

John R. Kasich, *Governor*
Tracy J. Plouck, *Director*

Trauma in Refugee Communities: Interventions and Cultural Humility

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Mental Health Administrator; Health Disparities Lead

Trauma Informed Care Summit

10:15am - 4:00pm

June 23, 2016



Learning Objectives

- ❑ Address common health and mental health issues within immigrant and migrant populations.
- ❑ Identify sociocultural issues for specific immigrant/migrant populations that may affect their health and mental healthcare experiences.
- ❑ Provide practical take-home points and tips about the cultural factors that healthcare practitioners should keep in mind when evaluating immigrant mental health issues.

[cultural humility among providers is built around the expectations that our interventions would be customized to each unique population and culture]

The purpose of the Summit is to promote the recognition of trauma as a public health concern and its impact on the emotional and physical well-being of individuals. We recognize the importance of implementation of theory to practice, sustainability and collaboration across all human services systems.

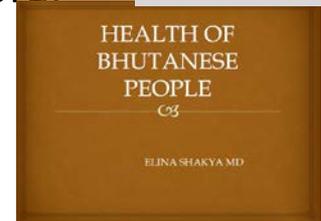
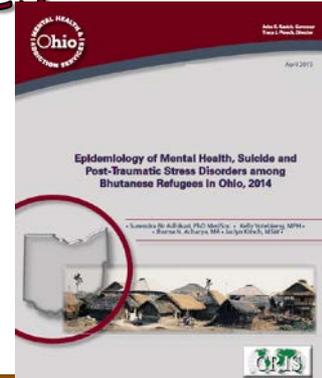
Networking and coordination across multiple systems as necessary for the delivery of effective evidence-based strategies and as key to trauma-informed approaches at the county and community level

The impact of trauma on special populations and the delivery of trauma-informed approaches to special populations

Institute: Trauma in Refugee Communities

PART I: Trauma in Bhutanese Refugees—Overview and Clinical Experiences

- ❖ Overview of trauma disparities in immigrants and refugee populations, with reference to Bhutanese communities; cultural humility; statewide unmet behavioral health needs (Adhikari); and
- ❖ Native Nepali clinicians' experience in treating physical or behavioral health conditions of Bhutanese Nepalis in NE Ohio (Dr. Shakya).



PART II: Federal Government Perspectives

- ❖ ACF—ORR) programming to address trauma in refugees/survivors of torture, technical assistance and grant opportunities (Tim Kelly); and
- ❖ SAMHSA programs and Trauma Informed Care initiatives, technical assistance and grant opportunities (Rosland Holliday Moore).



PART III: Community Perspective (BNCC)

- ❖ Community's own reflections on behavioral health illness burden and resilience (Jhuma N. Acharya).

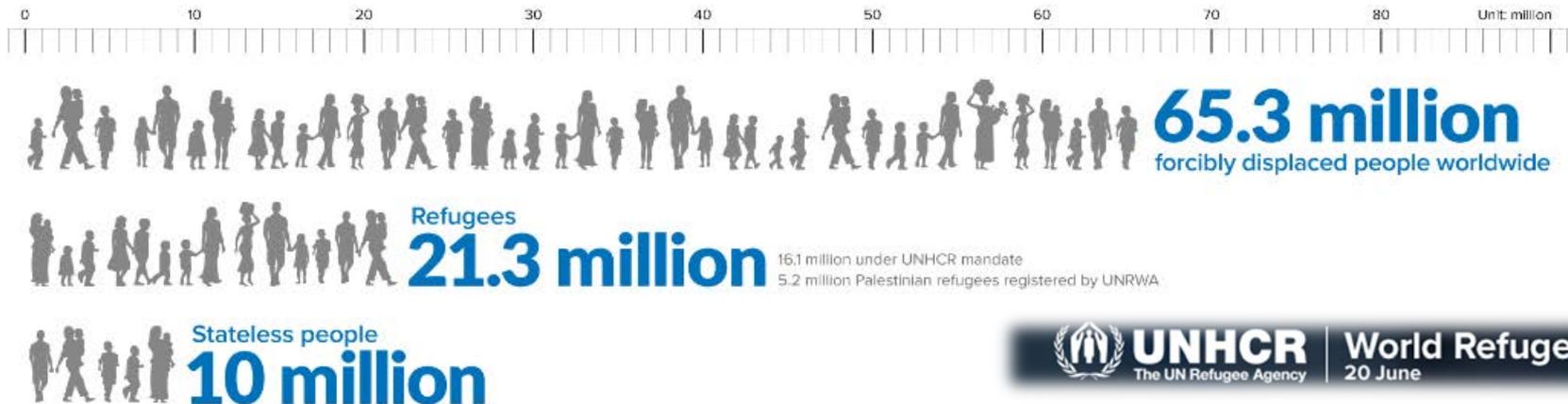


Session Layout

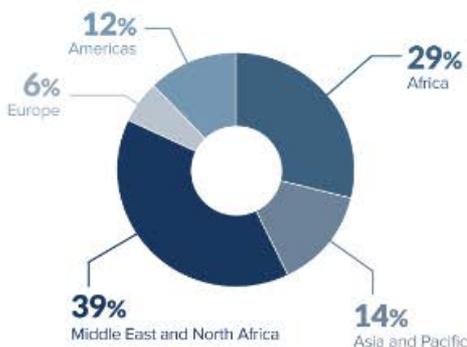
| Session | Coverage |
|--------------------------|---|
| 10:15 – 11:00 AM | Moderator/Presenter: Introductions (Adhikari) |
| 11:00 – 11:30 | Clinician Experience (Dr. Shakya) |
| 12:00 – 1:00 Lunch Break | |
| 1:00 – 1:30 | Federal Agency Perspective (ACF-ORR)– Tim Kelly |
| 1:30 – 2:00 | Federal Agency Perspective (SAMHSA) – Roslyn Moore |
| 2:00 – 2:30 | Q/A |
| 2:30 – 2:45 Break | |
| 2:45 – 3:15 | Bhutanese Refugee Community Reflections (Mr. Acharya) |
| 3:15 – 3:45 | Q/A |

Global Displacement Numbers Rising!!

Global Trends 2015 Statistical Yearbooks



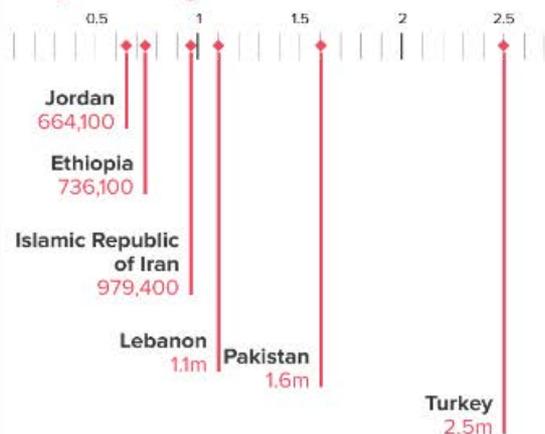
Where the world's displaced people are being hosted



54% of refugees worldwide came from three countries



Top hosting countries



33,972 people
 day forced to flee their homes
 because of conflict and persecution

9,700 staff
 UNHCR employs 9,700 staff
 (figures from December 2015)

126 countries
 We work in 126 countries

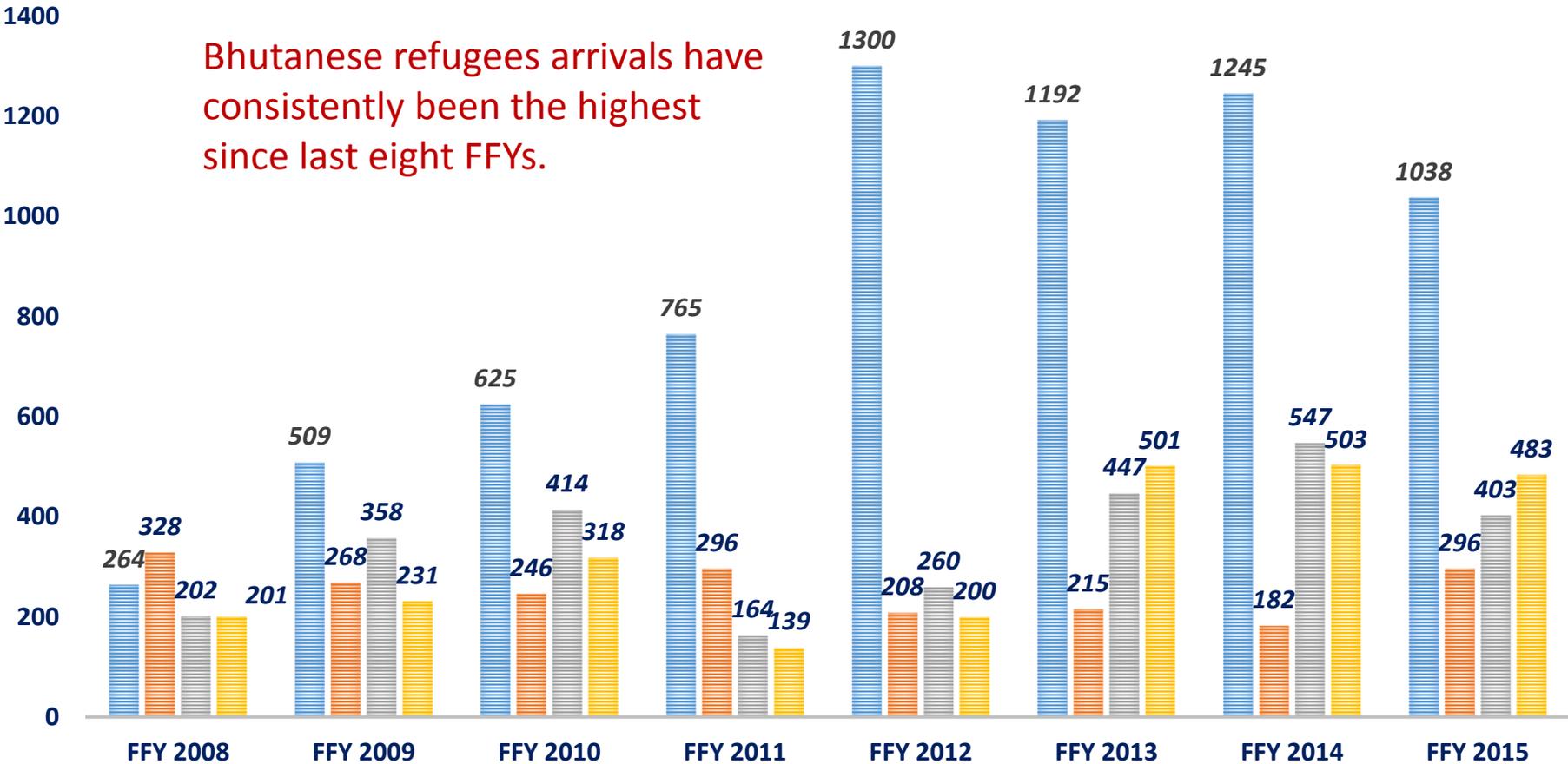
We are funded almost entirely by
 voluntary contributions, with 86 per
 cent from governments and the
 European Union.



Ohio: Top Four Refugee Arrivals, FFY 2008-15

TOP FOUR REFUGEE ARRIVALS BY COUNTRY OF DISPLACEMENT

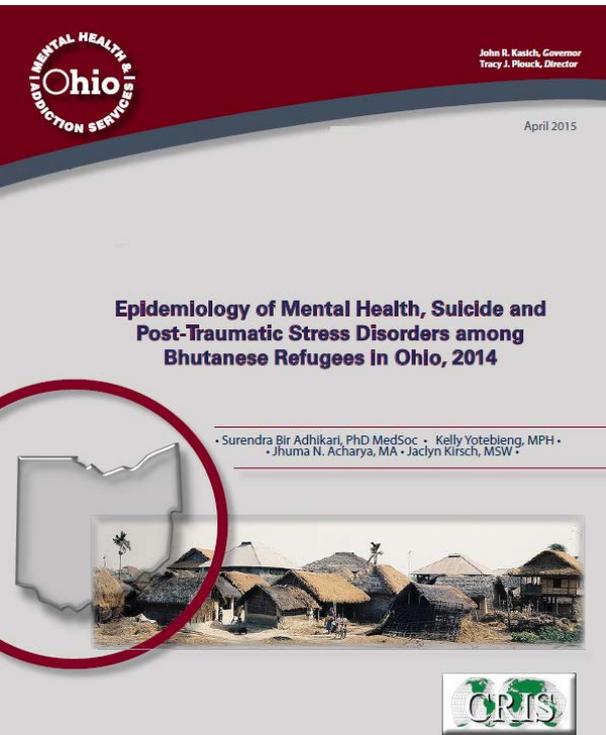
■ Bhutan ■ Burma ■ Iraq ■ Somalia



Source: Data isolated from ODJFS--Refugee Services data.



General/Clinical Overview: Case of Bhutanese Refugees



Ohio MENTAL HEALTH & ADDICTION SERVICES

John R. Kasich, Governor
Tracy J. Piosack, Director

April 2015

Epidemiology of Mental Health, Suicide and Post-Traumatic Stress Disorders among Bhutanese Refugees in Ohio, 2014

• Surendra Bir Adhikari, PhD MedSoc • Kelly Yotebieng, MPH •
• Jhuma N. Acharya, MA • Jaclyn Kirsch, MSW •

OHIO

CRIS

- Overview of trauma disparities in immigrants and refugee populations, with specific reference to Bhutanese communities; cultural humility and resilience; statewide unmet TIC needs and services.
- Bhutanese Nepali community in Ohio: psychosocial issues; physical/behavioral health issues and co-occurring behaviors; resilience and coping mechanisms.
- Prevalence of behavioral health issues (mental health disorders, anxiety, depression, PTSD); other physical health manifestations.
- Types and frequency of referrals to a psychiatry or other clinical specialty/practice.
- How are healthcare providers and other systems responding? Culturally competent approaches?

Migration Related Factors Affecting Mental Health

Table 1: Factors related to migration that affect mental health¹²⁻²³

| Premigration | Migration | Postmigration |
|--|---|---|
| Adult | | |
| Economic, educational and occupational status in country of origin | Trajectory (route, duration) | Uncertainty about immigration or refugee status |
| Disruption of social support, roles and network | Exposure to harsh living conditions (e.g., refugee camps) | Unemployment or underemployment |
| Trauma (type, severity, perceived level of threat, number of episodes) | Exposure to violence | Loss of social status |
| Political involvement (commitment to a cause) | Disruption of family and community networks | Loss of family and community social supports |
| | Uncertainty about outcome of migration | Concern about family members left behind and possibility for reunification |
| | | Difficulties in language learning, acculturation and adaptation (e.g., change in sex roles) |
| Child | | |
| Age and developmental stage at migration | Separation from caregiver | Stresses related to family's adaptation |
| Disruption of education | Exposure to violence | Difficulties with education in new language |
| Separation from extended family and peer networks | Exposure to harsh living conditions (e.g., refugee camps) | Acculturation (e.g., ethnic and religious identity; sex role conflicts; intergenerational conflict within family) |
| | Poor nutrition | Discrimination and social exclusion (at school or with peers) |
| | Uncertainty about future | |

Refugee Overseas Medical Examination

Table 3. Components of the Refugee Initial Overseas Medical Examination, Including Class A and Class B Conditions

Examination components

Full medical history (i.e., current medical conditions and medications, previous hospitalizations, social history, and complete review of systems)

Physical examination including, at a minimum: examination of the eyes, ears, nose, throat, extremities, heart, lungs, abdomen, lymph nodes, skin, and external genitalia

Mental status examination including, at a minimum: assessment of intelligence, thought, cognition (comprehension), judgment, affect (and mood), and behavior

Laboratory syphilis screen

Tuberculosis screen

Appropriate immunizations

Class A conditions: a physical or mental disorder (including a communicable disease of public health significance or drug abuse/addiction) that renders a person ineligible for admission or adjustment of status

Active or infectious tuberculosis

Untreated syphilis

Untreated chancroid

Untreated gonorrhea

Untreated granuloma inguinale

Untreated lymphogranuloma venereum

Hansen disease

Addiction to or abuse of a specific substance* without harmful behavior and/or any physical or mental disorder with harmful behavior or history of such behavior, along with likelihood that behavior will recur

Class B conditions: significant health problems affecting ability to care for oneself or attend school or work, or that require extensive treatment or possible institutionalization

Inactive or noninfectious tuberculosis

Treated syphilis

Other sexually transmitted infections

Pregnancy

Treated, tuberculoid, borderline, or paucibacillary Hansen disease

Sustained, full remission of abuse of specific substances* and/or any physical or mental disorder (excluding addiction to or abuse of specific substances, but including other substance-related disorders) without harmful behavior or with a history of such behavior considered unlikely to recur

*—Amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics.

Information from reference 4.

Refugees: Resettlement and Mental Health Struggles

Resettlement & Mental Health Struggles

Disillusionment
Disheartened
Powerlessness

Low self-esteem, difficulty
obtaining and maintaining
employment, feelings of
hopelessness, self-doubt,
difficulty communicating needs,
shame, stigma

Inability to build new relationships with others
and listening to authority figures, Frequent
Meetings about Program Compliance, Isolation
from new activities

Difficulty experiencing safety, Hypervigilance, Challenging
authority figures, Frequently late for meetings, Suspicious
about Government and Law Enforcement, Increased
negative behaviors

Extreme Fatigue, Nightmares, Physical ailments, Inability to
attend essential appointments

Struggle to provide basic needs; difficulty cooking, cleaning,
maintaining personal hygiene

Trauma Disparities: Select Refugees

| Trauma in Immigrants/Refugees | Literature |
|--|-------------------------|
| <p>Immigrants: Individuals may express psychological distress in different ways. And, the stressors that are considered traumatic may be different for different people.</p> | VA (Accessed, 6/20/16) |
| <p>Karenni (Burmese) refugees: Psychosocial risk factors for poorer mental health and social functioning outcomes included insufficient food, higher number of <i>trauma</i> events, and previous mental illness.</p> | Cardozo et al. (2004). |
| <p>Iraqi and Syrian refugees are found vulnerable to the burden of neuropsychiatric disorders. Possible interventions could include stroke risk factor reduction and targeted medication donations for multiple sclerosis, epilepsy, and schizophrenia.</p> | McKenzie et al. (2015). |
| <p>One study of Somali patients found that among <30 years and younger, 80% were diagnosed with psychoses; older male, and the majority of Somali female patients predominantly showed depressive and PTSD symptomatology.</p> | Jerome et al. (2011). |

Trauma in Refugees: Case of Bhutanese Refugees

| Symptoms of PTSD, depression, anxiety, as well as somatic complaints | Literature |
|---|-----------------------|
| The survivors had higher lifetime and 12-month rates of <i>ICD-10</i> psychiatric disorder. Men--more likely to report torture; tortured women--more likely to report certain disorders. | Ommeren et al. (2001) |
| The tortured Bhutanese refugees, as a group, suffered more and had higher anxiety and depression scores than non-tortured refugees. | Nirakar et. al (1998) |
| Number of PTSD symptoms, independent of depression and anxiety, predicted both number of reported somatic complaints and number of organ systems involving such complaints. | Ommeren et. al (2005) |
| Dramatically high incidence of mental illness including depression, anxiety and PTSD; and incidence of torture as a possible contributor to the illnesses. | Mills et al. (2008) |
| “Nepali-Bhutanese syndrome”? A form of depression that doesn’t fit clearly into any defined mental health disorder. “It progresses from them having aches and pains all over their bodies, to burning.... and, in extreme situations, not doing anything...” [Ken Thompson, a psychiatrist working with Bhutanese refugees in Pittsburgh] | Fusion (2016) |

Cultural Humility versus Cultural Competence

| Cultural Humility versus Cultural Competence | Literature |
|--|-----------------------------------|
| <p>Cultural Humility: Community- based clinical model where practitioners effectively use patient-focused interviewing and develop/maintain mutually respectful and dynamic partnerships with communities.</p> | Tervalon and Murray-Garcia (1998) |
| <p>Cultural Competence: In clinical practice, it is best defined as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves.</p> | Tervalon and Murray-Garcia (1998) |
| <p>Cultural Humility: Client perceptions of their therapist’s cultural humility were found positively associated with improvement in therapy, as mediated by a strong working alliance.</p> | Hook et al. (2013) |
| <p>Cultural Sensitivity: As medical school curricula incorporate more cultural diversity training, a patient-based learning approach with selected ‘hands-on’ experiences will create opportunities for students to increase their cultural sensitivity and competency toward religious values, family patterns, gender roles and ethno-medical treatments.</p> | Griswold et al. (2007) |

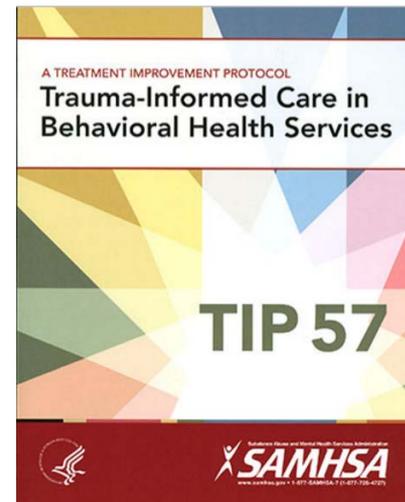
Cultural Humility Implications for Interventions

- Need to focus on posttraumatic stress disorder to address family-level processes, such as family relationship, communication, and resilience. [Ortal & de Jong, 2015]
- Physicians may require specialized training to learn how to initiate conversations about mental health and provide appropriate mental health referrals. [Shannon, 2014]
- Physicians need to screen for PTSD when survivors of extreme stressors present nonspecific somatic complaints. [Ommeren et al. 2005]
- Modifications in refugee policy may improve social functioning, and innovative mental health and psychosocial programs need to be implemented, monitored, and evaluated for efficacy. [Cardozo, 2004]
- It is pertinent to distinguish between stressors that are endemic to most immigrant experiences vs. those migrant stressors that precipitate trauma *per se*. [Foster, 2001]
- Clinical guidelines should continue to refine the assessment of immigrants' presenting mental health problems. (Foster, 2001)
- Working with Asian American trauma survivors entails an understanding of the effects of immigration and acculturation on the experience of and recovery from traumatic experiences. [Tummala-Narra, 2001]
- From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. [SAMHSA, Accessed on June 21, 2016]

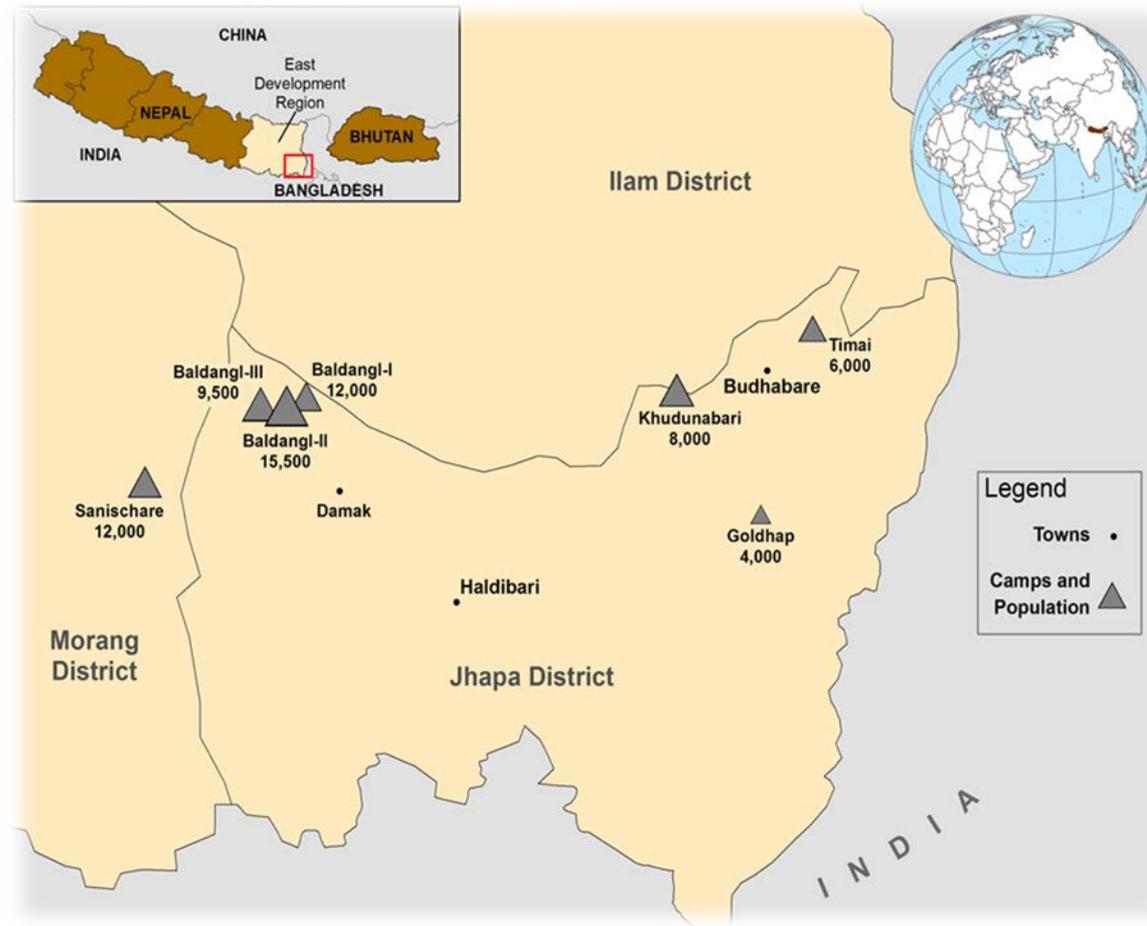
Trauma in Refugees and Immigrant Populations

- ❖ Disparate trauma burden among diverse resettled refugees and immigrants: Need to be sensitive to the socio-cultural characteristics.
- ❖ Trauma Informed Care (TIC)—how to make it culturally competent and relevant so that we can improve help seeking behavior?
- ❖ SAMHSA TIP 57: Defines TIC as: “..A trauma-informed approach to the delivery of behavioral health services that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and population. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic..”

<http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>



Who are Bhutanese Refugees?



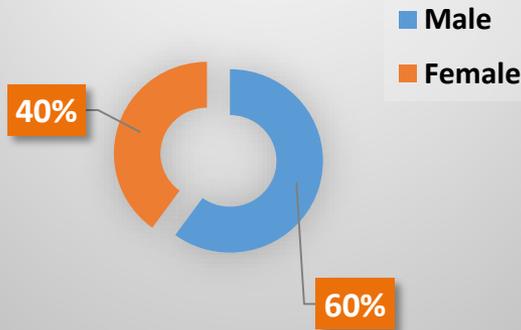
- ❖ People of Nepali origin living in Bhutan since 19th Century.
- ❖ Due to Bhutanization in early '90s, 1/6th of the Bhutanese fled Bhutan and resettled in Nepal.
- ❖ UNHCR 2013 report estimated 108,000 Bhutanese refugees in Nepali refugee camps.



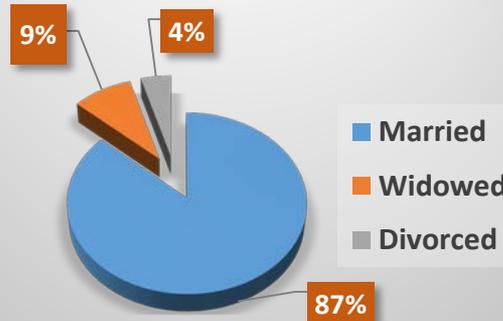
Bhutanese Refugee Camps/Nepal [Courtesy: CDC]

Demographic Sample Disparities

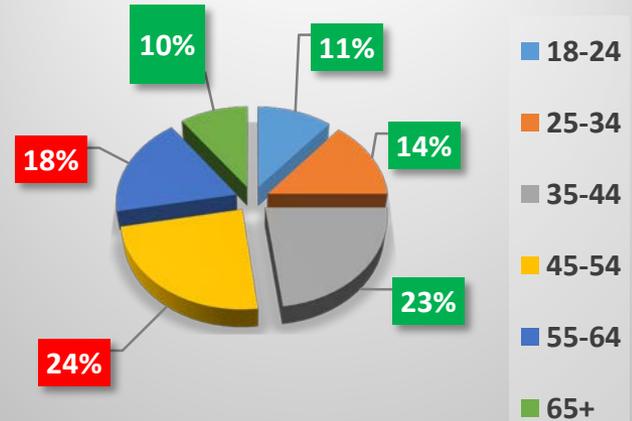
Bhutanese Refugees:
Gender [N=198]



Bhutanese Refugees: Marital
Status [N=198]



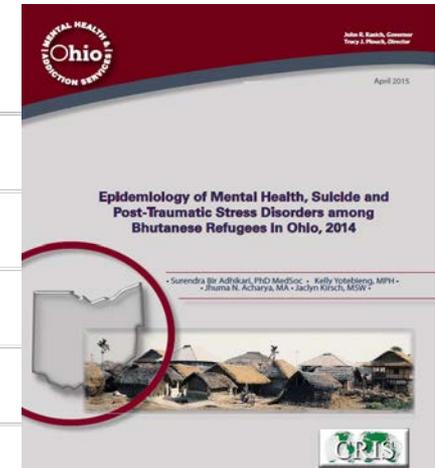
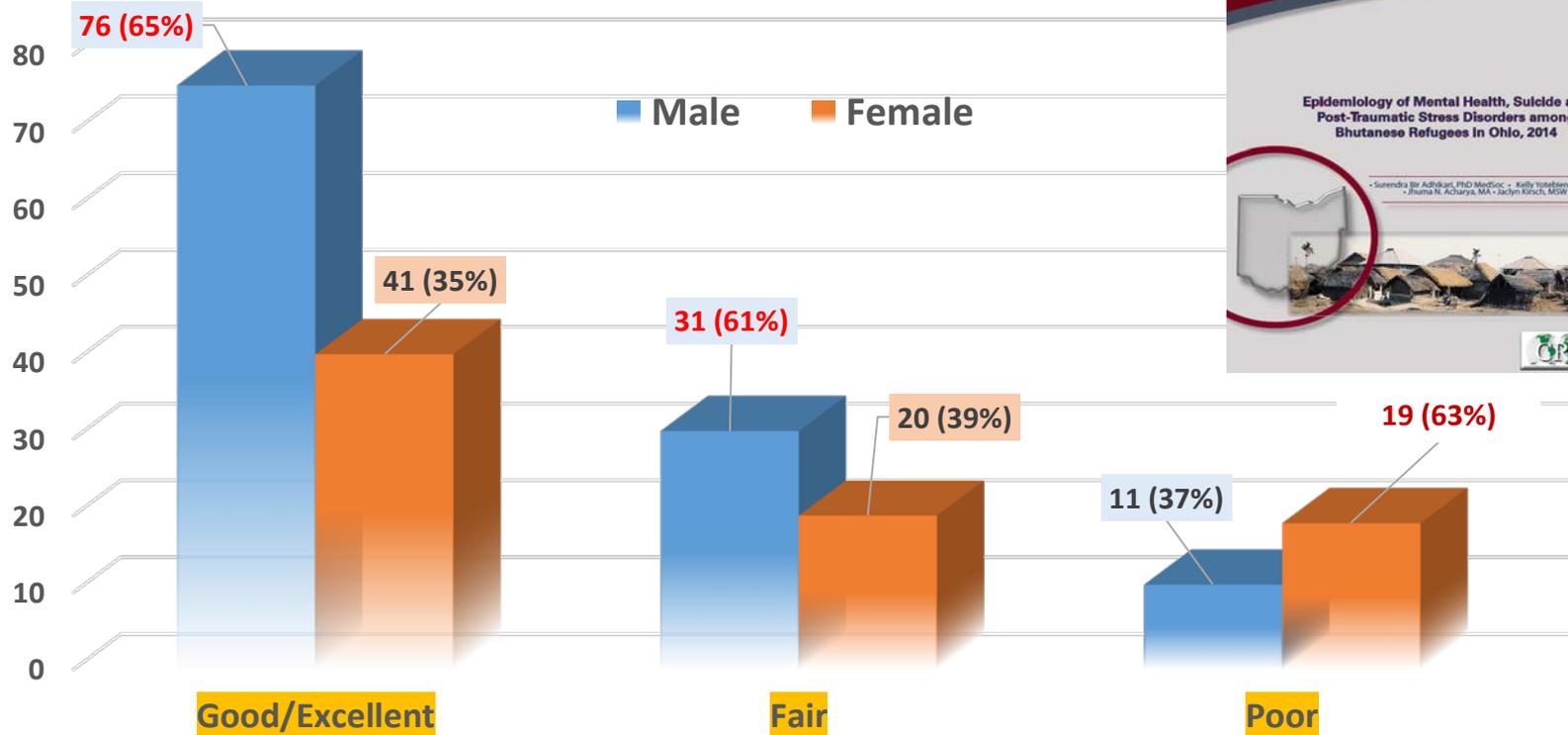
Surveyed Bhutanese Refugees:
Age Distribution



- **Education:** None, 56%; Grade 12, 9%; Some College, 7%
- **Read English:** Yes, 38%; Write English: Yes, 37%
- **Household Income:** 80% have \$15,000 or less per annum income
- **Religion:** Hindu, 81%; Buddhist, 11%; Christian, 8%
- **Ethnicity/Caste:** Bahun, 42%; Chhetri, 27%; Dalit, 12%; Janjati, 17%
- **Household Income:** 51% household have regular income earning.

General Health Status (Self-Reported)

GENERAL HEALTH STATUS: GENDER DISPARITIES [N=198]

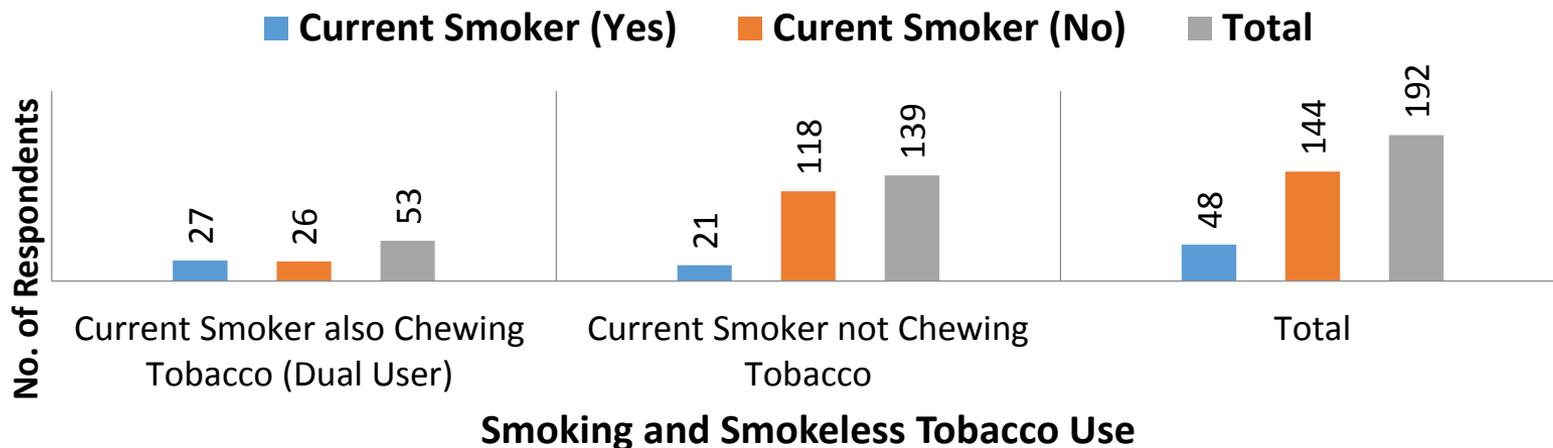


- ❖ Of those self-reporting “good to excellent” health, 65% were males.
- ❖ As for self-reported “poor health,” 63% were females.

Drug & Alcohol Use

- Drug Use/Alcohol:
 - ❖ Current Alcohol Use: Yes, 20% (n=39)
 - ❖ Standard drinks of alcohol daily (n=39): One, 34%; 2-3, 37%; 4-5, 12%, >5, 2.4%
 - ❖ Current smokers, 25% (n=50): N=200
 - ❖ Smokeless tobacco use every day, 23% (n=44): N=192
 - ❖ Dual tobacco use: About 28% smoke cigarettes and chew tobacco.

Figure 1: Dual Tobacco Use Behavior, Bhutanese Refugees, 2014



Mental Health [MH] Condition, Anxiety, Depression

- ❖ [N=199]: 13% were told by a doctor/MH professional that they have a MH condition.
- ❖ Someone in family diagnosed with MH condition: Yes, 21.4%.

25 Questions [Hopkins System Checklist-25]

[HSCL25 has 10 statements to measure anxiety & 15 to measure depression statements]

- ❖ [N=195]: 30% (n=58) suffer from anxiety symptoms.
- ❖ [N=192]: 26% (n=49) reported depression.
- ❖ [N=200]: 9% (n=17) have posttraumatic stress disorder symptoms.

[This compares with CDC 2012 national study findings of: anxiety symptoms at 19%; current depressive symptoms, 20%; and PTSD symptoms, 5%.

CDC Data Source: Ao, T., Suicide and suicidal ideation among Bhutanese refugees—United States, 2009-2012. MMWR. 2013;62(26):553-6]

Trauma Layer #1: Forced Displacement/Persecution



<https://www.youtube.com/watch?v=EYrXYnUCJI&index=1&list=PLypiJrod4DegRLwSFFwAF6EpGNXUKJa5p>



<https://www.youtube.com/watch?v=1hh7HaAiBIM>

Trauma Layer #2: Life of Confinement; Seeking a New Identity



<https://www.youtube.com/watch?v=EYrXYnUCJI&index=1&list=PLypiJrod4DegRLwSFFwAF6EpGNXUKJa5p>

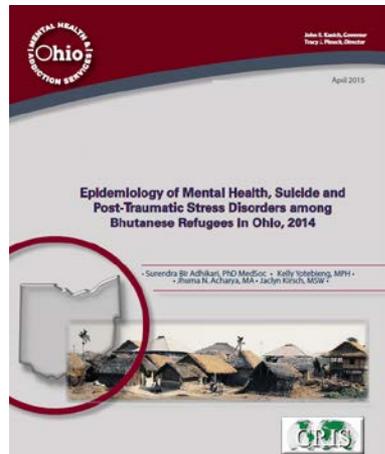
Trauma Layer #3: Post-Resettlement Challenges



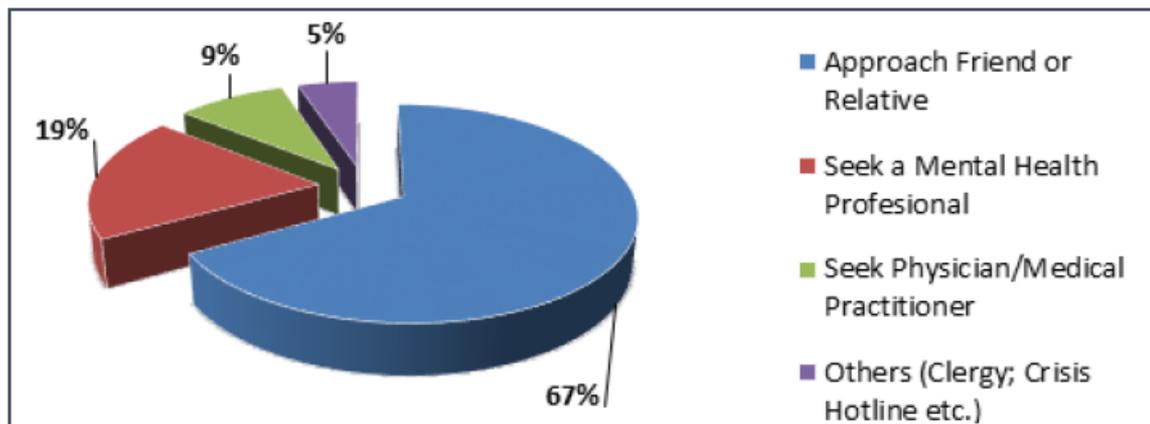
- CDC 2012 study highlighted high prevalence of suicide deaths, anxiety, depression and trauma in Bhutanese refugees.
- Adapted CDC study, added 7 questions and surveyed 200 respondents in Summer of 2014.



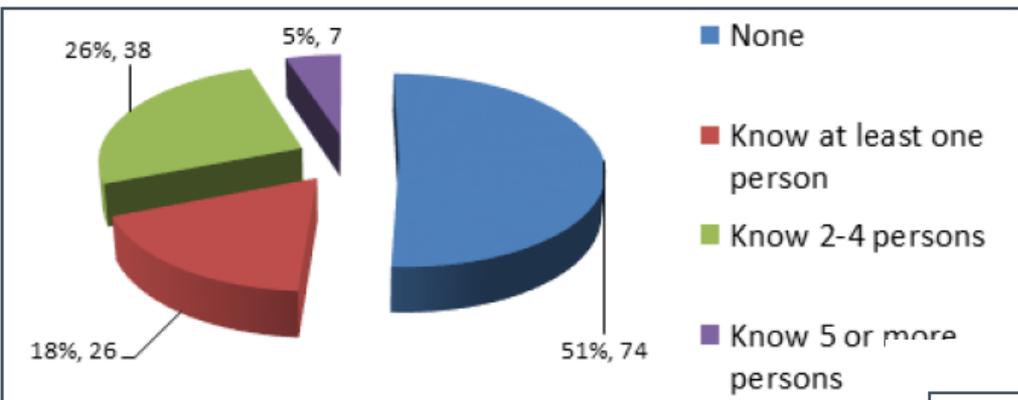
MH, Suicide, PTSD Burden: Bhutanese Refugees Case



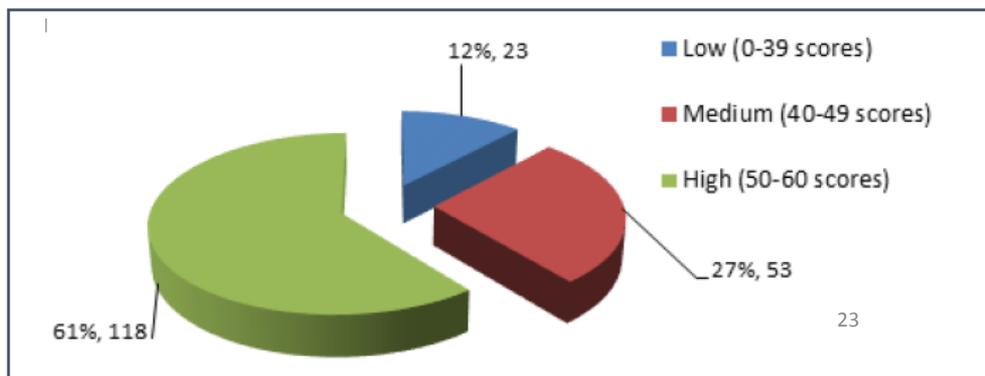
Type of Help sought if Felt Life not Worth Living



Knew People Who Took Own Life in Past 12 Months [N=145]



Perceived Social Support, Bhutanese Refugees, Ohio, 2014



Current Posttraumatic Stress Disorder Symptoms

Harvard Trauma Questionnaire (HTQ)

❖ [N=200]: 9% were experiencing PTSD symptoms.

❖ [N=199]: extremely experienced symptoms were:

- trouble sleeping (13.1%),
- difficulty concentrating (9.5%), and
- recurrent nightmares (8%).

16 questions were used to assess currently experienced PTSD symptoms. The prevalence of PTSD symptom was computed by using a scoring algorithm created by the Harvard Refugee Trauma Group based on the PTSD criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*.

Trauma/Violence/Persecution/Oppression Experience

[N=200]: Most common traumatic events experienced in Bhutan were (those with high responses):

Harvard Trauma Questionnaire (HTQ)—22 questions

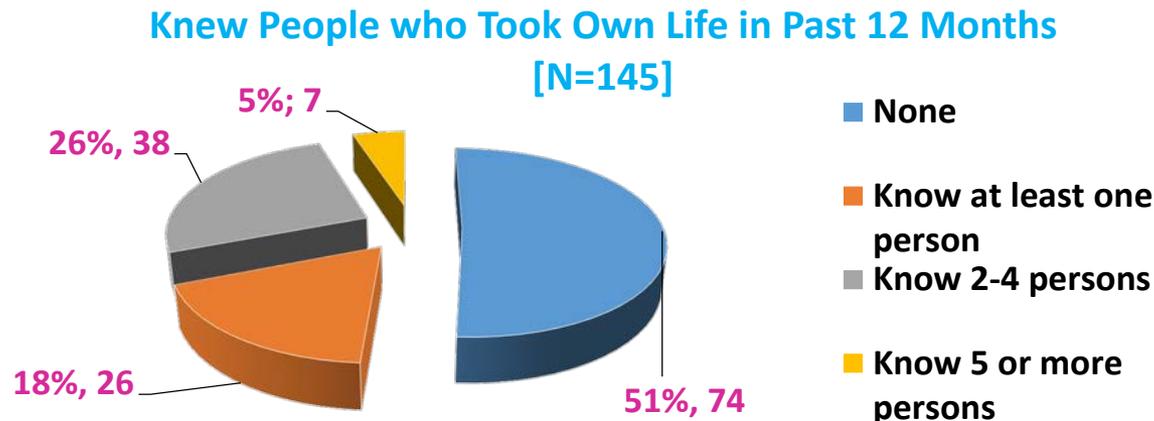
- lack of nationality or citizenship (80%; n=160);
- having to flee suddenly (72%; n=144);
- lost property or belongings, including seizures by the government (Bhutanese) (68%; n=136); and
- religious or cultural persecution (being forced to speak the national language or wear the national dress) (49%; n=98).

[HTQ-22 were used to analyze traumatic events experienced in Bhutan before being settled in refugee camps of Nepal.

Source: Mollica RF, Caspi-Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. The Harvard Trauma Questionnaire: validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis* 1992;180:111–6.]

Suicidal Ideation Assessment

- ❖ 6.2% (n=12) of 195 respondents were seriously thinking about committing suicide.
- ❖ Of 11 respondents who answered a question about suicide attempts, 3 (27%) reported attempting suicide.
- ❖ 38% of 114 respondents knew well a close friend or neighbor who ever committed suicide.
- ❖ Of 145 respondents who personally knew people who have taken their own life: 18% knew at least one such person; 26% knew 2-4 persons; and 5% knew 5 or more person.

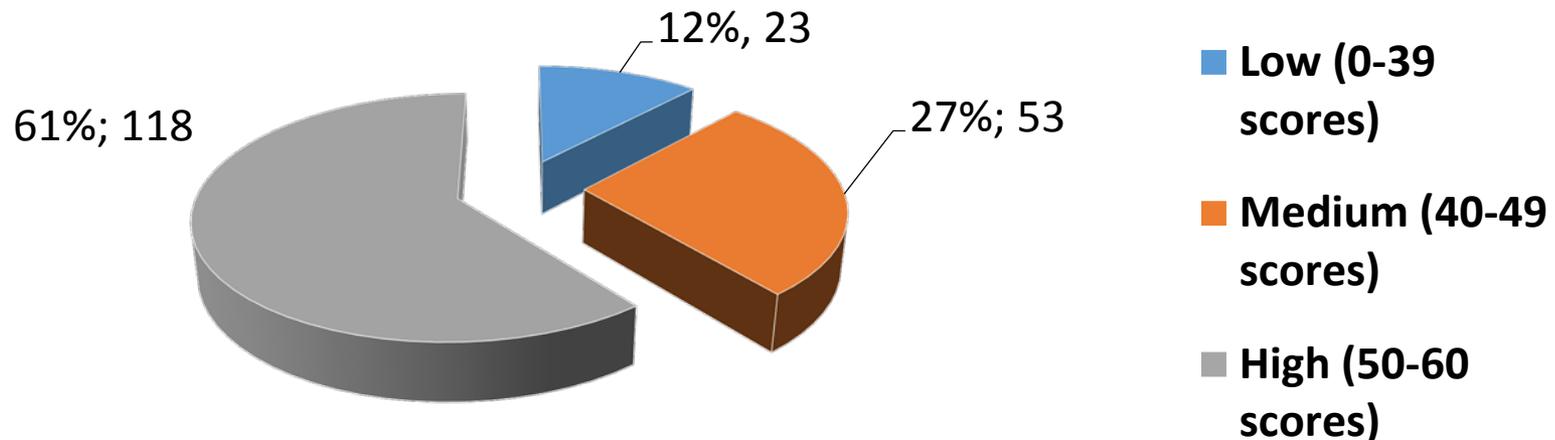


Social Support

Perceived Social Support Scale+

❖ 88% (n=171) of 194 respondents self-reported medium to high levels of social support. [this is very encouraging]

Perceived Social Support, Bhutanese Refugees, Ohio, 2014



+ Vonnahme, Lankau, Ao, Shetty, and Cardozo. 2014. Factors Associated with Symptoms of Depression among Bhutanese Refugees in the United States. *Journal of Immigrant and Minority Health*. Published online: 28 October 2014.

Migration Issues Experienced after Arrival in U.S.

Responses sought on 16 post-migration issues:

Examples: most “extremely” experienced post-migration difficulties:

- ❖ little help from charities or other agencies (70%);
- ❖ little help from government (69.5%); and
- ❖ language barriers (64.8%).

This contrasts to CDC study [N=404] which reported predominant difficulties as: language barriers (62%); lack of choice over future (46%); and worries about family back home (39%).

[Ao, T., Suicide and suicidal ideation among Bhutanese refugees—United States, 2009-2012. MMWR. 2013;62(26):553-6]

Coping Methods to Deal with Stress

Coping methods (5 components)#:

- ❖ “Withdrawal” [N=196]: 24% respondents avoided being with people in general.
- ❖ “Turning to friends or self-focused problem solving” [N=196]: 45% went to a friend to help them feel better about the problem.
- ❖ “Entertainment/leisure activities” [N=196]: 8% watched TV.
- ❖ “Religion and/or culture” [N=196]: 42% visited a temple or church; and 38% (n=74) participated in singing Hindu devotional songs.
- ❖ “Community support” [N=195]: 48% talked with community leaders; and 43% (n=84) joined community support groups.

#Source: Vonnahme, Lankau, Ao, Shetty, and Cardozo. 2014. Factors Associated with Symptoms of Depression among Bhutanese Refugees in the United States. *Journal of Immigrant and Minority Health*. Published online: 28 October 2014]



Study Findings: Policy Implications Moving Forward-1

- ❖ Close to 28% (n=53) of 192 respondents are dual tobacco users (smoking and chewing tobacco)

[a challenge from tobacco cessation standpoint; need unique tobacco quitting interventions.]

- ❖ That 30% (n=58) suffered anxiety symptoms; 26% (49) reported depression; and 9% (17) of 200 respondents having PTSD symptoms.

[This is reflective of the unmet mental health needs among Bhutanese refugees in Central Ohio]

- ❖ Higher rates of attempted suicides and suicidal ideation.

[critical need in the behavioral health community to step-up culturally and linguistically appropriate suicide counseling and awareness programs in the Bhutanese refugee community.]

Study Findings: Policy Implications Moving Forward-2

❖ Survey found high levels of exposure to trauma.

[informal conversations with community members suggest a higher degree of unreported unmet MH Tx needs]

❖ 62% self-reported language barrier.

[may have significantly impacted their ability to seek and/or utilize available resources and consequently contributed to higher levels of cumulative stress and depression.]

[Implication: Calls for appropriate community-based approaches to create awareness about services and resources available to foster an effective/positive resettlement.]

❖ Perceived Social Support Scale analysis revealed that 88% (n=171) reported medium to high levels of social support.

[this is very encouraging given high rates of anxiety depression and PTSD symptoms]

Preventative and Treatment Interventions

- ❖ Efforts and dialogue have been begun on developing culturally appropriate mental health outreach strategies and informational sessions for Bhutanese refugees in health and wellness.
- ❖ Federal agencies (e.g., ACF; SAMHSA) are being tapped unto for possible implementation of mental health trainings in Bhutanese refugee communities in key cities of Ohio.
- ❖ Other meaningful outreach strategies are being investigated to address the unmet mental health and PTSD treatment needs within the Bhutanese refugee population.
- ❖ Administration for Children & Families—ORR federal grant to Bhutanese community would help to build community capacities and launch a resource center to benefit the community.

Culturally Competent Promising Practices

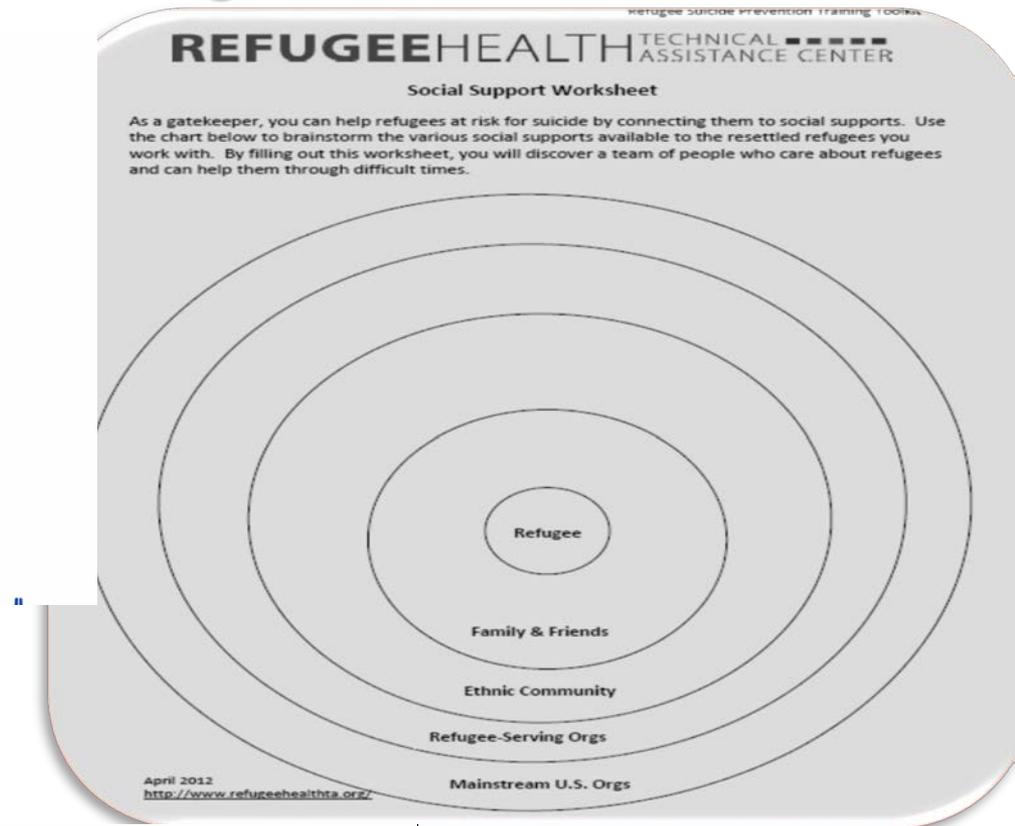
Title: Screening for Depression in Primary Care Setting in Nepal

Produced By: Shared Minds (www.sharedminds.org)

Content: Bibhav Acharya, MD (Narrator) and Soniya Hirachan, MD

Acknowledgments:

mhGAP, UCSF Department of Psychiatry, Possible, TPO Nepal.



Title: Screening for Psychotic disorders in Primary Care Setting in Nepal

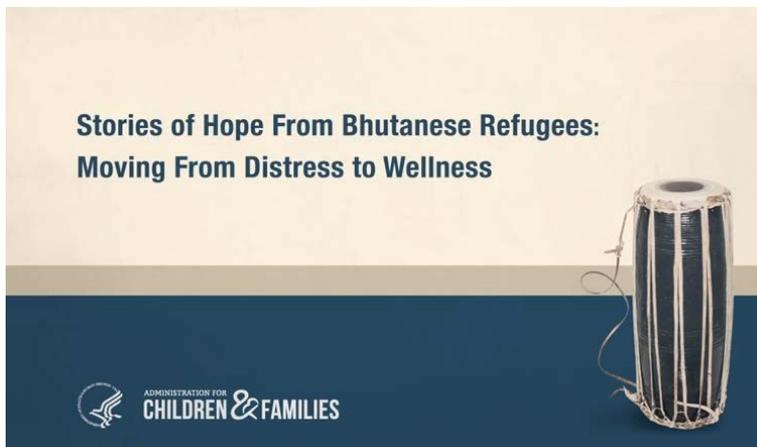
Produced By: Shared Minds (www.sharedminds.org)

Content: Bibhav Acharya, MD (Narrator), Soniya Hirachan, MD, Bikash Sharma, MD and Madhur Basnet, MD.

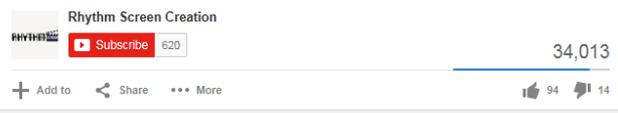
Acknowledgments:

UCSF Department of Psychiatry, TPO Nepal, Possible (www.possiblehealth.org)

Federal/Community Partnerships: Raising Awareness



New Nepali Song 2015| Stop Suicide Awareness Song | Full HD 1080p (Official Music Video)



<https://www.youtube.com/watch?v=EYrXYnUCJI&index=1&list=PLypiJro d4DegRLwSFFwAF6EpGNXUKJa5p>

Published on Mar 7, 2015
"Stop Suicide" Music Video

Concept of Suicide prevention awareness song and the "Stop Suicide" event are initiated by three Bhutanese artists, Amber Subba, Kishor Siwakoti and Arjun Rasaily and presented by the Menuka Memorial Foundation, a non-profit formed by Kishor Siwakoti in the memory of his late mother Menuka. The objective of awareness song and the event was to open up dialogue among the Bhutanese community about mental health issues with the hope that talking about mental illness will encourage treatment and prevention of suicide.

<https://www.youtube.com/watch?v=nXo9BdsMFuo>



References_1

- Cardozo et al. (2004). Karenni *refugees* living in Thai–Burmese border camps: traumatic experiences, mental health outcomes, and social functioning. *Social Science & Medicine* 58(12):2637-2644.
- Eckstein, B. (2011). Primary Care for Refugees. *American Family Physician* 83(4): 429-436. Accessed on June 20, 2016 at: <http://www.aafp.org/afp/2011/0215/p429.html>.
- Foster, RP. (2001). When Immigration is Trauma: Guidelines for the Individual and Family Clinician. *American Journal of Orthopsychiatry* 71(2):153-170.
- Fusion (2016). A mysterious mental health disorder is afflicting Bhutanese refugees in America. Accessed on June 20, 2016 at: <http://fusion.net/story/310750/bhutan-refugees-pittsburgh-mental-health/> 6/9/16.
- Hook, JN, Davis, DE, Owen, J, Worthington, EL, Utsey, SO. (2013). Cultural Humility: Measuring Openness to Culturally Diverse Clients. *Journal of Counseling Psychology* 60(3):353-366.
- Jerome et al. (2011). Psychoses, PTSD, and depression in *Somali refugees* in Minnesota *Social Psychiatry and Psychiatric Epidemiology* 46(6):481-493.
- McKenzie et al. (2015). Neuropsychiatric disorders among *Syrian* and *Iraqi Refugees* in Jordan: A Retrospective Cohort Study 2012/2013. *Conflict and Health* 9(1):10
- Mills et al. (2008). Prevalence of mental disorders and torture among Bhutanese refugees in Nepal: a systemic review and its policy implications. *Medicine, Conflict and Survival* 24(1):5-15.



References_2

- Nirakar et al. (1998). Impact of Torture on Refugees Displaced Within the Developing World: Symptomatology Among Bhutanese Refugees in Nepal. *JAMA*. 280(5):443-448.
- Ommeren et al. (2005). The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety and depression. *Journal of Traumatic Stress* 15(5):415-421
- Ommeren et al. (2001). Psychiatric Disorders among Tortured Bhutanese Refugees in Nepal. *JAMA Psychiatry* May 1, 2001, vol. 58, no. 5.
- Ortal, S., and de Jong. (2015). Family interventions in traumatized immigrants and refugees: A systematic review. *Transcultural Psychiatry* 52(6):723-742.
- Pratyusha Tummala-Narra. (2001). Asian Trauma Survivors: Immigration, Identity, Loss, and Recovery. *Journal of Applied Psychoanalytic Studies*, Vol. 3, No. 3, 2001.
- SAMHSA. Trauma-Informed Approach and Trauma-Specific Interventions. Accessed on June 21, 2016 at: <http://www.samhsa.gov/nctic/trauma-interventions>
- Shannon. (2014). Refugees' advice to physicians: how to ask about mental health. *Family Practice* 31(4):462-466.
- Tervalon, M., Murray-Garcia. (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved* 9(2).
- VA. <http://www.ptsd.va.gov/professional/trauma/other/ptsd-refugees.asp>

Trauma in Refugee Communities: Interventions and Cultural Humility

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THANK YOU !