugee population.

Lastly, I believe that it would be beneficial to consider positive aspects of refugee mental health in future research with the Bhutanese refugee community rather than limiting research to pathologies such as depression. It is certainly useful to examine the prevalence of depression, as is the focus of the current paper, but it is also possible to go further. Capitalizing on existing strengths and assets is central to the field of community psychology; this principle could be applied to research with the Bhutanese refugee population in Buffalo. In addition to measuring the presence of depression and investigating how to alleviate it, it would be worthwhile to measure overall functioning and resilience strategies and investigate how to strengthen them. In this way, we concern

ourselves not only with ameliorating the problem of depression, but with the holistic health of the community and in doing so, strive to foster well-being.

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Appendix A

Patient Health Questionnaire (PHQ-9): English version

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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Appendix B

Patient Health Questionnaire (PHQ-9): Nepali translation

विरामी स्वास्थ्य प्रश्नावली (PHQ-9)

नाम _____ मिति _____

विगत दुई हप्तामा तपाई तल दिइएका मध्ये कुनै समस्याबाट कति पल्ट सताइनु भएको छ ?

(आफ्नो उत्तर संकेत गर्ने "√" चिन्ह प्रयोग गर्नुहोस्)

	यस्तो हुँदै भएन	धेरै दिन यस्तो भयो	आधा भन्दा बढी दिन यस्तो भयो	प्रत्येक दिन जसो यस्तो भयो
1. कुनै चिजमा अति कम चाख हुनु वा रमाइलो नलाग्नु	0	1	2	3
2. निरास महशुस गर्नु	0	1	2	3
3. सुत्ने नसक्नु अथवा धेरै सुत्नु	0	1	2	3
4. थाक्नु वा शक्ति कम हुनु	0	1	2	3
5. भोक नलाग्नु वा अति धेरै खानु	0	1	2	3
6. आफ्नै बारेमा नराम्रो सोच्नु, जस्तो कि आफू असफल भएको वा परिवारलाई निराश पारेको महशुस हुनु	0	1	2	3
7. टेलीभिजन हेर्ने तथा पत्रिका पढ्ने जस्ता कुराहरुमा ध्यान केन्द्रित गर्न नसक्नु	0	1	2	3
8. अरु मान्छेले नदेख्ने वा नसुन्ने तरीकाले हिड्नु वा बोल्नु वा यसको ठ्याक्कै विपरित धेरै चन्चल वा कचकचे भएर स्वभाविक भन्दा बढी हिड्डुल गर्नु	0	1	2	3
9. आफू मरेको वेश भन्ने महशुस हुनु वा आफैलाई चोट पुर्याउन मन लाग्नु	0	1	2	3
कोलम जोड्नु होस्		+		+
कुल :				

(स्वास्थ्य कर्मचारीहरुका लागि: कुल अंकको व्याख्याको लागि यस सँगै हुने प्राप्तङ्क पत्र(scoring card) लाई हेर्नुहोस् ।)

10. यदि तपाईले कुनै समस्यामा चिन्ह लगाउनु भएको छ भने ती समस्याहरुले तपाईलाई आफ्नो काम गर्न, घरको रेखदेख गर्न र अन्य मानिसहरुसँग हेलमेल गर्न कत्तिको अप्ठ्यारो पारेको छ भन्ने कुरा उल्लेख गर्नुहोस् ।	केही अप्ठ्यारो भएको छैन _____ अलिअलि अप्ठ्यारो भएको छ _____ निकै अप्ठ्यारो भएको छ _____ अति धेरै अप्ठ्यारो भएको छ _____

Appendix C

Informed Consent Form: English version

Houghton College Psychology Department and Jericho Road Community Health Center

Study Consent Form

To the participant:

This consent form is designed to protect your rights and inform you of your responsibilities. The consent form will provide you with details about the study to allow you to make you an informed decision about whether or not to participate. Jessica Miller should also answer any questions you may have about how to do the task, and what is expected of you. PLEASE LISTEN TO JESSICA MILLER CAREFULLY AND ASK QUESTIONS IF YOU HAVE THEM.

Facts about your participation in this study:

- You are not required to participate in this study. You may refuse to participate, at any time during the study, for any reason, without any penalty from the researcher. You may ask to have your data withdrawn from the study, even upon completion of the study.
- There is no compensation for participating in this study, but the information you provide will be helpful to Jericho Road Community Health Center in its planning.
- By signing this form, you are acknowledging that you understand that, for the purposes of this study, data may be collected through written or verbal responses and audio-taped recordings. However,
    - All your responses are completely confidential. The only people who will have access to your data are the researchers (including Jessica Miller, Paul Young, and Ndunge Kiiti) and the medical staff at Jericho Road Community Health Center.
    - You will be anonymous when the data are finally analyzed and summarized, and your name will not be used.
    - You have a right to know what will be done with your data, and may withdraw from the study even upon completion.
- You have a right to know what the study is about when your participation is finished. Jessica Miller should explain what was done, why it was done, which conditions you were in, and what will be done with your data. Jessica will also supply you with study results if you request them, when they become available.
- You **MUST** be 18 years old to sign this form to consent to be in the study.

Appendix D

Informed Consent Form: Nepali translation

हगटन कलेज मनोविज्ञान विभाग र जेरिको सडक मन्त्रालय

अध्यान स्वीकार फारम

सहभागीहरुका लागि :

यो स्वीकार फारम तपाईको अधिकार सुरक्षित गर्न तथा तपाईलाई आफ्नो अधिकारको बारेमा जानकारी दिन बनाइएको हो । यो स्वीकार फारमले तपाईलाई यो अध्यान सम्बन्धी विवरणहरु उपलब्ध गराउछ ता कि तपाई यसमा सहभागी हुने वा नहुने भन्ने बारेमा शिक्षित निर्णय लिन सक्नुहोस् । जेसिका मिलरले यो काम कसरी गर्ने तथा तपाईबाट के अपेक्षा गरिन्छ भन्ने बारेमा तपाईसँग भएका सबै प्रश्नहरुको पनि उत्तर दिनु पर्नेछ । कृपया जेसिका मिलरलाई ध्यान दिएर सुन्नुहोस् तथा तपाईसँग कुनै प्रश्नहरु भएमा उहाँलाई सोध्नुहोस् ।

यो अध्यानमा तपाईको सहभागिता सम्बन्धी तथ्यहरु :

- तपाईले यो अध्यानमा भाग लिनु अनिवार्य छैन । अध्यान दौरान जुनै पनि समय जे सुकै कारणले किन नहोस तपाई अनुसन्धानकर्तालाई कुनै पनि जरिवाना नतिरी यसमा भाग लिन अस्वीकार गर्न सक्नुहुन्छ । तपाई यस अध्यानबाट आफ्नो सूचनाहरु अध्यान दौरान वा यसको समापन पछि पनि हटाउन लगाउनु सक्नुहुनेछ ।
- तपाईको सहभागिता वापत तपाईले कुनै पारिश्रमिक पाउनु हुने छैन, तर तपाईले उपलब्ध गराएका सूचनाहरु जेरिको सडक मन्त्रालयलाई आफ्ना योजनाहरु तर्जुमा गर्ने दिशामा सहयोगी हुनेछन् ।
- यो फारममा हस्ताक्षर गरेर तपाई यो अध्यानको प्रयोजनको लागि सूचनाहरु लिखित वा मौखिक रुपमा र श्रव्य रेकर्डिङको माध्यमबाट संकलन गरिन सक्छ भन्ने कुरा बुझ्नु भएको छ भनेर स्वीकार गर्दै हुनुहुन्छ । यद्यपि,
    - सबै प्रतिक्रियाहरु पूर्ण रुपले गोपनीय हुनेछन् । (जेसिका मिलर, पल योङ, डङ कीटी सहितका) अनुसन्धानकर्ता तथा जेरिको सडक पारिवारिक अभ्यासका स्वास्थ्य कर्मचारीहरुलाई मात्र तपाईको सूचनाहरु माथिको पहुँच हुनेछ ।
    - सूचनाहरुको अन्त्यमा विश्लेषण गर्दा तथा सारंश निकाल्दा तपाईको परिचय गोप्य राखिनुका साथै तपाईको नाम प्रयोग गरिने छैन ।
    - तपाईसँग सूचनाहरुलाई के गरिन्छ भन्ने कुरा जान्ने अधिकार हुन्छ एवं अध्यान समापन भए पछि पनि तपाई ती सूचनाहरुलाई हटाउन सक्नुहुनेछ ।
- तपाईको सहभागिता सकिए पछि अध्यान के का लागि गरिदैछ भन्ने कुरा जान्ने अधिकार तपाईसँग हुन्छ । के गरियो, किन त्यसो गरियो, तपाई कुन परिस्थितिमा हुनुहुन्थ्यो तथा तपाईको सूचनाहरुलाई के गरिन्छ भन्ने बारेमा जेसिका मिलरले बर्णन गर्नुपर्छ । अध्यानको परिणाम उपलब्ध भएपछि तपाईले अनुरोध गरेको खण्डमा जेसिकाले तपाईलाई ती परिणामहरु उपलब्ध पनि गराउने छिन् ।

यो अध्यानमा सहभागि हुन अनुमति दिनका लागि यो फारमा हस्ताक्षर गर्न तपाई **अनिवार्य** रुपमा 18 वर्षको उमेर पुगेको हुनुपर्छ ।

Appendix E

Questions used to frame the focus group discussion

1. What is depression?

2. Is there a way that people in your community think about or talk about depression?

3. When a person is depressed, what symptoms does he or she show? How do we know (how can we tell) when a person is depressed?

4. Is depression a problem in the Bhutanese community in Buffalo? Why or why not? (In what ways is it a problem?) How common do you think it is?

5. What does suicide mean to you? Why do people commit suicide? Does suicide happen as a result of depression?

6. What strategies can be used to combat depression? How can somebody help someone who is depressed?

7. How do Bhutanese people seek support in Buffalo when dealing with depression?

8. Is there anything else you would like to share that you feel would help me to better understand these issues within the Bhutanese community in Buffalo?