Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-Based Participatory Research: A Study in 2 Communities

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Objectives. We sought to understand the problems, strengths, and help-seeking behaviors of Somali Bantu and Bhutanese refugees and determine local expressions of mental health problems among youths in both communities.

Methods. We used qualitative research methods to develop community needs assessments and identify local terms for child mental health problems among Somali Bantu and Bhutanese refugees in Greater Boston and Springfield, Massachusetts, between 2011 and 2014. A total of 56 Somali Bantu and 93 Bhutanese refugees participated in free list and key informant interviews.

Results. Financial and language barriers impeded the abilities of families to assist youths who were struggling academically and socially. Participants identified resources both within and outside the refugee community to help with these problems. Both communities identified areas of distress corresponding to Western concepts of conduct disorders, depression, and anxiety.

Conclusions. There are numerous challenges faced by Somali Bantu and Bhutanese youths, as well as strengths and resources that promote resilience. Future steps include using culturally informed methods for identifying those in need of services and developing community-based prevention programs. (*Am J Public Health.* 2015;105:S475–S482. doi:10.2105/AJPH.2014.302504)

There are disparities in the mental health of refugee children and adolescents resettled in the United States compared with youths in the general US population. For instance, the prevalence of posttraumatic stress disorder and depression among resettled refugee children is estimated to be as high as 54% and 30%,[1] respectively, compared with an estimated 5% (posttraumatic stress disorder) and 11% (depression) of youths with these disorders in the general population.[2] In addition to specific psychiatric disorders, refugee youths experience overall greater psychological distress than those in the general population.[3] Youths in the general US population are exposed to adverse events that elevate risk of mental disorders[4]; however, the refugee experience, including flight from country of origin, displacement in a refugee camp, and third country resettlement, increases risk of being exposed to multiple acute and chronic stressors that accumulate and lead to differential mental health outcomes.[4–6] In addition, children in the US population in general have poor access to and underutilization of mental health services, but the situation is exacerbated by refugee status and its associated acculturative and resettlement stressors.[7,8]

Our study makes an original contribution to understanding the experiences of individuals and families in 2 refugee groups—Somali Bantu and Nepali-origin Bhutanese. Historically perceived as slaves in Somalia, the Somali Bantu community escaped the 1991 civil war and fled their homes to nearby Kenyan refugee camps.[9–12] In 2003, approximately 12 000 Somali Bantu refugees arrived in the United States.[13] Ethnic-Nepali citizens of Bhutan were expelled from their country of origin in the early 1990s[14] and lived in refugee camps in Nepal for almost 20 years.[15] Roughly 75 000 Bhutanese refugees have relocated to the United States since 2008.

COMMUNITY-BASED PARTICIPATORY RESEARCH AND REFUGEES

Community-based participatory research (CBPR) is an approach to research that engages researchers and community members in an equitable partnership designed to deconstruct the power differentials that typically exist in academic–community relationships.[16,17] In such partnerships, community members are engaged in all aspects of the research process, beginning with identifying problems that need to be researched to disseminating results to various stakeholders.[18] With its emphasis on respecting and privileging local knowledge and cultural context,[17] CBPR is well suited for research on eliminating health disparities among marginalized groups.[17–23] However, there has been limited application of CBPR in the field of mental health,[24] particularly with refugees.[25,26] Given the culturally based stigma around mental health issues in many refugee communities, CBPR is a promising approach to studying refugee mental health.[3]

In 2004, the first author (T. S. B.) was contacted by a Boston, Massachusetts, area resettlement office requesting help with emotional and behavioral problems exhibited by Somali Bantu refugee children in nearby schools. Follow-on efforts included consulting with Somali Bantu refugee families and local mental health providers. At the same time, the Chelsea Collaborative, a community-based advocacy organization in the Boston area, and the Shanbaro Community Association, an

organization created and run by Somali Bantu refugees housed within the Chelsea Collaborative, identified the need for a more comprehensive assessment of psychosocial issues specific to the Somali Bantu population. A joint partnership between an academic institution and 2 community organizations offered the opportunity to blend mutual goals of gaining greater cross-cultural mental health knowledge and community service needs.

The partnership successfully completed a needs assessment of the Somali Bantu community in 2012 and was interested in expanding its work to Bhutanese refugees. All parties, including individuals from the Somali Bantu and Bhutanese refugee communities, were included in the grant-writing process to secure additional funding for these purposes. Somali Bantu and Bhutanese community advisory boards provide ongoing project consultation with the research team, ensuring that the project is beneficial to both partners and the larger refugee communities.

The 2-part aim of this study reflects the unique and mutual goals of the CBPR partnership: understand the problems, community strengths, and help-seeking behavior of Somali Bantu and Bhutanese refugees and, in addition, determine local expressions of emotional and behavioral problems.

METHODS

Somali Bantu and Bhutanese refugees living in the Greater Boston and Springfield, Massachusetts, area between 2011 and 2014 participated in the study. Eligibility criteria for youths included being (1) between the ages of 10 and 17 years and (2) a Somali Bantu or Bhutanese first-generation refugee born outside the United States. Among adults, eligibility criteria included being (1) a Somali Bantu or Bhutanese refugee parent or caregiver of a school-aged child or (2) a Somali Bantu or Bhutanese refugee recommended by others in the refugee community as someone who was knowledgeable about psychosocial challenges faced by refugee youths, regardless of parental or caregiver status. Both youths and adults had lived in the United States a minimum of 3 months. For free list (FL) interviews in the Bhutanese community, research assistants (RAs) from the refugee community created a comprehensive community family list that included names and contact information of individuals in each household, along with eligibility status. For Somali Bantu participants, the research manager, a community organizer within the Somali Bantu community, had knowledge of all families in the area and eligibility status. The research team enlisted the help of additional leaders in both communities to ensure that lists were comprehensive, both in terms of identifying families residing in the area and assessing their eligibility status. Eligible individuals and families were approached for study participation by RAs until recruitment goals were met. A total of 40 Somali Bantu and 62 Bhutanese refugees participated in FL interviews. Snowball sampling was used to identify individuals for key informant (KI) interviews. A total of 21 Somali Bantu and 40 Bhutanese refugees participated in KI interviews. The FL interviewees were eligible for KI interviews if they were identified by community members and RAs as being particularly knowledgeable about child mental health. Among the Bhutanese sample, 10 out of the 40 KI participants also participated in the FL exercise. In the Somali Bantu community, 5 out of the 21 KI participants participated in both interviews. Table 1 has study participant demographics.

Procedures

Researchers collected data in the 2 communities sequentially by using the same methodologies, starting with the Somali Bantu community and concluding with Bhutanese refugees. Within each community, FL exercises preceded KI interviews (see "Free Listing Exercise" and "Key Informant Interviews" for more detail). Confidentiality was explained in detail in Maay Maay (Somali Bantu), Nepali (Bhutanese), or English depending upon participant preference. Informed consent was obtained for all participants before being interviewed. Both parental consent and child assent were obtained for interviews of those younger than 18 years. Participants had the opportunity to ask questions and seek further information about the study with great precautions taken to protect participant identities. Participants were interviewed in their homes or another location that ensured confidentiality. All Somali Bantu study participants were compensated for their time with $20 in cash. Bhutanese participants were compensated the same way until community leaders suggested it was more culturally appropriate to provide compensation in the form of $20 gift cards.

We recruited Somali Bantu and Bhutanese RAs from the local refugee communities through advertising via community leaders and organizations, including resettlement agencies. We gave priority to applicants fluent in their native language as well as English, resulting in a research team comprising individuals with a wide range of educational and work histories. The principal investigator and project director trained the RAs in ethics, interviewing, and mixed-methods data collection. Staff collected data either individually or in pairs, depending upon their skill level gauged through quality checks of interview recordings. The data collection approach replicated methods used previously for the study of local mental health terminology in a range of cultures and is described in more detail in the following sections.[3,27] Interviews were conducted in Maay Maay, Nepali, or English, depending upon the choice of the interviewee. All interviews were recorded. The FL interviews were not transcribed but detailed notes were taken during the interview. Researchers took notes during KI interviews and then interviews were transcribed verbatim. Translation checking was done through team discussions in the presence of the research manager.

Free Listing Exercise

The purpose of FL interviews was to gain a broad understanding of the problems, strengths, and resources within each refugee community. The procedure for FL data collection included asking 3 overarching questions including: "What are the problems of Somali Bantu/Bhutanese children in this community?" Participants were asked to give as complete a list as possible and interviewers probed, asking for "anything more," until the listing exercise was finished.

The RAs then reviewed the list and obtained details, clarity, and contextual information on each FL item mentioned. Two follow-up questions were asked regarding what people in the community did, if anything, to help each other with such challenges and what people did to get help outside the immediate refugee community.

TABLE 1—Study Participant Demographics: Greater Boston and Springfield, MA, 2011–2014

Characteristics	Somali Bantu			Bhutanese		
	Youths, No. or Mean (Range)	Adults, No. or Mean (Range)	Total No. (%)	Youths, No. or Mean (Range)	Adults, No. or Mean (Range)	Total No. (%)
Free list						
Gender						
Female	10	10	20 (51)	15	16	31 (50)
Male	10	9	19 (49)	15	16	31 (50)
Age, y	14.0 (11.0–17.0)	37.9 (25.0–57.0)	. . .	13.5 (10.0–17.0)	35.0 (18.0–61.0)	. . .
Caste						
Upper				16	11	27 (43)
Middle				11	15	26 (42)
Lower				3	6	9 (15)
Time in United States, y	5.2 (1.0–7.0)	5.3 (2.0–7.0)	. . .	2.6 (0.3–6.0)	2.8 (0.3–6.0)	. . .
Key informant						
Gender						
Female	2	9	11 (52)	10	10	20 (50)
Male	. . .	10	10 (48)	10	10	20 (50)
Age, y	14.5 (14.0–15.0)	39.2 (17.0–64.0)	. . .	15.0 (10.0–17.0)	35.5 (24.0–50.0)	. . .
Caste						
Upper				9	7	16 (40)
Middle				5	10	15 (38)
Lower				6	3	9 (22)
Time in United States, y	5.5 (2.0–7.0)	5.5 (2.0–7.0)	. . .	3.2 (0.4–6.0)	2.6 (0.2–5.0)	. . .

Key Informant Interviews

The purpose of KI interviews was to gather more information about the mental health and behavioral problems of children identified in the FL exercise and identify mental health syndromes in the community. Research assistants grouped FL problems related to children's thoughts, feelings, and behaviors together based on culturally informed understanding of the relationships among these problems. For example, in the Somali Bantu community, behaviors such as "children fighting" and "children not listening to parents" were clustered together. Initial KI interviews asked for more information about these problems, probed for additional problems closely related to these indicators, and asked for local terms used to describe the entire cluster of problems. Once a cover term for these behavioral problems was identified, this term was then used in later interviews and further explored. Thus, KI interviews followed an iterative process.

Interviews were followed by a debriefing session with the research team and investigators, after which the interview guide was revised. Accordingly, the interviews became increasingly focused on a set of symptoms or indicators and resulting syndrome terms. Research assistants tracked the indicators identified for each cover term by every study participant. Interviews also probed on the nature of the problem, its causes, and any gender and age patterns among youths. Interviews lasted between 45 and 90 minutes.

Data Analysis

We analyzed the FL interviews by a simple tally of conceptually equivalent (per research team group discussion and majority decision) problems, resources, and help-seeking behavior identified by the community and arranged according to rank order of frequency. Researchers used the Fisher exact test[28] to assess for significant differences in responses between adults and youths. For the purposes of mental health syndrome development, we analyzed KI interviews by tallying indicators mentioned by study participants. We grouped conceptually equivalent indicators together. For instance, in the Bhutanese community, KIs mentioned the indicators "talks filthy words" and "talks using bad words" to describe a child with behavioral problems. The research team decided that these indicators were equivalent and combined them to create an umbrella indicator "uses bad language/words" that encompassed both of these phrases. We retained and included indicators endorsed by at least 10% of the total KI sample for each refugee community in the final list of indicators for each syndrome.

The refugee research team and academic collaborators worked as a group to generate appropriate English translations of syndromes and indicators. Subsequently, results were reviewed with members of the Somali Bantu and Bhutanese refugee communities via "member checks" with community advisory boards and focus groups to validate and clarify syndrome terms and their accompanying symptom descriptions.

RESULTS

The most frequently cited problems in the Somali Bantu community included not having enough money to pay for rent, food, clothes, and other bills (53%), followed by children losing their religious or moral education (40%) and needing assistance in completing homework (40%). Communication between parents and children was also a frequently identified problem, with parents and children not speaking the same language (25%). The Somali Bantu community's intergenerational language limitation was described as posing particular impediments to the rearing of children and developing a positive child–parent relationship (Table 2).

When asked what helped children with these kinds of problems, the Somali Bantu refugee community was frequently identified, with 33% of participants reporting community support as a major protective factor. Both youths and adults reported that school personnel and parents worked together to help children with their problems. Regarding outside resources, 20% of participants identified

TABLE 2—Problems and Protective Resources Among Somali Bantu and Bhutanese Refugees Living in the Greater Boston and Springfield, MA, Area Between 2011 and 2014

Variables	Youths, No. (%)	Adults, No. (%)	Total, No. (%)
Somali Bantu			
Problem			
Financial problems	10 (50)	11 (55)	21 (53)
Kids losing their religious education; no madrassa	10 (50)	6 (30)	16 (40)
Trouble with homework	7 (35)	9 (45)	16 (40)
Language difficulties for parents	8 (40)	6 (30)	14 (35)
Problems with housing	7 (35)	7 (35)	14 (35)
Children don't listen to parents, have bad friends	10 (50)	4 (20)	14 (35)
School work difficult; worried won't graduate	5 (25)	7 (35)	12 (30)
Need a job; lack of jobs; don't know how to get a job	5 (25)	5 (25)	10 (25)
Language difficulties for children	4 (20)	6 (30)	10 (25)
Young and old need education; no place to study	1 (5)	8 (40)	9 (23)
No one to watch kids or taking care of children	2 (10)	7 (35)	9 (23)
Protective resources			
Somali Bantu community organization or other local community organizations	6 (30)	10 (50)	16 (40)
Maay Maay translators	5 (25)	10 (50)	15 (38)
Somali Bantu community support and strength	9 (45)	4 (20)	13 (33)
Teachers, school counselor, principal, teacher–parent working together	5 (25)	5 (25)	10 (25)
Friends	1 (5)	9 (45)	10 (25)
Call others in the community with good English to translate and help with paperwork	7 (35)	2 (10)	9 (23)
Government benefits, welfare, food stamps, housing subsidies	2 (10)	6 (30)	8 (20)
Hospitals or doctors	3 (15)	4 (20)	7 (18)
After-school tutors and programs to help with homework or help children learn English	6 (30)	1 (5)	7 (18)
Talk to parents about what is happening and get help	5 (25)	2 (10)	7 (18)
Bhutanese			
Problem			
Language difficulties	24 (80)	27 (84)	51 (82)
Financial problems	8 (27)	13 (41)	21 (34)
Bullying or teasing	12 (40)	6 (19)	18 (29)
Difficulty with homework	9 (30)	6 (19)	15 (24)
Distance to school or no school bus	7 (23)	7 (22)	14 (23)
Lack of friends	4 (13)	7 (21)	11 (18)
Fighting	6 (20)	4 (13)	10 (16)
Fear or scared	7 (23)	3 (9)	10 (16)
Loneliness	3 (10)	5 (16)	8 (13)
Depressed or sad	3 (10)	5 (16)	8 (13)
Protective resources			
Bhutanese community members	13 (43)	15 (47)	28 (45)
Parents or family–advise children, help with school work	13 (44)	12 (38)	28 (45)
Refugee or immigrant service organizations	10 (34)	13 (41)	23 (37)
Government programs–SSI, EBT, MassHealth	5 (17)	12 (38)	17 (27)
Friends–play with friends, share problems, help with homework	13 (44)	4 (13)	17 (27)
Relatives–financial help, help with homework, mediate conflicts	11 (37)	5 (16)	16 (26)
Neighbors–help with homework, financial help, give advice	4 (13)	8 (25)	12 (20)
Teachers–help with studies, language, resolve fights, encourage	4 (13)	5 (16)	9 (15)
Local hospital	6 (20)	2 (6)	8 (13)
Interpreters	. . .	5 (16)	5 (8)

Note. EBT = electronic benefit transfer; SSI = Supplemental Security Income.

government facilities and welfare services such as food stamps as helpful (Table 2). No statistically significant differences were observed between adult and youth responses.

Bhutanese Free List Exercise

The most frequently cited problems were related to language barriers (83%), including parents and children being unable to communicate with teachers and other school personnel. Similar to Somali Bantu refugees, not having enough money for food and rent was a commonly identified problem (39%), as was children struggling to complete their homework (24%). Fighting, loneliness, depression, and being scared were the most frequently reported behavioral and emotional issues faced by Bhutanese youths (Table 2).

The Bhutanese refugee community was identified as a major source of support to cope with these challenges (45%), with families, relatives, and friends providing financial help and assisting children with homework. In terms of resources outside of the Bhutanese community, participants frequently mentioned social services and welfare programs (Table 2). We observed no statistically significant differences between adult and youth responses.

Somali Bantu Key Informant Interviews

Participants identified 4 domains of mental health problems (Table 3). *Aasiwaalidin* was a commonly reported syndrome used to describe young people who were disrespectful to their parents and other elders, easily angered, disobedient, disinterested in engaging with work or education, participating in fights or bullying, and a range of other high-risk behaviors. A male participant younger than 18 years described

> When your parents tell you something and you're not listening, when they asked you to do something, you don't do it. . . . And then if your mother talk to you, and she say "don't go with these guys, they're bad." And you don't pay attention; you just go wherever you want.

Aasiwaalidin was described as occurring in both boys and girls, and more likely to develop in adolescence.

Participants used the term *wel wel* to describe children who worried. Children with *wel wel* were thought to exhibit fear about the future and worry about current life stressors. Many of

TABLE 3—Somali Bantu Local Mental Health Syndrome Terms and Descriptors

Syndrome Term	Descriptor	
	Maay Maay	English
Aasiwaalidin (conduct problems)	*Sharaf laawe*	Disrespectful
	Edeb laan	Lack of "asluup" (respect)
	Dherif	Easily angered
	Makoroof	Disagrees, argues, talks back to parents
	Karawai	Does not obey parents
	Ded-mekaalmeyay	Does not assist others
	Rabshoole	Has conflict with peers
	Dhega adeeg	Poor follow through
	Dantiis gorod	Self-centered
	Shaqa diid/Hool beel	Does not like to work; does not engage with education
	Mas'uul dare	Does not take responsibility for actions
	Kerway	"Making trouble" or bullying other children
	Gardaresti	Engages in fighting
	Daroogiste	Engages in negative behaviors (e.g,. drinking alcohol, gambling, joining gangs)
Wel wel (worry)	*Was was*	Worries about current and future life stressors
	Absi	Fear
	Fulemimo	Overly scared about things
	Dhug-la'aan	Poor attention
	Damiin	Forgetful
	Siseeg	Poor follow through
	Tiirman	Engages in quiet, isolative behavior
	Is shuujin	Weight loss
	Mathy dhuury	Headaches
	Indhu-dhuuru	Visual disturbances
Dherif (anger)	*Amal*	Quick to anger
	Murug	Feel as though they are under pressure
	Amal low	Easily upset by small issues
	Kifle	Defensive (get angry when you joke with them)
	Kerway	"Making trouble"
	Isfilit	Anger without reason
	Hanaang	Anger
Takoor (persistent sadness)	*Takoor*	Sadness
	Ma'abos	Low mood, always unhappy
	Tiire/joogow maqane	Being absent; your mind is elsewhere; not paying attention
	Shaleen daak	Not comfortable with friends
	Qurb rabshoole	Thinking too much about their problems (rumination)
	Rabshoole	Difficulty getting along with others
	Damiin	Difficulty learning

the reported symptoms are similar to Western diagnoses of anxiety disorders in children, and include inattention, forgetfulness, social withdrawal, weight loss, and somatic complaints. A male adult described a child with *wel wel* as "He is worried, worried all the time. . . . He is worried because he has a problem that he can't solve by himself."

A third syndrome, termed *dhirif/isfilit*, highlighted symptoms of persistent anger. Children with *dhirif* were thought to be defensive, quick to respond with anger, feeling as though they are under pressure, and easily upset by small issues. Whereas *dherif* explained general anger, *isfilit* characterized people who are always angry, are quick to anger, and show aggressive behavior. One female youth stated that *isfilit* youth "always do whatever they get in their minds."

The final syndrome described by participants was *takoor*, indicating persistent sadness. *Takoor* is characterized by sustained low mood, cognitive rumination, and difficulty engaging in social and educational settings. A female adult participant suggested "Some children, they're not happy all the time and we call them sometimes *wajmaabuus* ['gloomy-faced']. They don't talk a lot. They're always quiet." This syndrome was reported to affect both male and female children of all ages.

Bhutanese Key Informant Interviews

We identified 3 main domains of common mental health problems among Bhutanese study participants (Table 4). *Badmaas* is a syndrome similar to *aasiwaalidin* in Somali Bantu culture, and is characterized by conduct-related problems and maladaptive behavior. Participants described a *badmaas* child as being angry, bullying others, and getting involved in fights. Interviewees identified a *badmaas* child as someone who is arrogant, uses bad language, and disobeys parents, teachers, and elders. A male youth participant stated "[children who are *badmaas*] have negative thoughts about everything." Most participants identified more boys being *badmaas* than girls.

Dookhit was used to describe children who were persistently sad and whose "mind hurts." Similar to the Somali Bantu syndrome *takoor*, a *dookhit* child was someone with persistent feelings of loneliness. An adult female participant stated that with a *dookhit* child, "their 'heart–mind' may have been hurt," referring

TABLE 4—Bhutanese Local Mental Health Syndrome Terms and Descriptors

Syndrome Term	Descriptor	
	Nepali	English
Badmaas	*Naterne*	Disobedient
(conduct problems)	*Jjhagadama saamel hune*	Involved in fighting (fights, quarrels)
	Naramro bhasa/sabda bolne	Use bad language, words
	Lagu padarthako sewan	Use of addictive substances
	Dada-giri/chot (puryaune)	Bullying, wound verbally
	Fatah	Scoundrel, delinquent (vandalism, disobedient)
	Rish/rishaune	Anger, angry
	School ma aniyamit	Irregular school attendance
	Arulai kutne	Beats others
	Jharkine	Irritable
	Rakshi khane/piune	Drinks alcohol
	Churot/ganja khane	Smoking
	Ghamanda	Arrogant
	Awara	Roams aimlessly
	Padhaima kamjor	Weak in studies
	(Aruko)ijjat nagarne	Lack of respect (for others)
Chinteet (worry)	*Chintajanak/chinta*	Worry
	Rish	Anger
	Khulera nabolne	Does not talk openly
	Darr	Afraid
	Traseet	Scared
	Ekohorine	Fixates
	Aatmahatyako soch rakhne/ aafailai hani puryaune	Keeps suicidal thoughts; poses harm to oneself
	Dookhit	Sad
Dookhit	*Dukhi/dookhit*	Sad
(persistent sadness)	*Jharkine/bolna jharko manne*	Irritable
	Eklopan	Loneliness
	Ekohorine/tolaune	Fixate (rumination)
	Dherai nabolne	Someone who does not talk much
	Alaggiyeko	Isolated
	Mann dukhchha	Mind-hurts
	Aatmahatyako soch	Suicidal thoughts
	Padhaima kamjor	Weak in studies

to an ethnic Nepali Bhutanese manner of viewing emotion. A *dookhit* child was described as ruminating on things, not talking, and possessing suicidal thoughts. Female children were reported to be more prone to being *dookhit*.

A *chinteet* child was identified as someone who worried a lot, feared for the future, and was persistently concerned about things indicating features similar to the anxiety-related problem in the Somali Bantu culture of *wel wel*. An adult male said in describing a *chinteet* child, "they are worried also because of the newness [of life in America] . . . there's loneliness, which eventually will accumulate pressure," indicating that *chinta* could lead to worse problems.

DISCUSSION

Both Somali Bantu and Bhutanese refugee communities identified an overwhelming concern related to economic hardship as well as acculturative stressors. Refugees leveraged support from within their communities to deal with these problems and identified health care facilities, government assistance programs, and school personnel as resources they relied on for assistance. More in-depth assessment of emotional and behavioral problems of youths led to the identification of 4 mental health syndromes and 3 mental health syndromes in the Somali Bantu and Bhutanese communities, respectively.

A key feature of CBPR is the dissemination of study results back into the community. Thus far, FL data have been shared with area Somali Bantu and Bhutanese refugee organizations and local health care providers, presented at town hall meetings, and distributed to local school districts for advocacy purposes. Future plans include generating strategies to integrate local conceptualizations of emotional distress into the daily work of mental health providers, including screening and diagnosis.

Both *aasiwaalidin* and *badmaas* share symptom similarities with *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)* criteria for oppositional defiant disorder, intermittent explosive disorder, and conduct disorder.[29] The oppositional defiant disorder subtype of argumentative and defiant behavior might be particularly relevant and, depending upon the extent to which an individual lacks empathy and guilt, conduct disorder specified with limited prosocial emotions might be appropriate.[29] Children with *wel wel* and *chinteet* exhibited symptoms similar to what might be captured by generalized anxiety disorder.[29] *Takoor* and *dookhit* reflect Western conceptualizations of depression, captured in the *DSM-V* diagnostic categories of major depressive disorder and the newly created persistent depressive disorder, inclusive of both chronic major depression and what was previously called dysthymia.[27] The Somali Bantu syndrome of *dherif* may correspond best with the new *DSM-V* diagnostic category of disruptive mood dysregulation disorder.[27]

These results are part of an ongoing program of work to develop mental health screening tools and intervention models to promote better mental health among diverse groups of refugee children and adolescents. Free list and KI data are informing the modification of an evidence-based family strengthening

intervention that has been used previously with culturally diverse populations[30,31] to meet the unique needs of refugees. Adaptations may include the addition of psychoeducational materials on resettlement stressors as well as intervention components that address the relationship between the challenges of resettlement, positive parenting, and child mental health and resilience.

Limitations

Several limitations should be considered when one is interpreting the results. The sample was purposive, and findings may not generalize to other resettled Somali Bantu and Bhutanese refugee groups. Also, the initial syndrome terms identified here are not definitive of the range of mental health problems that are likely to exist among children and adolescents in these refugee populations. Despite these limitations, these findings are a significant contribution to understanding the mental health problems of refugee youths.

There are more than 10 000 Somali Bantu refugees in the United States,[32] with only a small amount of research having been conducted on Somali Bantu youths[33,34] or mental health in general,[35] and no literature specific to the mental health needs of Somali Bantu children and youths. Literature on Bhutanese refugees in the United States is equally limited, with only a few studies published on mental health,[36–40] none of which focus on the unique needs of youths. This is particularly concerning in light of recent figures indicating high rates of suicide among Bhutanese refugees in the United States and the fact that more than 75 000 Bhutanese refugees have relocated to the United States in the past 5 years.[41]

Conclusions

Community-based participatory research methods can be used to understand problems faced by refugee families and children resettled in the United States and can provide language and insights critical to fostering awareness-raising in communities and promoting engagement in preventive and treatment services. In addition to numerous risks, our findings highlight protective resources in refugee communities that can help to promote resilience and can provide a foundation for strengths-based interventions. The qualitatively driven CBPR approach presented here is one promising approach for addressing the mental health disparities facing refugee children and adolescents. ■

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T. S. Betancourt is the study principal investigator and designed the study, led data collection and analysis, and wrote the article. R. Frounfelker and T. Mishra assisted in data collection and analysis and writing of the article. A. Hussein supervised data collection in the refugee communities, provided oversight of study personnel, and assisted with writing of the article. R. Falzarano liaised with refugee communities, provided oversight of study personnel, and assisted with writing of the article.

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Human Participant Protection

Study protocol and methods were reviewed and approved by the Harvard T. H. Chan School of Public Health institutional review board.

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