

Article

Investigating Outcomes of a Family Strengthening Intervention for Resettled Somali Bantu and Bhutanese Refugees: An Explanatory Sequential Mixed Methods Study

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identified numerous individual, family and community-level resources (faith, family and community relationships, cultural values and practices) which refugees rely on to overcome difficulty and support adjustment and wellbeing [2,3].

At the same time, research also indicates that exposure to violence, trauma, and loss experienced in country of origin and during migration increases risks for common mental disorders (e.g., depression, anxiety, post-traumatic stress). Resettlement to the United States and other host countries introduces additional post-migration stressors and living difficulties (e.g., economic pressures, legal status, education and health care access) which often exacerbate risks to mental health. Several systematic reviews have identified high rates of depression, anxiety, and post-traumatic stress disorder (PTSD) among refugee adults and children [4–7]. Bogic et al., for example, found that resettled refugees in Western countries were 14 times more likely to be depressed and 15 times more likely to experience PTSD compared to the general population [4]. Similar disparities have been identified in refugee children and adolescents [6].

Forced migration can also separate families from extended kin, change family roles, and upend family configurations, potentially resulting in poor family functioning and child mental health consequences [8]. Traumas and stressors experienced across the migration continuum may also adversely impact the entire family system and can result in decreased family cohesion, reliance on harsh or ineffective parenting strategies, negative parent–child interactions, and increased risk of family conflict [9].

These shifting family dynamics, in turn, can further increase risk of mental health and psychosocial problems for children. For example, resettled refugee children sometimes adopt new roles to help their family meet their daily needs, such as interpreting or functioning as a cultural mediator for their parents. While adaptive in nature, this role expansion can complicate family dynamics and lead to anxiety and stress in children who may be exposed to sensitive or distressing information or pressures inappropriate for their age [10]. In addition to refugee children’s own direct experiences of trauma and stress, parental exposure to past trauma and ongoing adversity can affect parenting. For example, it may reduce their daily functioning or result in emotional dysregulation or emotional distance from children, dynamics which increase children’s risk of mental health problems [11,12]. Parenting can be complicated by resettlement, as caregivers find themselves in a new culture in which parenting practices from their country of origin may be at odds with parenting norms expected in their new environment, with limited support from extended kin or friends to assist with emotional needs or childcare responsibilities [13]. Parental isolation can contribute to poor parental mental health and resultant unhealthy parenting patterns contributing to increased family and parent–child discord. Such vulnerabilities create a family context that is challenging for children at a time when they most need assistance and support to navigate a new culture and context as resettling refugees [14].

Yet, it is important to also highlight the strengths and perseverance that refugee families and communities commonly exhibit, and which can be leveraged to support wellbeing and adjustment. The family is an important resource for refugee families and functions as a pivotal source of support for coping with past and ongoing challenges [15]. A study with Iraqi refugee families, for example, found that close family relationships, cultural practices in the home and a renewed focus on their future were critical ingredients in making meaning of resettlement related stress and adversity [16]. Indeed, family relationships are crucial to children’s developing sense of culture and identity. This is particularly true for many refugee families, where identity is often strongly grounded in relation to one’s family and community [17]. Moreover, many refugees rely more strongly on their families for support in the post-migration period, as migration can interrupt their previous social support networks. Positive social support from the family has been found to mediate the negative mental health outcomes experienced by refugee adults [18] and has been associated with better psychosocial functioning in refugee children [19]. For refugee children and adolescents, family-level factors including engaged parenting and family cohesion have been found to be important to fostering long-term resilience [20]. Thus, strengthening

family support, functioning, and resilience may be a critical approach for mitigating the effects of trauma and stress in families and promoting child mental health [21–23].

1.1. Resettled Bhutanese and Somali Bantu Communities in New England

New England's resettled Bhutanese community is an ethnically Nepali refugee population who had been residing in Bhutan while retaining their Nepali language and customs for several generations. In the 1980s, the Kingdom of Bhutan embarked upon a campaign of "Bhutanization" that resulted in many human rights abuses, including death threats and torture, towards the Lhotshampa population (ethnically Nepali Bhutanese) and their displacement from the country. They subsequently lived in refugee camps in eastern Nepal for over 20 years [14]. From 2007 to date, over 110,000 Bhutanese refugees have been resettled to the United States [24].

Resettled Bhutanese communities demonstrate strong resilience in the face of adversities, including a strong "culture of helping" in which families and communities proactively provide social support to individuals facing psychosocial challenges [25,26]. However, they also demonstrate high levels of mental health problems. Literature has found that experiencing torture was associated with mental health problems for Bhutanese not only while living in camps in Nepal [27], but also three decades later in the United States [28]. Research has also found that having less education and being illiterate in Nepali is linked to psychological distress, depression, and post-traumatic stress in resettled Bhutanese [29,30]. Most alarmingly, resettled Bhutanese have an increased risk of suicidal ideation, with rates of suicide being nearly double the US average in 2013 [31,32]. This increased risk of adult

1.2. *The Family Strengthening Intervention for Refugees (FSI-R)*

To respond to the significant mental health needs and strengthen adaptive capacities in resettled refugee communities in New England, researchers and community partners began using community based participatory research (CBPR) approaches in 2004 to assess and collaboratively develop family based programs for refugee children and adolescents. Following CBPR best practices, researchers partnered with existing community groups, first in the Somali Bantu and then in the Bhutanese community, with intentionality towards deconstructing power dynamics. Towards this end, community members were involved in each stage of the intervention development and delivery process [45]. Involvement included the use of community advisory boards (CABs); extensive measurement tailoring within each community; hiring and training community members as research assistants and interventionists; and collaborating with community members as co-authors on all study presentations and manuscripts. To ensure frequent opportunities for formal feedback, youth and adult CABs convened quarterly. CAB members shared community perspectives and cultural insight to provide project direction and guidance to the researchers to help improve recruitment, engagement, and retention, and problem-solve cultural or implementation barriers.

The resulting Family Strengthening Intervention for Refugees (FSI-R) has the central goal of promoting family functioning to reduce risk of mental health problems among youth. Designed for refugees, by refugees, the intervention was constructed to be delivered by trained community member interventionists across ten 90-min weekly home-visiting sessions. Interventionists selected from the communities all had shared life experiences as refugees navigating the resettlement process, were often parents, and had prior experience in social services or case management but did not hold advanced mental health degrees. Each session covered different topics related to resettlement and family well-being, such as improving communication, navigating the US education system, and learning positive parenting strategies. A central part of the intervention is the development of the 'family narrative' whereby families reflect on their migration journey to date and choose important family events to discuss, with the interventionist highlighting the family's unique

child relationships, parenting skills and navigation of informal and formal resources to promote child and adolescent mental health.

Figure 1. Refined conceptual model of the FSI-R.

The FSI-R is also informed by the stress adjustment paradigm [49] which identifies stress as resulting from an imbalance between external or internal demands and the personal and social resources to cope and manage them. To facilitate adjustment, the model includes components that aim to increase understanding of different forms of and sources of stress, particularly those common to refugee families and self-management of stress using techniques of behavioral activation, mindfulness and by strengthening social support.

The intervention also draws on the strengths-based perspective which views individuals holistically through the lens of their strengths and capacities and which are seen as

resettled communities and spoke the same languages (i.e., Maay Maay or Nepali as well as English), recruited all participants via phone calls, home visits, and community events. RAs completed ethics training online in addition to intensive training and supervision from study staff.

In order to be eligible for the study, families needed to have U.S. government refugee status, at least one child ages 7–17 years, and have lived in the U.S. for at least three months. If families were experiencing a crisis such as severe psychiatric illness, ongoing legal proceedings, they were referred to a higher level of care and were not enrolled in the pilot. Eligible families were randomized into the FSI-R or care-as-usual (CAU) arms of the study, described in previous publications [47].

Families in both arms participated in quantitative child and caregiver assessments in Nepali, Maay Maay, or English, which occurred pre- and post-FSI-R delivery. The post-tests were meant to be given to families immediately after completing the intervention. Some families took longer to move through the intervention modules than others; for intervention participants, the mean time between pre- and post-test was 12.91 months, and for CAU families, it was 9.81 months. RAs were blinded to group assignment and trained to collect survey data on digital tablets. In all, 146 Somali Bantu individuals participated in quantitative data collection (103 children and 43 caregivers) as well as 111 Bhutanese individuals (49 children and 62 caregivers).

Twenty families per community in the FSI-R arm of the study were selected via a random-digits table to participate in qualitative exit interviews post-FSI-R. One child and one caregiver were asked to complete semi-structured interviews from each family, conducted in Nepali, Maay-Maay, English, or a mix of languages. Out of the 20 families per community recruited, 11 Bhutanese families and 10 Somali families participated ($n = 10$ Somali Bantu caregivers, $n = 8$ Somali Bantu children, $n = 9$ Bhutanese caregivers, $n = 9$ Bhutanese children). These interviews were conducted between January and March 2019.

Finally, four interventionists ($n = 3$ Bhutanese and $n = 1$ Somali Bantu) also participated in semi-structured interviews about their experiences delivering the FSI-R.

Family participant demographic information is presented in Table 1.

Table 1. Demographic characteristics of family participants in quantitative and qualitative portions of the study.

		Individuals, n	Female, n (%)	Age, M (Range)	Years in U.S., M (Range)
Quantitative study participants (n = 257)	Somali Bantu children	103	61 (59%)	14.6 (8–22)	8 (8–15)
	Somali Bantu caregivers	43	34 (79%)	41.8 (28–70)	13.3 (12–22)
	Bhutanese children	49	26 (53%)	14.4 (8–18)	4.0 (1–8)
	Bhutanese caregivers	62	32 (52%)	41 (27–66)	4.3 (1–10)
Qualitative sub-study participants (intervention families only) (n = 36)	Somali Bantu children	8	4 (50%)	14.5 (11–17)	12.7 (11–15)
	Somali Bantu caregivers	10	9 (90%)	40.1 (32–52)	13.3 (12–15)
	Bhutanese children	9	3 (33%)	15.7 (12–18)	4.7 (1–8)
	Bhutanese caregivers	9	4 (44%)	46.1 (34–60)	4.6 (1–7)

2.1. Measures

Data on intervention acceptability, feasibility, and family and child outcomes were collected using quantitative measures [47] and semi-structured qualitative interview guides [50], as described in prior publications.

2.1.1. Quantitative Acceptability and Feasibility Measures

In order to evaluate intervention acceptability and feasibility, FSI-R participants were asked to complete an 11-item survey after completing the intervention. Items were either yes/no questions (e.g., “Would you recommend the FSI-R to a friend or neighbor?”), or scored on a scale of 0 to 2, where 0 represented dissatisfied, 1 was neither satisfied nor

dissatisfied, and 2 was satisfied (e.g., “How satisfied were you with the FSI-R interventionist?”). These satisfaction questions were re-scaled into percentages, where the percent satisfied was calculated as the percentage of “2” responses.

2.1.2. Quantitative Family Outcome Measures

Full descriptions of the outcome measures and adaptations made for this study have been published elsewhere [47]. Child-reported parenting practices were assessed using an adaptation of the Alabama Parenting Questionnaire (APQ) [52] developed for this study. Subscales included positive parenting ($\alpha = 0.83$, 6 items, high scores representing greater positive parenting, such as whether caregivers use encouraging language (i.e., telling the child they “are doing a good job” on homework, etc.), poor monitoring ($\alpha = 0.88$, 10 items, high scores representing poorer monitoring, such as whether the child “stay[s] out in the evening past the time [they] are supposed to be home”), and parental involvement ($\alpha = 0.77$, 10 items, high scores representing greater involvement, such as whether caregivers “play

Table 2. Joint display table: Integration of quantitative (point estimates comparing pre- to post-test change of the intervention versus CAU participants) and qualitative (interview data) about family outcomes.

Quantitative Results			Qualitative Results	Interpretation
Construct	SB ()	B ()		

A 40-year-old mother reflected, *“We do home family meeting and gathering, and talk about school, and felt more awareness and importance of talking with kids, felt closeness, know[ing] kids’ needs, and sharing. Very helpful.”*

However, interventionists also noted that they did not see the same degree of change in all families. Bhutanese interventionists believed that caregivers with higher education levels were better primed to implement the parenting practices they were taught in the intervention. One interventionist explained:

“With one family... Probably due to their educational status being a bit higher, both caregivers were educated. I got [a] very positive response from them. They said they used to have family discussions in some ways, but they realized they could do it differently and effectively, as discussed in the intervention.”

Another Bhutanese interventionist explained that, *“Every family has their own comprehension level. The families with a very low comprehension level, or illiterate families were also there.”* He found that these families with “low comprehension levels” would tell him it was not necessary to implement practices from the FSI-R:

“It will be different in different families. Some families are in good condition. These families take what I taught and suggest during intervention very positively; therefore, we can see positive impacts on these families, whereas some families do not even care, they are good until the intervention session exists, but after the session is over, they do not follow what was taught or said during the intervention session. I have continuously followed up with those families, but then they respond [that] they are okay! And their lifestyle or [their] relationship does not require any changes....For this, I can see I found impact in families 50–50.”

In this small-sample pilot, the differential impact between families well-positioned to receive the intervention and families facing more barriers to behavior change could have muted the quantitative improvements.

3.2. Child Outcomes

FSI-R child mental health outcomes are described in Table 3. Bhutanese families tended to remark on child mental health improvements more often than Somali Bantu families. Several Bhutanese families spoke about children seeming less anxious due to the intervention. A 12-year-old girl explained,

“Before this intervention, I wouldn’t tell anything that happened at school to my parents because I got really worried, cause I used to get bullied. Now, I tell my parents and they help me a lot. And my sisters, they’re there for me too. And I actually tell a lot of stuff to my parents about school, because that makes me more comfortable going to school and learning.”

A Bhutanese mother from another family, age 44, noted similar changes in her son.

“It’s been different. Like my child, if I have to say, is of scared type. But he’s not scared these days. He comes to me and says what needs to be done. It’s been good. It’s been going well in family too. I also understand more now, how children need to be loved. I experienced like that and it’s been good for children as well.”

In addition, a Bhutanese boy, aged 16, from another family explained, *“Now . . . I’m not shy anymore . . . I can help my family without being scared of them or what they think about me.”* He also noted, *“the Family Intervention has . . . made my family happier . . . more engaging with each other.”*

Similar to the qualitative accounts, Bhutanese children were observed to have significantly reduced depression ($\eta^2 = .9.20, p = 0.04$) following the FSI-R intervention compared to families in usual care.

Table 3. Joint display table: Integration of quantitative (point estimates comparing pre- to post-test change of the intervention versus CAU participants) and qualitative (interview data) about child mental health outcomes.

Quantitative Results			Qualitative Results	Interpretation
Construct	SB ()	B ()		
Depression/anxiety [†]	0.18	0.07	<p>“Our community ha[s] very little knowledge about mental health and people really doesn’t want to talk about it and people really doesn’t want to seek mental health help . . . so I think that piece of mental health information in that module was very helpful, and were having healthy conversation about those things. . . . In95 0 0 1 382.081 598.[e83 iId</p>	

about satisfaction, 85.7% of the Bhutanese community indicated that they were satisfied (the remaining 14.3% were neither satisfied nor dissatisfied) compared to 76.9% the Somali Bantu community being satisfied. However, when measuring satisfaction indirectly, via willingness to participate again and willing to recommend to a neighbor or friend, the Somali Bantu responded with 100% satisfaction, while the Bhutanese community came in lower at 64.3% and 85.7%, respectively. One possibility for the discrepancy between general satisfaction and more specific indicators of satisfaction among Bhutanese is the cultural emphasis placed on politeness and the desire to not offend an interventionist whom they know from the community. A Bhutanese interventionist noted, *"I have felt that they [participants] might have been dissatisfied [though]...they did not say openly that they were dissatisfied."*

3.4. Intervention Feasibility

Feasibility of the FSI was assessed quantitatively by asking caregivers about their satisfaction with the intervention length and their ability to get through each session in an efficient manner (Table 6). Bhutanese caregivers rated their satisfaction slightly higher than Somali Bantu caregivers, yet both were above 75% satisfaction. Interviews with caregivers, children, and interventionists alike reveal possible explanations for less than 100% satisfaction, many of which indicate difficulty with gathering family members at the same time and place to participate. Several interventionists described difficulty navigating caregiver's schedules, especially around employment and other commitments that conflicted with intervention meeting times. Regarding the length of the intervention, some reported that it was too lengthy, while many Somali Bantu caregivers in particular indicated that they could have used "more meeting session[s];" "more time to meet with the family;" or that "each family should get longer."

Table 6. Joint display table: Integration of quantitative (percent of caregivers reporting construct) and qualitative (interview data) about feasibility of the intervention.

Quantitative Results			Qualitative Results	Interpretation
Question	SB (%)	B (%)		
Satisfied with length	76.9%	92.9%	"Most of the time there was, 'Okay Mrs./Mr. So-and-So is not here today, so you want to come back another time?' You see one time a father is not home, but the mother says . . . , 'Okay today my husband is not here and my son is not there as well, so you want to just reschedule again' . . . If the father is missing or the mother is missing then the intervention wasn't fully delivered the way it is supposed to be."— <i>Somali Bantu interventionist</i>	It was difficult to bring all the members of a family together in one place for sessions due to their busy schedules, especially for Somali Bantu families, which tended to be larger.
Satisfied with how family was able to get through each session	76.9%	100%		

SB = Somali Bantu, B = Bhutanese.

4. Discussion

This mixed methods study adds nuance and depth to previous research which (1) indicated that the FSI-R pilot was generally acceptable and feasible with Bhutanese and Somali Bantu communities in New England and (2) found positive patterns in improved parenting skills and child mental health, with the need to have the effectiveness outcomes confirmed in a fully powered trial. Interviews with intervention participants reinforced these findings (including community member interventionists contributing to acceptability and feasibility and children's improved mental health), as well as suggested several plausible explanations for the potential patterns of differences in certain outcomes by the community. Qualitative interviews suggest that families with varying levels of education and social status may have responded differently to FSI-R. In addition, unique feasibility challenges for the Somali Bantu participants, such as large family sizes and language barriers between caregivers and children, will need greater attention in future iterations of the model.

Children who received the intervention demonstrated improvements in parent-reported depression and child-reported PTSD symptoms. Participants talked about how children were more comfortable opening up to their caregivers after the FSI-R. Indeed, previous literature indicates that refugees, such as previous studies with Bhutanese refugees suffering from mental health problems "keep their problems to themselves and try to work things out on their own" [62], so the FSI-R's approach to strengthening communication and connectedness is highly relevant for this community.

Regarding family outcomes, many interventionists and participants spoke about important changes that the FSI-R brought about. In Somali Bantu families, both children and caregivers reflected on how the FSI-R brought siblings together and strengthened their relationships. This is consistent with prior research on resettled Somali Bantu families, which found that sibling bonds strengthened after resettlement as their shared experiences

led siblings to rely on one another for support, including in the midst of strained caregiver-child relationships [63]. Sibling relationships were not assessed in this quantitative pilot but were often reflected upon in participant interviews, and therefore could be an important mediator or moderator of child mental health outcomes to examine in future studies.

Some unique challenges facing each community were illuminated by this mixed methods study. For example, participating Somali Bantu families had many children—almost three times as many as Bhutanese families, on average [47]—and both participants and interventionists spoke about how difficult it was to find space in everyone's competing schedules to hold FSI-R sessions with the whole family at once.

Language barriers between Somali Bantu caregivers and children also created a significant feasibility challenge to implementing the FSI-R, while also serving as a risk factor for poor family functioning. Because Somali Bantu families resettled several years before the Bhutanese families, many of the Somali Bantu youth were born in the United States, and they often did not learn their native language Maay Maay. Prior literature describes not only a language barrier between caregivers and children, but also a cultural divide, with caregivers sometimes frustrated with their children for not retaining their cultural and religious practices as they assimilate to American life [63].

the fact that the intervention was developed in close partnership with refugee communities, gaining input from community stakeholders along the way to craft a model that would be appropriate and responsive to the needs of families. Taken as a whole, this suggests that family-based mental health services can be useful for resettled communities. Qualitative insights from this study also shed light on future adaptations to family-based mental health

20. Weine, S.; Ware, N.; Hakizimana, L.; Tugenberg, T.; Currie, M.; Dahnweih, G.; Wagner, M.; Polutnik, C.; Wulu, J. Fostering Resilience: Protective Agents, Resources, and Mechanisms for Adolescent Refugees' Psychosocial Well-Being. *Adolesc. Psychiatry* **2014**, *4*, 164–176. [[CrossRef](#)]
21. Slobodin, O.; de Jong, J.T.V.M. Family Interventions in Traumatized Immigrants and Refugees: A Systematic Review. *Transcult. Psychiatry* **2015**, *52*, 723–742. [[CrossRef](#)]
22. Bunn, M.; Zolman, N.; Smith, C.P.; Khanna, D.; Hanneke, R.; Betancourt, T.S.; Weine, S. Family-Based Mental Health Interventions for Refugees across the Migration Continuum: A Systematic Review. *SSM-Ment. Health* **2022**, *2*, 100153. [[CrossRef](#)]
23. *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*; Institute of Medicine (U.S.); O'Connell, M.E.; Boat, T.F.; Warner, K.E.; National Research Council (U.S.) (Eds.) National Academies Press: Washington, DC, USA, 2009; ISBN 978-0-309-12674-8.
24. Cochran, J.; Geltman, P.L.; Ellis, H.; Brown, C.; Anderton, S.; Montour, J.; Vargas, M.; Komatsu, K.; Senseman, C.; Cardozo, B.L.; et al. Suicide and Suicidal Ideation among Bhutanese Refugees—United States, 2009–2012. *Morb. Mortal. Wkly. Rep. MMWR* **2013**, *62*, 533.
25. Chase, L. Psychosocial Resilience among Resettled Bhutanese Refugees in the US. *Forced Migr. Rev.* **2012**, *40*, 47.
26. Chase, L.; Sapkota, R.P. "In Our Community, a Friend Is a Psychologist": An Ethnographic Study of Informal Care in Two Bhutanese Refugee Communities. *Transcult. Psychiatry* **2017**, *54*, 400–422. [[CrossRef](#)]
27. Shrestha, N.M.; Sharma, B.; Van Ommeren, M.; Regmi, S.; Makaju, R.; Komproe, I.; Shrestha, G.B.; de Jong, J.T.V.M. Impact of Torture on Refugees Displaced Within the Developing World: Symptomatology among Bhutanese Refugees in Nepal. *JAMA* **1998**, *280*, 443. [[CrossRef](#)]
28. Frounfelker, R.L.; Mishra, T.; Carroll, A.; Brennan, R.T.; Gautam, B.; Ali, E.A.A.; Betancourt, T.S. Past Trauma, Resettlement Stress, and Mental Health of Older Bhutanese with a Refugee Life Experience. *Aging Ment. Health* **2021**, 1–10. [[CrossRef](#)]
29. Hess, R.F.; Croasmun, A.C.; Pittman, C.; Baird, M.B.; Ross, R. Psychological Distress, Post-Traumatic Stress, and Suicidal Ideation Among Resettled Nepali-Speaking Bhutanese Refugees in the United States: Rates and Predictors. *J. Transcult. Nurs.* **2022**, *33*, 314–323. [[CrossRef](#)]
30. Vonnahme, L.A.; Lankau, E.W.; Ao, T.; Shetty, S.; Cardozo, B.L. Factors Associated with Symptoms of Depression Among Bhutanese Refugees in the United States. *J. Immigr. Minor. Health* **2015**, *17*, 1705–1714. [[CrossRef](#)]
31. Ao, T.; Shetty, S.; Sivilli, T.; Blanton, C.; Ellis, H.; Geltman, P.L.; Cochran, J.; Taylor, E.; Lankau, E.W.; Lopes Cardozo, B. Suicidal Ideation and Mental Health of Bhutanese Refugees in the United States. *J. Immigr. Minor. Health* **2016**, *18*, 828–835. [[CrossRef](#)]
32. Frounfelker, R.L.; Mishra, T.; Dhese, S.; Gautam, B.; Adhikari, N.; Betancourt, T.S. "We Are All under the Same Roof": Coping and Meaning-Making among Older Bhutanese with a Refugee Life Experience. *Soc. Sci. Med.* **2020**, *264*, 113311. [[CrossRef](#)]
33. Ellis, B.H.; Lankau, E.W.; Ao, T.; Benson, M.A.; Miller, A.B.; Shetty, S.; Lopes Cardozo, B.; Geltman, P.L.; Cochran, J. Understanding Bhutanese Refugee Suicide through the Interpersonal-Psychological Theory of Suicidal Behavior. *Am. J. Orthopsychiatry* **2015**, *85*, 43–55. [[CrossRef](#)]
34. Meyerhoff, J.; Iyiewuare, P.; Mulder, L.A.; Rohan, K.J. A Qualitative Study of Perceptions of Risk and Protective Factors for Suicide among Bhutanese Refugees. *Asian Am. J. Psychol.* **2021**, *12*, 204–214. [[CrossRef](#)]
35. Hagaman, A.K.; Sivilli, T.I.; Ao, T.; Blanton, C.; Ellis, H.; Lopes Cardozo, B.; Shetty, S. An Investigation into Suicides among Bhutanese Refugees Resettled in the United States between 2008 and 2011. *J. Immigr. Minor. Health* **2016**, *18*, 819–827. [[CrossRef](#)]
36. MacDowell, H.; Pyakurel, S.; Acharya, J.; Morrison-Beedy, D.; Kue, J. Perceptions Toward Mental Illness and Seeking Psychological Help among Bhutanese Refugees Resettled in the U.S. *Issues Ment. Health Nurs.* **2020**, *41*, 243–250. [[CrossRef](#)]
37. Van Lehman, D.; Eno, O. *The Somali Bantu: Their History and Culture*; Cultural Orientation Resource Center at the Center for Applied Linguistics: Washington, DC, USA, 2003.
38. Besteman, C.L. *Making Refuge: Somali Bantu Refugees and Lewiston, Maine*; Global Insecurities; Duke University Press: Durham, NC, USA, 2016; ISBN 978-0-8223-6027-8.
39. Betancourt, T.S.; Frounfelker, R.; Mishra, T.; Hussein, A.; Falzarano, R. Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-Based Participatory Research: A Study in 2 Communities. *Am. J. Public Health* **2015**, *105*, S475–S482. [[CrossRef](#)]
40. Ellis, B.H.; MacDonald, H.Z.; Lincoln, A.K.; Cabral, H.J. Mental Health of Somali Adolescent Refugees: The Role of Trauma, Stress, and Perceived Discrimination. *J. Consult. Clin. Psychol.* **2008**, *76*, 184–193. [[CrossRef](#)]
- 41.

