

# Forced Acculturation & the Crushed American Dream

The Gap between the U.N. Departure Preparation of Bhutanese Refugees and the Resettlement Policies of the United States

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### Abstract

Utilizing a Community-Based Participatory Research model, a faculty member of a local university school of social work completed a qualitative needs assessment study to discover the Bhutanese elder's subjective view of their living experiences related to the gap between the departure preparation of the United Nations and the resettlement policies of the United States. The study participants included a social service administrator, two bilingual Nepali-English case workers, and thirty-eight Bhutanese community residents who participated in five focus groups led by a bilingual (English & Nepali) facilitator. The study found that the Bhutanese refugees identified a disconnect between their expectations for life in the United States, the American Dream, and the reality of life in the U.S. Their acculturation stressors are the language barrier, loneliness, social isolation, depression, deficient bilingual services in the areas of health care and social services, and deficient transportation. The study findings point to the benefit of implementing an action model by offering bilingual (English & Nepali) citizenship classes and social activities (arts & craft and weaving classes). In addition, this study's findings recommend that the United States Refugee Admissions Program needs to reevaluate the effectiveness of the resettlement services for refugees in the U.S. and, subsequently, to revise the program policy based on evidence-based service outcomes.

### The Problem under Study

In the early 1900s, the country of Bhutan (a small state surrounded by China and India) had four major ethnic groups (the western *Ngalong*, the central Bhutanese, the eastern *Sharchop*, and the southern *Lhotshampas*); the *Lhotshampas* included the "Nepali-Bhutanese" who originated in eastern Nepal and who primarily migrated to and settled in Southern Bhutan. As the Nepali-Bhutanese population grew, Bhutan enacted laws that marginalized the Nepali-Bhutanese by proposing The Citizenship Acts of 1977 and 1985 in which the Bhutanese government revoked the citizenship of the Nepali-Bhutanese.

Other policies mandated that all Bhutanese wear clothes of the Drukpa culture and prohibited the use of the Nepali language in schools. The Nepali-Bhutanese revolt for civil rights was met with the government closing schools and suspending health care. In 1992 most of those identifying with the Nepali-Bhutanese ethnicity, now referred to as Bhutanese refugees, fled or were exiled to India, and then were sent to refugee camps in Nepal. Bhutan and The Republic of Nepal have not granted citizenship to these refugees who have since been living in refugee camps. The Bhutanese refugees have had a long history of ethnic marginalization and repression of culture and language (Shrestha, 2011). Large third-country (Australia, Canada, Denmark, the Netherlands, New Zealand, Norway, the United States, and the United Kingdom) resettlement

programs began in 2007. By this time, adults migrating to the United States had spent years in the refugee camps in Nepal, and the children had been born in the camps (UNHCR, 2014).

According to the United Nations High Commissioner for Refugees (UNHCR), the United States of America has accepted 78,473 Bhutanese refugees out of the 92,639 who have been resettled from 2007 to January 2014 (UNHCR, 2014). The States that have resettled the most refugees are Pennsylvania (10%), Texas (9.9%), and New York (8.1%) (Centers for Disease Control and Prevention, 2014). Pennsylvania hosts a large number of Bhutanese refugees with 2700 to 3000 residing in the Philadelphia area and the Catholic Social Services of Lackawanna County, PA, estimates over 2,500 Bhutanese refugees in the Scranton, Pennsylvania area.

For the Bhutanese refugees, the task of rebuilding their lives in a new country while oftentimes still recovering from traumatic life circumstances, especially for refugee-status families, the elderly refugees meet challenges unique to their age and circumstances. Current refugee settlement policy and procedures limit the gap for the provision of pre-departure preparation and reception and integration services to the Bhutanese refugees who then rely on the thirty to ninety days of post arrival services. This incongruent policy and procedure forces the Bhutanese refugees to face the unexpected consequences of economic, social and cultural inefficiencies while living in small cities in which, historically, traditional residents have had limited exposure to multicultural and multi-ethnic populations.

The purpose of this study is: 1) to review the policy and procedures of pre-departure preparation from refugee camps and the post-arrival services for the Bhutanese refugees in the U.S, 2) to collect the voices of the Bhutanese elderly refugees about their integration experiences to their adapted new country, and then 3) to assist in the creation of an empowerment model of service delivery to the Bhutanese population in Northeastern Pennsylvania.

## **The Policy and Procedures of Pre-Departure Preparation for Refugees**

The United States, New Zealand, and Australia each provide a form of pre-departure orientation for refugees preparing to resettle in their country; however this orientation varies according to each country. For the United States, the United States' Resettlement Support Centers provide eligible refugees with one-to-five day pre-departure cultural orientation classes; the aim of these classes is to bridge the information gap through brief video presentations by recently resettled refugees who are from the same ethnic group (UNHCR, 2014d). Along with the Welcome to the United States orientation video, refugees also receive a Welcome to the United States resettlement guidebook, which informs them about the initial resettlement process (UNHCR, 2014d). Once refugees have completed the pre-departure orientation classes, admission to the United States is coordinated by the International Office of Migration (UNHCR, 2014c) and refugees traveling to the United States must take out interest-free loans to cover the cost of their transportation from their country to the United States, which they then must begin to pay back as soon as six months after their resettlement and must pay in full within three and a half years after their resettlement (UNHCR, 2014d).

## **The Aim of Resettlement for Refugees in the United States**

Upon the arrival of refugees in the United States, a number of sponsoring agencies will meet the refugees at their final destination in order to transport them to their initial housing, which had previously been arranged for them prior to their arrival in the United States (UNHCR, 2014d).

The goals of refugee resettlement services are to help refugees to be economically self-sufficient and help refugees to become fully integrated and involved members of society as soon as possible (UNHCR, 2014a; UNHCR, 2014c; UNHCR, 2014d).

The role of sponsoring agencies is to ensure that the basic needs of refugees are met for a minimum of thirty days and a maximum of ninety days after their arrival in the United States. The sponsoring agency will provide housing, furnishings, food, and clothing, as well as with assistance in accessing benefits and services (e.g. medical benefits), in enrolling in English language training, in accessing transportation to job interviews and training, and in orientating them to the community services that are available to them (UNHCR, 2014d). The sponsoring agency is mandated to provide these settlement services to refugees for a minimum of thirty days after their arrival in the United States (UNHCR, 2014d). In addition, through the “Matching Grant Program,” agencies maintain refugee cases and assure them housing, transportation, case management, and food stamps for a minimum of one hundred and twenty days after their resettlement (UNHCR, 2014d).

According to the UNHCR policy, refugees who resettle in the United States are required to file for an adjustment of status to lawful permanent resident after one year of being resettled in the country (UNHCR, 2014d). In addition, refugees who resettle in the U.S. may eventually become citizens; however, refugees are eligible to apply for U.S. citizenship only after they have lived for five years in the U.S. (UNHCR, 2014c; UNHCR, 2014d). Furthermore, in order to become a citizen in the U.S., a refugee is required to pass a citizenship test that displays an ability to speak basic English as well as knowledge of the country (UNHCR, 2014a; UNHCR, 2014b; UNHCR, 2014c; UNHCR, 2014d).

Acculturation is considered to be the process of a person learning about and adapting to the culture of one’s new community. The acculturation process involves many stressors, as adapting to a new culture can challenge one’s identity while adjusting to potential new ways of thinking and behaving. General stressors, such as language difference, loneliness and social isolation, lack of resources and dependence on children, changes in family relationships, social discrimination, lack of transportation, and poor health have been identified as affecting immigrant elders (Lee, 2007). Having an understanding of the new culture prior to resettlement can be helpful, especially for the elderly immigrant. A study conducted by New Zealand’s Department of Labor (nd) explored the Bhutanese refugee resettlement process and highlighted that some refugees had lived in a refugee camp for 18 years before resettlement. Refugee’s knowledge about the new country, the new culture, and pre-departure expectations were limited. The process of acculturation is often filled with uncertainty and traumatic loss—not only a loss of home, but also a loss of cultural traditions and a sense of identity (George, 2012).

## Literature Review

### Acculturation Stressors among Immigrants and Refugees

While there is information available on many ethnic groups to examine cultural traditions and views toward aging, there is no information in the literature specific to Bhutanese refugees. Bhutanese refugees are unique in that many lived in Bhutan before spending much of their lives in the refugee camp in Nepal. For this article, the literature on the impact of resettlement as a refugee is limited, especially for the Bhutanese refugee, and therefore, this literature review utilizes studies focused on other ethnic minorities' immigration and other refugees' stories of living in the U.S. Immigrant and refugee are used interchangeably in this section as one can consider that the stressors that immigrants face, refugees face.

### Eastern and Western Perspectives on Aging

The Western perspectives on aging are varied, according to the Pew Research Center Social and Demographic Trends (2009) survey of 3,000 adults in the United States which showed that fewer consider old age being attributed to having grandchildren and retiring from work. Higher percentages of individuals attributed old age to frequently forgetting, failing health, inability to live independently, and turning 75 or 85. Understanding the effects of old age on refugees from the eastern hemisphere requires a consideration of the refugee's cultural perspective of aging. A study in Massachusetts with 32 Cambodian refugees, ages 53-82, revealed the self-perception that old age begins when "the body has too many illnesses" and when one transitions into the "social role" of grandparent (Dubus, 2014, p 185).

Age is a cultural and social construct which forms the expectations of social roles, personal identity, health, and behavior. For example, in Cambodia, age is related to family roles and is associated with the birth of one's first grandchild (Dubus, 2014). Lagacé, Charmarkeh, and Grandena (2012) conducted a qualitative study of 17 elderly Somali immigrants in Canada to explore the differences between aging expectations in Somalia and Canada. The study indicated that part of aging in Somali was a sense of continuing to feel useful, but this notion was challenged while living in Canada.

Some participants said that they did not feel as respected in Canada as they believed they would have been if living in Somalia. They also commented on the busy lifestyle of their family and the feeling that they lacked interaction with others. They also asserted that limited language proficiency was a barrier to integration and interaction with others. The colder weather which relates to less walking (lack of transportation) also contributes to social isolation (Lagacé et al, 2012). Hugman, Bartolomei, and Pittaway (2004) performed a qualitative study which involved focus groups with Bosnian, Cambodian, Somali, Sudanese, and Vietnamese elderly refugees in Sydney Australia, as well as ten interviews with community workers. The study confirmed that elderly refugees feel their role in the family has changed due to migration and often they feel they are "ageing in the wrong place" (Hugman et al, 2004, p 148).

## The Effects of Language Barriers

English language proficiency is often a barrier for immigrants and refugees which limits acculturation and access to support and services (Choi, Davis, Cummings, Van Regenmorter, and Barnett, 2015; Lee & Holm, 2012; Kang, Domanski, & Moon, 2009; Kim, Kang, & Kim, 2015; Casado & Leung, 2002). Lee and Holm (2012) surveyed 160 elderly Korean immigrants who participated in the Korean Senior Center in Chicago, IL. Migrating in older age often leads to greater challenges in learning the new language and acclimating to the new culture (Lee & Holm, 2012). Casado and Leung's study (2002) of Chinese immigrants found that lower English proficiency was associated with higher depression scores.

Kang, Domanski, and Moon's (2009) study of 120 elderly Korean immigrants in Arizona also showed that depression was correlated with limited English language proficiency. Thus, they advocate that reducing language barriers will assist in the prevention of social isolation and reduce depression among immigrants. In addition, Kim, Kang, and Kim (2015) conducted a comparison study between elderly Korean immigrants, 128 who migrated to Canada and 117 who migrated to the United States.

The results showed that limited English proficiency was significantly correlated with depressive symptoms in the United States, but was not significant in Canada. One of the potential reasons for the lack of a significant impact of language on depression scores in Canada which was presented was that the immigrants in Canada belonged to an ethnic community with additional services that compensated for the lack of language proficiency (Kang et al, 2011). Choi, Davis, Cummings, Van Regenmorter, and Barnett (2015) conducted a study of 70 elderly Kurdish refugees to explore service needs and service utilization. The results showed that the participants had limited financial resources and English proficiency.

## Effects of Loneliness, Social Isolation & Depressive Symptoms

Mui and Kang (2006) studied 407 elderly Asian immigrants (Chinese, Korean, Indian, Filipino, Vietnamese, and Japanese) and examined acculturation stress and depressive symptoms. The study found that depression was correlated with poor health, stressful life events, distance from children, and the amount of time in the United States. Abu-Bader, Tirmazi, and Ross-Sheriff (2011) surveyed 70 Muslim participants from the Washington D.C. area to explore the relationship between acculturation, physical and mental health, and the locus of control for health.

The results showed that about half of the participants scored symptoms of depression. Over 75% of participants identified more with their heritage culture than with "North American" culture and indicated that depression is associated with greater affiliation with one's own culture (i.e., less acculturated) and poor physical health (Abu-Bader et al, 2011). Casado and Leung (2002) studied 150 elderly Chinese immigrants in a large city in the United States and examined the factors relating to depression, such as grief experience from immigrating, acculturation stress, length of residence in the United States, and contact with relatives. The results showed that those who had more visits with family showed fewer depressive symptoms. Higher depression scores were correlated with higher migratory grief scores and lower English proficiency. Also,

the older the person was and the longer the person had lived in the United States the lower the depression scores (Casado & Leung, 2002). In addition, older adults born in Mexico scored higher for depressive symptoms than the Mexican Americans born in the United States (Gerst, Al-Ghatrif, Beard, Samper-Ternent, and Markides (2010).

Cornewell and Waite (2009) conducted a study using data from the National Social Life, Health, and Aging Project (NSHAP) of over 3,000 older community-dwelling American adults, and found that older adults who are socially isolated are at a greater danger for physical and mental health risks, such as lower immune function, depression, and cognitive decline. Shiovitz-Ezra (2014) explored the relationship between loneliness and social support within the context of physical health for elderly individuals also using data from NSHAP.

The results showed that greater loneliness was associated with chronic health conditions and disability. Physical health may limit an elderly person's access to a social network causing isolation; conversely, social isolation may also negatively impact a person's physical health. Social isolation (i.e., not being in contact with people) has been found to negatively affect the health of elderly persons (Hawton, Green, Dickens, Richards, Taylor, Edwards, Greaves, & Campbell, 2010).

Hawton et al (2010) surveyed 393 older people in Devon County, United Kingdom looking at the relationship between health-related quality of life (HRQL) and social isolation. They found that health-related quality of life diminishes the more socially isolated an elderly person is (Hawton et al, 2010). As social isolation is linked to health problems, so are negative social exchanges. Negative social exchanges are considered to be relationship behaviors that are unpleasant, such as a person being critical, demanding, intrusive, or an individual being disappointed in another, or being excluded from an expected relationship (Rook, 2014).

The Centers for Disease Control and Prevention (CDC, 2006) estimated that about 20% of people over the age of 55 in the United States experience a mental health concern, most commonly depression, other mood disorders, anxiety, and severe cognitive impairment. The various complexities of resettling in a new country can compound mental health concerns for elderly refugees and immigrants. Stressful social relationships, especially for older adults may be linked to increased risk of disease and disability and a decrease in cognitive functioning (Rook, 2014).

Heikkinen (2011) conducted a qualitative study to explore the effects of social exclusion of elderly participants from the former Soviet Union who migrated to Finland. Results showed that the immigrants had low socioeconomic status and often faced social exclusion due in part by the receiving community's attitude toward the immigrants, but also due to immigrants' language ability and socialization opportunities.

The participants who did engage in social activities expressed more of a sense of belonging and integration into the community because of these activities. Han, Kim, Lee, Pistulka, and Kim's (2007) secondary data analysis of 205 elderly Korean immigrants in a large East coast city in the United States, also showed that high acculturative stress and lower social support were associated with higher rates of depressive symptoms (Kim, Sangalang & Kihl, 2012).

Furthermore, Verhagen, Ros, Steunenberg, and de Wit (2013 & 2014) conducted a study on the quality of life of 201 elderly Moroccan, Turk, and Moluccan immigrants in semi-urban Netherlands. Results found that loneliness was associated with lower quality of life scores.

## Effects of Limited Finances & Dependency on Children

Family dynamics can be a source of strength or stress for older migrants. Individuals who migrate later on in life most typically relocate to live with their adult children, often have fewer options to achieve acculturation, and tend to heavily rely on their children (Rote & Markides, 2014). Older members of refugee families may help or hinder the family during resettlement. Older family members may help maintain cultural traditions and give a sense of stability through the transition.

However, holding on to cultural traditions may also present a conflict for the family to make social changes and adapt to their new culture. Acculturation presents the difficult struggle of maintaining one's lifelong culture while fitting into the new community's culture. This can be particularly stressful for aging immigrants who often identify with the role of maintaining culture and passing on traditions (Lee, 2007). Migration in older age leads to greater challenges in supporting oneself financially and higher income is linked to fewer depressive symptoms (Lee & Holm, 2012).

Migration is generally associated with the search for new employment opportunities in order to better support one's life, and often this is associated with younger, able-bodied individuals who can work. However, elderly migrants often do not have this resource (Rote & Markides, 2014). The elderly are less inclined to migrate for employment and are less likely to search for work in their relocated home. Older Asian immigrants typically have a strong reliance on their family in whose culture it is considered an honor for children to take care of their parents (Kim, Datillo, & Heo, 2011).

The Asian elder may face changes and feelings of loss of power and respect because his or her role changes. Typically, the elder has the role of cultural preserver and makes decisions for the family and this is often undermined as the family unit adjusts to the new culture (Mui & Kang, 2006). Mui and Kang (2006) studied 407 elderly Asian immigrants (Chinese, Korean, Indian, Filipino, Vietnamese, and Japanese) in New York City and found that depression was correlated with longer distance from children (Mui & Lee, 2014). Some elderly have the cultural expectation of being taken care of by their adult children, while others dread being a burden on their children (Dubus, 2014; Lee, 2007). Kao and An's (2012) study of elder care for 193 Mexican Americans found that less acculturated Mexican Americans have higher expectations of family loyalty and the caregiver's perception of mutuality has a significant effect on expectations of elder care.

In addition, Almeida, Molnar, Kawachi, and Subramanian (2009) surveyed 3968 Latino participants and found that foreign-born Latinos reported higher family support compared to non-Latino Americans regardless of socio-economic status. Additionally, higher familial support correlated with higher rates of retention of culture. Foreign-born Latinos also are more likely to have primarily family social supports than non-kin friendship social supports, while U.S. born

Latinos and non-Latino Americans rely more on friendships than family for social support. While there is research on aging and life satisfaction among Asian immigrants and refugees, it is important to understand that there are distinct ethnic groups within the larger Asian culture, and that the different ethnic groups have different social and cultural norms that affect aging in a new environment (Barker & Saechao, 1997).

Shrestha & Zarit's (2012) study of two groups of elderly Nepali women in Kathmandu, Nepal show that social support, religiosity, and the role of family impact quality of life. Culturally, it is expected that the younger generation care for the Nepali elders (Shrestha & Zarit, 2012). Furthermore, the older adults resign from providing for the family which places them on the periphery of the household so that the son and daughter-in-law assume household responsibility. This is aligned with the tradition of the last life stage of the wandering ascetic outlined in the Hindu text, *Dharma Shastras*, where the male in late life relinquishes earthly possessions, embracing detachment and gives himself to religious devotion (Shrestha & Zarit, 2012).

### Effects of Living in a Small/Suburban Community

Migrants who resettle in small towns often face additional obstacles. Immigrants are often geographically dispersed and are not living in a community that shares their culture and language. The small town reception of the immigrant is also distinct and can have an effect on resettlement whether the receiving community's sentiment is welcoming, ambivalent, or hostile. Prins and Toso (2012) utilized a small town English as Second Language (ESL) service providers of rural Pennsylvania to explore community receptivity of immigrants. About 70% of the rural counties with a significant non-English speaking population participated in the mixed-methods study.

The study asked the service providers to identify their community's reception toward the immigrants and how they felt the immigrants were adjusting to the community. Results showed that there are categories or factors that influence immigrant reception in a small community: politics, labor market, immigrants' resemblance to locals (in physical appearance and behavior), and community institutions. In addition, Prins and Toso (2012) explain that different contexts of reception influence the integration (or lack thereof) of immigrants into the small communities. Immigrants in some communities were geographically dispersed and this affected the immigrant's participation in acculturation activities, such as English lessons. Smaller communities often struggle with obtaining funding to provide services because they do not have a large number of immigrants for whom to provide services.

Another study by May, Flores, Jeanetta, Saunders, Valdivia, Avalos, & Martinez (2015) with 11 host community residents and 17 Latina/o immigrants in a rural Midwestern community found that the community is very unintegrated even after 15 years of immigrant resettlement. May et al (2015) found that the community experienced separate social networks and have minimal interaction between native-born resident and immigrant. Latina/o immigrants discussed discrimination experiences in the community, negative social exchanges, and feeling excluded from resources. Dalla and Christensen (2005) conducted a study with 43 Latino immigrants to assess economic and community concerns and service access in a rural town in Nebraska. They followed up with 23 of the participants a year later to assess changes over the past year. Results

showed that concerns about the community did not improve over the course of the year, but specific concerns changed.

The first round of data revealed that the concerns were mostly about substance use, adult and youth education and language barriers, while the second round revealed less concern for substance use, but the same concern for language barriers and adult education. Also, for the first wave of data, participants indicated concerns regarding language development, skills training, youth activities, and affordable housing.

The second wave of data showed that participants were more concerned about job training. Participants also indicated concern for the treatment of immigrants and indicated awareness of discrimination (Dalla & Christensen, 2005). Dalla and Christensen (2005) also noted that immigration rates increase in small communities due to the jobs offered in rural areas, such as the meatpacking district. After spending a year in the community, some participants indicated they would like to see Latinos in leadership positions in the community to help community planning and integration (Dall & Christensen, 2005).

The type and nature of the community in which an immigrant resettles has been found to have an impact on their acculturation and well-being (Lee & Chan, 2009; Kim et al, 2015). Kim et al (2015) relate a difference to acculturative stress depending on community setting. The sample from the United States was from smaller cities while the sample from Canada was from a larger city. Participants from smaller cities, where ethnic communities are not well developed or where there is little diversity, feel more of an immediate need to acculturate to achieve well-being. Participants from larger cities with more ethnic diversity show less acculturative stress. Leaving one's home and resettling in a new nation often presents drastic changes in living conditions, culture, and relationships (Rote & Markides, 2014).

Elderly migrants who live in more homogenous areas surrounded by people who share cultural similarities tend to have more resources and better health (Rote & Markides, 2014 citing Almeida et al, 2009). Making friends and living in a supportive community can affect the acculturation and health of an immigrant or refugee. Neighborhoods affect one's resources, and often immigrants/refugees reside in poorer neighborhoods which limit their mobility and access to resources, as well as exposing them to unhealthy environments such as low quality housing and high crime rates (Rote & Markides, 2014).

## **Conduct of the Study**

To address the Bhutanese elder's perception of their life experiences in Northeast Pennsylvania, Marywood University's School of Social Work faculty developed the community-university, need assessment to collect the community residents' voices. This model, guided by a community-based participatory research (CBPR) approach, utilizes a partnership which focuses a number of principles: (1) viewing the community as the unit of identity that is involved in a co-learning process, (2) focusing on systems development while, at the same time, fostering community capacity building, (3) balancing research with action, and (4) promoting activities that are participatory, cooperative, empowering, and evidence-based (Israel, Schulz, Parker,

Becker, Allen., & Guzman.2003). A CBPR model creates collaborative and community-driven problem solving strategies among agencies, organizations and communities.

## Design

Utilizing the qualitative methodology of an empowerment need assessment and community-university action model included individual interviews with community-based Bhutanese service providers and focus group sessions for Bhutanese elderly residents. For this study, the primary purpose was to discover the Bhutanese elders' subjective view of their living experiences related to post-arrival services and to the community living at large.

## The Samples

The study samples were chosen using a purposive sampling method, a process that encouraged the participation of individuals who have experiential knowledge related to the intended study. Included in the sampling frame were: a social service administrator, two bilingual Nepali-English case workers and thirty-eight Bhutanese community residents who participated in five focus-group sessions. The bilingual (Nepali-English) community leader recruited focus group participants from the U.S. citizenship classes who self-identified as Bhutanese and were retired or older or homebound or who had elderly parents.

## The Focus Group Session Interviews

Acknowledging that the university researcher is viewed as an “outsider” in the Bhutanese community, whenever convenient dates and times for the Bhutanese community leader and Bhutanese community residents' willingness to participate after their citizenship classes, the university researcher accepted their invitation and conducted the study. The university researcher was aware that the focus group discussions with the participants would create trusting relationships between the participants and the research investigator that are critical for the long term relationship between the community and the university.

The Bhutanese community residents' average length of time in the U.S. was 4.2 years. The majority, 77 %, was between 41 and 61 plus years old; 98 % rented their homes, and the dominant language of 97 % was Nepali. The majority, 77 %, identified themselves as either retired or not working or not looking for jobs or unable to work; the average family size was 5.8 (for *demographic information* on the focus group participants see *Appendix 1.*)

A Collaborative Institutional Training Initiative (CITI)-certified bilingual (English and Nepali) moderator facilitated each focus group session, lasting between 40 and 60 minutes each. All the participants listened to the Nepali language consent form information which explained the nature of the study, indicated the voluntary nature of their participation, and cautioned participants not to use identifying information during the discussion. The researcher was sensitive about exposing personal information during the focus group discussion.

The focus group interview sessions focused on the following questions: 1) How do you feel about your community and the neighborhood where you live? 2) How do you feel about your

own health and physical condition? 3) How do you feel about the way you spend your time each day? 4) What would you want to do, if you had spare time? (See Appendix 2). The focus group questions were adopted from the Perceived Quality of Life Scale used by Fazel and Young (1988, p 232). The internal consistency reliability was .82. No incentive gift was given to focus group participants.

## Data Analysis

The focus group sessions produced rich data detailing each participant's unique and rich life experiences in their own words and perspectives. In this study, each focus group session was audio taped and transcribed by bilingual (English & Nepali) transcriptionists.

The Bhutanese community residents who participated in the focus groups identified the following as the top four community issues: (1) language barriers, (2) inadequate bilingual (English & Nepali) medical interpreter services, (3) inadequate public transportation systems, and (4) social isolation.

The participants also identified the top two service needs: (1) increase bilingual (English & Nepali) citizenship classes, and (2) create social activities (craft, needlework, etc.). These data serve to highlight participants' collective living experiences and to illustrate how their priority needs should be categorized in the community-university implementation process.

### ***Theme 1: Language barrier***

All the focus group identified language as their top barrier. The participants stated that their limited both expressive and written language proficiency has impacted their ability to access any medical service or medical and social service information as well as receiving job training and maintaining employment. Participants also stated that part of their social isolation is also due to their inability to engage in conversation with their neighbors where they live.

*"We only know Nepali so we need interpreters. If we have to go to the hospitals, we need help with language. In police cases, we don't have help with language. We are facing problems. We came to America, but we feel helpless due to language barrier."*

*"We don't know the language. If we knew the language, we would have been able to work. We only know Nepali but not English."*

### ***Theme 2: Inadequate Bilingual (English & Nepali) Medical Interpreter Services***

The participants expressed their inability to present medical care needs and, at the same time, being frustrated with the lack of trained bilingual (English & Nepali) interpreter services in local hospitals, clinics, and all other health-related services. In some cases, Bhutanese patients were not able to express their symptoms, unable to understand diagnoses, treatment plans and required follow up care. Lack of bilingual interpreting services creates an issue of hospital/clinic liability, doctor-patient confidentiality and could result in inadequate medical services to at-risk patients.

*“When we go to the hospital, language is a barrier. We wish they would provide interpreters. Some places do and some don’t and that is problem. If there were interpreters, it would be easier for us to explain all the health issues. There have been times that we didn’t seek treatment.”*

*“Some places have interpreters and some don’t. We have been given appointments in places that don’t use language lines. We then go to those places thinking there must be some help in place, then we find out there’s not help and we don’t understand the language, so we do what we’re told to do and when we get the bills after medical tests and appointments, we get surprised. So, language is an issue and we face problems.*

### ***Theme 3: Inadequate Public Transportation Systems***

Living in suburban communities where public transportation services is limited (weekdays, bus only runs from 6:30 am to 7 pm and weekends is up to 5 pm and bus route covers main roads). Older Bhutanese participants expressed frustration regarding their inability to have a car and drive for doctor’s appointments, attending language classes and participating in social gatherings unless their children provide rides.

*“Older folks don’t drive. If there was a vehicle to transport them to hospitals or language classes, it will be helpful. In hospitals, we face issues due to transportation and lack of interpreters.”*

*“We have to rely on our children for everything and to go everywhere. We have to wait for their day off to take us around. We don’t drive.”*

*“In winter, it gets cold and then snow, so walking could be difficult. Public bus is not coming near home and it’s not frequent. For older people they have to walk down to the bus stop and it’s difficult.”*

### ***Theme 4: Social Isolation***

The participants shared how they have been spending their time ever since they arrived in the United States. Their living conditions, life style, and roles have changed drastically. Their main roles are cooking for family, taking care of household stuff and watching their grandchildren while their sons/ daughters/ daughters-in-law are working. They feel stuck at home.

Even though they are busy with household work, but, at the same time, they feel socially isolated and bored. They want to have regularly planned social activities with other Bhutanese residents in their community.

*“We miss our birth place, we miss Bhutan, Nepal, we miss the place we grew up in and our friends and family. We live half our life in Bhutan then Nepal and we came to America to die (laughs). But, we are here and we’re not going back.”*

*“In Nepal, older folks could go around and do a few things. Over here, they just stay at home. If there was a hall, that would be great to meet in our own time.” “If there was a hall, people will gather and talk about what is going on. Then, if problems are identified, we will be able to help out each other. Right now, they are stuck at home.”*

While participants shared their perceived living experiences in their adopted country and the community, they also suggested what they would like to have: 1) the bilingual (English & Nepali) citizenship classes and, 2) the social activities such as craft, needle points, weaving, etc.

## **Suggested Program 1**

### **The Need for Bilingual (English & Nepali) Citizenship Classes**

All participants expressed that they consider the U.S. as their permanent country, so they want to study English and pass the U.S. citizenship test. For an average of 18 to 20 years, these Bhutanese refugees lived as stateless people in Nepal. Nunn, McMichael, Gifford and Correa-Velez (2016) interviewed 51 young adults with a refugee background from Sudan, Ethiopia, Eritrea, Afghanistan, Iraq, and Serbia, in Australia regarding the value of citizenship. The study reports that the participants shared that the greatest benefits for citizenship were: 1) mobility and security, 2) a sense of security which allowed them to travel abroad without fear of losing the right to return, 3) consular protection by the Australian consulate if needed and, 4) most importantly, formal citizenship protects against future displacement.

*“If someone who can speak Nepali could teach us in Nepali and English; for older folks, it would be easier...we have American teacher, she tries so hard but we struggle. When she asks what day is today, that I can understand, but the rest we can’t understand. I can maybe understand the month so, day and month; the rest I can’t understand.”*

*“We didn’t get education back home. There were schools but... we were sent away from Bhutan and the American government brought us here. We were citizens in Bhutan, but we had to leave. We’re here now, and we need citizenship here.”*

## **Suggested Program 2**

### **The Social Activities (Arts & Craft, Needle Point & Weaving)**

Many participants stated that they are busy with their household work (cooking, cleaning, etc. for the family) but they feel isolated in their community. When they lived in the refugee camps in Nepal, all their family members, relatives and friends lived in walking distance. In the current community setting, they feel geographically and emotionally disconnected from one another. Creating social activities such as arts & craft and weaving would encourage people to engage in social interaction and build social capital among the Bhutanese elders. The Bhutanese elder’s satisfaction with social groups with other refugees would help them to avoid isolation, make connections with others, and learn about other community services.

*“In the camp, we used to gather and knit hats, go to school. During school session, we went to school and during breaks, we did weaving.”*

*“We used to make clothes and we could keep it for ourselves. We made sweaters, scarfs. We were with friends, so we used to chat and work at the same time.”*

## **Discussion and Recommendations**

The goal of the United States’ resettlement program for refugees is economic self-sufficiency. In general, refugees reported difficulties in finding employment after resettlement in the United States. In the United States, refugees’ inability to speak English is the most prominent barrier to them gaining employment in the competitive market. Even though refugees may have advanced degrees and previous career experience in the field they seek to gain employment in, many are forced to work entry-level jobs for minimum wage (e.g. laborers) because employers are seeking to hire individuals with good communication skills (Khatiwada, 2013).

Other resettling countries, such as New Zealand, provide government-funded employment-related training for refugees who are at a disadvantage within the labor market (UNHCR, 2014c) and Australia provides Adult Migrant English Program’s Employment Pathways Program and Traineeships in English and Work Readiness (UNHCR, 2014a).

Through this, eligible refugees receive both English language tuition and experience in the workforce, which aims to assist them in preparing to be contributing members of Australia’s workforce (UNHCR, 2014a). In addition, Canada has implemented a process of assessing the skills and credentials of resettled refugees for the purpose of providing them with applicable employment information as well as to refer them based on their eligibility: Employment and Social Development Canada or Employment Assistance Services by which all resettling refugees have access to Canada’s National Employment Service, which provides them with information pertaining to the labor marker, the Electronic Labor Exchange, and the National Job Bank; these are mechanisms that assist unemployed refugees in gaining employment as soon as they arrive in Canada (UNHCR, 2014b).

By contrast, in the United States, there are vocational and technical schools and skilled occupations (e.g. medical and dental assistants, auto mechanics, etc.) that can train individual refugees, however these services are not provided by any resettlement programs or agencies and thus require payment by refugees (UNHCR, 2014d). Furthermore, a minimum of thirty days and a maximum of ninety days services after refugees’ arrival in the United States seems to be an irrational policy and an unrealistic expectation.

In general, Bhutanese refugees have identified numerous problems after their resettlement in the United States related to communication, emotional problems, and culture shock that have led them to experience mental stress. In fact, there are a plethora of post-migration stressors that can impact the adjustment of refugees to life in the United States including economic difficulties, discrimination, acculturation, enculturation, and employment (Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014).

Because communication is required for all daily activities, both children and adult refugees reported that not being able to speak English caused them severe mental stress and was a barrier to them being able to adapt more of the American culture into their lifestyle (Khatiwada, 2013).

Refugees are coming to the United States with little or no English skills; this prevents them from being able to communicate with health care providers including those working in mental health (Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014). As a result of these common post-migration difficulties, there is an especially high rate of suicide within the Bhutanese population after resettlement. Over thirty Bhutanese refugees have committed suicide since the summer of 2008 when the United States' resettlement program first began; in addition, it appears that the problem of suicide is worsening as seven Bhutanese refugees have committed suicide between November of 2013 and January of 2014 (Mishra, 2014).

According to Mishra (2014), a great deal of Bhutanese suicides are occurring as a result of resettled refugees experiencing a disconnect between their expectations of living the American Dream after resettlement in the United States and the reality of unemployment and low pay. According to Beehag, the Director of Refugee and Employment Services for resettlement agencies in Buffalo, New York, there exists little discussion regarding the topic of suicide among the Bhutanese population along with a lack of support and provision of services to help the Bhutanese to deal with the problems that they are facing (Mishra, 2014).

It has been found that mental health agencies' involvement during the early period of refugees' resettlement has been successful in preventing mental illness or in intervening when mental illness arises (Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014). Bhutanese refugees are facing emotional problems that result from a disconnect between their expectations for life in the United States and the reality of life in the United States.

For example, refugees apply for resettlement in the United States with expectations of earning a great deal of money and living the "American Dream"; however, they face a reality of unexpected problems and unemployment that leads not only to them experiencing difficulty maintaining their lives in the United States, but also leading them to experience poor mental health after this reality sets in (Khatiwada, 2013).

In addition, the culture shock that refugees experience after resettling in the United States also leads to emotional stress and even chronic depression for refugees (Khatiwada, 2013). However, there exist a number of barriers that prevent refugees who have resettled in the United States from accessing mental health services to treat their chronic depression and emotional stress. These barriers include limited knowledge and information about mental health as well as mental health services, lack of awareness of issues related to mental health, financial barriers (i.e. low socioeconomic status), and the negative stigma attached to the utilization of mental health services (Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014).

In order to meet the realistic and humanitarian goal of economic self-sufficiency and positive acculturation to their newly adopted country, it is imperative to review and renew the United States Refugee Admissions Program (USRAP). USRAP has not been restructured since its creation in 1980. The strengths of the USRAP have been identified to include the number of refugees resettled in the United States, which is more than all of the other nations combined, the initial reception plan for refugees such as greeting refugees at the airport, the provision of secure housing to refugees, etc., the partnerships between government agencies and volunteer agencies (VOLAGS) who administer the Office of Refugee Resettlement program through providing

refugees with temporary cash, medical aid, etc., and post-arrival language assistance which facilitates refugees' access to the services that they are in need of (Brick et al., 2010). Along with these identified strengths, various limitations of the USRAP would be its conflicting policy goals. This results from the fact that the program is divided between the Bureau of Population, Refugees, and Migration and the Office of Refugee Resettlement who hold very different views on resettlement (Brick, Krill, Cushing-Savvi, McGlynn, Elshafie., & Stone. 2010).

A second overarching issue is inadequate funding for the USRAP in terms of the expectations of the program. A third vital issue is the existing gaps in the coordination and planning, which lead to compromising the program's ability to prepare both refugees and receiving communities in the United States (Brick et al., 2010). A fourth overarching issue is the lack of evaluation of the USRAP; at this time, no one stakeholder has the responsibility of holistically monitoring and evaluating the practices of the program or the outcomes for both refugees and communities in terms of resettlement which adds difficulty to the ability to make evidence-based policy and program decisions (Brick et al., 2010). Based on the aforementioned literature review and the findings of this research study, we strongly urge the United States Refugee Admissions Program (USRAP) to review and revise the current program policies.

In terms of the micro perspective, the resettlement service providers need to understand how refugees experience the cultural differences and expectations (Dubus, 2014) and how trust is an important factor in refugees accessing care (Wangmo, 2011). Leaving one's home and resettling in a new nation often presents drastic changes in living conditions, culture, and relationships (Rote & Markides, 2014). Elderly migrants who live in more homogenous areas surrounded by people who share cultural similarities tend to have more resources and better health (Rote & Markides, 2014 citing Almeida et al, 2009 and Dugan-Day, Dollar & Kaf, 2015).

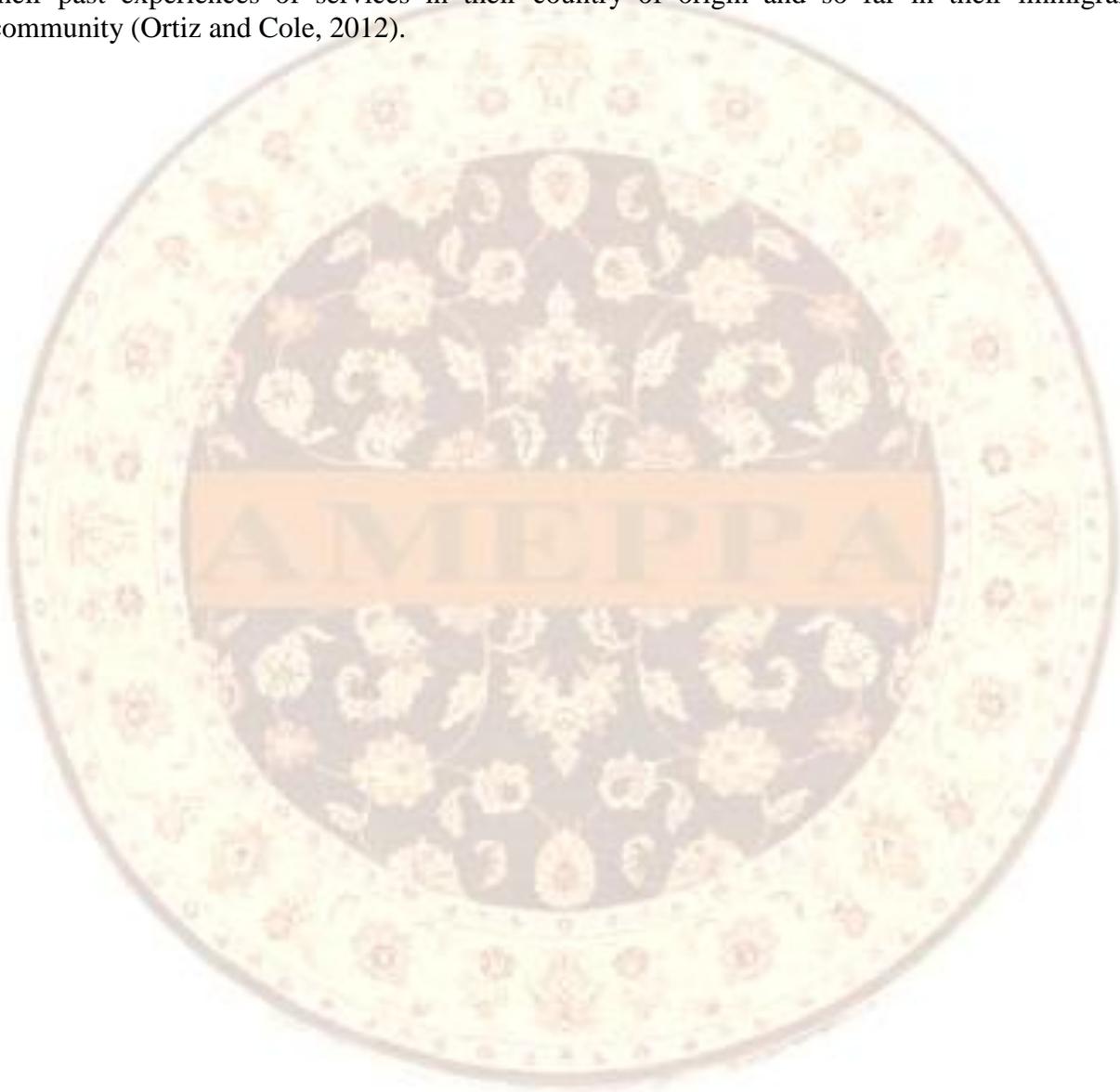
Making friends and living in a supportive community can affect the acculturation and health of an immigrant or refugee. Neighborhoods affect one's resources, and often immigrants/refugees reside in poorer neighborhoods which limit their mobility and access to resources, as well as exposing them to unhealthy environments such as low quality housing and high crime rates (Rote & Markides, 2014). Refugees and immigrants greatly underutilize social services (Chen, Jo, & Donnell, 2004), due to practical issues, such as lack of transportation, awareness of services, or language barriers (Murray, Davidson, & Schwietzer, 2010).

Elderly immigrants are more likely to require support from social networks and their small communities than the elderly who are native-born (Rote & Markides, 2014). Having a culturally sensitive program is important, as well as having a program where individuals can engage in cultural activities with others from their culture (Wangmo, 2011; Kang, Basham, & Kim, 2013; Miyawaki, 2013; Choi et al, 2015; Belt, 2015). Behnia (2003) conducted a qualitative study with 36 adult refugees regarding their experiences with social supports in Canada.

Results showed the importance of cultural sensitivity and language barriers in providing social services. Results also showed that participants reported satisfaction with support groups with other refugees to help them avoid isolation, have a place to be heard and understood, make connections with others, and learn about other community services. The Bhutanese elderly who participated in this study supports the literature review re: immigrant/migrant and refugee

population's acculturation stressors such as language barrier, social isolation, changes in family dynamic, lack of infrastructure of local transportation and lack of bilingual services.

Participants in this research suggested an increase number of bilingual (English & Nepali) citizenship classes and creating social activities such as arts & crafts and weaving classes. Their self-initiated service activities reinforce the value of the dynamic service model; services should be provided in the participant language and involve potential clients to express themselves about their past experiences of services in their country of origin and so far in their immigrant community (Ortiz and Cole, 2012).



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## Appendix 1

Demographics of Focus Group Participants: Bhutanese: (N=38, Male=25 Female=13)

Age	26-30	3	7.89%
	31-40	6	15.79%
	41-50	9	23.68%
	51-60	11	28.95%
	61 and over	9	23.68%
Marital Status	Single	4	10.52%
	Married	28	73.68%
	Living together	1	2.63%
	Separated	-	-
	Divorced	2	5.26%
Primary Language	Widowed	3	7.89%
	Nepali	37	97.37%
	Bilingual	1	2.63%
Religious Affiliation	Hindu	33	86.84%
	Buddhist	2	5.26%
	Christian	3	7.89%
Housing	Rent home	37	97.37%
	Rent apartment	-	-
	Own home	1	2.63%
Family Size		5.8	
Employment Status	Full-time	8	21.05%
	Part-time	1	2.63%
	Looking for work	11	28.95%
	Not looking for work	10	26.32%
	Retired	5	13.16%
	Unable to work	3	7.89%
Average years of living in the U.S		4.2	

## Appendix 2

The focus group interview questions:

- 1) How do you feel about your community and the neighborhood where you live?
- 2) How do you feel about your own health and physical condition?
- 3) How do you feel about the way you spend your time each day?
- 4) What would you want to do, if you had spare time?