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SEEKING LIFE BALANCE: THE PERCEPTIONS OF HEALTH OF
CAMBODIAN WOMEN IN RESETTLEMENT

by

Olivia Catolico, MSN

A dissertation proposal presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
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In partial fulfillment of the
requirements for the degree
DOCTOR OF PHILOSOPHY IN NURSING

Dissertation Committee

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ABSTRACT

This grounded theory study was an inquiry into the perceptions of health of Cambodian women in resettlement and the conditions that influenced their perceptions. Few studies of Cambodian women who escaped political conflict exist. Cambodian women were among the waves of Southeast Asian refugees who have resettled in the United States. The sequelae of significant life trauma upon the health of Cambodian women in resettlement have received little attention in the nursing literature. There is less information about their perceptions of health in resettlement as their beliefs about health and illness causation contrast with those of Western health care providers.

Thirty-nine Cambodian women, whose ages ranged from 19-80 years, participated in this study. The women were recruited through a social service organization, community contacts, and verbal referrals. Ninety percent of the women were Buddhist. Forty-six percent of the women were widowed. Among the participants, 52% arrived in the U.S. between 1979 and 1981, 20% arrived between 1982 and 1988, and 28% arrived between 1992 and 1999. A semi-structured interview guide of open-ended questions and a conversational approach to dialogue and data gathering facilitated the interview process. The researcher worked closely with one proficient translator for the duration of interviews in this study. The women were interviewed in their homes, at the social service agency, or at the local Buddhist temple.

Seeking Life Balance emerged as the core perspective of this study. Major thematic categories which supported this core perspective were Emerging from Chaos,

Patterns of Knowing, Caring for Oneself, and Reaching a Turning Point. The relationships between seeking life balance, patterns of knowing, and caring for self are important ones and must be supported in resettlement. These relationships ultimately result in consequences of Disharmony or Harmony. The perceptions of health of Cambodian women in this study are wholistic ones that have been forged by their experiences and life processes. The knowledge generated from this study will further health-related research about refugee women in resettlement and will contribute to theory building linkages that are largely absent from current nursing research.

DEDICATION

This work is dedicated to my son, Jonathan V. Catolico; to my parents, Concepcion and Agapito Catolico; to women of the world who seek harmony and goodness out of their life struggles; and to peace.

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In reality, one's achievement is the result of synergy and the interdependent efforts of many. There are indeed many, who in some way, have helped me complete this journey. However, I would like to acknowledge and thank very important persons whose commitment, expertise, and gifts, have helped me bring this work to fruition:

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TABLE OF CONTENTS

Chapter One: Focus of the Study.....	1
Background of the Study.....	3
Lines of Inquiry.....	8
Philosophic Underpinnings of the Study.....	8
Significance of the Study	10
Chapter Two: Review of Literature.....	14
Context of the Study.....	14
Historical, Sociocultural, and Contemporary Context	14
Origins of the Khmer Worldview	15
Yin-yang theory	15
Hindu influence on Khmer worldview.	18
Buddhist influence on Khmer worldview	19
The Role of Women in Cambodian Society	21
Sociopolitical and Historical Events Leading to Migration.....	26
Pre-1975 Migration	27
Migration: The ‘Wet Monsoon Killing Time’	28
Refugees and Asylum Seekers	32
Physical and Psychosocial Health of Displaced and Refugee Women in Pol Pot Times	33
Repatriation and Resettlement	35
Repatriation.....	36
Resettlement.....	38
Refugee Health.....	42
The Trauma Experience and Mental Health Sequelae.....	43

Migration and Internment	43
Severance of family ties.....	44
Torture.....	45
Resettlement and Post Traumatic Stress Disorder (PTSD).....	45
The Double Burden for Refugee Women: Ill Health and Cultural Socialization.....	53
Human Rights Violations.....	55
The Impact of Socioeconomic and Sociopolitical Infrastructure Upon the Health of Refugee Women.....	57
Conceptual and Methodological Issues in the Conduct of Research with Refugee Populations.....	59
Conceptual Issues.....	59
Perspectives on health and well-being.....	59
Marginalization of Cambodian women in the context of Western society.....	62
Invisibility of Cambodian women in the host culture.....	63
Invisibility of the health concerns of Cambodian women.	64
Alienation from health care services.....	65
Invisibility of immigrant and refugee women in research.	67
Methodological Issues.....	68
Instrumentation.	70
Entre and data collection.....	72
Recruitment and informed consent.	73
The Paradigm of Health-Illness and Its Relevance for Women in Resettlement	75
Synthesis and Critique.....	79
Chapter Three: Methodology	84

Grounded Theory Methodology.....	84
Data Collection.....	87
Recruitment.....	88
Setting	91
Participants.....	93
Translator Selection and Utilization	96
Interview Guide.....	97
Ethical Considerations.....	99
Informed Consent.....	100
Confidentiality, Anonymity, and Privacy of Data	102
Subject Risks and Benefits.....	103
Pilot Study.....	104
Data Analysis	105
Trustworthiness and Verifiability of Data.....	107
Reflexivity Issues Related to this Grounded Theory Study	111
Setting Aside a Personal Paradigm of Nursing and Health Care	111
Resolution of Gender Issues between Researcher and Translator	112
Attending to the Interview Process	113
Gaining Entree to the Community of Interest.....	114
Immersion in the Culture	115
Chapter Four: Findings.....	118
Core Perspective: Seeking Life Balance	118
Achieving Spiritual Fulfillment	120
The practice of Buddhism.....	120
Seeking spiritual refuge.	121

Exploring other spiritual perspectives in resettlement.....	123
Re-establishing Kinship	125
Wanting togetherness.....	127
Seeking out other survivors.	128
Engaging in Meaningful Work	129
Supporting Themes of the Core Perspective of Seeking Life Balance	131
Emerging from Chaos: The Context for Seeking Life Balance	131
Suffering.....	132
Loss.....	136
Leaving behind.....	141
Coming Here	142
Experiencing Challenges and Disillusionment in Resettlement	145
Work.	146
Family life.....	149
Patterns of Knowing: Conditions for Seeking Life Balance	152
Indigenous Knowing	153
Illness causation and illness prevention.....	154
Curative interventions.....	155
Indigenous knowing and the post-natal period.....	157
Informed Knowing.....	160
Forming Personal Ways of Knowing.....	163
Caring for Oneself: A Process of Seeking Life Balance	168
Identifying Imbalance: Min Srool.....	169
Self-care Strategies.....	171
Following tradition.....	171

Integrating options: “Half and half.”	175
Self reliance: “Knowing myself.”	177
Care Seeking from Others: A Process of Seeking Life Balance	181
Asking for Advice	181
Transacting Care through Others	184
Seeking out cultural preferences for care.....	185
Seeking out gender preferences for care.	186
Getting Access	187
Resorting to Western Medicine.....	187
Reaching a Turning Point: The Consequences of Seeking Life Balance.....	189
Disharmony.....	189
Harmony.....	192
A Theoretical Model of Seeking Life Balance.....	197
Chapter Five: Discussion of Findings	205
Seeking Life Balance and Other Relevant Theories and Models.....	206
Seeking Life Balance: Current Evidence for its Importance and Relationship to Health.....	217
Emerging from Chaos	219
Patterns of Knowing.....	221
Caring for Oneself.....	223
Reaching a Turning Point.....	227
Chapter Six: Critique and Implications of the Study.....	229
Critique of the Study	230
Acquiring Entre.....	230
Language and Communication	231
Consideration of Ethical Issues in the Study Design	233

Limitations of an Etic Persepective.....	233
Implications for Further Research.....	234
Development of a Theoretical Model	234
Future Studies of Health Perspectives of Cambodian Women in Resettlement.....	235
Exploration of Indigenous Perspectives of Health and Self-Care.....	238
Instrument Development.....	240
References	242
Appendices	277
Appendix A	278
Demographic Questionnaire.....	278
Appendix B	282
Interview Guides	282
Appendix C	287
Recruitment Brochure	287
Appendix D	291
Public Service Announcement.....	291
Appendix E.....	295
Appointment Reminder.....	295
Appendix F	299
Backtranslation Schematic	299
Appendix G	301
Consent Form.....	301
Appendix H	311
IRB Approval.....	311
Appendix I.....	315

Analysis Matrix.....	315
Appendix J.....	320
Copyright Clearance.....	320

LIST OF TABLES

Table 1. Sample Composition by Age*, Marital Status, Religion, Education, Year of Arrival, Employment, and Family Composition (N = 39)	95
Table 2. Major Themes and Subthemes that Emerged from Interview Data	119

LIST OF FIGURES

Figure 1. Traditional Yin-yang Symbol	16
Figure 2. A Theoretical Model of Seeking Life Balance	202

Chapter One

Focus of the Study

Global events of the last two decades resulting in sociopolitical conflict have generated waves of Southeast Asian refugees to the United States. Cambodian refugee women were among the waves of Southeast Asian refugees who have resettled in the United States. Many fled Cambodia as refugees to escape political conflict, which peaked during 1975-1979. This period was dubbed by Cambodians as “Pol Pot” times, named after the military figurehead of the Khmer Rouge army who ordered the devastation of his own people. Broad estimates of deaths at this time have ranged from 3.5 to 5 million. More precise estimates of mortality due to violence, execution, and deterioration of living conditions between 1970 to 1979 ranged from 2.2 to 2.8 million deaths, and 1.5 to 2.0 million deaths in 1975 to 1978 alone. These estimates illustrate the massive devastation experienced by the Cambodian people in view of the fact that the pre-war population of Cambodia in 1962 was 5.7 million (Heuveline, 1998).

Many Cambodian women are in poor health or at risk for diminished health and well-being (Jacobsen, 1992; E. Roed, personal communication, May 12, 1999). They suffered tremendous strain and chronic health problems as victims under the reign of Pol Pot. In an impoverished socioeconomic infrastructure ruined by decades of political conflict, women in Cambodia had little or no access to health care during the Pol Pot era. Their health status has been influenced by situational factors and

prolonged deprivation of basic human needs, which have exposed them to even greater risk for poor health.

Thirty years have passed since Pol Pot's era, and since then many Cambodians have migrated to the United States. Cambodian women have endured many hardships and traumatic life experiences. Their pain, suffering, and losses cannot be forgotten. However, despite years of resettlement in the United States, many Cambodians who initially arrived as refugees, continue to experience poor health and socioeconomic hardship (Asian Pacific American Legal Center of Southern California [APALC], 2005). Cambodian refugee women who have resettled in the United States from a subsistence economy have faced tremendous life burdens, such as poverty and lack of resources. Cultural barriers of language, health beliefs, limited access to health care, including the high costs of care, have an impact upon their health status. The fact that many Cambodians have been ill equipped for urban life characteristic of many resettlement communities presents another barrier. There has been little focus on health care needs and well-being of Cambodian women, even with the surge of literature about Southeast Asians in the last decade.

There is little information on the long-term sequelae of migrational experiences upon the health of Cambodian refugee women in resettlement. There is less information about their health perceptions in resettlement. The language and belief systems of Cambodians contrast with those of Western health care providers. These differences may create problems in diagnosis and treatment. The literature provides evidence that Southeast Asian refugees often seek health care attention for trauma-related symptoms through outpatient settings. The notion of "saving face" as a

cultural norm is preferable to the admission of illness. The presentation of vague and non-specific symptoms may be ignored or dismissed, without in-depth probing of what this symptomatology means to the Cambodian refugee. Symptoms may be indicative of underlying physiological disorders for which treatment is sought. On the other hand, symptoms may be indicative of depression or anxiety. Expressions of worry, sadness, or unhappiness may describe these underlying problems (Mollica, 2004; Summerfield, 2000). These simplistic terms, which provide cues to greater suffering and distress, should not be overlooked or dismissed.

Cambodian refugee women in resettlement have needs for health teaching and promotion, which may enable them to become more self-sufficient, benefiting themselves and their families. However, this cannot be accomplished successfully unless there is an understanding of what 'health' means to Cambodian refugee women in resettlement. This study focuses on understanding this phenomenon in Cambodian women. A much needed research emphasis on Cambodian refugee women may identify specific health care needs unique to their situation.

Background of the Study

Southeast Asians have comprised the greatest percentage of groups who have migrated to the United States since 1965 (U.S. Department of Health & Human Services [USDHHS], 2001). The United States Department of Health and Human Services has accounted for 645,266 Southeast Asian refugee arrivals since 1983. California accounts for 62% (411,566) of Southeast Asian refugee arrivals, followed by New York and Florida.

Survey information about Cambodians, as a specific ethnic group with distinct values and beliefs, is often aggregated under the “Asian or Pacific Islander” (API) categories. The category of “Asian or Pacific Islander” used in the 1990 census was changed to two distinct categories of “Asian” and “Native Hawaiian or Other Pacific Islander” in the 2000 census (United States Census Bureau, 2003, p. 4). However, even with this delineation in the 2000 census, data for subsequent years pertaining to population, vital statistics, health, and education are still reported using the previous category of “Asian or Pacific Islander” (United States Census Bureau, 2003). Aggregate data from survey information misrepresents or overlooks the uniqueness and needs of specific groups such as Cambodians.

According to the U.S. Department of Commerce, in 1990, there were approximately 147,411 Cambodians residing in the United States, with 46% residing in the state of California (Hein, 1995). At that time, approximately 60,000 Cambodians had resettled in Southern California, notably Orange and Los Angeles Counties (Martin & Widgren, 1996). The 2000 census has accounted for a total of 171,937 Cambodians in the United States (Barnes & Bennett, 2002).

Initial groups of Southeast Asians entering the United States had formal education and financial resources to facilitate the resettlement process. This earlier group starkly contrasts with Southeast Asian refugees of later years. Later refugees have been poorer and less educated. In California, Cambodians are among the Southeast Asian groups who have a high rate of poverty. Forty percent of Cambodians in the state live below the federal poverty line. When adjustments for regional differences in costs of living are factored in, 67% of Cambodians in California live

below the federal poverty line. The median household income for Cambodians in California is \$27,488.00, with a per capita income of \$8,493.00. Cambodians are also among the Southeast Asian groups who have high rates of public assistance in the state. Thirty seven percent of Cambodians in the state receive public assistance. Forty seven percent of Cambodians in California have less than a high school degree, and 56% have limited English proficiency (APALC, 2005). In Orange County alone, 45% of the total Asian population is limited in English proficiency. Orange County rates the highest among the seven counties in Southern California where the Asian population are limited in English proficiency. Forty percent of Asian households in Santa Ana city alone are linguistically isolated. Relevant to this study is the fact that out of the total Asian population (2,391,843) living in Southern California counties, 17% have no health insurance. The rate of uninsured Cambodians in Southern California is higher at 20% (APALC, 2005). Limited English proficiency, absence of marketable skills, and different cultural practices are socioeconomic barriers that hamper refugee resettlement in U.S. communities (Aday, 2001; T. Chen, personal communication, February 7, 1997; Leao, 1996).

One assumption found in the literature is that refugees in resettlement are generally incapable of self-reliance and decision-making in the determination of their health affairs and other aspects of their lives (Gerber, 1994; Catolico, 1997). This assumption may reinforce a public perception that refugees themselves are the source of problems, not the inability of health care providers or inadequacies in the delivery system (Bun & Christie, 1995).

Prior studies of Cambodian refugee populations have not been guided by theory or conceptual models. The focus of health care literature has been the emotional trauma endured by this refugee group. Empirical studies have tended to impose a Western biomedical framework upon symptom management for Cambodian clients without attention to underlying belief systems. Also, health care systems often report utilization rates of services offered and procedures performed. This emphasis may ignore health issues and health maintenance of people in resettlement. This emphasis is also provider-driven rather than community-driven. An example of this emphasis is reported numbers and ethnicity of people who have obtained or received health services, instead of the perceived concerns for which people in resettlement seek care in the first place. The effectiveness of ongoing follow-up care has not been emphasized. Short-term relief needs and post-traumatic stress disorder (PTSD) have been the focal points of research with refugee populations over the last two decades. Other studies with refugee populations have concentrated on acculturation patterns and adoption of host values and behaviors. The research focus on mental health and psychiatric illness among Cambodian refugees in the United States has ignored a needed focus on durable solutions and long term health promotion and health maintenance issues, which confront refugees in their communities of resettlement (Aday, 2001; T. Chen, personal communication, February 7, 1996).

The world community has acknowledged the health care needs of these Southeast Asian refugee women through United Nations (UN) initiatives. However, repeated emphasis upon these initiatives at subsequent UN Assembly meetings calls attention to the fact that there is much work to be accomplished in this area (United

Nations General Assembly, 1988; 1990; 1991; 1992; 1993). The World Conference on Women (United Nations, 1995) and its follow-up conference, Beijing+5 Process and Beyond (United Nations General Assembly, 2000; Women Watch, 2000), generated initiatives to improve women's health through multiple social, economic, and political pathways. These initiatives support the idea that health is a dynamic multidimensional concept. It is important to identify conceptions of health and influences on these conceptions from the worldview perspective of refugee women in resettlement. At a broader level, these conceptions influence nursing care and future nursing research.

Member nations participating in the women's conference, Beijing+5 Process and Beyond, reported major obstacles to the implementation of the women's health initiatives. These were (a) limited educational opportunities for women and girls, (b) violence and discriminatory practices against women and girls, (c) lack of protection of women and girls from rape in situations of armed conflict, (d) poverty, and (e) the absence of gender-disaggregated data needed for policy decisions (United Nations General Assembly, 2000; Women Watch, 2000).

The struggle for survival remains a vital issue for Cambodian women. The health sequelae of significant life trauma have received little attention in the nursing literature. Inquiry into factors that strengthen their capacity for maintaining health in communities of resettlement is lacking. The yardstick used to measure progress toward health goals does not consider their perceptions of what constitutes health, nor have changes in perceptions about health over time been addressed.

In short, the health of Cambodian refugee women in resettlement is a neglected concern. This concern has been addressed through a Western biomedical framework

of health. In essence, the voices of Cambodian refugee women and ideas of health that matter to them have been largely excluded from mainstream health care. They have been marginal to a health care framework, where they should perhaps form the very center. Cambodian women in resettlement may not share the same paradigm of health as members of the host culture. Their perspectives on what health means to them and those things that influence this health paradigm in resettlement are vital ideas, but unfortunately, largely absent from previous research studies and current literature. Mainstream interventions or solutions to health problems of Cambodian women may be well-intended, but presumptive.

Lines of Inquiry

The primary purpose of this study was to define health from the perspective of Cambodian women in the context of resettlement and to identify the conditions or circumstances that influence their perceptions of health. The lines of inquiry for this grounded theory study were: (a) what were the perceptions of health of Cambodian women in resettlement? and (b) what changes in their perceptions of health have occurred since resettlement?

Philosophic Underpinnings of the Study

The paradigm of grounded theory is based on symbolic interactionism or shared meanings, in which people in particular social contexts contribute to the construction of theory. Symbolic interactionism (SI) has its roots in sociology. Early protagonists of symbolic interactionism were Mead in the 1930's and Blummer in the late 1960's (Schwandt, 1994; Spradley, 1979). People act or respond to situations, circumstances, and things in view of shared meaning and interpretation of purposive

behavior. Key assumptions of symbolic interactionism are that: (a) people act on the basis of ascribed meanings, (b) shared meaning comes from interaction with others in the social context of culture, and (c) meanings are modified through encounters with people, things, and situations (Spradley, 1979). Behavior is then a symbolic act understood by other members of the culture (Adler & Adler, 1994; Atkinson & Hammersley, 1994; Schwandt, 1994).

In grounded theory methodology, the researcher interacts with participants to develop shared meanings. In this type of qualitative research, participants' values affect interaction with others. Personal voices of the participants are a key aspect of grounded theory. One anticipates variations in data that reflect the complexity of experiences and perceptions. This methodology is an inductive process, which is verified by categorical coding, context, patterns, and simultaneous factors. The construction of theory using this methodology will yield substantive information, which reflects the personal voices of Cambodian women in resettlement and relationships, patterns, and processes concerning their health. These relationships and processes will lead to the development of a conditional matrix (Glaser & Strauss, 1967; Strauss, 1987). Grounded theory, or theory generated from data, involves comparative analysis of emerging conceptual categories and properties. This inductive approach simultaneously studies both process and action through the interrelationship of evolving conceptual categories (Glaser & Strauss, 1967; Strauss & Corbin, 1998, 1994).

The research questions posed for this study, which are process questions related to experience over time, were consistent with this paradigm. Grounded theory

is appropriate for this study, because it is a theory building approach to understanding of the health issues of Cambodian women and will contribute to future nursing knowledge and research efforts. This method differs from other qualitative approaches (phenomenology, ethnography, ethnomethodology, and case study) in its emphasis on theory development. This method closes the knowledge gaps of empirical research and is a systematic way of conceptualizing data. Ultimately, generation of theory from relationships, patterns, and domains that evolved from this inquiry will assist nurses in the delivery of culturally sensitive and appropriate health care to Cambodian refugee women in resettlement.

Significance of the Study

As changing sociodemographics reflect an increasingly multicultural and pluralistic populace, nursing faces the challenge of providing culturally sensitive and appropriate care to specific ethnic groups. Given this challenge, it is imperative that nursing redefine and reevaluate its practice and the social context in which it occurs (American Nurses Association, 2003). The presence of Cambodians, one group of Southeast Asian refugees permanently or temporarily resettled, has added diversity to the composition of social context. Since the influx of Cambodians into U.S. communities, there has been little inquiry into what constitutes health from the refugees' perspective in their community of resettlement.

Categorization of symptoms, comparison and contrast of experiences, and correlations among pre- and post-migration factors have been the basis of health-related studies among Cambodian refugees. There is little in the way of nursing theory that offers conceptualization of perceptions of health and influences upon

health in this population. Presently, nursing theory does not provide linkages among cultural worldview and life transitions such as migration, resettlement, and health conceptualization. The effect of social and economic factors on the health of Cambodian refugees has not been addressed in current literature. Social and economic factors may be external conditions that influence health perceptions and subsequent health actions. Data on the influence of preventive and early nursing intervention upon health maintenance in this population is also absent from the current literature. Consequently, fragmented and isolated pieces of information contribute little to the advancement of knowledge and ways in which health and well-being needs can be effectively addressed in this population of women.

The U.S. Department of Health and Human Services (USDHHS, 1992; 2000), the World Health Organization (WHO, 1997) and the World Health Organization Quality of Life Group (1995) seek improvement of women's health. United Nations officials also acknowledge that there are inequalities in health care, especially for refugee women. Although women may have the same health conditions as men, they experience these health conditions differently due to poverty, economic dependence, violence and discrimination against women. All of these conditions affect health conceptions held by refugee women. The health maintenance of refugee women in resettlement is vital, as any health compromise they face affects the economic self-sufficiency of the immediate household (Rumbaut, 1989). This can spark a downward spiral of events since this group of women already contends with multiple socioeconomic strains, and limited or no access to health care resources. Nurses are in

a key position to identify these issues and bring awareness of them to initiate changes in care.

This study is of prime importance to the nursing profession for several reasons. First, the study provided specific knowledge about Cambodian women, whereas many other studies have aggregated results into a discussion of Southeast Asians overall (Krieger & Fee, 1994). Second, this study developed grounded theory about health conceptions of Cambodian refugee women in resettlement. Meanings ascribed to health are phenomena of importance to nursing practice and research as the health needs of society become increasingly diverse (American Nurses Association, 2003). Understanding these meanings can guide future studies and knowledge development in nursing. Health-related research about refugee women in resettlement contributes to theory building linkages that are largely absent from current nursing research. Third, understanding health beliefs of Cambodian women in the context of their culture helps nurses provide care and interventions specific to their needs. Cambodians hold unique beliefs about health and illness causation. Research with Cambodian women highlights that which is unique and specific to their health and well-being. Nursing is in a prime position to make a tremendous difference and to voice the perceptions of health of Cambodian women. Giving voice to perceptions of health is a form of health advocacy. Ultimately, dissemination of these perceptions will promote the engagement of these women at the center of health care decisions, rather than at the margins, and at the core of a health care framework, rather than outside of it. However, any efforts that will make a sustained difference and positive contribution in the health of women in resettlement will lie in first understanding them. Finally, this grounded theory study is

of importance to nursing, as it provides a model for future nursing research about health with other resettled refugee populations in the United States.

Chapter Two

Review of Literature

Context of the Study

The context of study is an essential element of grounded theory development. This review, therefore, is organized around four themes found in the literature. The first theme is that of socio-historical and important events that have significant bearing upon the worldview (belief and values) of Cambodian refugee women. Pre-migration, migration, and post-migration factors, and socio-cultural issues are integrated in this section as they provide an important foundation for this study. A second major theme in the literature centers on aspects of health during migration and resettlement, and issues of importance to women refugees. This includes studies pertaining to refugee health. Conceptual and methodological issues of research with refugee women are examined in the third section of this review. A final thematic pattern in this review addresses contemporary discourse about the validity of a Western paradigm as a referent for health and illness in Cambodian refugees.

Historical, Sociocultural, and Contemporary Context

This section of the review examines health and well-being perceptions of Cambodian women through the historical, sociocultural, and contemporary paradigms identified in the literature. It traces the roots of the worldview of Cambodian women

in resettlement, a worldview has been shaped by religious, social, and political influences.

Origins of the Khmer Worldview

“Khmer” is a synonym for Cambodian. More specifically, “Khmer” refers to the predominant ethnic group and language of Cambodia (Chandler, 1991). The philosophical origins of the Khmer worldview stem from Chinese, Hindu, and Buddhist influences. These belief systems are in stark contrast to the many political crises endured by this nation (Mabbett & Chandler, 1995). Harmony, balance, and one’s relationship to the universe are ideas integral to the Khmer worldview. Although these belief systems are inherent to Cambodia and shared by other neighboring Southeast Asian countries, Cambodians have battled domination by neighboring countries. Internal political factions among Cambodians led to strife and persecution of their own people, countryman and kin alike.

Yin-yang theory. Khmer beliefs about health and illness have their origins in “Yin-yang” theory derived from the Chinese. “Yin-yang” theory explains how entities function in relation to others and within the universe. All entities are comprised of dialectic polarities which form a whole. As an example, fire and water, light and dark, hot and cold are polarities which form entities. The body is believed to have “fire and water” components. All entities exist in relationship to other entities (Kaptchuk, 1983). The symbol for yin-yang is a circle, one side dark, and the other light, divided by a swirling line. “Yin” and “yang” mutually create each other and transform into each other. This mutuality and transformation are symbolically represented in Figure 1.

Figure 1. Traditional Yin-yang Symbol

From T.J. Kaptchuk. (1983). *The web that has no weaver: Understanding Chinese medicine* (p. 13). Chicago: Congdon and Weed. Copyright 1983 by McGraw-Hill Companies Inc. Reproduced with permission of McGraw-Hill Companies Inc. via Copyright Clearance Center.

Unlike the practice of Western medicine, Chinese medicine and yin-yang theory is not predicated upon anatomy, physiology, and symptom isolation and eradication. Instead, “Qi” and “meridians” are central concepts in the treatment of illness. “Qi” is the energy required to maintain harmony and balance. Qi is matter which can become energy, or energy which is transformed or materialized. Qi is acquired prenatally, from food, and from the air one breathes (Kaptchuk, 1983). “Meridians” are common pathways that intersect at various points in the body. Chinese medicine relies on the total configuration of symptom patterns as they relate to a specific meridian. “When a person is ill the symptom pattern is only one part of a complete bodily imbalance that can be seen in other aspects of his or her life and behavior” (Kaptchuk, 1983, p. 36). Chinese medicine recognizes patterns of disharmony and uses skills to restore health to achieve harmony and balance within a living organism. Patterns of disharmony are assessed relative to the patient’s relationship to other things, situations, and events. The goal of treatment is to reharmonize the patient.

“Yin” patterns of disharmony are identified by illnesses involving interior aspects of the body, a deficiency state, and a cold state. “Yin” illnesses are characterized by weakness, slowness, coldness, and underactivity. “Yang” patterns of deficiency are identified by illnesses involving exterior aspects of the body, an excess state, and a hot state. “Yang” illnesses are characterized by strength, forceful movements, heat, and overactivity (Kaptchuk, 1983). Disharmony and imbalance are defined in the following quotation:

Disharmony means that the proportions of yin and yang are unequal and there is imbalance. A deficiency of one aspect implies an excess of the other.

Extreme disharmony means that the deficiency of one aspect cannot continue to support the excess of another aspect. The resulting change may be rebalancing, or if that is not possible either the transformation into opposites or the cessation of existence ... Therapy brings configuration into balance, to restore harmony to the individual ... Harmony means that the proportions of Ying and Yang are relatively balanced. (Kaptchuk, 1983, p. 11-12)

Hindu influence on Khmer worldview. The Hindu influence upon the Khmer worldview is manifested in the belief that spirits guide the world of everyday life. Spirits represent supernatural forces which play an active part in Khmer life. Myths and symbols embedded in traditions and practices serve to interpret every aspect of life experience (Mabbett & Chandler, 1995; Thompson, 1991). Illness perception in the Khmer worldview is linked to spirit beliefs and a balance of life forces that flow between the invisible and tangible worlds. “Neak ta” (spirit possession) and “soul loss” (a state of disharmony due to the absence of souls that inhabit body organs and body parts) are causes of illness (Kemp, 1985). Shifts in the balance of forces such as “hot” versus “cold” principles, imbalance in “yin” and “yang,” and “bad wind” are the causative factors of illness (Kulig, 1994; Lew, 1991). Deficits or excesses of “bodily fluids, airs, or other elements in the universe” produce disease (Hoang & Erickson, 1985, p. 235). Treatment interventions are aimed at restoring balance among these factors.

Ebihara (1968) provided comprehensive details about Khmer culture before the fall of Cambodia at the hands of the Khmer Rouge. Her ethnographic study presented community life in pre-1975 Cambodia. Lay healers, or the “kru Khmer,” and monks engaged in the treatment of illnesses and alleviation of unfortunate circumstances experienced by households. Acceptable treatments for illness symptoms traditionally included soul-calling ceremonies, adornment with special amulets for spirit-caused illness, and treatment through the principle of opposition (e.g., treating illness believed due to “cold” forces with “hot” foods). “Coining” and “cupping” practices consisted of dermabrasion and the application of a heat source directly to the body. These practices permitted the exit of evil spirits, or “bad wind.”

Buddhist influence on Khmer worldview. Buddhism is another belief system that exists among Khmer people. Buddhism emerged from the life teachings of Siddharta Gautama who is thought to have lived from 563 to 483 B.C. (Bulle, 1987). It is not a separate belief system, but rather one that is superimposed upon spirit beliefs:

Buddhism ... had a special role in village religion as a token of ordered relationships and harmony between senior and junior, male and female, officials and subjects; gifts given to monks were tokens of the givers' rank and at the same time were covenants of conformity to the limits and responsibilities of rank...the Buddhist order stood for a social stability secure from excessive interference by the magic powers of spirits. (Mabbett & Chandler, 1995, p. 114-115)

Buddhism is a life philosophy which embraces the sanctity of all life. Therefore, one should live righteously. Righteousness permeates all thoughts, intentions, and deeds. One abides by central tenets through: (a) holding the right views or clean thoughts, (b) earning a righteous livelihood, (c) speaking and acting kindly toward others, and (d) putting forth effort, concentration, and mindfulness in one's actions (Smith, 1991). "Mindfulness" is a meditative practice where one attends fully to what is happening at the moment--one's feelings, thoughts, and deeds. The focus is not on the future, but on the moment. Through exercising this conscious awareness, one calms the mind and spirit (Hanh, 1975; 1987).

Buddhism emphasizes the earning of merit, acceptance of karma (one's fate or suffering in life), and the concepts of impermanence and rebirth. Through meritorious acts, compassion toward others, spiritual offerings, and adherence to the precepts of righteousness, one hopes to improve one's situation when reborn into the next life. These acts were also thought to appease certain spirits who have brought illness or misfortune. For example, young boys were encouraged to live in the "wat" or temple for a period time in the service of monks. In so doing, not only did they earn merit for their families, but received formal education and learned righteous ways of living. Meditative practices reinforce a spiritual consciousness that embraces Buddhist precepts for living and the ideas of impermanence and rebirth. The acceptance of suffering, rebirth, and impermanence are in contrast to Western ideas, which place heavy emphasis on a corporeal existence.

Buddhist monks have a special role in the community. They offer guidance to the community and uphold the social and religious mores of Cambodian culture.

Monks perform spiritual rituals and prayer offerings as supplication to ancestors on behalf of the stricken and their families. Both lay healers and monks provided culturally symbolic services believed to be effective therapeutic interventions.

Harmony is an important value in Cambodian culture. Respect for the sanctity of life and respect for one's elders and those in esteemed positions of authority are ways in which harmony is manifested. Harmony is also taught through modes of communication and expression. Direct eye contact with other persons is to be avoided as this demonstrates confrontation. Asking questions of someone else is a challenge to authority. Harmony is also promoted through the acknowledgement of, and value placed upon, group accomplishments versus individual accomplishment. Goals and values of the group supercede those of individuals. "Saving face" and the maintenance of family honor are also tied to the idea of harmony. Public admission of problems and involvement in culturally unacceptable social behavior are ways to bring dishonor to one's family. The community network of family and extended family promoted the cultural concept of harmony by serving as the primary source of aid and help for problems (Duncan, 1987; Ebihara, 1968). Physicians, monks, and kru Khmer are not the only persons responsible for helping one regain balance and harmony. It is also an expected duty of family, relatives, friends, and teachers to advise.

The Role of Women in Cambodian Society

Socioeconomically, Cambodia is an underdeveloped country and lacks the technology for mechanization of agricultural tasks (United Nations Development Program [UNDP], 1999). Many families continue to live in poverty with annual incomes of \$200.00 or less. Since rice provides the primary means of subsistence and income for many families, communal activities of daily living revolve around a

successful harvest. Typically, an average season yields 800 pounds of rice per acre, less than half of that cultivated in neighboring countries. A crop of this size could potentially yield \$600.00 or less which must last the family an entire year (Beresford, Sokha, Roy, Sisovanna, & Namazie, 2004; Chandler, 1991). Families still rely on crude methods of farming and supply all of the needed physical labor to produce a saleable crop. Women are expected to work alongside men in physically demanding tasks. Preparation of paddies for planting, pulling, transplanting, and harvesting consume much of daily life (Beresford, et al., 2004; Headly, 1991). However, survival necessitates supplementation of the family income in addition to carrying out traditional expectations of Cambodian women. These expectations include caring for children, cooking, cleaning, and managing family finances. Many women marginally augmented family income through petty trade and produce sales at the local market. Women may earn some economic independence, but at the cost of working at two or three competing jobs (Beresford, et al., 2004; Chandler, 1991; del Carmen, 1990).

Cambodian refugee women did not have ready access to opportunities in their source culture that would propel them into upwardly mobile opportunities in their host culture (culture of resettlement country). Traditions in the source culture afforded education and skills training to young men and boys. These opportunities were denied to young women and girls until the 1960's when the government allowed them to participate in public education (Duncan, 1987; Yusof, 1990; UNDP, 2002a, 2003a, 2003b). Men had more marketability than women for upwardly mobile employment opportunities. Hence, for women, absence of skills or abilities upon arrival in a

competitive host economy are barriers to employment, education, and health care access (Melznyck, 1988; Paltiel, 1993; Beresford, et al., 2004).

Aggravating factors that diminish the health of refugee women overall are sociocultural ones. The gender disparity between males and females is prevalent and embedded in Southeast Asian cultures. Women and girls are assigned a second-class status in society. From birth, women are disadvantaged in many ways. The birth of a male sibling, marked with celebration and festivity in his honor communicates the value placed on the boy child. The girl child on the other hand is taught from an early age to exercise restraint and to be servant to others. As a young girl, she rises early to tend to domestic chores, which consist of collecting fuel for firewood and carrying water. She waits on others first, eats last, and eats less. Chronic malnutrition and vitamin deficiency are among the long-term consequences she suffers (Waslien & Steward, 1994; UNDP, 2000). These problems affect her health status during childbearing years and as she ages. With little or no access to health services, her health will deteriorate. In addition, the pressures of poverty force young girls and women to work regardless of age or health status.

Women and girls had less opportunity for education. With little education and no literacy skills, employment opportunities for women were limited (Department of Public Information & Education, 1990; Gay & Underwood, 1991; Sok, 1995). In addition to domestic work, women worked long hours in agricultural work or assembly line productions with outmoded equipment and little input concerning work conditions (Limbu, 1996). Women contributed significantly to economic efforts through agricultural work and the informal job market. However, the disparity in

income and job opportunities continued to keep women on the fringes of society as an invisible and devalued workforce (Jacobson, 1993). Women-headed families in Cambodia earned the annual equivalent of \$600.00-\$1000.00 United States dollars from 3 months work of harvesting and selling rice (Chandler, 1991; UNDP, 1999). Somehow with that income, women were faced with feeding their families, as well as selling enough to maintain the family throughout the year. Furthermore, other labor-intensive efforts that are unrecognized in women's work are the production of consumable goods necessary to sustain their families.

“To be Cambodian is to be gentle, quiet, and kind” (Levin & Hott, 1991). Young girls learned proper conduct, appropriate dress, and family responsibilities from their mothers. A soft voice, diversion of one's gaze away from another, and proper covering of the body, limbs included, are mannerisms becoming to a young lady. In Cambodia, appropriate ages for marriage of young females were between 16 and 20 years of age (Burki, 1987; UNDP, 1998, 2000). Public displays of affection among young couples, such as holding hands, indicated a serious intent to marry.

Tradition mandated that women remained at home to care for families and elders and manage domestic household affairs. They also bore the responsibility for maintaining family honor or socially acceptable status within the community. Family honor or status was judged according to the degree to which women adhered to traditionally acceptable ways of behaving (Kemp, 1985). In keeping with traditional roles, women kept the family together, spiritually and physically. They quelled family disruptiveness or disturbances to keep family peace and harmony (Burki, 1987; Headly, 1991).

According to Ebihara (1968) legal codes in Cambodia defined the traditional gender roles between spouses as non-egalitarian, where power and decision-making in the family rests with men, who have absolute power over the family and household matters. Men in the families controlled or restricted spousal or female offsprings' activities to avoid bringing dishonor to the family name (Kulig, 1994). In spite of gender roles as defined by legal code in the source culture, however, Ebihara (1968) noted that women wielded considerable power and authority both overtly and covertly within the family system. Women were by no means submissive. They managed fiscal transactions of the household, initiated commercial ventures to earn income, and had property rights including ownership and disposal of the same. Other research further described an egalitarian relationship between spouses and the decision-making role of women in family health care (Frye, 1991; 1995), irrespective of prior legal codes.

The Cambodian woman's role in maintaining family equilibrium and managing stressful problems was accomplished through non-confrontational behavior and withdrawal from issues at hand (Frye & D'Avanzo, 1994a; 1994b). For example, '*koucharang*' (also written as '*kit chroeun*') or 'thinking too much', a culture-bound syndrome, was handled through the use of encouraging words, discouraging sad thoughts, and constant vigilance and physical presence with the family member. Confinement of the issue within the boundaries of the immediate family, or nonadmission of problems 'saved face' and avoided dishonor. The notion of saving face discouraged outside help-seeking. Such an act stigmatized or ostracized one from the Khmer ethnic community (Foulks, Merkel, & Boehnlein, 1982). Hence,

somatization, instead of the admission of problems, was a culturally acceptable way of communicating suffering, distress, and the need for help (Frye, 1995).

Thus far, the resultant health sequelae of migration, internment, repatriation, and resettlement of Cambodian women have been addressed. The double standards that refugee women confronted within these situations have been discussed. Throughout these life events and transitions, women faced adverse conditions, loss of family and possessions, threats to personal safety and security, and stigma. Their plight and worldview that framed their perceptions have been poorly understood. Consequently, this misunderstanding has been conveyed into other areas of inquiry.

Sociopolitical and Historical Events Leading to Migration

The term refugee reflects the legal status of one who has a well-founded fear of persecution based upon race, religion, nationality, or a political opinion (UNHCR, 1968; Kronenberger, 1992; Fontaine, 1987). Although there is a distinction between refugees who seek out-of-country protection, and internally displaced persons within a country, the latter may also have well-founded fears of persecution. Migration is the actual process of re-location or displacement. As it relates to refugees, this event is involuntary.

Sentinel events that generated Cambodian refugee flows provided an important backdrop for this study. They illuminated contemporary problems and challenges faced by Cambodian refugee women in resettlement. Historical background information, the genocide of 1975-1979, and current sociopolitical events are discussed in this section.

Pre-1975 Migration

Historically, a number of pre-existing situations provided the foundation for other events. Domination, invasion, and internal strife were key events which characterized the history of Cambodia in the 19th century (Mabbett & Chandler, 1995). Vietnamese and Chinese traders dominated Cambodian seaports. Rulers of surrounding states have eyed its geographic location as a convenient site for trade, a gateway to conquest of other neighboring countries, and a commodity to possess for its fertile and bountiful deltas. The kings of 'Angkor' (a historical term used to describe the Cambodian empire as well as monumental building constructed to represent their quest) attempted to keep the country free from foreign power. This was a major goal of Angkor's successive rulers from 700 to 1300 A.D. Nonetheless, the influences of trade and conquest were woven into the culture, most notably through religion and political governance (Mabbett & Chandler, 1995).

Civil wars were fought on Cambodian soil between Vietnamese and Thai factions. Internal strife within Cambodia itself added to the uprisings and foreign invasions. Foreign pressures from bordering states and loss of territory to repeated invasions contributed to the decline of the monarchy as well as the country's control over its own economic resources. Ultimately, Cambodia became a French protectorate while its political governance fluctuated between Vietnamese and Thai domination. These early political factors have left a historical legacy of strife which has become embedded in 20th century Cambodia (Beresford, et al., 2004; Chandler, 1992; UNDP, 2002b, 2003a).

During the early 1940's, the Cambodian monarchy became a puppet mechanism of French rule. In 1954, Cambodia formally attained independence from

France. This was by no means an end to political bickering during this period.

Escalating events and factors in the 1960's and 1970's included: (a) a decline in the power of state represented in the Cambodian monarchy, (b) United States foreign policies related to economic and military aid, and (c) internal political corruption and instability within Cambodia (Drachman, 1992; Kiernan, 1996). By 1973, the Khmer Rouge (a combined Vietnamese-Cambodian Communist Party shield) controlled much of Cambodia (Chandler, 1992).

Migration: The 'Wet Monsoon Killing Time'

The spiritual worldview of Buddhism embraced by the Khmer people has influenced their role as a nation in the political tide of events and their perception of current resettlement issues. This view is perhaps what has sustained their resilience and fortified their endurance in national crises. However, it can also be argued that in embracing spirit causation of life events and tolerance of suffering, the Khmer have played a lesser role in determining their country's direction. Historians have described Cambodia as a passive victim of history (Criddle, 1987; Mabbett & Chandler, 1995).

A web of events led to the involuntary mass migration out of Cambodia. When Vietnam divided into North and South factions during the Vietnam War, the United States provided military and economic aid to South Vietnam in its resistance against communist forces. During this period, Cambodia was used as a military supply route by North Vietnam. The United States airstrikes over Cambodia cut off the supply route in an attempt to eliminate the North Vietnamese communist stronghold in South Vietnam and Cambodia. Once again, Cambodia was caught between two warring factions and left with its homeless, injured, or dead. A 1973 ceasefire between the United States and the Vietnamese communist faction led to the withdrawal of

Vietnamese troops from Cambodia (Chandler, 1991). This did not signal the end of conflict, but the beginning of a revolution, which Cambodian refugees referred to as “Pol Pot times.”

The Khmer Rouge, who were allied Vietnamese and Cambodian guerilla forces continued the war into 1975. Pol Pot led the Khmer Rouge, an organization known as the Communist Party of Kampuchea (CPK). Their political aims were to revolutionize and re-structure Cambodia. A web of tangled political alliances and party rhetoric masked their true aims from the public. Pol Pot believed that foreign influences resulted in the suffering and tragedy of Cambodia. Through his Four Year Plan, Pol Pot would rid the country of any foreign interference, implement a collectivized system of agriculture, and rapidly move Cambodia toward industrialization. “Angka,” the revolutionary government organization, saw and knew all. “Angka has the eyes of a pineapple,” people were told (Marston, 1994, p. 107). Veiled threats such as these were intended to force people into submission. All efforts were for the benefit of “Angka” (Chandler, 1991). Mandatory reeducation sessions provided the mechanism for mass indoctrination of the party philosophy, “With rice we have everything.” Public confessions and recitations of party slogans were the substance of meeting activity.

Only by the elimination of “counterrevolutionaries,” and all enemies, foreign and internal, could Pol Pot forge ahead with his vision of government. The Khmer Rouge dismantled all traces of Cambodian culture and society. The period from 1975 to 1979 has been dubbed by historians as the ‘Wet Monsoon Killing Time’, a period of mass genocide where many were executed by the Khmer Rouge--government leaders,

royalty, Buddhist monks, educated professionals--doctors and nurses, skilled business people, and community elders. These citizens who bore knowledge and social responsibility for ensuring the preservation and transmission of Cambodian heritage and culture were persecuted. Survival meant maintaining silence and feigning ignorance about one's knowledge, skills, or abilities. Stories of survivors provided an account of famine, hard labor, and a mind-numbing existence under the Khmer Rouge (Hein, 1995). No one escaped daily slogans blasted over loudspeakers: "To keep you is no benefit; to destroy you is no loss; even the slightest infraction can lead to disappearance" (Criddle, 1987, p. 104). The Khmer Rouge destroyed the foundations of Cambodian culture and stripped people of human dignity. Family members witnessed the execution of other relatives or were pitted against one another. People were forced to confess to wrongdoings of which they had no knowledge:

Anyone could charge another with real or supposed failings...new villagers were expected to 'confess' without knowing the charges. It was a dictum of Angka that in our society of comrades, the faults of another were only pointed out to help that person improve; therefore the 'guilty' were expected to submit to the humiliation of a 'kosang' (a formal warning), to 'reconstruct themselves' into good people by confessing and repenting ... for a minor infraction. A kosang usually brought denial of food for the next day, reduced rations, or extra work. A person was 'called to see Angka' or sent for 'reeducation' if they committed a 'serious crime' or after they'd received several kosangs ...children were encouraged to report failings in their parents and other adults; their word was taken as fact. An envious neighbor, or one harboring a grudge, could cause

trouble or even death by accusing his enemy of failure to live by some Khmer Rouge rule. (Criddle, 1987, p. 93)

Forced labor, separation of families in work camps or prisons, and elimination of personal property and possessions were actions undertaken to ensure successful implementation of Pol Pot's Four Year Plan to re-structure government. Homes, communication systems, transportation systems, and Buddhist temples, the seat of Cambodian community, were destroyed. The sick had no recourse for health care. Disease and malnutrition were rampant. From an approximate population of 6 million in Cambodia at the beginning of the 1970s (Mabbett & Chandler, 1995) at least one out of every seven Cambodians lost a family member to starvation, disease, or execution (Chandler, 1991; Levin & Hott, 1991; Heuveline, 1998). The actions of the Khmer Rouge, Cambodians pitted against Cambodians, violated a Buddhist precept which upheld the sanctity of life. Those who bore witness to human suffering and personal losses had no expression of their anger, grief, or mourning. Survival under the Khmer Rouge took precedence over outward expressions of traumatic pain. Life rituals and rites of passage such as marriages and burials, were afforded little dignity. Marriages occurred during brief mid-workday pauses in labor camps. Rows of grooms and brides dressed in their black pajama like uniforms of the day faced each other as the Khmer Rouge, instead of Buddhist monks, officiated over the ceremony. Families could not mourn and appropriately bury their dead. There were no Buddhist monks to offer prayers for the deceased or to console the survivors. Consequently, families believed that the spirit of the deceased member would wander aimlessly in the next life (Criddle, 1987).

Ironically, in 1976, Pol Pot proclaimed himself as prime minister of “Democratic Kampuchea” (DK), the former Communist Party of Kampuchea (CPK). The name change did nothing to mask the anarchy which continued under Pol Pot’s reign. Tuol Sleng, an interrogation facility, and the many mass graves throughout Cambodia are vestiges of Pol Pot times (Chandler, 1991; 1992; Hein, 1995).

These lived accounts of human rights violations have only been detailed in the literature (Criddle, 1987, 1992; Pran, 1997). These injustices continue to shroud contemporary discourse within the international community on aid, policy-making, refoulement, repatriation, and United Nations supervised elections in Cambodia (Chimni, 1993; Gibney, Dalton, & Vockell, 1992; UNDP, 2002b).

The above events have produced a generation of refugees, and many at one time have lived in border and refugee camps for indeterminate periods of time. From these political events came major asylum-seeking refugee flows to Thailand, China, Malaysia, Hong Kong, Indonesia, and the Philippines (Hein, 1995).

Refugees and Asylum Seekers

Unlike immigrants who migrate voluntarily, refugees have no choice. Basic requirements for safety and survival are the immediate needs of refugees. Internal displacement, asylum in another country, and long-term resettlement in another country are the pathways which refugees trod. Internal displacement is movement to another location within-country. Many refugees have sought immunity from political persecution, outside of Cambodia in “second” or “third” countries of asylum.

Thailand, an initial asylum granting country provided “border camps” or “refugee camps” positioned in Thailand along the Cambodian border. One important distinction between border camps and refugee camps is that the latter are officially supported by

the international community, the United Nations High Commissioner for Refugees (UNHCR). Other nearby countries or “second countries” of asylum--Singapore, Malaysia, and the Philippines--served as launching points to resettlement in “third countries” of asylum. In second countries of asylum, refugees received orientation about third countries where they would resettle. The resettlement process may take several years. The United States, Canada, and Australia have served as “third countries” of resettlement.

*Physical and Psychosocial Health of Displaced and
Refugee Women in Pol Pot Times*

The lives of Cambodian women were significantly re-defined during Pol Pot times. Women lived and worked under intolerable conditions. Health care was non-existent under the Khmer Rouge regime. Communicable diseases proliferated under unsanitary conditions, contaminated food and water supplies, and absence of waste disposal systems. Outbreaks of diarrhea, cholera, hepatitis A and B, dysentery, and tuberculosis were common. Puerperal fever and hemorrhage were maternal complications of childbirth. Chronic malnutrition, orthopedic and neurological injuries, and war injuries were common among women (Sapir, 1993; Toole & Waldman, 1993). Infants born to childbearing women in re-location camps suffered from consequences of poor maternal health and inadequate care--low birth weight, respiratory infections, and diarrheal diseases (Gann, Ngheim, & Warner 1989; Gove & Ali-Salad, 1987). Sickness or illness was a sign of weakness, and cause for one's “disappearance.” People preferred to suffer silently, rather than report illness to the Khmer Rouge authority and risk mysterious disappearance or death.

The many human rights violations to which women were subjected affected their physical and psychosocial well-being. Perpetrators used conditions of terror and political violence to subordinate and oppress women (Muecke, 1992a). As family units disintegrated under armed conflict, females became 'fair game.' Widows, women separated from spouses, and unaccompanied or unsupervised young girls were subject to abuse and exploitation. Women were exploited through abduction, rape, prostitution, and demands for sexual favors in exchange for food, cooking fuel, documentation of legal status, and transportation (Wali, 1995a). Furthermore, cultural mores inhibited women from reporting rape. Public knowledge of this information would result in ostracism or death (Wali, 1995b; Muecke, 1992b; Rehn & Sirleaf, 2002). Violence and aggression against refugee women are not mere casualties of war, but political weapons that demoralize a nation.

Cambodian women also contended with events and situations over the course of migration that have long-term psychosocial impact. In addition to inadequate food and shelter, the absence of basic safety needs, such as freedom from harm or interpersonal violations placed women at risk. Chronic uncertainty as to whether or not refugees had recourse to a safe haven country and access to aid resources are other issues that have psychosocial impact. There has been increasing advocacy for the human rights of refugee and displaced women. These rights include protection in all aspects of emigration--including safe living conditions in border or refugee campsites and safe passage to, and protection within, an asylum country or country of resettlement. Although the United Nations General Assembly has strongly declared in its resolutions the rights of women to protection, human rights violations of refugee

women continue (United Nations General Assembly, 2000). The United Nations High Commission for Refugees UNHCR has been criticized for its policy structure which has been ineffective in dealing with refugee flows and root causes of these problems (Hathaway, 1995; Muller, 2004). The notion of state sovereignty gives sole authority to states for managing migrants within its borders. Ironically, those displaced in their own countries have no recourse outside their own governments (Tiso, 1994; Wali, 1995a; UNDP, 1997).

Refugee women have faced major uprooting, personal traumatic events, and intense and rapid changes. There has been minimal effort to address physical and psychosocial issues of women in the international community. In areas of armed conflict, humanitarian programs offer little follow up and health care assistance for women traumatized by rape (Sapir, 1993; Rehn & Sirleaf, 2002). Aid organizations often overlook the social context which people endure (Muecke, 1992b). Short-term, and episodic relief, without concern for self-sufficiency and long-term development has been a band-aid approach which reinforces a crisis-orientation to problems rather than one that re-builds a sense of community. Mollica (1990) proposed community-based interventions in border camps directed at teaching refugee women psychological coping skills. Such skills in turn could benefit other family members and promote self-reliance.

Repatriation and Resettlement

The survivors of this period of devastation brought about by Pol Pot's dictatorship were confronted with either repatriation or resettlement in another country. Neither of these choices offered stability. Those who contemplated

repatriation faced the overwhelming issue of starting their lives over again with little or no resources. Those who contemplated resettlement elsewhere faced the issue of re-establishing their lives in a different country. In either situation, Cambodian women were neglected in repatriation efforts and dealt with the resettlement challenges that were before them.

Repatriation

Repatriation is the act of returning to one's country after taking refuge in another country. It is one alternative to resettlement in another country. Thirty years have elapsed since the Khmer Rouge genocide. At one point, many refugees lived in encampments along the Cambodia border. Refugees were suspended in limbo and the chronic 'temporariness' of their situation. Those who contemplated repatriation had to weigh the benefits of returning home versus a fear of the resurgence of Pol Pot times. Southeast Asian women who have resettled in various parts of the United States and in Canada have expressed experiences of difficulties encountered in resettlement and the uncertainties of repatriation to their respective countries (American Public Human Services Association, 2004; Downs-Karkos, 2004; Fowler, 1998; Pho & Mulvey, 2003; Simich, 2003).

The United Nations High Commissioner for Refugees (UNHCR) had the task of coordinating and organizing repatriation efforts (United States Committee for Refugees [USCR], 1990). Consequently, during its peacekeeping mission, the United Nations Transitional Authority in Cambodia (UNTAC) supervised repatriation of 367,500 Cambodians between April 1992 and May 1993. Some 160,000 internally displaced Cambodians also returned to their homes (USCR, 1994).

The difficulties confronting women at a personal level, remained visible in the larger socio-political infrastructure. Marginalization of women was a continuous theme throughout women's lives in refugee camps and in repatriation efforts. Relief efforts to the refugee camps consisted of health care supplies, field organization skills, equipment, and food. However, food distribution and medical services frequently favored male refugees. Women received less food and were the last to receive medical attention (USCR, 1990).

Repatriates who returned to Cambodia were offered three options. Option A included 5 acres of land, a housing plot, \$25.00, tools, and food rations for 400 days. Option B included a housing plot, wood, \$25.00, an agricultural kit, and food rations for 400 days. Option C consisted of a money grant--\$50.00 adult, \$25.00 per child, household/agricultural kit, and food for 400 days. Ninety percent of repatriates selected option C which afforded an opportunity to choose relocation near relatives. However, for refugee women singled by war who became heads of households, Option C was not much of an alternative. Women-headed households still struggled with issues of economic self-sufficiency for their families. Khmer women were in need of financial and development resources to rebuild their lives. However, women repatriates were denied credit, bank loans, and property inheritance (Gay & Underwood, 1991). Disability resulting from dismemberment by landmines created an extra hardship upon women-headed households, in that they had no secondary source for health care, aid, or domestic resources to keep their families afloat. They remained at the tail end of policy decisions, and had no voice on issues that affect them. This continued in the process of resettlement in asylum countries.

In spite of UN efforts to ease transition back into Cambodia, repatriates tried to re-build their lives amidst a heavily damaged socioeconomic infrastructure. There were thousands of active land mines implanted everywhere. These have been the cause of limb loss for many. Farmers do not wish to risk their livestock, also an important source of labor and livelihood, to graze on land that is riddled with mines. Large pockets of land have been left unattended for this reason. Roads that have been ravaged by the Khmer Rouge and civil warfare have rendered health care clinics, markets, and other businesses inaccessible. Cambodia has continued to rebuild and develop its socioeconomic infrastructure (UNDP, 1997, 2003b, 2004).

Resettlement

For the purposes of this study, resettlement refers to the establishment or semblance of permanent residence within the United States. This excluded repatriation. In 1990 there were 147,411 Cambodian refugees who resettled in the United States, with 68,190 Cambodians in California alone (Hein, 1995; Leao, 1996; Martin & Widgren, 1996; U.S. Census Bureau, 2002). The 2000 census has documented 171,937 Cambodians in the United States with 70,232 (41%) living in California (Barnes & Bennet, 2002; U.S. Census Bureau, 2001). There are 28,226 Cambodians in Los Angeles County. Of this number, 17,396 (62%) live in Long Beach city. There are 4,517 Cambodians in Orange County with 1,767 (40%) living in Santa Ana city (U.S. Census Bureau, 2001). Ultimately, over time, refugees acquired permanent residence as legal immigrants or citizens. Early waves of Southeast Asian refugees to the United States provided the cultural network for subsequent waves. This first wave were educated and had personal financial resources to begin anew. Subsequent waves of refugees, however, had no kin networks, were less educated or

illiterate, and poorer than earlier waves. This pattern existed among Cambodian refugees as well. In 2002, 13.9% (415,000) of the total Asian Pacific Islander population in the U.S. were female headed households, as compared to 12.3% (188,000) in 1990 (U.S. Census Bureau, 2003). In 1999, 15% (4,017) of Asian female-headed households in Long Beach, and 6.7% (474) in Santa Ana were in poverty (U.S. Census Bureau, 2001).

Refugees granted asylum in the United States had freedom from persecution, but ultimately faced other barriers to survival here. The denial of economic and developmental resources essential for basic needs, health, and self-sufficiency was no refuge, but a hardship. Re-construction of kin and tightly knit cultural networks in communities of resettlement has been an overwhelming task for many families. The destruction of families in 'Pol Pot' times eradicated the core value of unity and harmony which family units represented.

Prolonged disruption of the family system for uncertain time periods erased markers of family identity, such as rituals, celebrations, and routines. The uncertainty of family boundaries and relationships, where members were physically absent but psychologically present, added to this disruptiveness. The absence of significant others to help comfort members, share tasks, and reorient and interpret family events increased the psychosocial burden (Patterson & Garwick, 1994; Davis, 2000).

Cambodian women who came from an agrarian economy to the United States shifted from a rural environment to a highly technological, industrial, and urban one. Women had limited skills and economic resources to support themselves in upward mobility. This jeopardized the economic survival of women, especially women who

have experienced spousal loss through death, divorce, or physical separation from the extended family.

Without professional or technical skills and economic assets, these women had few resources to manage daily living. They assumed collateral duties formerly held by spouses in overseeing household and family responsibilities (Paltiel, 1993). Many low-paying jobs often taken by these women in a host country afforded little security associated with the formal job market, such as environmental work safety and occupational stability (Kneipp, 2000; S. Nan, personal communication, June 28, 2002). Immigrant women have been relegated to lower paying jobs or had no choice but to accept lower paying jobs. One reason identified for this was that, their educational and occupational skills, which served them well in their source culture, were not recognized as credible in the host culture. Therefore, women had few choices but to earn a living through the informal trade market, which reaped little income and involved long workdays under intolerable environmental conditions. Fatigue, life strains, and a vulnerable socioeconomic position increased their risk for diminished health and well-being (Aday, 2001).

The United States government established resettlement policies which permitted the rapid resettlement of refugees in the United States. Such policies contained provisions for 'landing' grants and other time-limited resettlement assistance. Health care, job skill training, legal assistance, housing/living subsistence, and English-as second-language (ESL) classes were some of the social services offered under this program. However, there was major quandary over the inability of states to implement federal resettlement policies, when states received little federal

funding (Goldberg & Scoffield, 2004; *World Refugee Survey*, 2004). The irony in this process was that programs were cutback or discontinued. Often, these were development programs whose goals were to assist women and their families in resettlement in their new communities. The popular confusion between refugee status and undocumented immigrants complicated policy and funding matters related to developmental programs (Fontaine, 1987; Goldberg & Scoffield, 2004; van Selm, 2004).

Out of deference or respect for authority, a fear of involuntary return to the source country, or the absence of advocacy, women remained silent, and accepted their situation as fate or karma. The survivalist strategy of staying silent that aided them during the Khmer Rouge regime no longer served them in the host culture. Experiences of trauma in civil warfare, migration, and the shock of adjustment to a host culture were multiple issues that women confronted during resettlement. Stigma ascribed to ethnic minorities for being different was an additional strain. Nursing research studies have identified common themes of downward mobility, marginalization, and isolation in refugee and immigrant women of different ethnic backgrounds (Anderson, 1987; Lipson, 1992; Meleis, 1991, 1996; Meleis, Arruda, Lane, & Bernal, 1994).

Since immediate survival and the acquisition of new skills were vital to resettlement programs and policies, women focused their efforts upon immediate needs. Mental health needs associated with traumatic experiences and past losses were submerged in resettlement efforts. Furthermore, the admission of mental health issues relegated one to a lower status in Cambodian society (Leao, 1996). This cultural belief

coupled with the need to meet basic physical necessities left mental health needs unattended. Not only were these needs left unattended, but they became compounded as women and their families settled in host communities.

Thus far, this review has covered pre-migration, migration, and post-migration influences on the health and psychological well-being of Cambodian women. This section has also covered sociocultural influences affecting their health. A discussion of health and its relevance to Cambodian women ensues.

Refugee Health

This section will review and critique health-related studies of particular importance to Cambodian refugees. Mental and physical health were two areas of emphasis in the literature. As the first wave of Southeast Asian refugees entered the United States, the health care community knew little of cultural differences, but faced the immediate task of ministering to health needs. Early United States studies of refugee trauma from the 1980's to 1990's concentrated on identification of symptoms based on a Western diagnostic framework of PTSD or psychiatric disorder. Studies have examined multiple variables contributory to PTSD and isolated the factor structure of tools developed for use with this population (Boehnlein, Kinzie, Ben, & Fleck, 1985; Carlson & Rosser-Hogan, 1991, 1994; Chung & Bemak, 1996; Chung & Kagawa-Singer, 1993, 1995; Devins, Beiser, Dion, Pelletier, & Edwards, 1997; Foulks, Merkel, & Boehnlein, 1982; Kinzie, 1993; Kinzie, Boehnlein, Leung, Moore, Riley, & Smith, 1990; Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984; Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987; Mollica, Wyshak, & Lavelle, 1987). Studies related to the physical health of this population have been primarily

descriptive, documenting the number of instances of symptom reports, or looking comparatively at symptom reports across Southeast Asian groups (Baughan, White-Baughan, Pickwell, Bartlome, & Wong, 1990; Gong-Guy, 1986; Mollica, et al., 1993; Rumbaut, 1985). The treatment of mental and physical aspects of health in research as separate, isolated entities which are independent of socio-cultural context and values, negated the wholistic perspective of health. This major gap was identified through review of literature. The lived experience and the cultural influence upon health perspectives have been discounted. Health care professionals may have dealt with one aspect but not the other. Consequently the health care approach to groups who have suffered much remains a fragmented one, rather than a wholistic one.

The Trauma Experience and Mental Health Sequelae

Studies of refugee trauma addressed the mental health arena. Many of the data were obtained in these early studies by interview or self-report through the use of interpreters, trained Cambodian mental health workers, and other health care providers familiar with the history and cultural norms of Cambodians. These descriptive studies identified types of personal trauma experiences during camp confinement or forced labor (Mollica et al., 1993) and the incidence of somatic symptoms associated with PTSD.

Migration and Internment

Significant trauma experiences reported by Cambodian refugee groups were separation and isolation from family, torture, and deprivation of basic human needs under the Khmer Rouge. Many relief shelters were established along the Thailand-Cambodian border during the 1975-1979 crises. Two types of shelters were "border camps" and "refugee camps." "Border camps" were situated right on the

border of the asylum country and the country where conflict occurred. These were the nearest sites for immediate evacuation, but also the most insecure. As such, border camps did not provide the safe haven which refugees sought (Tiso, 1994). "Refugee camps," on the other hand were legally designated as relief centers by the United Nations High Commission for Refugees (UNHCR). Refugee camps were surrounded by walls and supported by international relief efforts and security forces. Aid organizations in camps assisted with medical care, physical needs, and ultimately facilitated resettlement in other countries. However, there was little organized international effort to respond immediately to psychological trauma. Receiving communities of resettlement have struggled in meeting these long-term needs (Tiso, 1994; *Global Refugee Problem, 2004*). Although border and refugee camps were intended as a temporary measure, many refugees remained in these shelters for 10-15 years awaiting resettlement or repatriation. During this period, many hoped for word about their families or the possibility of family reunification, however remote.

Severance of family ties. Dissolution of the family unit was a global experience for Cambodian refugees. Men, women, and children, separated into different internment camps, were subjected to hard labor. In Mollica et al.'s (1993) study of 933 refugees who had been in camp confinement, over half were either forcibly separated (84.4%) or isolated (68.6%) from family members. Prevalent conditions like these destroyed the centrality of family, an important value in Khmer culture. Even worse for families was the knowledge that many of their adolescent sons and daughters were recruited to implement military rule and to report or spy on others who did not abide by party philosophy (Welaratna, 1993). Trust became non-existent (Hein, 1995). Oral

histories of survivors and documents retrieved from Tuol Sleng, the infamous Khmer Rouge prison, attested to these facts (Chandler, 1992; Criddle, 1987; Riley & Niven, 1996).

Torture. Torture is a frequently reported trauma experience cited in the literature. According to salvaged archives from Tuol Sleng, oral history studies, and survivor accounts, torture was a means of forcing from innocent civilians contrived confessions of crimes against the Khmer Rouge. These extracted confessions fueled other human rights injustices. Electric shock, beatings, cigarette and acid burns, stabbings, underwater immersion, and prolonged periods of hanging by the limbs were a few of the methods employed. Consequently, head injury, neurological, and musculoskeletal problems and chronic pain are permanent physiologic deficits resulting from the violence inflicted (Chester & Holtan, 1992; Mollica, et al., 1993; Ta, Westermeyer, & Neider, 1996). Physicians were often brought in to assess the victim's tolerance for punishment; the goal was to force a confession before death. The complicity of medical personnel in this activity accounted for a profound lack of trust in seeking assistance from health care professionals in general (Chester & Holtan, 1992; Geiger & Cook-Degan, 1993; Laborde, 1989). Torture compounded by the uprooting experience had an additive effect on psychological status. While some survivors had long-term psychological effects, others did not (Basoglu, 1993; Laborde, 1989). The effect of cultural influences upon psychological trauma is an unexplored arena.

Resettlement and Post Traumatic Stress Disorder (PTSD)

As refugees were absorbed into resettlement communities, efforts to provide health care focused on mental health needs, namely post-trauma needs. Consequently,

post traumatic stress disorder (PTSD), also termed post traumatic stress syndrome, has been a central topic in post-resettlement refugee studies over several years (Basoglu, 1993; Boehnlein, et al., 1985; Carlson & Rosser-Hogan, 1991, 1994; Chung & Kagawa-Singer, 1993, 1995; Glassman, 1988; Green, 1993; Kinzie, 1993; Kinzie, et al., 1984; Kinzie, et al., 1990; Mollica, Fredrickson, Ben, Fleck, & Karls, 1984; Mollica, et al., 1993; Nicassio, 1985; Rozee & van Boemel, 1989; Shalev, Bonne, & Eth, 1996).

Medically defined, PTSD is a cluster of symptoms that occurs subsequent to the personal experience or witnessing of a trauma event [death, serious harm or injury, or threat thereof, and other acts of human-perpetrated violence] (American Psychiatric Association, 1994; Kinzie, 1993; Kira, 2001; Othmer & Othmer, 1989). It is a medical diagnosis within a taxonomy of psychiatric disorders, frequently confirmed in many refugee populations. Re-enactment or re-experiencing of the event is triggered by symbolization or some resemblance of the trauma. The diagnostic criteria included recurrent or intrusive thoughts of the event, flashbacks to the stressor event, impaired social or occupational functioning, psychological distress, or physiological responses [difficulty sleeping, irritability, anger, diminished concentration, hypervigilance, and startle response] (American Psychological Association, 1994; Kira, 2001; Othmer & Othmer, 1989; Shalev, Bonne, & Eth 1996). Under Western medical criteria, many Southeast Asian refugees arriving post-war in the U.S. in the late 1970's were diagnosed as psychotic, schizophrenic, or severely depressed (Kinzie, Tran, Breckenridge, & Bloom, 1980). Both clinical and non-clinical populations who reported symptomatology were formally diagnosed with PTSD using the DSM III

criteria (Carlson & Rosser-Hogan, 1991, 1994; Mollica, 1990; Mollica, et al., 1992).

Reliance upon Western medical criteria may have resulted in misdiagnoses and inappropriate treatment of refugees.

Other studies, while still focusing on post-trauma, attempted to define and predict relationships among variables and other contributory factors that accounted for unexplained psychosomatic symptoms. Expressions of hopelessness, helplessness, and worthlessness surfaced in interviews of 2,190 Southeast Asian refugees, including Cambodians. Other symptoms commonly self-reported in these interviews were trembling, sweaty hands or feet, and "heart beating hard" (Chung & Kagawa-Singer, 1993).

Pre-migration predictors of anxiety among earlier waves of refugee arrivals were the number of trauma events experienced and length of time in refugee camps. Women and the elderly were more likely to have anxiety than men or younger people. This was true of both early and recent waves of arrivals. Formal educational level was an additional predictor of distress (Carlson & Rosser-Hogan, 1991). People with formal education were able to cope with their situation more effectively than those who had no education at all. In comparison with other Southeast Asian groups, Cambodians experienced the highest levels of depression and anxiety, and had the highest percentage of PTSD over time (Kinzie, et al. 1990).

Post-migration predictors of depression for earlier waves of refugee arrivals were the number of years spent in camps, employment, income, and English speaking skills. For groups who were considered then as recent arrivals in the United States, receipt of public assistance was a significant positive post-migration predictor of

depression (Chung & Kagawa-Singer, 1993). One explanation offered for this was that adjustment in resettlement is strongly interrelated with the establishment of financial self-sufficiency.

The incidence of somatic symptoms was frequently cited in conjunction with PTSD. In addition, somatic symptoms and PTSD may have persisted in the absence of organic etiology. However, there is little discussion about the latter. The presence of persistent somatic symptoms without an organic bases may have signaled a culturally appropriate plea for help and assistance with more serious psychosocial and emotional issues (Friedman, 1992; Frye & D'Avanzo 1994a). Patients may not report major depressive symptoms, but report somatic ones, such as headache, stomachache, and poor sleep. Weakness, dizziness, decreased appetite, and fatigue were commonly reported (Chester & Holtan, 1992; Chung & Kagawa-Singer, 1995; Mollica, Wyshak, & de Marneffe et al., 1987; Mollica, et al., 1993). Cambodian refugee patients with depression had more frequent office visits and more prescriptions for long-term medication therapy (tricyclic antidepressants, antipsychotics, benzodiazepenes, and hypnotics) than the non-depressed group. Additionally, there were statistically significant differences in the number of somatic complaints reported by depressed patients compared to non-depressed patients, with depressed patients reporting more somatic complaints (Baughan et al., 1990).

Van Boemel and Rozee (1992) concluded that talk therapy in a group setting and acquisition of transactional skills improved the health of Cambodian refugee women. Furthermore, indicators of subjective well-being (feelings about family, social relationships, social participation, ability to perform tasks, spiritual life, and

adjustment to living in the United States) were negatively correlated with health complaints, generalized somatic complaints, and feelings of isolation.

The after-effects of trauma remained prevalent among survivors in the United States long past the migration event. Case studies of Khmer Rouge survivors who were interned or confined in concentration camps documented the incidence of suicidal ideation, difficulty in concentration or decision-making, and fear of being killed. These symptoms did not diminish over time, but were instead aggravated by real or potentially stressful situations. Potential loss of financial support and requests to perform a task were some examples of potentially stressful situations: "They acted as if life was tenuous and death remained a very real possibility at all times" (Kinzie, Frederickson, Ben, Fleck, & Karls, 1984, p. 649).

Many Cambodian refugees were referred to outpatient clinics for mental health care. Outpatient settings were treatment centers for severe as well as broader problems, including somatic complaints, anxiety, and adjustment reactions. One questions the outpatient clinic setting as an appropriate point of care identified for this population for two reasons. First, personal problems were considered private matters, not to be discussed publicly with strangers. The admission of mental illness in a family and open discussion with persons outside of family boundaries negatively affected the family's socioeconomic status. These actions would bring social rejection, ridicule, and family dishonor.

Second, for a group that has experienced migration and mass violence, continuity with a health care professional would be an important factor in healing and health maintenance. There are multiple factors in current health care settings that may

not have afforded this continuity. Buddhist monks, elders, and kru Khmer were among many persecuted in 1975-1979. Traditionally, they were sought as support systems for their counsel and treatment. Without their guidance and interpretation of cultural values to outsiders, trustbuilding and family involvement in mental health treatment were a challenge. Lack of attention to these cultural norms through ignorance or lack of awareness was frequently identified as a study limitation or an implication for future research with this population (Ratliff, 1995).

Few studies of PTSD in refugees were based on a theoretical framework. Theory-generating studies that linked cultural phenomena and health in this population were also limited. The last 2 decades of research reiterated the prevalence of PTSD among Cambodians. In one sense, Cambodians are a homogeneous group bound by the common experiences of genocide, violence, loss, and victimization. It is no surprise that the PTSD label applied to this group, clinical and non-clinical populations, and those who were in treatment as well as those who were not in treatment.

Also, Cambodians are a distinct group whereby an entire nation of people have had some personal experience of life under the Khmer Rouge regime. With this fact in mind, there has been little consideration of cultural phenomena in the development and utilization of psychometric instrumentation. The use of measurement tools that have been developed with clinical groups of patients in Western society must be weighed with respect to reliability and validity across cultural groups. One cannot assume that the psychometric properties of instruments developed under a set of

conditions will remain stable when used with other groups [non-clinical or cross-cultural groups] (M. Quayhagen, personal communication, February 21, 1995).

As a blanket term, however, the label "PTSD" constrained the healing/helping potential of indigenous belief systems for this group. Cambodians may not understand the diagnostic label of PTSD or Western treatment of this disorder, as many believed that angry spirits or past wrongdoing is the cause of illness or distress. To alleviate illness or distress, they would, instead, turn to prayer, seek the advice or blessing of monks, or make spiritual offerings to appease angry spirits. To a Western health care professional, these indigenous rituals may seem to have little therapeutic value over psychotherapy and medication. There has been minimal discourse about health care strategies that have been successful with Cambodian refugees. The focus on past trauma, mental illness, and psychological distress including depression and anxiety, prohibits 'upstream' thinking and the generation of culturally congruent and viable health promotion alternatives. This limited the exploration of other wholistic dimensions that may or may not have contributed to the health and well-being of resettled Cambodian refugees. Furthermore, a focus on past trauma without interventions perceived to be useful by this group may be as damaging as prior traumatic experiences.

There was little overwhelming evidence that demonstrated the effectiveness of traditional Western psychiatric therapies, such as individual counseling, and antidepressant medication with this group. Some Cambodian refugees remained symptomatic, while others are asymptomatic. What accounted for these differences remains to be studied. The sequelae of trauma suffered among refugee women, and the

context of cultural norms in which it occurred, has been ignored (Swiss & Giller, 1993). Few studies have focused specifically on the health needs of women survivors of the Khmer Rouge regime. Although key studies of PTSD and psychological distress in Cambodian refugees were accomplished landmarks in research and tool development, they briefly acknowledged the percentage of participants who were women, their ages, marital status, and medical diagnoses and little else (Carlson & Rosser-Hogan, 1991; 1994; Chung & Bemak, 1996; Chung & Kagawa-Singer, 1993; 1995; Mollica, et al., 1992; Mollica, et al., 1993; Nicassio, 1985). Mollica, Wyshak, & Lavelle (1987) noted particularly that Cambodian women without spouses demonstrated more severe social and psychiatric impairments than all other women from Vietnam and Laos. Unless the cultural disenfranchisement of Cambodian women is acknowledged, the health issues of Cambodian refugee women, including mental health or other psychosocial impairments, cannot be effectively addressed. In short, the absence of inquiry in this arena indicates inattentiveness to their wholistic health needs. Adherence to cultural norms of keeping troubles private may be mistaken for an absence of problems.

Re-direction of research efforts toward a grounded theory will identify dimensions of health as seen from the perspective of refugee women. Ultimately, this may facilitate the development and refinement of health measurement tools and determine appropriate and culturally congruent health care interventions for this group.

The Double Burden for Refugee Women: Ill Health and Cultural Socialization

For women, changes in traditional gender roles resulting from migration led to further isolation from the ethnic community and loss of family support. As voiceless entities in both source and host cultures, Cambodian women have had the dual task of resolving grief due to uprooting events and adjusting to resettlement in a new environment. Demands to comply with competing value systems of both cultures added to the struggle for survival. Women had the additional burden of contending with the health consequences of denial of basic needs, camp confinement, and torture and abuse of women under the Khmer Rouge. Women-headed families without spousal or extended family support were most vulnerable to health consequences throughout migration, internment, repatriation, and resettlement (Wali, 1995b; Women Watch, 2000; Rehn & Sirleaf, 2002).

Malnutrition and infectious diseases were the causes of many problems women faced during migration and camp internment. Anemia, pellagra, scurvy, and goiter were deficiency-related illnesses rampant during these periods (Brown & Berry, 1987; Gove & Ali-Salad, 1987; Toole & Waldman, 1993). Descriptive and oral history studies validated the fact that many died of starvation or witnessed starvation of their children, spouses, or relatives. Descriptions of a single ration under forced labor and internment conditions consisted of a thin watery gruel with a few grains of rice (Criddle, 1987; Welaratna, 1993). Other complications among malnourished childbearing women were low birth weight infants, and pregnancy-related complications, such as hemorrhage and puerperal infection, miscarriages, and stillbirths (Freedman & Maine, 1993; Paolisso & Leslie, 1995). Hypertension, and

related conditions during pregnancy, pre-eclampsia, and eclampsia also threatened health (Koblinsky, Campbell, & Harlow, 1993).

Crowded and unsanitary camp conditions, contaminated food and water, poor food storage, and inadequate waste disposal, not only endangered the health of expectant women and their newborns, but accounted for many infectious diseases also rampant during migratory and internment conditions. In addition to environmental conditions, inadequate medical care or inaccessibility of medical care further aggravated the decompensating health status of refugees. Epidemics were common occurrences. Cholera, hepatitis, dysentery, diarrhea, intestinal parasites, tuberculosis, respiratory tract infections, and meningitis were prevalent disorders in dense living conditions (Catanzaro & Moser, 1982).

Hypertension was another frequent clinical finding in Southeast Asian (SEA) refugees. Women were no exception. Since hypertension is essentially a stress-related disorder, it is not surprising that many Cambodian refugee women had hypertension. The significant stress factors in their lives contributory to hypertension may have been linked to basic survival needs and economic sufficiency for themselves and families. Sexually transmitted diseases, reproductive tract infections, and cervical and breast cancers accounted for significant mortality (McDermott, Bangser, Ngugi, & Sandvold, 1993; Paolisso & Leslie, 1995). Women may not seek out health care due to costs of care, lack of time, and the unavailability of culturally appropriate health care services. Other reasons for avoiding organized health care facilities were communication barriers and stigma or shame associated with their physical condition. Furthermore,

inadequate and untimely health screening may have delayed much needed intervention.

Human Rights Violations

The victimization of refugee women, unaccompanied, single, widowed, and young girls, have been previously documented in the PTSD literature. The incidence of rape and sexual abuse of refugee women remains an issue of grave concern. There was little documentation, however, of international efforts to provide immediate care and intervention to prevent or address these human rights violations (Friedman, 1992; Swiss & Giller, 1993). Timely international interventions with programs to address mental health needs in camps were absent (Mollica, 1990; Sapir, 1993). Women have been targets of victimization throughout their migratory search for refuge and safe haven. Consequently, the perpetrators of gender violence from which women fled continued to harass and terrorize them along escape routes, camps, and in asylum or resettlement countries (Roe, 1992). Women were subjected to victimization and rape in exchange for food, shelter, medicines, border crossings, documentation papers, and transportation (Amnesty International, 1995; Heise, 1993; Friedman, 1992; Rehn & Sirleaf, 2002; Wali, 1995b).

Abductions and forced prostitution, and the coercion of women and children for drug trafficking jeopardized safe passage. There were few mechanisms to report, monitor, and track the disappearances of women en route to relief centers (Wali, 1995b). In a study of 933 refugees confined in camps along the Thai-Cambodian border, the percentage of women reporting rape and sexual abuse decreased from 17% to 5.9% over a 10-year period (Mollica et al., 1993). These figures indicated an active effort to address the safety needs of women in refugee camps. However, they were

nevertheless misleading due to the double standards refugee women confronted within their own culture. Women faced violence and abuse from both non-domestic and domestic perpetrators. As a result, because they did not conform to the cultural ideal of virtuous Cambodian women, they were outcast from family and community.

Traditional cultural expectations, family disintegration, victimization, and oppression under the Khmer Rouge accounted for these double standards. Women in Cambodian culture kept the family physically and spiritually intact. They bore responsibility for carrying the family integrity (Ebihara, 1968). The social status accorded to the family in the eyes of the community was determined by virtuous actions and words of the woman (Ledgerwood, 1994).

Gender violence and widowhood made it even more difficult for women to live up to cultural expectations. Consequently, women were disenfranchised by family and community at a time when assistance was most needed. The physical and emotional abuses of women resulting from rape were cause for family, relatives, and community to exclude them from support. As outcasts, women had no recourse in obtaining help in dealing with immediate and long-term effects of rape. Such acts of dehumanization against women were attributable to one's fate or karma (Friedman, 1992). The avoidance of social devastation and cultural rejection kept women from reporting human rights violations, especially when reliance on family was the primary means of assistance (Chester & Holtan, 1992). Discussion or knowledge of these incidents outside the family circle brought further shame and dishonor to oneself and one's family (Friedman, 1992; Heise, 1993; Roe, 1992). Women were not only subjected to external violence, but also to spousal abuse. One reason for spousal abuse cited in

literature was the re-assertion of male authority in a disintegrating family system (Ho, 1990; Kulig, 1994).

The Impact of Socioeconomic and Sociopolitical Infrastructure Upon the Health of Refugee Women

The impact of human rights violations against Cambodian refugee women extended beyond personal boundaries into socio-economic and political realms as well. In crises and conflict between warring factions, governments accepted and permitted the depersonalization of women (Roe, 1992). The United Nations High Commissioner for Refugees (UNHCR) is an official position within the United Nations organization that has been established to protect the rights of refugees. However, it previously had no specific provisions for the safety of women, or consequences for governments who committed violations against women. The UNHCR was non-specific to women in its language and definition of "refugee." Therefore women were disenfranchised under refugee law (Wali, 1995a; 1995b). United Nations programs designed to provide refugee assistance were often legislated and managed by men who did not fully grasp the needs and problems of refugee women (Friedman, 1992).

The 1995 International Women's Conference in Beijing raised disturbing questions regarding the rights of refugee women. Representatives of several United Nations governments contended that the rights of women, including the protection of human rights and access to resources, must be contingent upon "local and cultural traditions and beliefs" (Amnesty International, 1995, p. 7). The denial of economic and financial resources needed to rebuild women's lives has a tremendous impact on the physical health status of women which ultimately affects the health status of their

families (Paltiel, 1993; United Nations General Assembly, 2000; Women Watch, 2000). In recent years, the United Nations has taken a more active role through ratification of specific resolutions in the protection of refugee women and their human rights (United Nations General Assembly, 2000). Resolutions also addressed follow-up and monitoring of strategic objectives pertaining to refugee women's health, access to resources, and gender equality. International efforts have heightened global awareness of the plight of refugee women (United Nations, 1995; United Nations General Assembly, 2000; Women Watch, 2000).

Thus far, the resultant health sequelae of migration, internment, repatriation, and resettlement of Cambodian women have been addressed. The double standards that refugee women confronted within these situations have been discussed.

Throughout these life events and transitions women faced adverse conditions, loss of family and possessions, threats to personal safety and security, and stigma. Their plight and worldview that framed their perceptions have been poorly understood. Consequently, this misunderstanding has been conveyed into other areas of inquiry.

The next section of the literature review addresses methods used in health-related research with refugees resettled in the United States. Health issues coupled with resettlement in an alien cultural context and shifting family roles posed difficulties for women in resettlement. Essentially, the theme of fragmentation persisted in conceptualization and operationalization of studies. Not only does this sensitize the researcher in working with at-risk groups, but also makes one aware that fragmentation, at some level, may also represent a prolonged extension of loss and unresolved grief to participants.

Conceptual and Methodological Issues in the Conduct of Research with Refugee Populations

As a whole, literature provided evidence of the struggle to identify and clearly define what constituted health and well-being for Southeast Asian refugees who resettled in Western society. This struggle has been manifested in conceptual, methodological, and ethical issues related to the conduct of research with the population of interest. A conceptual issue is the perspective from which health and well-being have been defined. Methodological issues are related to measurement and instrumentation, data collection, recruitment and informed consent. What has been clearly absent from studies has been the integration or consideration of unique beliefs and behaviors representative of worldview. What has been evident instead are Western presumptions.

Conceptual Issues

Conceptualization and operationalization of key ideas is central to the design of quantitative studies. However, for the most part, concentration on the adoption of host culture behaviors dealt with nominal levels of measurement. Examples of this level of measurement have been one's preferences for food, style of dress, spoken language, customs, and lifestyle habits of the host culture over one's source culture (Celano & Tyler, 1991; Suinn, Ahuna, & Khoo, 1992). The adoption of host culture behaviors as a requisite for well-being in the host society was an inaccurate presumption. Closer examination of presumptions such as this one provides important insights and background information for this study.

Perspectives on health and well-being. The philosophical foundations of research on health and well-being stem largely from a Western paradigm. From a

conceptual viewpoint, two major perspectives of health and well-being extrapolated from the literature are the 'micro' and 'macro' perspectives (Catolico, 1997). The micro perspective emphasized that well-being is defined by the possession of certain attributes. They are categorized as positive feeling-states (Bradburn, 1969; Nelson, 1990), autonomy, self-esteem, and mastery (Heidrich, 1993; Ryff & Essex, 1992).

Personal abilities such as self-awareness, adjustment, the ability to cope with stress (Hung-Ru & Bauer-Wu, 2003), and resilience (Christopher, 2000) are consistent with the micro perspective of well-being. Other personal abilities associated with the micro perspective of well-being are self-agency (Daaleman, Cobb, & Frey, 2001), self-responsibility (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1996), self-assessment of one's health, and management of recurrent symptoms (Musil, Morris, Haug, Warner, & Whelan, 2001). Cognitive processes associated with well-being are the ability to gather and process information, interpret and understand one's illness, and to maintain positive intentionality (Daaleman, Cobb, & Frey, 2001).

One's sense of life satisfaction, life integration (Ryff & Essex, 1992), and self-actualization (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwork, 1996) are individual perceptions of well-being. Hungelmann and others (1996) included a spiritual perspective, such as one's core beliefs, as an aspect of well-being. There has been similarity among these conceptual definitions but no single definition of well-being that incorporated these attributes or characteristics.

The micro perspective of well-being emphasized the personal or individual possession of attributes and characteristics. Essentially, this perspective indicated or implied that responsibility for change in adverse conditions, events or removing

barriers lies with the individual. Problems and difficulties encountered are the result of one's choice. The individual holds responsibility for acquisition of necessary survival skills. The social infrastructure in which the individual resides is not seen as a source of barriers or perceived difficulties faced by refugee women in resettlement. The micro perspective reflects the dominant Western focus on individualism. This Western focus contrasts with a Cambodian cultural value which encourages reliance on one's immediate and extended family. Therefore this view is not a useful one from refugee women's vantage. This view separates Cambodian women from their source cultural values. It is also incongruent with the notion of karma.

The macro perspective warrants discussion because it is central to the migration experience. The 'macro' perspective is shaped through interactive or intersubjective experiences (Wenger, 1993) and societal values. The macro perspective emphasizes the socialization process in the host culture. Differences and an inability to "fit in" are the emphasis of previous studies. This pattern of preconceived biases and assumptions underlies previous studies with Southeast Asian refugee populations.

Previous studies have been based on the assumption that interaction with the host culture and adoption of host behaviors induces cultural change for the better. Essentially, well-being was predicated upon exposure (Suinn, Ahuna, & Khoo, 1992), effective functioning (Rivas & Torres-Gil, 1991), adjustment and acculturation (Celano & Tyler, 1991; Ward & Kennedy, 1993), and adaptation and acceptance of host ways (Ranieri, Klimidis, & Rosenthal, 1994). The macro perspective promoted the idea that survival in a host culture required abandonment of behaviors and

practices that reflected the values and beliefs of one's source culture. This notion is predicated on ethnocentrism.

Other definitions of health and well-being were derived from focus groups of women who lived in communities along the U.S. border. Their definitions are inclusive of relationships to self, family, and community. Definitions of health and well-being determined by these groups were: (a) a balance and integration of physical, social, emotion, and spiritual elements of life, (b) harmony and stability within family, and close relationships, (c) support, empathy, and communication with friends and within communities, (d) equality, power, and respect, and (e) living in a society that values people, relationships, and diversity (Kasle, Wilhelm, & Reed, 2002). These definitions suggest integrative relationships within one's life context, rather than the possession of personal characteristics or abandonment of cultural beliefs and behaviors.

Marginalization of Cambodian women in the context of Western society.

Conflicting worldviews between one's source culture and the host culture create a vicious cycle, in which women are alienated from needed social and health care resources (D'Avanzo, Frye, & Froman 1994; Frye & D'Avanzo, 1994b). Furthermore, geographical resettlement in communities of their own ethnicity further isolates them from mainstream resources, and reinforces discriminatory and stereotypic views of such communities. For example, other-defined reality for Cambodian women in the host culture eliminates them from the broad picture. Government and non-government agencies in the United States have determined how ethnic groups are categorized by census data. Even less information is known about Cambodian resettled women

because many surveys of households have assumed they are male-headed, and that any patterns of employment within the household referred to males (Krieger & Fee, 1994; Proctor & Dalaker, 2003). The absence of information about Cambodian women in resettlement has rendered them invisible.

Invisibility of Cambodian women in the host culture. The views of well-being as seen and defined by Cambodian women in resettlement in the host culture were largely excluded (Burki, 1987; Mitchell, 1987; Ong, 1995). Because of this exclusion and invisibility of Cambodian women in Western society, there is little data available about them. Their perspectives of health and well-being may be unrepresented or inaccurately depicted in the nursing literature.

Terminology which defined or described persons outside of the mainstream emphasized stigmatization (Stevens, 1992). “Immigrant” and “refugee” imply “foreigner” and “outsider” status. “Women in resettlement” affords a more nonjudgmental description with human dignity and respect than “immigrant” or “refugee.”

A macro perspective offers a more useful viewpoint of health and well-being because it depicts a realistic view of problems and demands imposed within a sociocultural context--both source and host cultures. In the long run, how these women participate in society related to decisions which affect their health and daily lives is closely tied to how they are portrayed in the macro scheme of things. Essentially Cambodian women in resettlement are not portrayed with needs at all. They are viewed as static entities, not as evolving women who are affected by transitional life experiences, multiple strains, and perceived change. Members of the

host culture who interact with Cambodian women may also do so from their own assumptive filters. In other words, they believe that Cambodian women operate from the same mainstream perceptions. The underpinnings of well-being as a macro social construction has filtered into the conduct of research and how health issues of refugee populations have been approached. Furthermore, although stable cognitive, affective, and perceptive dimensions of well-being have been identified, these dimensions were established with subjects classified as middle class by socioeconomic standards of over 20 years ago (Bradburn, 1969; Carp & Carp, 1983).

Invisibility of the health concerns of Cambodian women. The health concerns of Cambodian women have been rendered invisible in the host culture. The concept of health may be defined differently by a group. The conceptualization of health as it is defined by Cambodian women is lacking. Evidence for this lies in their experiences of marginalization, isolation, and differential treatment in resettlement. Immigrant women sought health care, not necessarily for physical health reasons, but for depression and loneliness. Advice given by health care providers to immigrant women for emotional health was often impractical or inappropriate, because it was based on the providers' personal life experiences and viewpoints. Health care professionals have dismissed the emotional concerns of immigrant women. Their emotional concerns were not viewed as major health issues. In situations such as this, health care professionals communicated a power differential between immigrant women and themselves, thus assigning a subordinate role to immigrant women (Aroian, 1990; Muecke, 1992a). Consequently, women do not pursue further help for emotional care, but retreat into isolation. The separation from mainstream health care resources and

services promotes a vicious cycle in which women continue to exist on the fringe, remain overburdened with competing demands from source and host cultures, and increase their vulnerability to health risks (Anderson, 1987; Lipson, 1992; Meleis, Arruda, Lane, Bernal, 1994; Meleis, 1991; United Nations Development Fund for Women [UNIFEM], 2002).

Dependency on one's social group or family for assistance is heavily emphasized in Khmer culture (Lew, 1991). The group orientation is a stark contrast to the Western focus on independent decision-making and personal accountability for one's affairs. Although the group focus is a predominant one in which women have the central role of providing support to others, there has been little discussion in the literature about where and how women draw support for themselves. Skodra (1992) asserted that the experiences of immigrant women are made invisible. The invisibility of their experiences isolates them not only from much needed health care resources, but also from socio-political resources to promote change.

Alienation from health care services. There are few studies that have scrutinized relationships among provider interactions and utilization of services by refugee populations. Inequitable distribution of and inaccessibility of health care, poor quality of care, and negatively perceived interactions by refugee women provide an argument that health care provider decisions are made with social criteria in mind—gender, ethnicity, and socioeconomic status (Krieger & Fee, 1994; Stevens, 1992). Dyck (1992) and Stevens (1992) have argued that institutional policies and practices have sanctioned culturally insensitive patient-provider interactions and have permitted culturally inappropriate treatment interventions without regard for beliefs and values.

Flaskerud (1988) and Flaskerud and Akutsu (1993) found that Asian patients who utilized “mainstream” programs were diagnosed differently than those who utilized ethnicity-specific health care programs and services. Other research related to utilization patterns of health care service use among Southeast Asian refugees and immigrants indicated they were less likely than other ethnic minority groups to seek services for psychosocial stress, identity conflict, and Post Traumatic Stress Syndrome (PTSD) symptoms (Gim, Atkinson, & Whiteley, 1990; Hu, Snowden, Jerrell, & Nguyen, 1991).

Refugees surveyed in the Detroit area about their physical and mental health status, barriers to care, and utilization of health services indicated the unavailability of services for their needs (Young, Bukoff, Waller, & Blount, 1987). No discussion followed concerning how health care systems could respond to the demands and issues posed by these refugee groups. Trained bilingual interviewers collected the health data. However, there was little discussion about this process other than the translation of a survey tool into five different languages. Participants indicated language barriers to having their problems fully understood by the doctor, and understanding what the doctor was trying to communicate to them was especially problematic. Vietnamese respondents chose a category listed solely as “other” to indicate their source for health care. No discussion followed as to why “other” sources were sought out by Vietnamese respondents. These respondents had one or more untreated health problems which were not identified in this study. There was an underlying assumption that existing health care services were appropriate, and that measurement tools were adequate and sufficiently understood by refugee groups. Other literature indicated that

the same state of affairs related to barriers to care, utilization of health services, and the unavailability of services has continued to persist (Azaroff, Levenstein, & Wegman, 2003; Ro, 2002; Sent, Ballem, Paluck, Yelland, & Vogel, 1998; Stewart & Napoles-Springer, 2003; & Uba, 1992).

Invisibility of immigrant and refugee women in research. The concept of health as it defined by Cambodian women is central to the conduct of research. Without this, research may be constructed upon inappropriate assumptions and implemented with inappropriate instruments. Studies directly related to the conceptualization of phenomena and the experiences of health and well-being of Cambodian refugee women specifically, have been unprecedented. This gap in knowledge may result in flawed methodology or poorly designed studies with inadequately defined concepts.

The literature has identified an increasing awareness and understanding of health risks and needs of distinct Southeast Asian immigrant groups within the context of their respective sociocultural belief systems (Gilman, Justice, Saepharn, & Charles, 1992; Klessig, 1992; Mo, 1992; Ying & Miller, 1992). There has also been an increased research interest in looking at the health care needs of refugee and immigrant women in general (Aroian, 1990; Meleis & Rogers, 1987; Meleis, 1991; Skodra, 1992; Sue & Sue, 1990). Krieger and Fee (1994) called for development of social measures and strategies to understand relationships between social categories, such as economic strata, and health. These relationships have yet to be fully understood even though there has been efforts made to disaggregate data specific to distinct Southeast Asian populations (APALC, 2005).

Clearly articulated in nursing studies is the need to understand the health concerns of immigrant and refugee women in terms of their socio-historical-cultural context and value systems. Although previous studies have pinpointed a need for further study in these areas, there have been few attempts in nursing research to determine how these women maintain health and manage multiple demands of resettlement (Meleis & Rogers, 1987; Miller & Chandler, 2002; Murray, Manktelow, & Clifford, (2000). Few advances have been made in nursing research in exploring changes during migration and resettlement of immigrant and refugee women and their strategies for coping with such changes (Aroian, 1990). Minimizing the health concerns brought forth by women and ignoring the social, historical, and cultural embeddedness of these concerns reflects the dominance by the host culture. Skodra (1992, p. 96) eloquently asserted, "It is the meaning women attach to their experiences which facilitates an increase in personal power and a sense that change in life situations is possible when it is desired." The process and meaning of change and health maintenance strategies of immigrant and refugee women in migration and resettlement can be best explored through qualitative study and participatory research (Lipson & Meleis, 1989; Muecke, 1992b).

Methodological Issues

Previously cited research has contributed to the general pool of knowledge related to refugee groups. However, there has been no consistent theoretical framework cited in these studies to guide research or to build upon previous studies. Acton (1994) supported this conclusion in noting the wide range of instruments used to measure well-being, and in the overlapping definitions of well-being with other concepts such as mood, self-esteem, morale, quality of life, stress, social support, and

life satisfaction. Additionally, instruments developed by researchers have been normatively referenced upon dominant group characteristics which raise the issue of ethnocentric bias when used with minority groups (Clark, 1987; Flaskerud, 1988). An assumption is that life experiences of resettled Cambodian women can be adequately measured and described by 'frequency', 'degree', or 'intensity', or other Likert type scales. In reality, the worldview of resettled Cambodian women does not parallel Western scales such as these. Measurement tools that have a more visual and graphic approach to capturing data about the refugee experience such as ecomaps, genograms, and culturagrams have emerged in the psychosocial literature (Davis & Cannava, 1992; Saleeby, 1994). The use of visually-oriented tools and narrative dialogue, stories, and questioning techniques serve to assist in reconstruction and rebuilding of community and family ties. They help discover meaning underlying significant events, relationships, and situations in light of having survived difficulties (Kelley, 1994). Such tools may be more compatible with the Cambodian experience, beliefs, values, and philosophic outlook, than existing measurement scales. Visual and pictorial images may facilitate communication, understanding, and critical inquiry about their reality (Freire, 1993). While measurement tools have adequate reliability and validity, they do not capture evolving meanings and change over time related to women in resettlement.

Tools with adequate psychometric properties have been translated into other languages for use with non-English speaking populations. Im and Meleis (1999) addressed culture-specific issues related to the health of Korean women. Essentially how women handled their physical health issues was related to ascribed gender roles,

socio-cultural expectations, perceptions toward symptoms, and the women's attitudes toward health and illness. A Korean-translated version of the Cornell Medical Index was used with this group of women. The relevance of this instrumentation with respect to the cultural paradigm of these women was not discussed. Backtranslation, conceptual equivalence, and semantic meaning in tool development are critical research issues that have been addressed in the literature (Davis & Cannava, 1992; Devins et al., 1997; Ferketich, Phillips, & Verran, 1993; Henderson, Sampsel, Mayes, & Oakley, 1992; Jones, 1987; Jones & Kay, 1992; Lipson & Meleis, 1989; Sperber, Devellis, & Boehlecke, 1994). However, discussion in studies about these issues is all too rare. One cannot ascertain the truth of research outcomes unless these key properties are an integral part of the process of inquiry. The difficulty in conceptualization of meaning in the context of culture and transliteration has been previously acknowledged. Subtle nuances and idiomatic expressions in the Cambodian language increase the difficulty in the quantification of measurement tools. Two key studies in tool development, the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist-25 (HSCL-25), have attempted to address these psychometric issues with Cambodian refugees (Mollica, et al., 1992; Mollica et al., 1993).

Instrumentation. The Harvard Trauma Questionnaire (HTQ) was validated among Cambodians who lived in confinement along the Thai-Cambodian border and those who had resettled in the United States. The questionnaire asks about trauma that one has experienced, seen, or heard about. Administration of the HTQ took place upon arrival in the United States and within 8 weeks of an initial clinic visit. Questions are

phrased in a culturally acceptable, neutral, and non-threatening manner. Translation and backtranslation studies were conducted in Khmer, Lao, and Vietnamese by bilingual Southeast Asian mental health clinicians. Blind backtranslations into English versions were accomplished by qualified individuals. The most sensitive questions are asked last in accordance with cultural customs. Backtranslation of the tool by those who were familiar with the culture and the design of questions that were culturally acceptable perhaps contributed to the tool's acceptable psychometric properties.

The Hopkins Symptom Checklist-25 [HSCL-25] (Mollica, 1987) also helps people identify physical symptoms in a manner consistent with cultural idiomatic expressions. Like the HTQ, it helps people attach words to their feelings. Terms selected for the questionnaire stem represented cultural descriptions of symptoms or physical conditions from a study of 933 Cambodians who lived in confinement (Mollica, et al., 1993). From this group, 82.6% reported *bebotchit* (deep sadness inside oneself); and 24.8% reported *chcoot* (lost mind). Many experienced *srangot srangat* (38.8%) a visible sadness more severe than *bebotchit*; *ah sangkim* [hopelessness] (52.9%); *ett damlay* [worthlessness] (37.0%); and *proouychit* [worrying sadness] (56.3%). Some (10.6%) experienced *saplap kluon*, (suicidal feelings), during the previous week.

The HTQ and HSCL-25 are landmark instruments with psychometric properties that have been referenced with Cambodian refugees. They have been useful as initial screening instruments for refugees. Nevertheless, as with other studies of refugee trauma, the HTQ and the modified HSCL-25 have been developed using the equivalent of Western dimensions of mental illness--anxiety and depression. Studies

that detail successful interventions and treatment outcomes, and studies that either highlight or detail refugee women as an important subset of a sample, are largely absent.

Entre and data collection. Entre and the process of data collection is another important link in study design. Primary investigators had limited language skills in Khmer, or lacked them altogether to communicate sufficiently and directly with Cambodian study participants. The literature indicated that entre to the population of interest was achieved through introduction by a respected member of the community or through a member of the research team who was Cambodian and understood the culture. Data collection has consisted primarily of face-to-face interviews conducted in the clinical setting or in the home setting, at which point, questionnaires were read and translated to respondents in the source language. Translators asked the interview questions, re-read them, and served as interpreter between researcher and subject. Multiple instruments as part of a study were administered in this manner (Carlson & Rosser-Hogan, 1991). Self-report by the respondents themselves was another method of collecting information if the respondent possessed English-speaking skills. These approaches have implications for recruitment of subjects, informed consent, and accuracy and quality of the interpretation of data.

Another methodological issue infrequently acknowledged is the interactional processes between refugee patient, the health care provider, and interpreter. These processes may influence decision-making and ultimately, health outcomes (Carol, 1991). Likewise, the interpersonal encounter between researcher and participant influences data collection, recording, interpretation, and analysis (Sawyer et al., 1995).

Gender, knowledge of culture and traditional social relationships in Cambodian society, bilingual skills, and sensitivity to potentially embarrassing questions for the patient are factors that may misrepresent communication and intent. The process of translation and the use of interpreters may distort communication (Jacobs, Shepard, Suaya, & Stone, 2004; Kamath, O'Fallon, Offord, Yawn, & Bowen, 2003; Maneesriwongul & Dixon, 2004; Tang, 1999), and violate patient privacy, especially when querying gender-specific and sensitive issues. For these reasons, Sawyer et al. (1995) proposed matching between researcher and subject to address this concern. These ideas raised in the literature call attention to specific aspects of the research process. These aspects are maintaining sensitivity to culture and gender relationships and establishing clear guidelines for the role of the researcher and the role of the translator.

Recruitment and informed consent. The global experiences which enveloped Cambodian survivors present an issue in designing quantitative studies. The establishment of control groups with this population is neither feasible nor realistic (Basoglu, 1993), as many have been subject to the very same or similar experiences.

Recruitment and retention of large numbers of subjects may be influenced by several things. First, privacy, or saving face, is an important consideration. Women may not readily volunteer to participate or answer questions unless they first observe others doing so. Traditionally, activities that concern women required permission of the eldest male in the household (Leao, 1996). This may pose difficulty in obtaining informed consent and recruitment of large numbers of research participants. Secondly,

activities that would impose an economic or logistical burden, undue discomfort or hassle may deter participation.

Travel for any distance to a meeting site, transportation costs or lack of transportation, and finding care for dependents or children at home may be hindrances to participation. Advanced scheduling for meetings or appointments can be difficult, as some participants may not have telephones. Increased mobility may also be a deterrent to recruitment and retention as people search for better job opportunities or better housing (DeSantis, 1990).

One must be cautious in not presenting an additional burden to this group as they participate in research, especially with interviews in the home setting (Demi & Warren, 1995; Clark, 1987). It is customary to offer food and drink, which may present an unnecessary expense for many who depend on limited financial resources. In fact, incentives or tangible benefits for their participation in research should be offered (DeSantis, 1990). Formal organizational networks that would facilitate access to this group are few. Finally, research has concentrated on that which has been considered 'pathological'. Therefore, there may be a reluctance to contribute or participate in research to avoid this labeling.

Few studies have elaborated on the process of obtaining informed consent as known in Western culture. The notion of informed consent may be a foreign one to Cambodian women in resettlement. Transliteration and language constraints may be reasons why there is little discussion of issues related to informed consent. How participants are informed about risks and benefits in view of literacy skills has not been discussed widely in studies. As a vulnerable group at high risk for health

problems, the issue of coercion must be addressed. Survival strategies learned from past experiences included compliance with authority figures and stating what they perceived others wanted to hear. One must be aware of the potential for exploitation with vulnerable groups in recruitment, obtaining informed consent, and interpretation of data so as not to be patronizing or demeaning (Demi & Warren, 1995). Research participants provide valuable data and information about their experiences, perceptions, and health status, often in exchange for a small incentive. Flaskerud and Nyamathi (2000) advocated for the provision of health care resources which these groups often lack in fostering their research participation.

*The Paradigm of Health-Illness and Its Relevance
for Women in Resettlement*

The need to get beyond a limited perception of refugees in resettlement as dependent and traumatized people still exists. There are studies that have given rise to other dimensions of health and well-being in resettlement, and are specific to Cambodian women. Khmer women emerge as influential decision-makers in health care matters for their families. As a group in transition in the United States, health care decisions are influenced by causation, pragmatics, familism, and language and cultural comfort (Frye, 1989). Cambodian women have had to re-negotiate their identities throughout migrational, transitional, and resettlement periods in their lives (Burki, 1987).

Cultural embeddedness, cognitive bargaining, and social location are concepts which may influence their survival strategies. Embeddedness is the validation of one's role in relation to family, network, and socio-cultural values. Cognitive bargaining is gathering, analyzing, and using knowledge in one's interaction in social spheres.

Social location is the personal meaning one has in relation to family, life-cycle roles, the social system, and events occurring within this system. As women in transition, Cambodian women continue to negotiate with new and familiar support networks to resolve their problems. Mitchell (1987) asserted that Cambodian women in resettlement have rebuilt their lives for themselves and their dependents through the use of information and instrumental support. Ledgerwood (1990) examined the changing comportment of resettled Cambodian women in the United States. New roles are taken on by women out of necessity. This has changed the gender conceptions of women and challenged the traditional Cambodian social order and the perceived status of their families. These eventual transitions in the context of resettlement affect their perceptions of health and their health status. One surmises that there are unexplored dimensions of health relative to culture, context, and resettlement that enable women to persist and continue as family caregivers and decision makers in spite of multiple adversities and painful losses.

Debate has challenged the existing paradigm of health care. The social, economic, and political realities that influence health care equity are reflected, to some degree, in the conduct of research, health care intervention provided to refugees under medical care, and stereotypic attitudes of health care providers toward refugees. The detached approach to the diagnosis and treatment of medical problems without regard for the value systems of a source culture has been challenged. The role of indigenous value systems and their influence health beliefs and personal health decisions is not fully understood. Finally, there is the question of how the existing social, economic, and political infrastructure ultimately supports the dominance or imposition of a

Western value system in the treatment and care of marginalized or stigmatized groups (Stevens, 1992; Ro, 2002).

Psychometrically stable instrumentation, and attention to the transliteration process, including idioms and the range of nuances, have failed to capture an explanatory model of illness (Eisenbruch, 1991; Fabrega, 2000). The concept of 'hot' and 'cold' imbalance does not translate into parallel mental structures in a Western paradigm of health and illness. Likewise certain physiological concepts for example, coronary artery disease, do not translate into Khmer because the mental concept has not existed in the culture (Carol, 1991; Jackson, C., Rhodes, L.A., Inui, T., & Buchwald, D., 1997).

There is inherent bias in the imposition of Western criteria (diagnostic and treatment systems) upon people of non-Western cultures. As previous sections of this chapter have described, the bias is in the cognition, experience, mental structures, processes, and attitudes of a Western health care value system, which may have no parallel in another culture. This bias pervades interpersonal context and is ultimately embedded or bound up with the larger social, political, and economic infrastructure (Fabrega, 1989, 2000). Brody (1990) argued for understanding the 'macrocontext' of health problems and issues in a sociocultural context and its impact upon the 'microcontext' of the clinical encounter. Culture as a causal variable is highly contextual and woven with complex social networks. One cannot predict behavior or interpret data without knowledge about the culture. To do so would lead to inappropriate conclusions about the data (Clark, 1987).

A common assumption is that since the refugee response to trauma is a universal one, diagnostic and treatment approaches to trauma should also be universal.

Bracken and others (1995) are critical of this assumption:

Western models of diagnosis and treatment assume a universalist position regarding response to trauma...Healing is a multifaceted phenomenon...Individual treatment therapy is only one type of healing...The experience of illness does not occur in isolation but rather within the context of a whole set of cultural family and individual values and orientations. These shape the experience of illness itself and determine which therapeutic strategies will be tried. (p. 1075)

Furthermore, the focus on the Western model only 'medicalizes' larger social, political, and economic problems facing refugees. It ignores the political dimension of suffering when in fact, "Interventions need to be 'sociocentric' where the individual's recovery is intimately bound up with the recovery of the wider community" (Bracken, Giller, & Sommerfield, 1995 p. 1080).

A reductionistic view of the human experience is reiterated in Fabrega's (1989) assertion that scientific objectivism and cultural relativism (differences in beliefs, feelings, behaviors, social traditions) are contradictory. Perhaps the point that Fabrega has attempted to communicate is that the empirical objectivity of Western science cannot be applied to, or is not useful for, cultural interpretations of behavior. The two paradigms of knowledge are contradictory. The themes of social institutional control, bureaucratic practices, and power differentials between health care provider and refugee women stifle independence and decision-making about their health needs and

neglect their participation in shaping social policy (Muecke, 1983, 1992a, 1992b; Ong, 1995). Ong (1995, p. 1253) asserted that, "As patients in clinics, Khmers are compelled to rethink the relationship between bodily integrity, social status and war memories on the one hand, and biomedical forms of domination on the other."

The continued traditional focus and approach of individual treatment versus healing of groups and community reinforces inequities in health care, and medicalization of broader issues intimately bound with health care and research. Gerber (1994, p. 288) proposed research that "taps into restoring connections and meaning between individual and community, spiritual and material, mind and body, person and place." Through the acknowledgement of opportunities for growth out of the migration experience and the use of narrative dialogue in exploring meaning, women may rebalance their priorities and blend cultural influences, rather than be torn apart by the past (Falicov, 1995).

Synthesis and Critique

Each wave of Southeast Asian refugees that resettled in the United States stimulated scientific inquiry. Each successive wave brought a higher awareness of relevant health-related issues. Research in the late 1970's to mid- 1980's highlighted post-traumatic stress disorder. Studies in the mid- 1980's to 1990's continued to address PTSD, and observed symptoms or behaviors that were without physiological explanation. Refugee studies in the 1990's focused on assimilation and acculturation in host communities of resettlement.

Mental health has continued as the focus of research studies concerning Cambodian refugees. Depression, anxiety, PTSD, and somatization are recurrent

themes. Pre-and post-migration factors have been examined as causal links to depression, anxiety, and PTSD. Peripheral to these causal links are the utilization of outpatient clinics offering health services to this population. In these major areas of inquiry which followed or paralleled mass exodus of Southeast Asian refugees from one country to another, few linkages or references were made to cultural worldview and the health and illness paradigm of Southeast Asian groups. These references to cultural paradigms in this respect were sporadic and inconsistently addressed in studies.

The paradigm of health and illness held by Cambodians, in contrast to a Western one, has been treated distinctly and separately in the literature. The dominant Western paradigm of health and illness pervades research studies, at the expense of devaluing the other. It can be said that Cambodians have a more wholistic outlook on health and well-being as these ideas are also intimately intertwined with religion, illness causation, and spirit beliefs. However, this contrasting paradigm of health and illness has been regarded as a negative influence.

This review has examined health issues of Cambodian refugee women from migration, to internment, to repatriation, and to resettlement. This review also brought into focus many factors that affect the health and well-being of Cambodian women. Furthermore, disregard for the health-illness paradigm in Cambodian culture carries a double burden for women. They continue to survive at the margins of health care. Studies have ignored the needs of women. Research conclusions pertaining to them are lost in a conglomerate report of results. In the effort to highlight and intensify findings of significance, findings pertaining to women are treated insignificantly. The

health-related issues of refugee women are unique, and as equally deserving of further study regardless of statistically insignificant findings in the literature. Statistical insignificance should not infer less value on the experiences and suffering of women. The next wave of research should address health and illness concerns of refugee women within a sociocultural context, in their communities of resettlement.

There is little mention in studies of the fact that much of the socio-cultural-religious and economic infrastructure which represented Cambodian worldview values has been destroyed by their own people. The impact of this upon a nation of people, in contrast to eradication by an outside faction, has tremendous ethical implications for informed consent and study participation. First of all, the idea of 'informed consent' as a requirement for the conduct of research may be foreign to Cambodians. Second, the issue of trust is a major concern. Cambodian people have learned from past life experience under the Khmer Rouge regime that giving information or signing records or papers ultimately led to torture, death, or loss of family members. Hence, endeavors that may require responses to questions or a signature may generate suspicion, or fear of withdrawal of any support or benefits people currently receive. Sensitivity and awareness to these issues might have resulted in different study designs, framing interview questions differently, or the use of other methodological approaches altogether. Ethical concerns are inadequately addressed in studies. The use of Cambodian translators for instrument development and as interpreters for interviews is acknowledged briefly in studies. However, researcher access and entry are not discussed in detail. This is important especially with

vulnerable populations. Potential resistance to participation and erosion of trust due to past experiences will demand patience, tact, and cultural competence of the researcher.

Study designs have been essentially descriptive or correlational ones.

Instrumentation included the use of culturally referent descriptors or terms to facilitate more accurate collection of data—symptoms, feelings, traumatic experiences.

Psychometrically stable instruments have been referenced with Cambodian populations. Instruments have also been used comparatively with other Southeast Asian groups who were likely to have been exposed to similar experiences. However, instruments such as HSCL-25 and Harvard Trauma Questionnaire are based on a Western paradigm of illness, including signs and symptoms. As such they may also imply Western methods of treatment intervention and response to treatment. This is an assumption that all experiences are similar and would likely respond to similar methods of treatment.

Few long-term studies discuss successful treatment outcomes, save for the fact that over time, refugees ‘persist’ in meeting medical diagnostic criteria for certain categories of illness (e.g., depression, PTSD). There has been little mention of studies resulting in successful long-term interventions with this population. Perhaps the focus on rebuilding family and community, and trustworthy networks may have been more palatable than engendering individual response to Western treatment therapies.

Previous research studies have been implemented without consideration of conceptual and philosophical bases, underlying values, beliefs, or historical impact, all of which have affected the reality of Cambodian women today. Consequently, the

focus of research and results may be askew because the foundational and conceptual bases are grounded in faulty or misleading assumptions.

This section has examined multiple factors that affect the health and well-being of Cambodian women. In summary, for Cambodian adults who have suffered trauma, the length of time in United States does not diminish symptoms. For those who suffered trauma, in intergroup comparison studies with other Southeast Asian groups, Cambodians were shown to have the greatest distress. There is a valid concern expressed in the literature about the use of a Western paradigm as a cultural referent for health and illness among Cambodian refugees. A grounded theory approach toward health as seen from the perspective of Cambodian women in resettlement would afford an opportunity for growth out of experience and exploration of dimensions of health and illness as seen through their eyes. Knowledge discovered through grounded theory methodology in this study will contribute to the advancement of nursing research and health promotion with refugee women.

Chapter Three

Methodology

The life facets of Cambodian women have been explored up to this point in Chapter Two. The methodological challenge lay in capturing the essence of their health perceptions. Vital to the outcomes of this study was the consideration and integration of these facets in the conduct of research. This chapter describes the methodology used for this study, recruitment, setting and participants, ethical considerations, pilot study, data collection and data analysis strategies. Worldview and life experiences in pre-migration, migration, and resettlement frame beliefs and values that govern behavior in health and illness. Qualitative inquiry, namely grounded theory methodology, was relevant for this study, as subjective perceptions, change, interactional processes, and situational conditions were integral aspects of this inquiry. Qualitative inquiry was also appropriate for this study in capturing the individual's viewpoint on health within the context of their cultural worldview and life experiences. The collective views of participants in this study will aid nurses in providing health care sensitive to the needs of Cambodian refugee women in resettlement.

Grounded Theory Methodology

The lines of inquiry for this study explored the perceptions of health of Cambodian women in resettlement and events or conditions which influence them.

Therefore, grounded theory was an appropriate qualitative methodology for this research (Benoliel, 1996). Grounded theory is an inductive method which simultaneously studies both process and action through the inter-relationships of evolving conceptual categories (Creswell, 1994; Glaser, 2001; Glaser & Strauss, 1967; Morse & Field, 1995; Strauss & Corbin, 1998). The continuous comparative analysis of explanations and incidents (or process and action) served as the basis for the formulation of conceptual categories. Theory which evolved from these conceptual categories is essentially 'grounded' in the data.

Assumptions underlying grounded theory research are ontological (nature of being), epistemological (origin of knowledge), axiological (nature and types of value—morals, religion), rhetorical (speaking, writing), and methodological (Creswell, 1994). In other words, theory development may be rooted in a way of being, knowing, believing or valuing, and speaking. Inherent in grounded theory is the sociological concept of symbolic interactionism. Meaning and interpretation of behavior are derived from social interaction and interconnectedness among people in a given culture or context (Blumer, 1969; 1980).

Participant interviews were the primary sources of data for this study. Individual life experiences and perceptions of women which form collective ones, are valid sources of data. Therefore, the type of data collected was contextual and descriptive in nature.

The concepts of theoretical sampling, sensitivity, and saturation are vital to this research methodology. Theoretical sampling is the process of data collection whereby the researcher decides what data is needed and from whom to collect it, based on

concurrent coding and analysis of existing data (Glaser, 2001; Glaser & Strauss, 1967). Theoretical sampling is determined by concepts emerging from ongoing data analysis.

Theoretical sensitivity is both an ongoing process and stance. As process, the researcher continually examines the emerging data for purpose (rationale or reason), origin (a locus of action), and structure or organization (a function or sequence) (Spradley, 1979). Maintenance of theoretical sensitivity facilitates the development or formulation of categories and hypotheses (Glaser, 2001; Glaser & Strauss, 1967). The researcher maintains an open frame of mind and does not force premature closure to tentative interrelationships or hypotheses by subscribing to a pre-conceived theory.

When no additional data about a category or group are found, theoretical saturation occurs (Glaser, 2001; Glaser & Strauss, 1967). At this point, the researcher may stop data collection or go on to other groups or categories. This may include data collection from comparison groups or a search for negative cases. Theoretical sampling, sensitivity, and saturation facilitate the discovery of categories, properties, and concepts and the interrelationships among concepts.

Grounded theory permits systematic analysis of data through stages of coding. Constant comparative analysis is ongoing throughout the research process. This interplay between data analysis and data collection allows for analytic rigor through conceptual density and verification of relational statements or hypotheses between concepts (Strauss & Corbin, 1994). The multiple and sequential stages of data analysis are open, axial, and selective coding (Strauss & Corbin, 1998). Open coding is the labeling of events and phenomena. Axial coding seeks to establish connections or

relationships between people, events, context, strategies, and conditions. Selective coding is the validation and conceptualization of the central phenomenon.

“Theoretical coding,” which establishes relationships between substantive codes and hypotheses, ultimately generates grounded theory. Patterns and processes of interaction with specific consequences and related conditions offer predictability if they occur elsewhere under similar circumstances (Strauss & Corbin, 1994).

Conceptualization emerges through the analytical process of constant comparative analysis and theoretical coding (Glaser, 2001; Glaser & Strauss, 1967). It is the conceptualization, not description, upon which grounded theory is built (Glaser, 2003).

Since subjective views and life experiences of the participants provided substantive data for analysis and theory generation, semi-structured interviews were an appropriate method of data collection (Appendix A, Appendix B). The interview guide developed for this study (Appendix B) facilitated exploration of women’s health perceptions in resettlement. It also facilitated inquiry into relevant sociodemographic and historical data that had significant bearing upon this study. This methodology captures richly dense information needed for conceptual analysis. The interviews provided an appropriate vehicle for women to identify health concerns and related issues without implying stigma or shame.

Data Collection

Aspects of the study related to data collection are discussed here. These are recruitment strategies, the community setting, study participants, the interview guide, and ethical considerations.

Recruitment

Multiple strategies were used to recruit community participants for this study. Recruitment through a social service agency, community contacts, and verbal referrals from study participants as well as the translator were the main recruitment methods. One strategy was communication and information dissemination about the study. The researcher worked primarily through a social service agency to announce and post information about the study. Vehicles for communicating information about the study were scheduled staff meetings, community gatherings, and special events sponsored by the agency. Agency staff who worked with families in the Cambodian community were informed about the study and agreed to help recruit and refer clusters of women to the researcher. These staff also maintained confidentiality about their referrals.

A brochure in English and Khmer with appropriate graphics and illustrations was reproduced, and distributed to key contacts and respected leaders in the community (Appendix C). As a second recruitment strategy, the brochure briefly explained the highlights of the study purpose, who to contact for more information, how to volunteer for the study, what participation would involve, location, and who might benefit from this research.

The researcher's informal networking through trusted members and contacts in the community was a third strategy for recruitment. These contacts included schoolteachers, social workers, counselors, and health care professionals who are Cambodian. Other contacts were religious leaders, outreach workers, and other health care professionals. The contacts were also Cambodian women in the community who have assumed a leadership role through the trust of others.

A fourth strategy for recruitment was to utilize important locations in the community. Key locations in the community also served as access for recruitment. Outpatient clinics, the public health department, and Cambodian-owned businesses constituted key locations.

A fifth strategy for recruitment was the participants' recommendation and referral of other women for the study. Recruitment through a verbal referral process from women who have completed interviews led to other contacts who volunteered their participation in the study. This was an important method of recruitment and yielded the most participants. Women might have been reticent to participate unless they saw and observed that other women choose to do so. This protective behavior stemmed partly from past experience under the Khmer Rouge and partly from a traditional cultural need to acquire approval from a spouse, head of household, family elder, or family authority figure (S. Heng, personal communication, July 25, 1998).

Respect for cultural traditions during the recruitment process was important. Khmer women who met the study criteria and participated in a pilot study were also instrumental in encouraging other women to volunteer for the study. These women worked in social service settings, schools, and health care. They have been involved as volunteers and paid staff members of the agency that provides social services to the Cambodian community. They lived in Cambodia under the Khmer Rouge, and were familiar with the Cambodian community in the immediate area. The researcher anticipated that some women would come forth and volunteer for the study as a result of having received general information or hearing about the study. These women contacted either the translator or researcher by phone to arrange an interview date and

time. Other key persons who identified potential participants through informal networking contacts, directed participants to contact the translator, researcher, or to call any one of the phone numbers listed on the brochure. The translator also referred women who agreed to participate in this study to the researcher.

Announcements (Appendix D) backtranslated into the target language for community newsletters, newspapers, and public broadcast channels that catered to the Cambodian community, were other planned recruitment strategies for this study. However, these were not needed. Cambodian student associations that met on college campuses in the area were planned as another indirect source of recruitment. Students might have known of relatives, friends, or extended family members who met study criteria. This method of recruitment was not needed.

A mutually agreeable time, date, and location for an interview was established with a phone call by the translator. In the event there was no phone available in the participant's home, plans were made to have the translator personally contact the study participants to remind them of their appointed interview. This was not an issue as all participants were able to be reached by phone to arrange an interview. An appointment reminder (Appendix E) was also developed to mail to the interviewees as a retention strategy of participants for this study. These were not needed. A home interview was preferable and mutual efforts were made to arrange this with women at a point in the day when there were minimal interruptions, distractions, or the invasion of privacy by the presence of other family members. Women did not have to worry about transportation with home interviews. Alternate sites that were used to conduct interviews were the social service agency and the local Buddhist temple as women

knew how to get to these sites. Prior arrangements were made to use the agency as an alternate interview site if women preferred this. A closed room or office at the agency was designated for this purpose. A third alternative for a mutually agreeable interview site was the local Buddhist temple in the community. The majority of interviews were conducted in this setting, as it was convenient for women. It was a central place of prayer and worship, news, socialization, and planning of events associated with religious holidays.

Study volunteers were informed that an initial interview might last from 1 to 1.5 hours. A written reminder of the appointment in Khmer was prepared to be mailed to the participant's home (Appendix E). This was not needed as the translator telephoned all participants one to two days prior to the scheduled appointment as a reminder of the interview. The telephone call also served as a reminder for those participants who might not have been literate.

Consistent and steady efforts of the researcher at rapport building spanned a three-year period. This was accomplished through the researcher's volunteer activities in health screening fairs, health teaching programs, and participation in youth development programs and cultural holiday celebrations. Additionally, the researcher cultivated informal networks with community outreach workers and university students of Cambodian descent, who also volunteered at the social service agency. These informal networks helped facilitate access to study participants.

Setting

A Southern California community social service organization was the main source of recruitment of participants for this study. The organization is a voluntary non-profit agency. It is situated in the heart of Orange County's Cambodian

community, and is within walking distance to the neighborhood where many of the organization's clients reside. Approximately 50 feet of space separates the densely populated, 2-story housing units of the neighborhood from the physical building of the organization. A railroad track frequently traveled by freight and commuter trains runs between the two areas. Several small businesses, a police substation, a major grocery store chain, and elementary and high schools border the residential area. They are also within walking distance. Public buses traverse major cross streets nearby. There are several independently owned vendors whose food and produce trucks line the street corners of the residential area.

There were about 4,000 Cambodian residents in this area. Approximately 85% received public assistance, and about 5% to 6% were unemployed (Cambodian Family, 1996; H. Leao, personal communication, July 2 1996). The community organization afforded a transitional bridge for resettled residents through job skill training and placement, English as second language (ESL) classes, youth development programs, health referrals, and other social services for Cambodian clients. There were also Hispanic residents in the area who participated in the agency's programs. A small number of Azerbaijan immigrants were also served by the agency. The agency has established affiliations and referral networks with major universities, colleges, and health care centers in the area.

Agency programs have been funded with major grants from the State of California. Staff have received awards from the State for their community-focused efforts. A primary mission of the organization is to provide assistance to refugee populations in resettlement, to enable them to become contributing members of

society. The organization is also a vehicle for acknowledging the uniqueness of the culture through celebration of special holidays and cultural programs. These events are a venue for health screening, promotion, and education. Aside from this, representatives of various agencies provide information about legal services, low cost health insurance, Medi-Cal, and Medicare.

Participants

Perceptions of health may vary based on life experiences, responsibilities, and roles. The collective experiences of women provided valuable perspectives about their perceptions of health. Women were not excluded from this study based on their marital or employment status, or their living arrangements. Women who were between the ages of 35 and 65 years, and who arrived in this country within the last 5 years were originally targeted as participants for this study. This age span of the women would have permitted a range of perceptions about health from migrational and resettlement experiences. At the outset of the Khmer Rouge regime in 1975, these women would have been between 12 and 42 years of age.

A total of 39 participants were interviewed for this study. Some potential recruitants who initially expressed verbal willingness to participate in the study declined their participation due to family responsibilities. Family responsibilities included care for immediate and extended family, as well as non-kin persons living in the household. The inclusion of extended family or non-kin persons within households may shift or vary as the situation of these specific individuals changes (Rumbaut, 1985). In this study for example, an extended family member, such as an elderly widowed parent, alternated between residences with other adult children in another city. Care-giving responsibilities resulting from changes in the household composition

was why some women chose not to participate. In this grounded theory study, non-kin persons returned to Cambodia for a few months out of the year to be with relatives there.

Women-headed households that had children under 18 years of age at home constituted 21% of resettled Cambodian families in the U.S. (Hein, 1995). In this study, four of the study participants (10%) were heads of households with sole responsibilities as the single wage earner for minor dependents, extended family, or fictive kin who live with them.

Actual participants who were recruited, who agreed to participate in the study, and who gave their informed consent had been in the U.S. beyond 5 years at the time of their interviews. Table 1 presents aggregate demographic information relevant to this study which includes age, marital status, religion, education, year of arrival, family composition, and employment. Ages of participants, which ranged from 19 to 80 years, were beyond the original established parameters for this study. The breadth and depth of their experiences provided rich data. Forty-six percent of the women in this study were widowed. Ninety percent of the women were Buddhist. Over half of the women (59%) had an opportunity to attend school. Eight of the women (20.5%) had arrived in the U.S. in the five years prior to the interview. Fifty-two percent of the women arrived in the U.S. between 1979 and 1981, and 28% arrived in the U.S. between 1992 and 1999. Twenty women (51%) lived with immediate or nuclear families. Family composition of participants' households also included extended family, or non-kin persons. Over half (56%) were working at the time this study was conducted.

Table 1.

Sample Composition by Age*, Marital Status, Religion, Education, Year of Arrival, Employment, and Family Composition (N = 39)

Ages (19-80 years of age)		
	<i>n</i>	%
19-28	7	18
29-43	12	35
44-63	8	21
64+	11	29
Marital Status		
Unmarried	6	15
Married	15	39
Widowed	18	46
Religion		
Buddhist	35	90
Other	4	10
Attended School		
Yes	23	59
No	16	41
Year of Arrival in US		
1979-1981	20	52
1982-1988	8	20
1992-1999	11	28
Presently Working		
Yes	22	56
No	17	44
Family Composition		
Live with Immediate Family	20	51
Live with Extended Family	14	36
Live with Non-kin	2	5
Live Alone	3	8

*N = 38 as there was one non-disclosure of age

Those who spoke English as a second language, as well as those who were non-English speaking were eligible for participation in the study. Fluency in speaking, reading, or writing English was not a pre-requisite for participant selection, as a Cambodian translator was employed for this study.

Translator Selection and Utilization

The researcher, with the assistance and recommendation of agency staff, selected a translator who had the trust and respect of the community. Since trust and respect are paramount characteristics valued by the Cambodian community, the selection of a translator who met these criteria helped diffuse social status or caste issues which might have affected the data. A male translator assisted the researcher during the interviews. The translator was Cambodian, bilingually proficient in Khmer and English, knowledgeable about the community, the culture, and the health-illness perspective of both Khmer and Western cultures.

The interview guide developed for this study consisted of descriptive and exploratory questions pursuant to the women's personal perceptions about health. The researcher and translator planned a mutually agreeable schedule to conduct participant interviews. Since the translator volunteered to assist the researcher outside of normal duties as an agency staff member, the researcher compensated this person for assistance rendered for the duration of interviews.

In the participant interview phase, the researcher worked closely with only the one proficient translator employed for this study. Working through one proficient translator in the interviews yielded dense and rich data. Proficient translation through one individual facilitated the deciphering of interview content in Khmer in a consistent manner. The added benefit of working with one translator facilitated the rapport

building process in an informal but tightly networked community of women. This individual was oriented to his specific role during data collection. Conveyance of true content and idiomatic expressions that represented thoughts, beliefs, and actions of women was of major importance. Preservation of 'in vivo' codes was important in this study.

Interview Guide

A semi-structured interview guide with open-ended questions was used in interviews (Appendix B). Categories of questions that guided this inquiry were structural, descriptive, and exploratory (Spradley, 1979). Structural questions addressed broad domains of knowledge and generally required an explanation ("What happens when you are well?" "What happens when you are not well?").

Descriptive questions asked about use of words in the context of one's worldview and routine processes or activities. These questions provided an opportunity to listen and elicit information in a non-judgmental way ("How did you learn about health?").

The exploratory questions informed that aspect of this study which addressed inquiry about change, influencing factors, or conditions. These type of questions required explanations and re-statement ("How have your views about health changed?").

An independent translation service was also employed in backtranslation of the interview guide (Appendices A & B). The interview guide provided a semi-structured approach to the inquiry. It was important to use terms that were appropriate and familiar to people who came from a common background. The translator understood

the process of backtranslation, and fully concurred with the translation of the research tools as backtranslated by an independent agency.

The Cambodian to English backtranslations of the demographic and health perception questions (Appendices A & B) contained a sentence which directed participants to write their responses. This was an insertion by the interpreter of the independent translation agency, which was not contained in the source version of the English interview guides. In the actual interviews participants were interviewed only and were not asked to write their responses.

The use of a semi-structured guide in conjunction with a conversational approach to dialogue and data gathering was paramount to ensure and the maintenance of rapport during this process. As appropriate with this culture, less threatening questions were asked first, followed by those that were more sensitive.

Sociodemographic and historical information was gathered, followed by questions about personal health perceptions in the context of resettlement. Sequencing questions in this manner enabled the trust-building and rapport process during the interview and, in some cases, over the course of several interviews. Grounded theory necessitated modification in questions and theoretical sampling based on data analysis.

A blind backtranslation process was employed for specific aspects of the study (Appendix F). Backtranslation ensured conceptual equivalence of the interview guides used in this study. The backtranslation process was also integral to this study, as the study concerned the health perceptions of women based on their worldview. The majority of Cambodian residents living in the area came from rural and farming communities in their country. The translator employed in this study was familiar with

nuances and idiomatic expressions of the Khmer language in these type of communities, and the need for back-translated research tools.

In addition to verbal inquiry, the researcher documented observations, conditions, situations, events, and other relevant data in the form of field notes or written memos. Prior to taking leave and thanking the women for their contribution, they were able to ask any questions of the researcher. The participants were informed of the possibility of a return interview at a later date. An appointment for a subsequent interview was an open option. Participants were free to contact the researcher or translator for concerns, issues, or questions related to the study.

Ethical Considerations

Approval through the University of San Diego Committee on the Protection of Human Subjects was obtained in accordance with University protocols (Appendix H). The capture of nuance, meaning in cultural expressions, and other rich, dense information in understanding health perceptions of Cambodian women in resettlement was essential to this study. Ideally, audio tape recording would have facilitated this. However, equally important in this study was the prevention of any insult or disrespect to the culture. Tape recording might have generated fear and anxiety in such a tightly networked community that might have prohibited participant recruitment for interviews. Tape recording in itself could have evoked painful memories of Khmer Rouge interrogations. During these interrogations, tape recordings and written logs were a means of extracting 'confessions', true or untrue. This information was used to persecute individuals, families, or groups of people. Therefore, in keeping with the idea of maintaining cultural respect, tape recording was not used. The use of a tape

recorder, a visible and symbolic reminder of a traumatic past under “Pol Pot” times, could have evoked undue distress, uncomfortable feelings, or painful emotions. In that sense, tape recording as a method of data collection, coupled with the researcher’s historical knowledge of what Cambodians have endured, would have been unethical.

Since a decision was made to exclude tape recordings of interviews for reasons described previously, the researcher relied on taking written notes during interviews to collect data. The need for this was explained to the participants prior to the start of the interview. The participants understood this and voiced no objections or expressed concerns about this. They often waited politely or paused before continuing on with their responses and stories as notes were written. The translator was not required to take written notes during the interview, as the key role of this individual was to capture content, expressions, and nuances of meaning.

The researcher did not encounter physical abuse incidents or evidence concerning abuse of children or adults during the course of this study. The researcher would have reported facts or evidence to Child Protective Services or Adult Protective Services as required by law of health care professionals. “Saving face” remains a strong value in the Cambodian culture. Elimination of this value by reporting incidents such as child abuse or domestic violence could have disrupted the study and prevented other women from participating.

Informed Consent

The idea of informed consent was also explained to the participants prior to the actual interview, and why it was needed. They were informed of what to expect in the interview process with the researcher and the translator. The aims of the study, potential benefits and risks, confidentiality and anonymity were explained in Khmer.

As part of the consent process, the rationale for the researcher's need to take written notes during the interview was explained to them. The consent form contained both English and Khmer translations (Appendix G). Women were also informed that successive interviews, to be mutually arranged, might be necessary for further clarification about an idea. Although follow-up interviews were indicated and scheduled for further inquiry about cultural expressions or in vivo codes, there were cases where these were canceled by the participants. A clause explaining the legal obligation of health care professionals to report incidents of abuse to protective services was included and explained to the participants in Khmer.

Participants were also informed that aggregate study results to be shared through publication or verbal and written communication at meetings or program planning projects of the agency would not identify any individual. The reason for disseminating study results was explained prior to consent. Women were informed that knowledge gained from this study would be used to help others in health care to gain a clear understanding of what health means to Cambodian women in resettlement. Participants had an opportunity to ask any questions about the study. After the study has been explained and all questions satisfactorily answered, the women were interviewed upon their consent.

The consent form (Appendix G) addressed the University's requirements for informed consent in language understandable to the women, as it was to be read or explained to them. The consent form also took into consideration varied abilities of literacy. Providing information about this study to the women and obtaining their informed consent was accomplished in several ways: (a) verbal explanation was given

in Khmer followed by written consent in Khmer, (b) verbal explanation was given in English followed by written consent in Khmer, (c) verbal explanation was given in English followed by written consent in English.

There were some instances of functional illiteracy encountered among the participants. In the instance where women neither read nor wrote Khmer, but were able to write their name, the translator read the consent aloud to the participant in Khmer. Upon consenting to an interview, participants signed their names on the consent form which was witnessed by the translator and researcher. In instances where the participant was unable to write her name on the consent form, the translator read the consent aloud to her, and she made a mark, signifying her informed consent. Additionally in this instance, the translator wrote the participant's name next to the mark. Consent obtained in this manner was also witnessed by the translator and researcher. In the instance where women consented to an interview but were unable to sign or mark the consent form, the translator and researcher signed a statement explaining precisely this circumstance where women gave verbal consent. The requirement for a written signature or mark as part of the informed consent process might have elicited wariness and suspicion for reasons previously described with tape recording. However, none of the women withheld consent or withdrew from the study. All participants received a copy of their respective witnessed consent form.

Confidentiality, Anonymity, and Privacy of Data

The researcher ensured confidentiality and privacy of data. Study volunteers were informed that all records related to the study, written and electronic records (computer files of data pertaining to the study), would be maintained in a locked file cabinet. Signed consent forms were kept in a separate locked area. The researcher had

sole access to the data. The translator who assisted the researcher also signed an agreement to ensure compliance with the same ethical standards of conduct as the researcher in maintaining confidentiality and privacy of information. Information gathered for this study was not used by anyone other than the researcher. Publication or presentation of study findings would not identify any individual. Written or oral communication of study findings through agency staff meetings, or program planning meetings where families participated did not identify any individual.

Subject Risks and Benefits

Participation in this study presented minimal risk. An anticipated risk during the course of interviews was the potential arousal of thoughts and feelings which might have evoked a range of emotions from the participants. Individuals were free to terminate the interview or withdraw from the study if they were unable to continue. In spite of emotionally laden moments during interviews, and having been offered the option of stopping the study and re-scheduling the interview, the women persisted in continuing their stories and responding to questions. The researcher did not terminate any of the interviews prematurely, nor were participants dropped from the study as the interview process and the questions themselves did not provoke undue distress. As arranged in advance, the social service agency in the community where many of the participants resided was a ready referral source to other agencies and health care professionals, including counselors. Religious leaders and lay healers within their own personal networks were also available to the women.

Potential benefits for women in this study were identification of strengths, conditions and factors that influenced health perceptions and validation and re-framing of their personal experiences. Secondary benefits would result for nurses, and other

health care disciplines. Nurses would benefit by acquiring a better understanding of health as perceived by Cambodian refugee women in resettlement. Benefits of this study for women in resettlement, other individuals, groups, communities, and health care workers, far outweighed the risks.

Pilot Study

A pilot study was conducted prior to data collection. The researcher and translator who assisted in home interviews and five Khmer women who had command of both English and Khmer were involved in the pilot. All five women were escapees. The main purpose of the pilot study was to establish conceptual equivalence and semantic meaning of the interview guide (Jones, 1987). The initial interview guide queried women directly about “health.” Women in the pilot study did not readily respond to the initial questions, “What is health?” and “What are your views about health?” As a result of the pilot, the semistructured interview guide was subsequently revised, so that more concrete and simpler words were used. Instead women were asked, “What happens when you are well?” “What happens when you are not well?” (Appendix B). When questions were reframed in this way, women were more responsive and conversant in sharing their stories and experiences. Simpler questions engaged the women in dialogue. A less direct form of questioning reminded them less of having to answer to a militaristic interrogation, such as that which they experienced under the Khmer Rouge.

The simpler revision of the health question based on the pilot study was not backtranslated into a revised form by an independent translation service. In the pilot study, consensus among the women participants and the translator, along with

concurrence from faculty mentors, provided the grounds for credibility and trustworthiness of the revised health question and its related probes. The pilot study participants and the translator emphasized that the revisions were simple enough to ask of participants consistently in both English and Khmer, and concrete enough to enable responses to in either English or Khmer.

The pilot study was important in establishing working processes between researcher, translator, and participant. The involvement of the translator in the pilot study helped determine the best method of collaboration with the researcher during interviews. As a result of the pilot study, it was determined that the translator had no need to take notes during the interviews. Attention to faithful translation of content and meaning was the translator's prime responsibility in this study. The pilot study addressed logistical issues pertaining to the appointed place of data collection, as interviews occurred in the home and before or after temple services. These issues were central to data collection and were important to anticipate--appropriate greeting and farewell, note-taking, possible distractions or obstacles.

Data Analysis

After each interview the researcher and translator debriefed together to ensure all questions were answered, and to translate any interview segments that were conducted in Khmer. The debriefing period also helped identify responses that represented 'in vivo' codes. This period also provided direction for theoretical sampling of cases--exemplar, intensity, variety, and critical case sampling (Glaser, 2001, 2003; Morse, 1994). Grounded theory methodology permitted some degree of variability in the structuring of interview questions to pursue a line of inquiry based on

theoretical relevance and theoretical sampling. Theoretical sampling, which is cumulative, permitted depth of focus, consistency, variability, and flexibility. Therefore participant selections were purposive to (a) identify exemplar characteristics (extreme sampling), (b) explore particular experiences (intensity sampling), (c) observe commonalties or shared experiences (maximum variety sampling), or (d) confirm or disconfirm critical incidents (critical case sampling) (Morse, 1994).

For those interviews conducted with minimal translation assistance, the researcher used a computer to transcribe notes of the interview. Women who have had English as second language (ESL) also responded in both Khmer and English. The translator accompanying the researcher in interviews translated the interview segments conducted in Khmer. For those interview sessions where the participant chose to respond predominantly in Khmer, the translator assisted. In either situation where the interview was conducted partly in Khmer or English, the researcher instructed the translator on the importance of preserving any 'in vivo' terms used by the women in their responses. There were some terms for which there were no English descriptors. The researcher debriefed immediately with the translator to capture meanings and expressions about health perceptions spoken in Khmer. The researcher electronically transcribed extensive written notes taken during interviews and debriefing notes completed with the translator post-interview.

Continuous comparative analysis through open, axial, and selective coding was a concurrent process during data collection. At the open and axial levels of coding, the researcher identified relevant data, labels, relationships, variations, and categories.

Through this comparative process in analysis, the researcher identified terms, labels, subcategories, or categories of information included in open and axial coding. Selective coding defined semantic relationships among subcategories and categories which identified a core concept, or central phenomenon. Themes and patterns at this level of coding emerged. The core concept or central phenomenon emerged from continuous comparative analyses through the levels of coding. A conditional matrix was used to organize categories of data around the core concept. In the final analysis, the matrix illustrated relevant and meaningful categories of data (setting and context, demographic variables, time, informants' perspectives, relationships, social structure, strategies and consequences) as they related to the core concept (Creswell, 1994; Schatzman, 1991; Strauss & Corbin, 1998). Dissertation committee members were available to the researcher throughout the data collection and analysis phases for the researcher's critical reflection about the data and feedback on the coding process. Worksheets for coding data were used throughout analysis (Appendix I). Software word processing and spreadsheet programs were used in organizing data for analysis.

Trustworthiness and Verifiability of Data

Validity in qualitative methodology is the trustworthiness of the data (Denzin, 1994a) or credibility of given descriptions about a phenomena (Janesick, 1994). The strengths of this study lay in the trustworthiness of the data as it was provided by key informants who were refugees and immigrants. Even though there is a distinction in these categories, women who transitioned to the U.S. as refugees or immigrants, may encounter similar issues and challenges in seeking health care. A person of refugee status fears persecution and faces internal or external displacement from their country

of origin. An immigrant person, on the other hand, may have arrived in the U.S. under voluntary conditions and different circumstances.

Altheide and Johnson (1994) defined validity as useful, serviceable, and applicable knowledge loyal to the phenomena under study. The selection of key informants who knew Cambodian culture was one way of building a valid audit trail. The audit trail for trustworthiness (validity) in this study included culturally appropriate wording, and translation-backtranslation of the interview guide so that inquiry was consistent across interviews with multiple informants. Clarification and verification of content within individual interview sessions established validity (Morse, 1991).

Pragmatic validity or member checks, observation, and written records served to establish an audit trail for study verifiability (validity). A search for negative cases, observation, interview transcriptions, field notes, process notes, memos (code, theoretical, and operational notes), and diagrams enhanced the credibility of the data (Denzin, 1994a). This audit trail provided evidence of: (a) events and incidents that supported emerging, representative, and conceptual categories, (b) theoretical formulations which guided data collection, (c) integrative relationships and patterns (hypotheses), (d) discrepancies in data and their influence on integrative relationships and patterns (hypotheses), and (e) decisions in selecting a core category (Strauss & Corbin, 1998). Faculty mentors who are content experts and experienced with qualitative methodology provided trustworthiness (external validity) for this study (Sandelowski, 1993).

Reliability in qualitative methodology refers to the consistency in responses, or occurrence of a repeated characteristic among different informants who are posed the same questions (Brewer & Hunter, 1989; Morse, 1991). This 'dependability' or repetition of a reported event or characteristic stands for a class of events, and is representative of the informant group (Denzin & Lincoln, 1994b; Harper, 1994). This recurring class of events is associated with the purposes of the research (Altheide & Johnson, 1994). Verifiability across subjects and situations is another definition of reliability in a qualitative study (Brink, 1991).

Furthermore, if conditions have changed over time, the reported recurring event, characteristic, or class category remains relevant to the issue at hand or the study purpose (Rist, 1994). The dependability (reliability) audit trail also included the researcher's field notes, personal and process notes, and a reflexive journal. The reflexive journaling throughout the research process systematically addressed:

(a) logical inferences used in sifting and weighing data; (b) determination of an appropriate category structure for consistent inclusion or exclusion of data; (c) representative coding categories; (d) researcher bias such as premature closure, unexplored data, or oversight of negative cases; (e) sensitivity to informant factors such as fatigue, anxiety, and emotional reactions; (f) enhancing credibility through debriefing with the translator, and (g) further clarifying and verifying data with informants (Huberman & Miles, 1994; Morse, 1991).

Other ways in which dependability was achieved were through the researcher's transcription of all written notes, conversations, and dialogue which took place during the interviews, clarification of participants' statements through the interview process,

and constant comparative analysis of data. Compilation of written records during and immediately post-interview of what transpired captured key content, observations, and behaviors. The researcher accomplished this immediately upon completion of the interview. The researcher and translator debriefed together after each interview to ensure accurate translation of meaning for any or all interview segments conducted predominantly in Khmer.

This study had conceptual credibility as concepts generated in this study emerged from data, data fit, and relevance based on the perceptions of the study participants. The analytical processes of open, axial, and selective coding provided conceptual credibility for the study. The fact that participants were interviewed in a community of resettlement populated with other Cambodians lent contextual credibility of time, place, and people. The shared history of their past experiences and cultural ways of knowing has influenced their lives and their ideas about health in varying degrees.

General study findings were shared with informants. This was done verbally at the temple where women often gathered weekly. The translator assisted in this communication. The women acknowledged general findings through an accepting, quiet manner, and through their body language. During this sharing of information there was head nodding in a positive manner signifying validation of the researcher's statements. This return visit provided an appropriate time to thank the women for their contribution.

Reflexivity Issues Related to this Grounded Theory Study

Issues concerning the researcher's reflexivity in this study concerned (a) the suspension of a personal paradigm of nursing and health care as a source of potential interference in the study, (b) the resolution of gender issues between researcher and translator, (c) attending to the interview process, (d) gaining entry to the community of interest, and (e) immersion in the culture. These issues were simultaneous processes occurring during the conduct of the study.

Setting Aside a Personal Paradigm of Nursing and Health Care

The researcher's education and work experience were largely within the U.S. Therefore, it was important to be aware of personal biases and views and to keep these in check. Reactive thinking or a reactive response to the women's conceptions about health would have created a barrier to further discussion. The opportunity to collect rich data and descriptions would have been missed. Also, had the researcher interjected personal views about certain practices and their long term side effects, these might have been received as a negative judgment about women's actions. These practices are the use of alcohol and the use of antibiotics which may be obtained-over-the-counter through various resources. It was also important to be non-reactive to statements concerning the absence of caring for oneself and waiting too long to seek professional help. Had the researcher decided to interject impromptu teaching about health promotion concepts, this, too, might have been received as a negative judgement, and would have changed the tone and purpose of the interview from seeking knowledge to giving information. Since this was a tightly networked group of women, a negative encounter could have easily prevented further interviews. Suspension of personal professional biases also meant avoiding premature

identification of women's problems, and refraining from offering an explanation of what might be wrong. Refraining from responding kept in check any false assumptions the researcher may have had in recommending inappropriate strategies or interventions.

Of interest to the researcher was the observation that the interviewees were more familiar with what physicians do rather than what nurses do. The interviewees had ideas of what nurses do as some of had encounters with nurses and one of them had a daughter who was a nurse. There was only one instance in which an interviewee described how she benefited from what a nurse taught her during her stroke rehabilitation. Again, refraining from a reflex action to teach others about the contributions of nursing, facilitated ongoing dialogue and sharing of participants' stories.

During analysis and coding of data, it was important to maintain awareness of the tendency to use terms found in the literature, such as "acculturation" and "assimilation." Their useage would have introduced a bias associated with a Western paradigm. Remaining true to the data—women's stories, their words, and their expressions—was vital in raising the data to a conceptual level. The difficult work of expressing this data conceptually might be viewed as artificial expressions of meaning. However, it is only through such work and efforts to remain true to the participants' meaning that changes in care can begin to take place.

Resolution of Gender Issues between Researcher and Translator

The researcher and translator agreed on a method of working together during the pilot study. However, with several of the earlier interviews, the translator took it upon himself to interpret rather than translate responses. This became evident with

observations of lengthy discourses between translator and participant, followed by a one-word or a short phrase response given to the researcher in response to her inquiries. The translator believed he only needed to provide a concise response. His comment provided evidence of interpretation instead of translation, "I cut them off already when they give the answer to your question." Having worked as an interpreter in a large acute care hospital, he became accustomed to interpreting and providing concise patient responses to clinicians.

As an outsider, building trust with the translator was paramount in seeking entry to the cultural community of interest. It was important to resolve these differences early in the data collection process without diminishing the translator's skills, knowledge, and integrity. The community of interest trusted and respected this individual. His assistance in recruiting and scheduling participants was invaluable. Once these differences were resolved, the translator was able to better assist the researcher in pursuing a line of inquiry. The researcher viewed these early researcher-translator interactions from a perspective of equality, decision-making, and power within these interactions. However, it was important to suspend these personal views, and more important to acknowledge traditional Cambodian social and cultural hierarchy that would influence the working relationship.

Attending to the Interview Process

Working through a translator also created yet another set of unique problems for the researcher. Being mindful of the purpose and direction of the interview as the women's responses and stories unfolded, required the researcher's constant attentiveness to the people involved in the process and the process itself. There were simultaneous processes that required the researcher's unwavering attention in the

course of an interview. These were: (a) maintaining a key focus on the interviewee by directing questions to her although it was through a translator, (b) directing and maintaining the focus of the interview, (c) attending to the interviewee's responses and comments through the translator and formulating an appropriate follow-up question, and (d) interacting with both interviewee and translator. It was sometimes challenging to track these processes, and yet continue to maintain the flow of ideas, or re-direct and re-focus, while transcribing notes and observations.

Gaining Entre to the Community of Interest

Gaining entre to the community of interest meant trust-building, maintaining visibility, and being fully participatory in community activities over a prolonged period. All of these activities were integral in gaining entre. A large part of building trust was staying visible and active in community events central to the women's lives. Since the temple was a venue for worship, socialization, and learning, several interviews took place in this setting. It was important to respect the women's participation in services without giving the appearance of wishing to conduct interviews only. Therefore interviews were conducted before or after services. The researcher's role as participant-observer during this time provided valuable insights.

Community health fairs sponsored by a social service agency were another venue for health promotion and socialization. These were planned during cultural celebrations. The researcher's volunteer involvement in these activities furthered trust building, entre, and recruitment of interviewees. This was important, however unrelated some of these activities may have been to the researcher's immediate goals of recruitment and data collection. In seeking entre, the researcher participated in the youth program as tutor, chaperone, and first aid instructor. Providing CPR

demonstrations and health screenings at annual health fairs was a means of staying visible. Another means of gaining entry to the community of interest was that of teaching life skills to employees of the social service agency who in turn would be trainers for continuing this work within the agency. Many of the families interfaced with these employees through the agency programs. Recruitment through word of mouth and personal referral by the employees was invaluable. A willingness to participate in what the community and agency perceived as vital in furthering their goals was perhaps most effective in acquiring entry. An equally important and difficult issue was that of making a decision to terminate the formal relationship as participant-observer-researcher in the community of interest. It was rewarding to be accepted into this community and to participate in furthering the health mission of the social service agency. Nevertheless, the work of analysis and development of a substantive grounded theory was a priority.

Immersion in the Culture

Immersion in the culture was vital in acquiring a deep understanding of it as well as keeping a reactive mindset in check. This immersion was a concurrent process as the study was conducted. Means of cultural immersion included participation at Cambodian New Year celebrations and other traditional celebrations. Attendance at cyclical events such as Buddhist Days that had spiritual meaning, as well as attendance at life events such as funerals provided insightful glimpses of their lives. Immersion also included reading culturally related literature and attendance at teachings and lectureships presented by the Dalai Lama on his visits to the U.S. While there may be differences between Tibetan Buddhism and Mahayana (Theravada) Buddhism, which many Cambodians practice, there are also similar philosophies

which helped provide insight into a central aspect of women's lives and perceptions in this study.

Staying attuned to current events and developments that affect Cambodian women in their communities of origin and resettlement was another means of immersion. Women in resettlement maintain close ties with families, relatives, and friends in Cambodia. These bicultural ties influence their lives. A most recent development noted is the Ministry of Women's and Veterans' affairs in Cambodia, a branch of government headed by women, whose purpose is the advancement of women there.

In closing, grounded theory methodology was used to explore the perceptions of health of Cambodian women in this study. Several important cultural issues were taken into consideration in the design of this study. First, rapport-building was essential in the recruitment of participants. Subsequently, recruitment of participants occurred through communication at group meetings or functions, referrals by other study participants, and networking within the Cambodian community. Second, inquiry into Cambodian women's perceptions through interview required effective translation that captured their thoughts and experiences. Paramount to this was the importance of trust and respect in one who served as translator. Therefore, a translator who met these qualifications was selected. Third, closely related to the issue of translation was the need for the backtranslation of key instruments used in this study to ensure conceptual equivalence of instruments. The informed consent, written information advertising the study, and the initial interview guide were backtranslated by an independent agency. Plans were in place to obtain informed consent from women who were not literate in

Khmer. Fourth, the political history of this culture and widespread practice of using tape-recordings as confessions during “Pol Pot” times were taken into consideration. Sensitivity to such experiences were handled by taking written notes during the interview instead of tape recordings.

Chapter Four

Findings

The perceptions of health of the women in this study were multifaceted, influenced by their cultural roots, the devastation of war and traumatic events, and their resolve to leave the past behind and rebuild their lives. Their life experiences, encounters, and ideas about health form a unique perspective of seeking life balance. Perceptions of health have been formed and transformed. A cultural worldview, which persists to date, has been the basis of their formed ideas about health. The chaos in their lives, conditions in resettlement, and how they initiate and negotiate care for themselves have transformed their ideas about health. The findings of this study reflect their will and courage to rebuild, renew, and find meaning in their lives in resettlement.

Core Perspective: Seeking Life Balance

The core perspective that emerged from the interviews was *seeking life balance* (Table 2). Seeking life balance provided meaning and purpose in women's lives in resettlement. It was a dynamic perspective enriched or diminished by evolving processes and changes occurring over a continuum of displacement, transition, and resettlement. The women's encounters throughout this continuum led to discovery of other ways of knowing and caring for themselves.

Table 2. Major Themes and Subthemes that Emerged from Interview Data

Core Perspective: Seeking Life Balance Achieving Spiritual Fulfillment Re-establishing Kinship Engaging in Meaningful Work			
Context: Emerging from Chaos	Condition: Patterns of Knowing	Process: Caring for Oneself	Consequence: Reaching a Turning Point
Suffering <ul style="list-style-type: none">• Loss• Leaving Behind	Indigenous Knowing	Identifying Imbalance	Disharmony
Coming Here	Informed Knowing	Self Care Strategies <ul style="list-style-type: none">• Following Tradition• “Half and Half”- Integrating Options• “Knowing Myself” - Self Reliance	Harmony
Experiencing Challenges and Disillusionment in Resettlement <ul style="list-style-type: none">• Work• Family Life	Forming Personal Ways of Knowing	Care Seeking from Others <ul style="list-style-type: none">• Asking for Advice• Transacting Care through Others• Getting Access• Resorting to Western Medicine	

As the unifying perspective of this study, seeking life balance was a drive to create meaningful continuity in one's life. It was a continuous striving for the restoration of a natural order. This was evident in the women's ways of thinking, being, and doing in resettlement. Through this central perspective, founded in spiritual and cultural beliefs, and theoretical philosophies, the women achieved a sense of cohesion. Seeking life balance was characterized by achieving spiritual fulfillment, re-establishing kinship, and engaging in meaningful work.

Achieving Spiritual Fulfillment

Achieving spiritual fulfillment was a significant and integral aspect of the women's lives whereby they strove to live the ideals of Theravada Buddhist tenets. "I believe in Buddha" and "Buddhism is a part of my life" are illustrative statements of these efforts. Achieving spiritual fulfillment was a way of being in the world guided by spiritual beliefs. Striving toward a way of being in accordance with doctrine was accomplished in a spiritual community of followers, *sangha*. Participation in the spiritual community was evident in these interviews.

The practice of Buddhism. Living according to Buddhist doctrine was accomplished through dharma, the practice of Buddhist beliefs. This is reflected in the women's devotion to precepts and the application of these precepts to their everyday lives. This interweaving of participation in the spiritual community with the practice of their faith was evident in their lives. For example, one woman stated,

I am happy when I make a small donation to the temple or to family and relatives. "Happy" is to be around family, to go the temple to worship, to have a job and to do a good job, not to have others angry at you, to pray, and to do good.

The women derived a sense of happiness from participation in sangha, the spiritual community. An important manner of participation closely aligned with spiritual precepts was to help those in need. As emphasized by an interviewee, “This is ‘giving’, the opposite of greedy.” Acts of giving to the sangha were perceived to ultimately result in earning merit or benefit in their next life. Giving was accomplished by donating money, material goods, or volunteering one’s help. Doing these acts with the intention of helpfulness earned *bonn* or merit:

I have some money to offer up to good for my parents and my family. I come to the temple to get goodness for my parents and my family. Get *bonn*—do good deed for my parents and my family...I offer food to the monks and pray.

Adherence to the precepts in the performance of good deeds extended to fostering relationships with family. Therefore an aspect of achieving spiritual fulfillment was a striving toward harmonious relationships with family:

We (participant and her mother) pray together...to be calm. When I come here to the temple, I know that I am loved, respected, and cared for...I find happiness here. Here I am calm. I learn to be calm and not angry. Prayer helps me inside. It also helps me with my children...to teach them.

Seeking spiritual refuge. In striving to abide by Buddhist precepts there was also the recognition and correction of one’s human frailties. Women recognized the fallibility of their own human nature. They sought refuge in the teachings of their core spiritual beliefs which kept their fallibilities in check. The women continuously strove for improvement through spiritual practice:

Let’s say that 70% of the time I am helpful, not angry, calm. I come and pray to meditate and improve the other 30%. Or sometimes it may be 90% to 10%. As a human being I am not perfect, but I try all the time to do good...I let go, I “release”...release what has bothered me. I don’t hold angry thoughts against others.

It was during especially difficult times, that spiritual beliefs provided inner fortitude. Such strength, which underscores the meaning of achieving spiritual fulfillment, was illustrated in the resolution of a long-standing business problem.

Regarding a bothersome business issue with the city, one participant stated:

Buddha gives me patience and an open heart. Mainly a lot of patience. I believe in the teachings of Buddha—no lying, no drinking, no stealing. When I feel so sad and so angry I think about these things. I restore my spirit. Stay calm. I do meditation sometimes. It calms you down, too. It calms you down a lot. If I can do it two to three times a week, that's good.

Women found refuge in Buddhist teachings when they were distressed over inevitable problems of everyday living. Seeking refuge took the form of going to the temple, meditation and prayer, or focusing on specific teachings, "The teachings help keep me calm. Calm mean[s] physical calm and spiritual calm. When I listen to cassette [of teachings], I try not to think about any worries."

Seeking refuge in one's faith was best exemplified in the following quote where a participant confronted her distress about her family losses and fear of dying. Her focus on dharma provided comfort in her distress, as she contemplated her next life:

Koucharang? Thinking about the past? No. This does not concern me. I think only of the law of the Buddha. When I think a lot [koucharang] I don't sleep well, too. I don't think about the past. No more...only Buddha's law. Sometimes when I listen to the tape [audiocassette of Buddhist scholar], it keeps me awake. I focus on dharma. I think about dharma—the law of the Buddha. When you hear something you think deeply, profoundly about that thing, then I am happy. This is how I pass the time when I cannot sleep. This is my life. I don't worry about dying. Do you know about the cycle? We are born, grow old, and die. This is why I earn *bonn*. I earn *bonn* through meditation as much as I can. Nobody can escape from dying. I need to do something good for myself to earn *bonn*...I am afraid to die soon. Now that I am alive I can practice my Buddhist faith. While I am alive I can continue to do something to get more *bonn*.

Koucharang translates as “thinking too much.” Beyond the literal translation lies the women’s recognition and awareness of loss, pain and horrific experiences, embedded in their lives. They did not discount these life aspects, but reconciled with these experiences, and found solace in their spiritual beliefs. The women were aware according to Buddhist beliefs that they cannot escape the “wheel of life” or the cyclical events of birth, life, aging, and death, and the inherent suffering within this realm of existence. They sought to alleviate this suffering through dharma. Core spiritual beliefs provided a pathway for being in the world in spite of undesirable circumstances. Calmness, forgiveness, and acceptance were ways of being in the world. Buddhist spirituality teaches one to be disciplined in these attributes.

Exploring other spiritual perspectives in resettlement. In resettlement, other spiritual perspectives were explored in achieving spiritual fulfillment. Such explorations may seem to be a major departure from the beliefs and practices of Buddhist doctrine. However, this exploration also represented an attempt to seek out those spiritual ideals that provide an enlightened pathway for being or existing in the world. At the core of this exploration was the statement, “I strive to do good” which resonates with one’s Buddhist beliefs:

In the camps [refugee camps] Christianity converted people. People heard about scripture there. I keep my mind open. The degree of one’s belief depends on the individual. I consider myself open-minded. I am open to both Christianity and Buddhism. Buddhism teaches you to believe in good principles. It is also easy for me to adopt Christianity. Christianity also preaches to do good. However, there is conflict in Christianity because it preaches that you can believe only in one god. I embrace both Christianity and Buddhism. I am an eclectic. I have guilt over burning incense. My conscience teaches me otherwise. But at my wedding I burned incense too. There is a struggle—but I have a need to do both. I go to the temple [Buddhist temple] and will worship with the monks. I strive to do good. For my ancestors’ spirit, I burn incense to show respect. Some Cambodian people will say, “I don’t

believe in doing that stuff!” But I believe it. My aunt and uncle converted to Christianity. Some Cambodians converted to Mormonism, the Mormon religion. I do not convert to Mormon beliefs.

There was an open-mindedness to the spiritual ideals of other religions. A participant clarified her own reasons for exploring other perspectives. She distinguished for herself outward forms of worship and true happiness and meaning in life:

I have been confronted with this [conversion to another religion]. [Long pause]. Religion is not important. Belief in God, *any god*, can give you the same *hope* and the same *warmth*. You look to a figure to *tell you* what’s right and what’s wrong. As far as *happy*, for me it means being content. I believe that whatever you do, you can do it, as long as you are happy and content in what you are doing. If you are not happy with what you do, you won’t do anything, you won’t get anywhere. Why do it then? What’s the point?

The women were not averse to the exploration of other spiritual ideals. Other spiritual ideals were not viewed as competing with their Buddhist beliefs. Instead, other spiritual ideals were held as acceptable paradigms that co-existed and operated in the women’s lives. Other spiritual ideals resonated with what women found meaningful in their own lives. The women were accepting of different beliefs. A fundamental spiritual perspective, “seeking good” and “doing good,” remained as a stable core belief even in the exploration of other perspectives:

I’m not into religion. I was raised as a Buddhist, but I am converting to the Mormon Church. I have converted totally to the Mormon belief. Usually the older Cambodian women have strong beliefs in Buddhism. I believe in doing good things, and having faith. If I do good, it will come back to me, maybe tomorrow, maybe it will come naturally when I least expect it—but it will be reciprocal.

In her conversion, she maintained the notions of “doing good” and reciprocity which resonate with the Buddhist tenets of her upbringing.

The women's references during interviews to a Cambodian adage, "One does not stray too far from the tree," lends interpretation to the exploration of other spiritual perspectives. An interpretation is that women maintain a linkage to core spiritual beliefs expressed through the practice of other spiritual perspectives. Essentially, one may search for other explanations of meaning in life. Looking beyond, or outside of the suffering and acceptance of fate associated with Buddhist spiritualism perhaps influenced some of the participants' decisions to convert.

Nonetheless, the majority of women in this study were followers of Theravada Buddhism. They strove for spiritual fulfillment and self-improvement by abiding with the precepts of their Buddhist beliefs. In their self-exploration of other faiths and personal choice to follow other faiths, the interviewees still maintained a core perspective of "doing good." They embraced other religious belief systems that foster spiritual values similar to Buddhist beliefs. "Doing good" was the basic tenet which informed their choice to practice their Buddhist faith, to practice their Buddhist faith in conjunction with another faith, or to convert altogether.

Re-establishing Kinship

Re-establishing kinship was another theme in seeking life balance. Relocation and displacement of families resulted in widespread dispersion of family members. Women who survived the war and relocated to another country were often unaware of other family survivors:

I came here when I was age ten, in 1980. I graduated from Wilson high here in Westminster. Originally, when I left Cambodia, I lived in France for one year. My Dad was here in the U.S. in 1975. He didn't know that I was in France. When he found out that I was there, he completed papers and sponsored me to come here to the U.S.

Such dispersion hindered family reunification. The uncertainty of family member escape or survival remains a concern for women in resettlement. Pre-occupation with the dispersion of family elsewhere, by choice or circumstance, continues to be a foremost source of worry:

Well, I had 12 children. Two died. Now I have ten. I live with here with my number four daughter. One daughter here [Santa Ana], three daughters in New Hampshire, one son in Maine. My older son was in Australia. My other children live back in Cambodia. I have four daughters and one son here [in the U.S.]. I have one daughter and four sons in Cambodia. I worry and I miss them very much.

Their greatest hope was to someday re-unite with their children by bringing them here to the U.S.

This background helps to locate the theme of re-establishing kinship relative to its importance to the core perspective of this study, seeking life balance.

Re-establishing kinship was a striving to re-create a pattern of family groupings and relationships in resettlement, to meet the need for togetherness, and to rekindle the mutuality and reciprocity of relationships in resettlement. Re-establishing kinship was an effort to preserve relationships among immediate family and networks of extended family. Such groupings were a significant part of Cambodian culture prior to the attempts of the Khmer Rouge to eradicate these bonds.

Compositions of immediate and extended families of women in this study included groupings of (a) school aged children and a parent or parents; (b) adult children, their immediate families, and a widowed parent (most often a mother or grandmother); and (c) other relatives who no longer have immediate family.

Another constituent of some families were non-relatives who were without family nearby or who were without any immediate family survivors. These persons were

often elders who had nowhere to stay or live or friends and acquaintances that families knew from Cambodia who needed a temporary place to stay while finding jobs here in the U.S.

Family groupings of immediate, extended, and non-family members facilitated caring for and helping one another and fostering relationships. Elderly participants in this study helped care for their grandchildren while parents worked. An example of this caring and reciprocal relationship among members living in one household follows:

Now I help take care of P ____'s kids [her grandchildren]. Before, yes, there were things which make me unhappy, but not now. I don't worry about anything. Before I worry about working hard for the family. Now the children are all grown—no worries. The kids are all grown up. They can take care of me. They take care of me, I take care of them, they take care of me...

Adult sons and daughters cared for their frail and sometimes ill mothers who live with them. Conversely, elderly women also cared for their adult children who had health problems.

Wanting togetherness. Wanting togetherness captures the centrality of immediate and extended family in resettlement and what the women did to maintain this centrality in resettlement. Spending time together and being with their families whenever possible and feasible re-kindled family bonds and was a priority in their lives. The women's explanations of staying with the family, making time for family and children supported this sub-theme. These explanations came from women who have shared the common experience of family separation for indeterminate periods of time, sometimes months or years. In view of this common experience, the frequency of family gatherings took on new meaning in terms of maintaining togetherness in a post-survival environment:

I am so happy to be in reunion with my family! I am not afraid anymore that the Khmer Rouge will kill me. We have a gathering, a reunion every week. You know, every Saturday the kids come.... Yes, yes... family *most* important! Everything else is minor. Everyone *here* [emphatically she points to the ground to indicate that everyone is here in the U.S.]. Everyone here, happy and healthy. Everyone here and safe. *Safe*. My family's safety is *more important* than my wellness.

Time physically spent together was a celebration of the safety of those present. It was also a reminder that they have survived.

Seeking out other survivors. Wanting togetherness extended beyond time spent together, and also included seeking out other sole survivors. The desire for togetherness reflects an empathic understanding of survival experiences under the Khmer Rouge that shroud those in resettlement. It is through such awareness, sensitivity, and common identity, that survivors seek one another out. They remain attuned to the loss and tragedy likely experienced by other Cambodians. Wanting togetherness in resettlement compensates for the void left by absent or missing family. The inclusion of those who are alone into an existing family structure maintains semblance of a cultural social system and the relationships within it. A social worker, who lost her entire family consisting of her husband, daughters, siblings, and parents, explained:

The Cambodian families stick together. Even if the kids live here [at home] until they are older, we want togetherness...we don't want anyone to be alone. Parents live with their children. Or they live with a relative—a sister, aunt, uncle. They live with a relative that lost a partner. Relatives do not want a family member to be alone. Even with me, some of my Cambodian friends don't want me to live alone.

The women were vigilant for other Cambodians who have endured a common experience of hardship, escape, and survival. When they encountered others, the shared experience helped forge a bond of understanding and connectedness. It was

through this mechanism that the women hoped to hear of news of lost family, relatives, and friends. Such an encounter occurred in the researcher's presence. Two of the study participants attended a funeral service at the local temple. Through conversation, both participants, an older and a younger woman, re-discovered they were in-laws. At this same gathering, the younger interviewee also re-discovered a childhood friend. Initially they had not recognized each other as each commented how different the other looked. Through an exchange of questions and a flurry of recall of remembrances, people, relatives, childhood memories, and shared events, they re-validated their recognition of each other and their friendship.

While it may not be possible in resettlement to recreate the residential patterns of physical proximity that existed in Cambodia, some re-establishment of family groupings occurred in resettlement. The togetherness and helping relationships fostered by women among family and non-kin, re-defined and re-established the boundaries of kinship in resettlement. The re-patterning of family structure and the re-establishment of relationships among kin were a significant part of who these women were. The re-creation of kinship networks and togetherness served a purpose beyond the re-establishment of helping networks and social infrastructure. These were vehicles for ensuring the survival of the culture and its values, including traditions and family customs. The transmission of values came from living, learning, and being with others, day-in and day-out.

Engaging in Meaningful Work

Engaging in meaningful work was activity or the pursuit of activity that provides direction and purpose for life. It gave the women a sense of place in resettlement. Participants were engaged in various forms of work. Some were

currently in school pursuing their education in various disciplines—teaching, public administration, nursing, medicine, or human and social services. Involvement in work-study programs offered opportunity in a developmental area of interest.

Participants sought out opportunities for upward mobility through work:

...I can help people without going to the temple...I like the support here...The director hired me with the understanding I would go back to school...we are all accountable. I am learning a lot here...It's neat to work with others who are involved in the other programs. We can talk freely to one another—share what's going on—and solve problems together...I am the project coordinator for the tobacco control program.

The nature of their work demonstrated their involvement and commitment to helping others:

I am helping a client clear his D.U.I.'s [driving under the influence of alcohol] so he can get his driver's license back. Without his license he cannot work. It's not only him that suffers, but his family suffers because he is not working...I like to help people...here, I like my work. I can help people....I like my job, I like helping people. I like to see them get their lives back together.

Notable in this description of one's work, is the preservation of the family. The women in this study maintained an orientation toward the centrality of family, as evidenced by the need for kinship discussed in seeking life balance. It was not only liking the job, as this interviewee described, but essentially, through her work, she derived greater satisfaction from helping others achieve a sense of integration and restore a sense of harmony within their own lives.

Participants also worked as equipment manufacturers, health liaisons, teachers, social workers, counselors, and accountants. Their work provided a sense of normalcy and stability. Self-employment illustrated skill in running a successful business. Some of the women owned and managed their own food and import stores, and worked

alongside their employees. They took pride in their hard work that enabled them to provide for their families and their children's education.

Volunteerism was another form of meaningful work. Women prepared communal meals for special times of worship such as Buddhist Days (days of worship which coincide specifically with the full moon every quarter). They donated time and effort in organizing preparations for cultural celebrations.

Achieving spiritual fulfillment, re-establishing kinship, and engaging in meaningful work were interwoven in the women's lives. These mattered greatly to the women in this study, and collectively were important in striving toward life balance in resettlement.

Supporting Themes of the Core Perspective of Seeking Life Balance

Major themes arising from this study provided substantive concepts for theory development. These themes are emerging from chaos (context), patterns of knowing (condition), caring for oneself (process), and reaching a turning point (consequence). Each of these major themes and subthemes, as a whole, are part of a larger process and an ongoing life continuum (Table 2).

Emerging from Chaos: The Context for Seeking Life Balance

Emerging from chaos was the contextual backdrop for this study. Chaos was the devastation inflicted by the Khmer Rouge under Pol Pot's dictatorship. This state of affairs in which the women lived was a complex web influenced by historical, political, and ideological factors. There was very little that remained of institutions which represented socio-cultural and religious values. The eradication of temples,

schools, government, and a citizenry who held keys to Cambodia's history, as well its future, left nothing to begin anew. It is this context of complete devastation from which these women emerged escaping persecution. Fear of persecution was an everpresent preoccupation, "My son-in-law came to the U.S. to study... Pol Pot killed him. I was terrified! I am thinking any day now the Khmer Rouge will take my daughter and kill her too!"

Any vestiges of core cultural values were cause for persecution:

I also remember that one of my nephews had only one more year to finish his doctorate. He could not see anything without his glasses. He wore his glasses all the time. The Communists took him away and killed him because he was highly educated.

Interviewees frequently described the fear they felt for themselves and their families during these times of persecution. The complete destruction of socio-cultural foundations and institutions upon which people had built their lives was unfathomable.

"Suffering," "coming here," and "challenges and disillusionment" are three themes of this category. Vivid and sorrowful recollections surfaced as interviewees shared experiences of suffering. Coming to the U.S., another phase in these women's lives, was characterized by a transitional period in refugee camps and a migratory period to reach a resettlement destination. Once the women arrived in resettlement, they experienced challenges and disillusionment.

Suffering

The theme of suffering encompassed personal hardships the women experienced during the war. These entailed family separation, forced labor, starvation, near dying, and escape at great risk. Separated family members were transported to various work camps for hard labor under the Khmer Rouge. This was daily drudgery

family members faced. Separation of family members precluded the care of young children who became ill:

In Cambodian time I have lots of problems with Communists. No food! My son and daughter really sick! Son had diarrhea--big stomach. Old people took care of him. Old people do burning on [son's] skin. You know this? Put candle on skin, the glass over it. During Pol Pot times I could not take care of kid myself. In Pol Pot times I have to leave them with old people. I had to work. Old lady baby-sit for me. Put kid for old people. I cannot take care of kid myself. I had to work on farm. When done working, I pick up kid. Kid cannot sleep, I cannot sleep. I was really skinny in Pol Pot times, I weigh only 95 pounds, and I am tall--I am 5'6"-5'7." Me and my husband were not together in Pol Pot times. My son was about two to three years old, my daughter was about three to four years old. At night, when finish work on farm, I would take my kid back home to sleep with me. At 4:00 A.M. the loud bell ring to wake [us] up to go back to work again.

This scenario was an experience endured by several women and their families. The inability of women to care for their own children as they would have wanted, was also suffering. The circumstances of separation prevented women from providing a sense of security, safety, and nurturing relationships at a vulnerable point in their children's lives. The only recourse women had to guarantee some measure of safety for their children, although it meant daily separation, was to yield to the demands of the Khmer Rouge at the time. Refusal to work as ordered by the Khmer Rouge meant certain death. Compliance with the orders of the militia was the only recourse for survival, however miserable it was.

Although women labored at farming, in addition to digging ditches and graves at work camps, they were never provided with enough food. The Khmer Rouge withheld food, and starvation became a means of mass torture. The following statement describes an experience that was all too common for the women in this study:

Every day we worked hard. I planted rice, built a dam to store water. We were awakened every day at 4:00 A.M. It took them [Khmer Rouge] two hours every morning to get things straightened out. Then we had to walk to the fields. The first three to four months the Khmer Rouge fed you well. Then the torturing times came. We only had rice porridge and salt. They [Khmer Rouge] cut back the food. There were only a few grains of rice in the porridge. That's the time I had to dig for things to eat--lily roots, going into the jungle looking for leaves, grass, roots, and keeping occupied for not being hungry. I looked for green vegetables growing on the water. I was hungry.

Interviewees validated their experiences of suffering by starvation. Over time, repeated encounters of deceit, such as the initial provision of food followed by starvation, engendered within the interviewees roots of distrust of others.

Some families, who escaped to refugee camps across the Thailand border, still faced the problem of inadequate food supplies. Escapees were forced to depend on whatever provisions were available to them, which amounted to nothing at times. Without money, basic physical needs for survival went unmet. The only valuables that some kept on their person during escape were jewels, which were used to barter for food. Hardships persisted in the border refugee camps. The absence of food for an infant daughter was a particularly painful experience for one woman.

Christy born in Thailand camp. There in the camp there was *no* medicine. The nurse at the camp helped me. Christy suckled till it burned--my nipples burned--because there was *nothing* [no breast milk]. Milk at the camp *very expensive*! I did not have any [breast] milk to feed Christy. I sold my gold [jewelry] at the refugee camp to buy milk, so Christy can survive. Her life cost *gold*. If I cannot make it [not having enough money to buy food] I cut my own gold to buy milk for her. She cried a lot. She cried all night. I went to Myroot. It is close to the ocean. There was an open market there. Milk is cheap. I bought milk there--then she can thrive.

The recollection of malnutrition and near starvation experiences were reminders of those torturing times. A participant who escaped as a young child indicated:

I only know that I had bad health, the worst health of all siblings. My mother tells me that I was sick all the time. Once it took me one month to recover. I had high fevers...my hair fell off. That's why my hair is so thin now....We only ate soybeans—soybeans and rice.

Women often alluded to their experiences of sickness and starvation where they clung to life by a tenuous thread. A life of suffering also meant loss of control over one's physical functions, and desperation and helplessness brought about by the political ravages of the time. These characteristics were evident in one woman's vivid recollection of a near-death experience, representative of others who had similar experiences during this time:

I knew I was dying. I was seeing my mother and she was calling my name. I knew I was dying and I was just waiting for my last breath. I said "goodbye" to my sister. I felt like a piece of cotton ball--like nothing, just floating away. My sister cried and cried, and said to me, "You can't leave me behind!" I said to her, "What can we do? We have no medicine." My sister used water and took a coin and coined me all over. After she coined me I didn't die. I struggled to be alive. I had no will to live. I was thinking about my mom and my grandma, and I was fighting to survive. I was waiting for my last breath. After that ordeal I went to bathe in the river. I was *so skinny*. People knew that I should have died, but when they saw me so skinny, they would just shake their head [shakes her head negatively]....I was *starving*. I had malaria. I took traditional medicine. I took a bitter flower and squeezed it to get it concentrated. I drink it. It helped malaria a little bit. Then the malaria came back. No one thought I would live. I had dysentery. All I had to eat was fish. My BMs were pure oil. I ate the root of the banana. I went into the jungle to find what I could eat. I ate roots, leaves, bark. My sister ate animals. I could not get myself to eat animals like she did. Our diet depended on where we lived and what we could find....

Such accounts of hardship prevailed among many families. Escape became the focus of existence. In their search for safe haven people were willing to assume risks associated with escape:

I escape with my eight sisters. They are all dead now. I am the only one living. I walked for two days and nights to get to the [Thailand] border. I got into a big farm truck that was loaded with corn. I hid under the corn and crossed the border. I was so lucky that the guards did not search the truck! Then I walked more miles to reach the [refugee] camp. I had food with me but it was not much....

Another participant shared her family's experience of risk during their escape:

You know it was very hard to escape the country in 1979. The Communists let no one escape. Hard. Very hard. We escape in 1979. We walked straight for two days and two nights too. Most of the time we walked at night...You know, I remember my father only had a little teapot. When we were hungry or thirsty he would only give us just a *drop*--just a little bit. I was 14. We escaped across the border to the camps in Thailand.

The above examples of suffering further illustrate the sense of desperation and the misery that individuals and families were willing to endure to escape persecution.

People had no control over the political ravages that occurred and the effect these events had upon their lives. In spite of the helplessness associated with their suffering, perhaps they retained some control over their own destinies and futures by making the decision to escape, even at great risk, rather than accept fate under the Khmer Rouge. Escape provided a glimmer of future hope. Separation, sickness, and hunger were not the only experiences of suffering during the war. They also endured great loss, and left behind stable and familiar ways of living.

Loss. Loss emerged in this study as the experience of death of family members or relatives. Loss, whether witnessed or unwitnessed was inevitable during this period. Participants witnessed deaths of loved ones due to illness, starvation, or persecution. A woman, who cared for her husband at home until the time of his death, lost her sons shortly after. There was a frantic tone followed by a heavy sadness in her voice as she recalled this experience:

My husband sick all the time...Within nine days after my husband died, my two sons also died. I took one son to the hospital. The doctor gave him serum. His body did not accept it. The other son I did not take to the hospital. I took him to get traditional medicine....I take care of my husband all the time. I was married to him for seven years then he passed away.

Buddhist spiritualism accepts the inevitability of death. However, it is difficult to accept multiple losses of several family members within a short period of time. One can see this in the interviewee's words above, in her decision- wavering to resort to traditional medicine to save her second son, after the loss of her first one. Social institutions such as hospitals, and the professionals who worked within them, doctors and nurses, were also targets of persecution during this time. Therefore, health care facilities and treatment for illnesses and other rampant diseases were scarce or non-existent. Women sought whatever was available to them.

Other women referred to loss of family members who died of starvation:

I recall one day my niece would just hug me and say, "Auntie, I do not want to die." I hugged her and tried to reassure her she would not die. My niece would wake up every morning, crying, nervous, and shaking [she motions with her extremities to illustrate her niece's behavior]. My niece is dead. My sister and my niece were sent to a work camp—a prison. They both died of starvation.

Starvation was a form of suffering commonly described by the interviewees. It was not solely starvation that inflicted death, but the totality of the devastation which occurred, in which any single malicious event gravely compounded other events. Illness, hard labor, starvation, and persecution, took their toll upon human lives.

Participants hesitated at acknowledging witnessed persecutions of family members. When this information voluntarily surfaced in interviews, participants did not discuss these events in detail. With rampant evidence of senseless persecution everywhere, death in one's own family was a matter of time. Participants had a sense of foreboding when such an event would occur:

Suddenly, I was told I had to leave to go work in another village. I had to wait for a truck on the highway to pick me up. When I saw my mom [adoptive mother] that morning, I had a feeling that I would not see her again. That morning she hugged me, and kissed me, and told everyone around her that I was her beloved daughter. I thought to myself, "This is it. I will not see her

ever again.” I asked her why she was doing this, because it was very unusual. Cambodians don’t kiss or hug in public. That morning, I washed her clothes for her in the pond nearby. It was getting late. Then I said goodbye.... Everything is very vivid for me as I am talking to you. I can see clearly in my mind as if I were there again. I witnessed the death of my two older brothers under the Khmer Rouge. I did not witness the death of the three little ones. My siblings were attached to me. I did not witness the death of my adopted mother. I had a feeling she was dead. My grandmother died in my arms. I think she just gave up.... We were three months here in this place, then we moved to another area. We had to walk through the jungle. I heard some conversation taking place among others who were walking, “Did you know R_____’s mom died?” I went to this person when I heard her talking. They did not want to tell me. When I approached them they suddenly became quiet. I made her tell me.... When it was break time in the field, I went off by myself. I went out there and screamed, I cried so loudly, and called my mother’s name. I was alone.

This interviewee struggled alone with her sorrow. For her to have lost a parent, although an adoptive parent, a grandparent, and multiple siblings in the context of senseless killing, was to have lost one’s meaningful human connections in the world. Her isolation and sense of desolation was expressed, “I am alone.” She was not surrounded by others to buffer her pain of loss, nor was she comforted.

Several interviewees vividly recounted the loss of immediate family members and in-laws, either witnessed or unwitnessed. In sharing and recollecting this time of great suffering in their lives, one can only surmise their experience of overwhelming grief. Women also drew their own conclusions about the existence or loss of family members from bits of information pieced from others in the labor camps. Open inquiry about family members in such an oppressive and distrustful environment posed a risk. Silence camouflaged one’s intelligence or education. More importantly it was a means of staying alive and avoiding persecution by the Khmer Rouge. Emotions were suppressed for the sake of survival. The following example shows there were no outward expressions of grieving or final rites of dignity afforded to the deceased:

She [grandmother] died a few weeks after I arrived. We had built our home from hay. When the wind blew, the house blew down. When it rained, we got wet. I told my grandma if she had to go to the bathroom at night to call me. One night she went out alone to the field and fell and hurt herself. Before she died, I asked her why she didn't wake me. She said she thought I was tired and wanted to let me sleep. She died the same night another woman in the village died. So Khmer Rouge buried my grandma and this other old woman on the same day. They dug one hole for two bodies.

Any outward display of emotion could have been misinterpreted as non-compliance with military rule. Rather than risk further probing by the Khmer Rouge about other family members through punishment or torture, silence was the only protective recourse. The inability to give appropriate respect to the spirits of the deceased added to a sense of overwhelming grief. Perhaps over time, this burden of not being able to follow through with cultural rites may result in disharmony and a state of unhappiness.

News of unwitnessed persecutions that somehow reached respective survivors of the deceased triggered escape. A family calculated their escape to avoid the arousal of any suspicions about their activity. A participant disclosed a non-witnessed account of persecution occurring within her own family:

At the time my father's life was jeopardized. He was educated and his life was in danger. My mother's family too was jeopardized. My mom had an uncle who had his head chopped off. He was left at the roadside...beheaded...just laying there. My family had no time to plan. We left escaping out of our own town. My father left for Phnom Penh first. Then my mom and I followed him there in the next week. The Communists saturated Prey Veng. They noted people going to and from Phnom Penh to Prey Veng. These were just ordinary people who were going to and from work. They were killed with no questions asked... My grandmother had 12 kids at the time. Three of them were killed.

Some of the study participants surmised persecution of family members, although unwitnessed, given the circumstances they saw:

I never saw my mom. Communists take her away to kill [illustrates by placing her hands at her back in handcuffed position]. Father was alive in Thailand. I saw him last in 1975. He cried and said, "This is the last time I will see you,

now you go.” I told my father I wanted to stay with him. But he said “No, you must go.” The Khmer Rouge came and my father told me to go.

Family members who separated during escape, were able to account piecemeal for other family members who did or did not survive. An unwitnessed account follows:

When we escaped to Thailand I was scared. We were separated. I lost my grandma under the Khmer Rouge. My other siblings and biological parents...they died one year before my adopted mother died. We were all going through the same thing—all under the Khmer Rouge. I did not witness the death of my biological parents and siblings. I lost all my brothers and sisters. There were nine of us all together. I was number five in the family. Now, only three of us left. There is sibling number two, me, and the number six child in the family that are alive. I’m not sure if my other older sister is alive. To this day I don’t know if she died or not.

Family losses regardless of cause left women with feelings of emptiness.

Emptiness was expressed as a void in participants’ lives. In one woman’s terse words, she says stoically, “We were empty. Communist make us [give us] pain. With Communist, we have nothing.” For women who were young minors at the time, emptiness was the loss of the naturally occurring support and help offered among family members. Even caring for ill or dying family members during the war provided purposeful activity. Without this activity there was emptiness. Emptiness was characterized by the loss of togetherness that had been an integral theme in their lives:

I was married with four children. We all lived together—the six of us, along with one brother, and two maids. So we were nine people altogether in my house...I feel quiet. I have to accept the fact that I have lost my family during the war, and I adjust to a new situation. My adjustment is living without family—I lost all my family during the war. [Pause]. These are uneasy times. [Pause]. It is not easy... I had two girls, then a boy, then another girl. I lost all of them. The youngest died with me.

Emptiness was also reflected in the absence of having someone to share meaningful activity. Women found it difficult to express this perceived void they felt. One woman described in her words, “I feel light.” Her use of the term “light”,

captured her description of her present life now devoid of meaning and activity, which could only be fully acknowledged through her past life circumstances and experiences of her loss.

Experiences of loss were associated with hidden feelings of grief and emptiness as illustrated in the examples above. A desperate need to escape persecution and the miserable conditions of their existence took precedence above all else. They were willing to leave behind personal effects which symbolized former ways of life as they knew it, as well as their planned futures.

Leaving behind. Leaving behind emerged in this study as the abandonment of property, careers, and plans. Out of a basic need for survival, escaping chaos meant abandonment of those things acquired or built over a lifetime—homes, farms, businesses. These provided a familiar means of stability and economic self-sufficiency:

When my husband was well and alive, he built seven houses—one for me, and six other houses for our extended family—my brothers, my sisters, and my uncle. When my husband died, I stopped working on the farm. I had to rent the land to somebody else.

Stable professional careers the women enjoyed were also left behind:

Before leaving Cambodia, I used to plant things, and sell things in the market. I make money. I buy my own books, buy my own pens. I went to school for 12 years in Cambodia. I finish high school in Bataambang. I was a teacher in Cambodia. I taught old and young people. I taught Cambodian language and mathematics... I will go back to Cambodia and teach again... [pause] maybe, and maybe not. I also speak French and taught French. I was a French teacher also in Cambodia. My mother spoke French, not English. I taught French to students in Cambodia, and they can speak and write French within five months.

Not only did the women abandon their personal property and a way of economic stability, but they were also forced to leave behind a sense of independence, and self-

direction toward intended goals and accomplishments. Future life plans were left behind or terminated prematurely:

My mom worked so hard to raise my three brothers, three sisters, and me. My mom worked hard to send us all to school. I have one young brother who is a doctor. All of us went to school. I went to the university to study to become a dentist. I went for two years—I was almost a dentist. Then the war came. I have a brother that has been studying for two years now to become a dentist. I have one brother [who] is finished with dentistry school now...

There was the hope of returning one day to recover what was abandoned and to rebuild what prosperity one had formerly:

I had a grocery stand. I did not grow or plant anything myself. I was the middle person, the seller. I sold plants, vegetables, fruits. I will go back to Phnom Penh. I have my own home there...I will go back, but not now. The country is not really in peace. Before, when I was in Preveang Province, I never went anywhere. Then I moved to Phnom Penh. There I went everywhere for business!

Participants readily discussed what they were forced to leave behind. Although they longed for what they once had, they recognized the need to prepare for another phase of their lives. Coming here to the U.S. represented that next phase.

Coming Here

Coming here to the U.S. was characterized by transitional and migratory experiences. Some of the women came directly to various states in the U.S. and others came to the U.S. via the Philippines. The women experienced discomfort and uncertainty in not knowing what the future held. During this time, the women embarked upon departure preparations from the border refugee camps to the point of arrival in the U.S. Women in this study remained in camps from varying periods of three months to almost three years. Transitional preparations at the camps included interviews with immigration officials. These were perhaps first encounters of another perspective:

I was born in Cambodia. My family...left for a border city. Then in the early 1980's my parents moved to Khao I Dang camp for one year. From there we moved to a place called Savin—it is in Thailand. We stayed in Savin for one year, then moved back to Khao I Dang for two years... We moved to another camp afterwards. It was called Trong Site—we pronounced it as "seet." Trong Site was in Thailand. This was the first stage for coming to America. We stayed there for one year.... When we escaped, my dad carried me through the whole ordeal. I have since told him how I appreciate how he raised me. He just smiled. When we were getting ready to come to America, the immigration people interviewed him. He was *so nervous* at the interview, he forgot my birthdate. My father doesn't remember months and dates, he remembers by seasons—the changing of the seasons in Cambodia. He remembers the year, but he couldn't recall the month and date of my birthday. So what happened is that I have my older sister's birthdate, and my older sister has my birthdate—on paper. But technically, my sister and I and my Dad have it all sorted out.

Health screening tests and physical examinations were part of the transitional preparations. The women experienced discomfort as they were subjected to physical examinations. Moreover, examination by a male physician was an uncomfortable procedure which some of the women found culturally unacceptable. This was one transitional experience which women faced, and some chose to forego resettlement because of this:

I had to go through health screening in Thailand. That consisted of standing naked in front of a man who looked at every inch of you. Some of the girls I knew refused. They said, "I would rather stay here or go back to Cambodia than to endure that." I said, "I don't care. I just want to get the heck out of this place." I had skin test for TB [tuberculosis], it was negative. I had x-ray. They screened you for skin disease. When I arrived in America I was screened again for TB.

Mobilizing preparations to move out of the refugee camps to a resettlement destination was not an easy task. Again, the women faced potential risks. A participant who was a young woman of 22 years of age at the time recalled several willing sponsors:

There was a couple in Canada, there was a single man--a Jamaican man in Costa Mesa, and a couple in Europe from Ireland... The couple in Oregon sponsored me to come to the U.S. In Chon Buri I worked for the Embassy, the Immigration and Naturalization Service (INS) and a Joint Voluntary Agency. I worked as a translator... My new boss was like a sister. Her husband worked as

a volunteer dentist in the camp. I toured the camp with him and translated. They returned to the United States. I wrote to them in Oregon. They wrote back. We kept in touch. They processed papers in my name and sponsored me. I got advice from the people in the Embassy. They [in the Embassy] told me not to go with the single man in Costa Mesa. "He might have not so good intentions," they said. "You are a young single woman, you don't know him. Don't go with him." They also advise me not to go with the couple in Europe, Ireland. I watch the news and I see all the fighting and bombing going on there between the Catholics and the Protestants. I don't want to go there, I said to myself.

Unexpected circumstances during migration were another uncertainty. A woman, who was a young child at the time, left the camp with her family. However, besiegement by authorities at multiple checkpoints threatened to separate their family and prevent transport to the U.S.:

My mom told me that my hair was so thin, everyone used to tease me and call me "French girl," because my hair was reddish, and I was so *skinny*. All my sisters are dark-skinned. I am lighter than they are. They all have thick black hair. My hair is thin. They have long legs. I am short. I used to feel bad. They tease me and say, "Because of *you*, we almost *didn't* come to *America!*" The U.N. [United Nations officials] thought I was adopted. In the Philippines everyone was on an airplane, except me and my dad. I was so scared. My dad was crying and begging them, saying that I *was* his daughter. A Caucasian man who spoke Thai helped my dad. My dad speaks Thai, Lao, and Cambodian. So we *ran* to the airplane to get on *quickly*.

Some women came alone and were preceded by other family members. Adult children who preceded their parents helped financially. Relatives who came first to the U.S. subsequently sponsored other relatives and family members.

The process of coming to the U.S. was a bittersweet experience for interviewees. The women were desperate to escape persecution and unconscionable conditions in exchange for great risks. They yearned to leave the temporary refugee camps where their lives were held in suspension, for a place of stability instead, to resume normal lives. They looked forward to resettlement with both hope and trepidation. The interviewees anticipated a better life, future, and opportunity coupled

with the anxiety and uncertainty of not knowing what awaited them in resettlement.

The women also looked forward to family reunification but did not anticipate the legislative hassles associated with this process. Subsequently, another theme relevant to the emerging context of their lives was that of experiencing challenges and disillusionment in resettlement.

Experiencing Challenges and Disillusionment in Resettlement

Once the women arrived in the U.S., they experienced other challenges and disillusionments. Challenges facing the women were those of language, education, their living situation, and earning a living. Through various programs sponsored by the government, churches, communities, and social service agencies, the women began to learn other transactional skills. Learning English was an initial skill commonly described by the women.

Facing challenges required resolve in pursuit of an education and personal goals, in spite of disdainful treatment:

I was 22 years old. I told my sponsor family that I wanted to be a nurse. I wanted to do my GED in 1 year, I wanted to take ESL. I took classes at community college. My dad [U.S. sponsor] suggested that I go to a Christian school in the Seventh Day Adventist [SDA] system. I told him I have no money. He said, "We'll pay." I went to the SDA academy. I took 5 classes—English, History, Chemistry, and Biology, Reading. Then after my day at the academy, I went to community college in the evening to take writing class and my GED class. In 1 year I finished my GED...My dad [sponsor] said, "Why don't you go to Walla Walla College? You can take courses at the community college and then transfer to Walla Walla." I took 2 years of study in the community college, I started in the summer of 1983. I went every summer for 2 summers and 1 year. I got through my general studies in community college...I fight for everything. I had to read things over 3 times. The kids made fun of me in Christian school because of my broken English. I never flunked.

In addition to language skills and pursuing education, finding a place to stay and finding work were priorities. One participant recalled that her family of eight

members lived in a one-bedroom apartment in Long Beach with a single relative. Some of the women were taught job skills here and found work at local factories or at the schools they attended. Others preferred to manage their own businesses. Initially, the women found gainful employment to meet survival needs and support their families. However, finding work they could do here in a new environment generated other experiences and related issues for them.

The experience of disillusionment in resettlement was another aspect of these women's lives that surfaced in the interviews. Having endured hardships and transitions to escape persecution, the disillusionment of refuge in resettlement concerned work and family life.

Work. Survival here took precedence over plans to retire. In Cambodia, women who worked all their lives anticipated a long-awaited retirement. They were looking forward to more relaxation and family time. However, resettlement in the U.S. changed this:

My husband scare me. Before coming here he work for eight years. I was born in 1940, but when we come here, he put down on papers that I was born in 1948 so I could get a job. He heard that if you are too old in U.S. you cannot get a job. I will be 59 year[s] old in August. I went to change this on green card. When I went to get citizenship my papers still say I was born in 1948. I want to change it. I have a witness, a close relative, ready to change papers, but my husband still say "No!" My husband make me so mad! So upset! I tell him about this all the time! My birth certificate correct, counts right age. Green card count right age. For citizenship papers my husband still put 1948. I could retire! I am here 18 years in U.S. I wait [to retire]. Very upset!

Another disillusionment in resettlement concerned a work-related irony to be dealt with. The women escaped political upheaval in Cambodia only to contend with an unfamiliar political environment here. Self-sufficiency in the successful operation of self-owned businesses and the efforts to reach this point, meant nothing to city

officials. As an interviewee looked back on her situation in resettlement, she paused to reflect momentarily. Although she speaks with restraint, her voice was full of emotion.

Her words were punctuated with a pointed finger and clenched fists:

I was angry! I was *so angry* that the city told me to move my shop! The city divided my property. Part of my business was in one city, and part of it in another city. My business sat on the property line between these two cities. I *fought* with the city for *years*! I fought with them to recover the costs of moving. The city did not give me any notice or any time—not enough notice to take care of everything! They just said move it! It took *five* years... I did everything myself—filed papers, when I had to go to court, I went. The city gave me \$15,000.00—that's nothing. The new roof alone that I replaced on my store costs me \$10,000.00. I could not sleep for long with all of this going on. I calm myself. I think on Buddha. Everything and anything can happen. Some bad things happen all the time. I think to myself, take time to solve it, *be patient*. The city harassed me all the time. They call me every week to tell me that I have to move in three months. Then they call again to tell me I have only two months to get out. They did not even offer to help me. They told me that I had to move, and I had to find my own place. Not easy to find a place for a new business. For the first three years, I do everything my self—went myself to the city. Then I found a lawyer to help me—an American lawyer.

The kind of work the women found in resettlement was another disillusionment they faced. In Cambodia, the women had a sense of familiar purpose and a means of self-support through their work, whether they taught, attended school, farmed, or sold their goods at market. In coming to the U.S., these women left behind stable work, careers, and educational plans only to confront difficulties in making an adequate living here. A former teacher, for example, expressed her dissatisfaction with her current job as an assembly line worker and the difficulty she has had in finding transportation to work. For the most part, the women understood and were familiar with the subsistence economy in Cambodia. Here in the U.S., they were unfamiliar with a capitalist economy and became acutely aware of the monetary disparity that exists between the two countries. "Work hard" or "working hard" expresses the

difficulty they have with this disparity, “Things are so expensive here. Everything costs money...expensive...there’s bills. I have to work hard.”

An interviewee drew a parallel between the work demands of the Khmer Rouge and the work demands of sustaining a living here. Her commentary put into perspective the context of the women’s lives from the point of their leaving Cambodia to the point of coming here. Her commentary highlights a superficial view that others have of women in resettlement based only what they see. With determination, she stated:

Hard to make money. People who never work hard can’t do it. Only if you work hard under the Communists you can work hard here. I get up at 3:30 A.M. to come to work...I am here until now 4:00 P.M. I sleep only 3-1/2 hour at night. Sometimes I feel sleepy in store. Some people are jealous. They think we have an easy life—make lots of money. But I work very, very hard. I never took one cent from the U.S. government. No welfare. Only work, work hard!

There were other disillusionments of work in resettlement, which impinged especially on their health and their family lives. Having once endured illness and starvation in Cambodia, the work that women face here, takes its toll it upon their health. Women described the type of work performed in factory settings that suggested potentially unhealthful conditions:

Before, when I first came here...I worked in an assembly, like a factory. There was no air, no windows, I got sick easily. Now I gained weight, and I am not sick. I can walk around on break, go out, breathe the air.

I paint airplane parts. I have to unmark them, clean them, and repack them... I stand on my feet all day... I work from 5:00 A.M. to 3:30 P.M....sometimes from 5:00 A.M. to 5:30 P.M. When I go home I cook, eat, clean; lie down a little bit, rest.

A participant took note of how she felt at the end of her work day as a computer cable assembler, “I cry, because I hurt. My back hurts, my back—tired. I get a headache.”

The demands of a long work day require physical stamina:

Here, I still worry a lot about the business. I have little money. I spend a lot of money for the employee and the baker. See? [She picks up strands of her chin length hair]. Lots of gray hair! I come to work when sick a lot. Work hard to send kids to school. Husband work harder than me. My husband go to work when the baker sick. Sometimes my husband work 14 hours a day, come home, watch TV. Then worker or baker call in sick, he put on his work clothes again and go back to work same day...I stand up all day, feet hurt, knee hurt. I do a lot of lifting. I buy cake flour—costs over \$50.00 for a 50 pound bag. I have to lift all the supplies myself.

The women endured family separations and losses in Cambodia, only to have less time with their families here. The necessity of having to work and the demands of full-time employment competed with family responsibilities in their personal lives.

The women verbalized this concern in terms of family expectations:

You know I get up in the morning—get the kids ready for school and the babysitter. Then I work all day. After work I go pick up the kids. Then I go home, cook for my family, bathe the kids, help them with their homework, clean the house a little bit. I'm tired. Then the same thing again the next day. When my husband comes home from work, he just sits down, relaxes, and watches T.V. And he takes a nap yet! He works ten hours a day. But me, I do all these other things. The wife or the woman is expected to stay home and take care of the kids and everything around the house. They are still expected to do everything in the house, *plus* work...Men work and come home—that's all.

Frustration, as expressed by this interviewee, centered on her role in the family. The conception of traditional gender roles and expectations of women within the family have not changed in resettlement to accommodate for role adjustments.

Family life. A larger concern beyond the necessity of work and competing tasks was sustaining the centeredness of family kinship and unity. There was little time for fostering relationships, which is contrary to the centrality of family in Cambodian culture:

Parents are busy with their business and work ...they are not close to their children. When they need you, you are not there for them. When they need you, you don't help them to have respect and love in the family. Sometimes it's hard to be like that here.

Women who lived as extended family members with an adult son or daughter also experience remote relationships:

My family supplies me with money, but things are not really enjoyable. My family thinks I am just "old." They work mainly, but I don't get much help from them. It is hard for me to move about; it's hard to go [out]. I have to stay home when they work. The family works. I never see them. All I see is that my family works—my daughter and son-in-law are so busy working. They have no time to relax. Everything is not enjoyable. I am old and afraid of dying one day.

It was difficult also for an extended family member when adult children and their respective families moved away. The extended family member felt distanced both physically and emotionally from them. In resettlement, there was a break in the naturally occurring system of help, which existed previously in Cambodia when families lived close to one another. It was hard to deal with this separation. Separation was an inevitable occurrence during the war. In a place of refuge however, the disintegration of family centeredness was difficult to comprehend, especially when the women lived with surviving family members. There was an irony in work and family life in resettlement. In risking escape, the women perhaps hoped that family relationships, and a means of self-sufficiency and independence would be restored once in resettlement. Instead, these women have experienced frustration, isolation, and increasing fragmentation of family relationships.

Formerly, in Cambodia, it was customary for women to have the responsibility of managing money for the family. The loss of fiscal independence in resettlement is another disillusionment for women, as it spurred an unwanted dependence upon others. This created uncertainty in the women's lives:

Before my husband was a teacher. He gave all the money he earned to me. Now I have to work...I cook and take care of the grandkids, do laundry, get groceries, help around the house...my kids do not pay me for helping

them...On Buddhist Day, my daughter gives me \$10.00 to come to the temple. It is to give to the temple. It is not for me because I have free room and board with my daughter. On Saturdays and Sundays they [daughter] take me around to the mall, to the grocery store...[long silence follows]. It is a big difference for me not to manage money for my family. Before my husband made money. Now I have to wait for the kids to give me money...it is not easy for me.

Legislative barriers which keep families apart are other ironies of being here in resettlement. This added to the burden of emotional distance which the women experienced with their families. Nevertheless, such barriers did not deter their ongoing resolve to reunite the family:

I live alone, so I have to manage alone all by myself. My son sponsored me to come here to the U.S. He doesn't think anything more about me. He doesn't think much about me. It's as if he throw me away and left me high and dry.... [Tears well in her eyes]. I do housework, I cook, I clean, I stay with someone and watch their house while they are away at work. I help. I have someplace to stay. I do this as a service for someone who has given me a place to stay. I am like an attendant. I have nowhere to stay. I do not have an address, no transportation. It's hard to get around. I stay with a former student of Mr. ____'s in _____. He and his wife work and I help cook, clean, do laundry, take care of the house when they are gone, I plant things. This is someplace for me to stay, to live, I put down the address at C ____ F ____ [an incorporated social service agency] when I am required to provide an address. I move around a lot.... I'm somewhere down here on the floor [there is laughter, followed by a pause, and silence]. My son sponsored me to come here. I applied for SSI [Social Security]. The SSI office asked about my son, and I told them that my son moved away. The SSI office said that if I can find my son, they will ask my son to provide me with some support—some financial aid....I want my single daughter to come here. When I first came here, I sponsored three of my kids in Cambodia. The U.S. Embassy in Bangkok accepted my case. However, the INS only accepted two of my children. I wanted to bring one more son here. I asked the INS one more time if I could sponsor my other son. They told me I had to wait five more years. It is now five years this year....I have waited so long. I even called Minnesota, and they told me that I had to wait....The case is in Minnesota and I am here. I only reason I stay here is to benefit my kids.

There was a simultaneous and spontaneous burst of laughter from both the participant and the translator as the interviewee stated, "I'm somewhere down here on the floor."

At that instant, within each of themselves, both readily identified with the participant's

experiences or encounters of disillusionment and destitution in resettlement. This moment of humor masked disappointment. Being “somewhere down here on the floor” was the participant’s expression of being at low point, perhaps the lowest point in her life. Even at this low point, her focus was oriented toward family reunification. Despite persistent individual efforts, encounters with legislative barriers to family reunification may fuel an increasing sense of distrust and disillusionment in resettlement. The repeated occurrences of these encounters over time may ultimately contribute to a sense of ongoing unhappiness or disharmony.

In spite of their suffering, the risks and uncertainties in coming to the U.S., and their encounters with challenges and disillusionments, once here, their lives are a growing and evolving continuum. Once here in the U.S. they experienced other encounters with knowledge and information.

Patterns of Knowing: Conditions for Seeking Life Balance

Patterns of knowing are interactions and experiences of knowledge and information described by the women in this study. “Indigenous knowing” and “informed knowing” were two key themes which emerged in this category. These interactional and experiential encounters informed women and ultimately influenced self-care and help seeking processes. A third theme was that of “forming personal ways of knowing.” This third theme was characterized by contemplation of existing health beliefs and exploration of other health paradigms.

The first two themes are discussed in the following section. Key persons who impart knowledge and information, the means by which women acquire knowledge

and information, and what women know are presented here. The third theme is discussed last as it is an outgrowth of indigenous and informed knowing.

Indigenous Knowing

Indigenous knowing was knowledge and information encountered within a cultural network of people. The women possessed this knowledge and brought it with them in resettlement. This knowledge had been passed on to them orally, from mothers and older women. Such knowledge was also acquired from those persons traditionally sought in the culture for advice and guidance, monks and traditional healers or *kru Khmer* (also known as *achaa*).

Indigenous knowing was also encountered within the context of family or others with whom the participants had a close or trusting relationship. Often these people were the participants' mothers and women friends. Respectful deference was accorded to women as they become elderly and move past the responsibilities of raising their children. Having reached this pinnacle in life, credibility for giving advice to others lay in life experiences and survivorship, "My mom advises me and I agree with her. My mother has life experience. She has done a lot of things. She has done some wrong stuff in her life and she teaches me to do the opposite."

As elderly women eventually became extended family members themselves, they freely advised others in the household. An interviewee who also had several extended family members living with her was informed through her own observations of them, "I learn from my family. You open your eyes and you see whatever you see. That's how you learn."

Indigenous knowing was also encountered at the local temple. Here, where there are opportunities for informal learning, the women mingled in the company of friends, mothers, mothers-in-law, and other older women of the community:

I come here [to the temple] a lot. [I] just listen. If the advice is not for me, I just throw it away, and keep what I believe is good for me. If it is good advice I keep it.

Illness causation and illness prevention. There is a plethora of indigenous knowledge rooted in spiritual and cultural beliefs, and Eastern theoretical philosophies as discussed previously. These philosophical underpinnings were reflected in a manner of thinking. Central to a cultural paradigm of illness was the concept that one is born into suffering. This has been an acceptable explanation for illness which has defined the experience of these women. The presence of illness or disease results from negative actions in a previous life. Good deeds alleviate torment such as illness or disease in the next life, "...When we are born we always have disease because of kamm...because we did not do good in the past." Provocation of angry spirits is another indigenous phenomenon which explains illness:

When someone is sick, it is often connected with a spiritual thing. People get sick because their ancestors are angry, or someone did witchcraft on you, or they made an angry spirit mad....So they invite monks to come to the home and give a blessing. They may also cook food, burn incense and call on the angry spirit to give the inhabitants of the house good health. They call on the spirits to help them make a good living and not to be angry.

Protection from angry spirits is sought from monks:

I remember *katah*. It is like a steel string...like aluminum foil...that kind of consistency. It is folded or wrapped around a string. It is blessed by the monk and worn around the waist to protect from bad spirits.

Blessings are also sought from monks to facilitate a better outcome or improvement in one's lot:

I hope to get a blessing from the monk. It may help me. The monk will look at my hands and tell me what lies ahead. I also like the pouring of water over my head with the monk blessing... Yes. The monk's predictions may or may not help. Sometimes things turn out better, sometimes things stay the same, sometimes things turn out worse! [burst of laughter from participant and translator].

The provocation of illness by one's former negative actions or by the arousal of angry spirits as the women believed, were dealt with by protective actions--the monk's blessings or one's prayers and offerings of appeasement to angry spirits. There was a recognition that these protective actions may have no direct effect upon illness prevention. Nevertheless, these actions symbolized a belief in traditional values and paradigms of knowing.

Curative interventions. Curative interventions repeatedly surfaced in the interviews. The women acknowledged lay persons in the culture, kru Khmer, as experts in curing illness. The women sought out kru Khmer for their mastery of indigenous knowledge:

There are two kinds of kru Khmer. One relies on Chinese medicine. This is the *tnam chen sac*. The other type relies on the boiling of herbs and leaves. This kind of kru Khmer learns by word of mouth. They take leaves from the tree trunks and leaves of fruits, like guava fruits, to cure illnesses like diabetes. They all learn from each other.... People sometimes learn these practices from the monks. Or people also learn by inviting a religious man who ranks below the monk to the home to teach them, help them. This person is known as an *achaa*.

While indigenous curative interventions have been the domain of kru Khmer, the women were knowledgeable about these interventions and readily identified them. They expressed familiarity with the various components of traditional medicine, which consisted of roots, leaves, barks, and flowers. They also articulated the technical differences between indigenous sources of knowing:

I remember the difference between Cambodian traditional medicine and Chinese traditional medicine. Cambodians use fresh herbs prepared and ground with a mortar and pestle. Chinese traditional medicine consists of dried roots. They put things in a crock pot and allow the ingredients to simmer. I know that the Cambodians will take herbs, make a paste, drink liquids, rub pastes on them. For rashes and headaches, Cambodians will take herbs, mix pastes that they rub on their skin.

Traditional practices were aimed at releasing illness-causing agents from the body--bad wind and humoral toxins. The cultural notion of bad wind as a causative factor in illness provided the rationale for coining (*koss chall*), pinching (*chap kchall*), and drawing or sucking out (*kao eak*) illness. These are traditional strategies intended to release bad wind, thereby getting rid of illness. A widespread practice was *koss chall*, or coining, which is described as “stroking the bad wind.” There was a specific technique often elucidated by participants for effective coining, done over a body part between bony prominences:

Good coining means you have to coin and stroke every inch in the area [of skin]. The strokes must be very close to each other--you don't skip any area of skin. [Participant simulates coining strokes on soft tissue next to the sternal and clavicular areas. The direction of each stroke moves from the center of the body to the periphery]. You cannot go over bone. You have to go between the bony areas or you will get hurt. You do it till the skin changes color--like a reddish-brown. It will look like this color [points to an orange colored folder on her desk]. You coin with Vicks vapor rub. So when you sleep at night you breathe the vapors and you feel better.

Knowledge of other curative interventions to alleviate illness included the notion of drawing out the illness from the body. A participant demonstrates *chap kchall*, “taking sickness away”, a method of using thumb and index finger to pinch and pull the skin between the eyebrows away from the forehead. *Kao-eak* was another practice based on the idea of bad wind as the source of illness. It is a traditional strategy used to draw out illness and humoral toxins:

Kao-eak...is [use of] a sticky thin, a stick substance...this is Chinese medicine practice where you place this substance on the temples to suck out the sickness. People will also put a burning candle on their forehead and then a cup over this. It makes a suction. When you take the cup off, it leaves a red mark.

Humoral toxins thought to cause illness were eliminated from the body:

When one's face is yellow, this is believed to be due to not eating a lot. So they [parents] make a cut, and they let something bleed out. This is supposed to help you get better, to take poison out of their blood. That's what I've seen some parents do to their kid.

Indigenous knowing was a frame of reference for women as it has been very much a part of their experience. These interventions proved effective:

When I had a high fever, my mother would get leaves from a certain tree that had a sticky sap. She would rub this all over my body to help cool me down and get rid of the fever. It worked because I got better.

Hot-cold imbalance, rooted in an Eastern paradigm, was also thought to cause illness. Certain foods with "hot" or "cold" properties are consumed to restore balance. The intake of "hot" foods does not refer to temperature or spiciness, but rather its intended therapeutic effect that will help bring the body back into balance. The women also possessed indigenous knowledge about curative or aggravating properties of food with respect to hot-cold imbalance:

Some foods cure too—like *tralach*--cucumber. If you eat cucumber, it will cool you down inside. If you have an infection from a cut, you should avoid seafood, like crab lobster, codfish, beef. If you eat these foods, Cambodians believe this will worsen your infection.

Indigenous knowing and the post-natal period. Indigenous beliefs and knowledge about post-natal practices consistently surfaced in the interviews.

"Warming", another indigenous strategy, was known to all of the women in this study. This, too, was transmitted orally through mothers, mothers-in-law, or elderly women at the temple who freely offered advice to younger women. Warming strategies, both

internal and external, were those self-care practices intended to: (a) discharge bad blood or humoral toxins present in illness, and (b) restore the hot-cold balance in the body.

Although pregnancy and childbirth were not considered illnesses, the women were advised of warming practices. The women were concerned with the post-natal period and the loss of blood and fluid associated with the birthing process. The interviewees specifically discussed warming practices as they related to the post-natal period. The loss of blood and fluid created a “cold” or “yin” state, which is a state of imbalance. Warming practices were intended to restore the hot-cold balance especially associated with pregnancy:

Everything that is done around childbirth practices is geared toward helping cleanse the body, and getting the body back to normal... It is believed that after you have a baby, women have “bad blood.” To rid of the bad blood you have to “heat up” the body. This is believed to dissolve and discharge whatever toxins there are in the bloodstream. This prevents the body from getting “cold” and is supposed to rejuvenate and cleanse you.

The use of the term “cold” in this context did not refer to core temperature or perfusion from a Western perspective. It was a distinctly Eastern perspective, describing a state of imbalance within the body.

Ang pleung, another common practice discussed by participants, literally translates as “fire.” This practice has been consistently transmitted within the culture from the older generations to succeeding ones, as “...Everyone learns this way. Everyone does it after labor.” It is a charcoal fire placed under a stilted bamboo bed, used for a special reason for several weeks following the baby’s birth:

Ang pleung, fire, this is where the mother will lay on a bed or like [a] stand [with a heated charcoal fire underneath] after her baby is born. The purpose of this is to chase away bad spirits who may be after the baby.

“Warming” is another common practice passed on from other women to those of childbearing age.

You put the herb in the vodka, you keep it for one year, then you drink it after the baby is born. You don’t need much...If you take it after you have your first baby, it will keep you younger. This helps you take care of the body after baby [after giving birth to a baby].

In the weeks following childbirth, women will continue their intake of herbals with alcohol, “We put roots in wine...and we take it after eating to make the body warm.”

This admixture of traditional Cambodian medicine had a therapeutic effect, “It [use of herbals] will help warm up your body and to wash out bad blood.”

Fully wrapping or covering oneself was another warming practice initiated in the post-partum phase of childbirth. This aids in internal warming:

You know they [older women] believe that after you give birth you must wrap yourself all over...from head to toe in warm clothing. This is supposed to keep [you] warm, even in the summer you are supposed to do this! You even have to cover your head!...They also believe to keep warm after labor you have to eat food with pepper and ginger—that will warm you on the inside...you are not supposed to take a bath for one month after childbirth...Also women are not supposed to drive after childbirth.

Another known method of warming was the application of external heat and pressure to the abdomen. This was intended to restore a normal abdominal appearance after childbirth:

[After the baby’s birth] You burn a rock...or heat it in the oven...wrap it with a towel, but not too tightly, so that the heat will transfer through the towel. This practice is to reduce swelling of the abdomen that happens with childbirth. You place this on your stomach, abdomen. The heat will reach your stomach and will help with the burning of abdominal fat. The lining of your abdomen will be swollen and the heated rock is to decrease the swelling.

To an outsider, the women’s indigenous knowledge of practices surrounding the post-natal period may seem superstitious and illogical. To an outsider, it would be difficult to validate or predict outcomes of these practices. However, one must look

beyond these post-natal practices as mere superficial rituals to comprehend the women's depth of belief in them. These practices were rooted in the paradigm of Chinese medicine and yin-yang theory, which have existed for centuries. As such, people have come to trust and rely upon time-honored practices to fend off illnesses, malicious spirits, and to restore energy and balance. Indigenous knowing and traditional practices have a predominant history in this culture. Such predominance has strengthened the perceived effectiveness of these practices among their followers. In retrospect, attempts by the Khmer Rouge to eradicate the culture have not proven effective as evidenced by the indigenous knowledge and practices detailed in these interviews. Although the women have encountered other ways of knowing in resettlement, their validation and transmission of traditional beliefs and practices, illustrate the survival of a culture.

Informed Knowing

Informed knowing, on the other hand, is that knowledge and information encountered in resettlement through educational sources. These sources of informed knowing were key people in the women's lives, media, their own education, and experiences. The philosophical underpinnings of this knowledge and information which women encounter stem from a Western paradigm. In this paradigm, pathophysiology explains illness. This Western paradigm contrasts with the spiritual, cultural, and Eastern theoretical underpinnings of indigenous knowing.

Informed knowing was encountered through key people who have either learned things through their formal education here or who have had encounters of their own and now share what they know. Family, women friends and co-workers, and

health care workers are influential persons from whom the women acquired knowledge and information.

Adult sons, daughters, and even grandchildren who have attended school here were a source of informed knowing. They advised and encouraged the women, as one 60-year-old illustrated, "My daughter tells me if I don't work I'll get sick. So I have to work a little bit at my age." The women also encountered knowing through women co-workers, "I learned [about health] from my co-workers. They teach me what to do, how to take care of myself when I am pregnant. They tell me about going to the doctor for checkups... These are women who work with me." Encounters with health care workers also informed women, "I learn from the doctor too. He taught me and tells me in a simple explanation. I believe what he [doctor] taught me is helpful to me. He talk slow so I understand."

In addition to key persons encountered above, popular media, such as radio, television, and literature, were other means through which the women were informed about illness prevention in resettlement. The women were cognizant of health information communicated through the popular media, "I read books, I watch news, I watch the TV programs and special reports. Others I know have high cholesterol and high blood pressure. I know I have to exercise to help this and prevent problems later." The women stayed informed and aware of other news in general which may affect their lives. An interviewee who cared for her elderly mother along with her two young children explained:

I also educate my mom and tell her about what's going on in the news everyday. She lives with me. We sit and watch the news together and I explain to her what's happening. I translate as we watch the news. My brother and sister are here too. They speak English, but they don't help her. I like to

translate to my mom the news when we watch TV together. This way she knows what is going on around here.

Formal education through a community college or university was another way in which the women acquired knowledge or information. The process of getting a formal education facilitated knowledge acquisition in other ways:

I memorized everything. I had to memorize psychology, philosophy. I did well in biology and chemistry. These things shaped my notions about health. My step-dad shaped my ideas about health. I talked a lot with [step] dad about hormones, the body; I had a lot of coaching. He was a dentist and we would go over physiology. We would sit and talk after dinner and he would explain. We would sit and talk like how you and I are talking now.

In these examples, encounters of knowledge and information occurred in the context of home, work, and school.

Through interactions and experiences of informed knowing the women encountered a Western paradigm of knowledge. The women knew of predisposing factors that influence health, "I also have good genes...I learned about good genes from work." Technical terms were included in dialogue and explanations which indicated grasp of another referent for illness. They articulated their knowledge of body systems and disease transmission:

The doctor says my immune system is working to fight the stuff [sinus infections]...Here, I have many respiratory problems. I have a stuffy nose, fevers. I've had bronchitis, and sinus infections. I think this is because I am a teacher now. I think I catch a lot of things—colds, fevers, infections, from the kids in my class...I think the chalk residue in the classroom gives me problems too... I was tested in the camp for TB, tuberculosis. I tested negative for TB in the camp. I think because I am working with kids, I converted to a positive TB test... And I am cold all the time. I wear a heavy coat even in the summertime. The school nurse tells me I need more fat on my body. So I don't even open the windows in my classroom so I don't get cold.

A pragmatic approach to new ideas facilitated application of these ideas to their own lives. They grasped the consequences resulting from adverse interactions and the notion of prevention:

Health is *very* important. You cannot eat whatever you want without getting sick. You cannot just do anything you want—you'll get killed. For example, if you are eating and you have allergies to something, you can get killed. So you have to be careful about what you eat...[Health means] clean. Personal cleanliness is very important for health. You have to take care of yourself. And if you are sick, or you have a disease or illness, you must be cautious about not passing your contagion to others...I learn about these things here [workplace at the social service agency]. I taught myself. I don't watch TV or read newspaper or books. I am too busy. I learn about these things myself because I'm too busy to go to school—no time to go to school. I just observe others. I have seen what has happened to other people who haven't cared for themselves. So I have to stimulate myself to learn. I just see what happened to *real people* on M_____ Street.

The women also knew results of their diagnostic tests, such as x-rays, and could explain in simple terms and what these mean for them. A 71 year old proudly proclaimed, "I have no high blood pressure, no headache, no hemorrhoids, no prolapse. Everything clean. I went to the doctor and he said everything is fine. I am healthy. No worries. Everything clean." The women wanted to be informed of what is happening to them, and they wanted explanations given in an understandable manner. Informed knowing has provided women with an expanded worldview which they have accepted. They did not deny traditional knowledge which had been orally transmitted for generations. Perhaps, just as the women have been open to exploring other spiritual perspectives in resettlement, they were also open to exploring other ways of knowing that reflect their own ideas of restoring energy and maintaining balance.

Forming Personal Ways of Knowing

Personalized notions of health and illness began to develop. Through knowledge encounters in resettlement coupled with indigenous knowledge, the women

contemplated previously held notions or existing ones, and attempted to comprehend another paradigm of illness and its treatment. The women encountered choices and options within a paradigm of indigenous knowing or informed knowing, or both. As the women contemplated certain traditional practices and beliefs, they examined the effectiveness of these. In an attempt to comprehend another paradigm of illness and treatment, the women offered explanations that illustrate other formative ideas:

A lot of things don't seem justified. Like ginseng, swallow spit. These things don't help. At least I don't think there's any justification for their effect... Well, for example, the swallow spit. People will climb to great heights just to get to a swallow's nests to collect supposedly their spit. They brew this into a broth with sugar for energy... When you coin, you rub your skin with a coin and some oil. Actually what happens is that you break down the capillaries... Once my mom did that to me and I ran away. It was horrible. It was an awful burning sensation... I think medications weaken your immune system... so I stay away [from medications].

In contrast to the above example, past experience shaped a steadfast belief in the effectiveness of traditional medicine:

Well you know, I still believe very much in Khmer traditional medicine. I learned about modern medicine from doctors at the hospital, but my beliefs in modern medicine are gone. My grandkids try to explain to me [about modern medicine]. You know I have one granddaughter who graduated from a university. The other granddaughter is an M.D., and another grandchild is a pharmacy student. I still believe in traditional medicine. Maybe my son took the wrong food. Traditional medicine made him ill, but maybe he ate the wrong food. He ate shrimp and seafood before he became ill, so the disease came back and he died.

The women consented to Western treatment for themselves as they comprehended the need for it, while still remaining steadfast to indigenous habits. The following example illustrates how the women made sense of both indigenous knowledge and knowledge acquired in resettlement. An interviewee consented to a hysterectomy as a cancer treatment. She understood the need for this as explained to

her by her RN daughter. During her hospital recovery, she did not comprehend why she could not chew betel, a traditional habit similar to tobacco-chewing:

In the hospital I was bored to death, because I could not chew my betel [small dark brown seed which stains teen and gums a blackish color]. I was not allowed to have it. I was so upset for these three to four days! I did not experience any discomfort while I was in the hospital. I was in the hospital three days. They [hospital staff] helped me get well. I wanted to chew my betel seeds to clean my mouth.

She agreed to a Western intervention, and yet she was adamant about not giving up a traditional habit. To the interviewee, the importance of her comfort during her recovery and the imposed restrictions on betel were unrelated. From her point of view, her wish to continue betel chewing and the reasons for doing it, were legitimate hygienic practices, and a minor violation of hospital rules.

Personal knowledge prompted recognition of a serious situation in which women acted and sought help:

I almost lost my daughter [silence]. Now I know how my mom felt at the time she lost my brothers and my father. She [daughter] had a high fever and a urine infection. She did not go to the bathroom. I didn't know....[silence]. She likes to play a lot in bubble bath for a long long time. Then she had a high fever. Her fever jumped up right away. It happened quickly in just a day or two. One day she was fine, the next day she was so ill. Her temperature was higher than 103. She had no brain damage, she is so lucky. She had the fever and it jumped so fast. Luckily my husband came from work. He arrived just in time. We took her to the emergency room. We took the ambulance. She is doing much better now. She is just getting over some stomach upset. But she is eating now. So I think the stomach upset is gone.

In such critical situations, the women had a need for information that expedites or resolves the immediate problem. They wanted to be informed of consequences or dangers.

Personal knowledge coupled with their spiritual beliefs in resettlement influenced their choices and options:

The temple plays a part in health perceptions. Buddhism preaches principles—no drinking, no gambling, keeping peace of mind. If you drink it affects your health, right? If you gamble it affects your state of mind, your finances. And if you don't have peace of mind that affects your health too.

The above example illustrates a pragmatic approach to living. It represents the fact that the women associated and integrated spiritual principles with lifestyle choices.

They understood the relationships between choices and how this affects them.

The following illustration exemplifies how the women melded their perceptions of indigenous and informed knowing in an individualized way. The acceptance of sickness or disease was part of suffering in this temporal life. However, the disciplined adherence to Western treatment and self-monitoring was aligned with spiritual ideas of “doing good” for oneself. Spiritual beliefs were a strong influence upon actions:

My fate is different... When we are born we always have disease because of ...because we did not do good in the past. So in this life we have to suffer whatever—bonn or kamm for this life. The more bonn we have, the more happiness we have. The more sickness we have, we have to pray for more bonn. Sickness has troubled me. My left thigh has troubled me. The bone in my left thigh is not aligned. I have pain in my left leg a lot. I have diabetes, stomachache, and high blood pressure. My vision is not clear from the diabetes. I had a stroke. So I am numb on the right side [motions with her hand and draws an imaginary line down the front of her body, from her forehead to torso, as if to divide it into two equal parts].... I am calm. I believe in Buddha. When we have our bodies, we have sickness that comes along. When we are born we have suffering. Even the Buddha had sickness. When I listen to the cassette [of B___ S___, Buddhist preacher and scholar] I am calm. I have no anger with anybody. I don't worry about anything. Everything is caused by what I did in my past life. I go to the doctor every month. I believe in Buddha—action and result. You do good you get good. You do bad you get bad. The doctor gives me Western medicine. I am on medication for high blood pressure. Sometimes I take this medicine, sometimes I don't. I exercise, I walk, I do range of motion with my arms. When my blood pressure is high, I take medication. When it is low I don't take it. I take my own blood pressure. I use a meter to test my sugar levels four times a day. I used to test for my sugar levels four times a day. Now I only do it once a day every two to three days. I am very careful about my diet. I don't eat just anything I want. I do not eat any sugar. My food has less salt and less sugar.... When I had a stroke I stayed in

the hospital...A nurse taught me for one week... The stroke made me weak. It is difficult to walk, talk, hold, and sleep. It is hard to find a day when I feel good. I can do a few things, then I am easily fatigued. I cannot even lift P____'s small son. I can walk around the pool when I am feeling well. I eat one meal a day. I eat before 12:00 noon, and I follow eight precepts. I eat breakfast and lunch, I don't eat past noon.

Core themes of achieving spiritual fulfillment and indigenous and informed knowing are integral perspectives that influenced this participant's self-care. She did not express a preference for one paradigm over the other, but rather utilized both in a manner that was useful and meaningful with respect to her limitations and her strengths.

There was an integration of both indigenous and informed knowing in one's worldview which gave rise to other evolving perceptions and the inter-relatedness of different aspects of health:

In Cambodia, "health" meant physical health. Since I have been living here in the U.S. health also includes "mental health," one's mental state. For me, in Cambodia, health was "physical." Now I know that health also has a "mental" aspect. I know how stress can affect health. I know that attitude affects health. What you read affects health. What you experience affects health. What you eat affects health...The older you get, the more experience you have affects your life too—the way you live, the way you see things. Five years from now you will change—based on experience, exposure, attitude, and behavior—these things affect your health.

I believe in wholistic medicine...I don't discount traditional medicine, but I also believe that health is a wholistic concept...I also believe there is a spiritual aspect of health. How you believe affects how you heal...Health is also mental health. Health is spiritual, physical, and emotional. If I am happy inside, my immune system will be better off. Happiness is controlling your emotions. Your emotions affect your health.

The patterns of knowing among the women in this study—indigenous, informed, and their developing ways of personalized understanding—influenced the process of caring for themselves. These patterns were evident in the self-care and care seeking strategies presented in the following category, caring for oneself.

Caring for Oneself: A Process of Seeking Life Balance

The category of caring for oneself which emerged in this study was a progressive course of action, initiated and undertaken when women identified or experienced imbalance. In resettlement, caring for oneself addressed a perceived imbalance for which women sought immediate resolution and results. The emergent problem facing these women in resettlement was that of co-existing harmoniously in a society in which worldviews about health and illness are alien to their own. Finding this precarious balance between worldviews was central to a sense of well-being. It was their nature to find a life balance which ultimately resulted in a greater harmony. This section presents what women did to take care of themselves as opposed to what they know. "Care for self first" was a simple yet encompassing in vivo code that captures individualized and diversely adaptive self-care strategies. It reflects a definitive process, and the cultural and spiritual perspectives the women maintained in resettlement. This in vivo code also reflects economic conditions that influence their actions. What women chose to do first was influenced by limited or absent economic resources for health care, such as health insurance or Medicare.

Caring for oneself consisted of an individualized system of primary self-care strategies. Actions initiated and undertaken by the women included (a) following tradition, (b) integrating options, and (c) self reliance. Each of these successive strategies was intended to remove or minimize illness and its immediate consequences. Secondary strategies in caring for oneself consisted of care seeking from others. Care seeking from others involved (a) asking for advice, (b) transacting care through others, (c) getting access, and, finally, (d) resorting to Western medicine.

Identifying Imbalance: Min Srool

Min srool was an in vivo code which denoted the cultural concept of worry, and signified imbalance. The women readily identified a state of imbalance by verbalizing their concerns about feeling badly or not feeling well, and they worry. *Min srool* was a precursor to action. Among this group of women, it was acceptable to express worry. However, they were less open about disclosing specifically what worried them. No matter how varied or how different each woman's individual experience of illness or its symptoms, not feeling well was expressed as *min srool*. Therefore when a participant responded "min srool" one had to probe further what "min srool" means specifically to the individual (personal telephone communication, S. Smith, April 5, 1999).

Min srool jet [also spelled *jed* by some participants] and *min srool kluon* further captured interpretations of not feeling well. *Min srool jet* expressed worry about one's relationship with others:

My in-laws had issues when I got married to my husband. They believe that you do not say how you feel about things. You do not say anything negative...I suppressed a lot of my character from my in-laws...My husband's parents' philosophy is this, "What's yours is yours, and what's mine, is mine. I will lend you something, or give you something, but you must give it back or pay me back." This is my number one personal stress! This is different from my parents. My parents' philosophy is, "I'll provide and give to you, so you can do good for yourself, and take care of yourself."

Maintaining harmonious relationships was a key aspect of their lives, whether it be within one's immediate family, among in-laws, or even with co-workers. The importance of harmonious relationships supported the theme of re-establishing kinship. Relationships, especially with family have been a recurrent thread throughout this study.

Min srool kluon expressed worry about one's physical welfare. An example of an individual interpretation of this concept comes from one woman who has born two children, " 'Min srool kluon', for me, it means morning sickness, contractions, it is physical." The women identified their worries about the physical imbalance they experienced:

I know when I am sick and not well when I get dizzy. I get dizzy, tired, nauseated, and I have no appetite. The color of my face is drained, pale, and I sweat at night.

I can't sleep well. That is my major problem. I don't sleep. And when I don't sleep, I get a headache, I get dizzy. Also if I don't eat good, I get sick too. I can't live without rice either. I have to eat rice.

Their descriptions and expressions of *min srool kluon* identified what they experienced, and what they felt. These descriptions may not be particularly associated with a specific illness—it just is, as the women described it.

In contrast, *min srool kluon* also signified feeling badly as associated with specific indicators with which they have become familiar, such as blood pressure, "I feel fatigued, when I get a headache, when my blood pressure is low. This is what I mean when I don't feel good."

Worry about recurrent symptoms, and the impact of this upon patterns of living was a concern. They worried about carrying out responsibilities when they are not well:

It is hard to care for my family or self. Like when I'm sick—I neglect my daily responsibility, I neglect my health, my lesson plans, I don't correct papers, I get less sleep. When I am sick I have to go in to work...I *have* to go in. It's hard to get a substitute. I get very tired, I lose weight. My body experiences aches and pains. I do not get proper nutrition. I eat whatever I get my hands on or I eat junk food. Then I gain weight.

Subsequently, *min srool*, or worry, propelled women toward self-care strategies.

Self-care Strategies

Women initiated specific self-care strategies to alleviate physical discomforts and the disruptions that imbalance brought to their daily lives. There was an emphasis on physical care as they have predominantly encountered this knowledge in resettlement. Self-care consisted of following tradition and integrative options whereby women used a combination of indigenous and Western medicine. Finally, an outgrowth of the previous two strategies was that of self-reliance whereby women were confident in making their own decisions about self-care.

Following tradition. Following tradition was the first type of self-care strategies used. These were predominantly indigenous strategies women had relied upon in the past. Following tradition as the first strategy of self-care was consistent with their indigenous knowledge of prevention and cure. What women did first, was based upon their cultural knowledge as identified and discussed under the subtheme of indigenous knowing (Table 2). Past suffering and cultural and economic conditions had a role in choosing indigenous strategies as the first course of action. These strategies had been widely practiced and orally transmitted within the culture. During “Pol Pot times,” women survived without health care resources, and even now in resettlement, they must still contend with the lack of resources to obtain health care. Nonetheless, the use of traditional practices demonstrates a survival of cultural knowledge. Feasibility and practicality also influenced the choice to follow tradition first:

Bittermelon [a type of green vegetable] good medicine. Take leaf for fever, cold. Squeeze it [leaf] and drink juice [of leaf]... We learn to care for ourselves with herb medicine. We work hard... Care for self first, then go see doctor—too expensive, no Medicare, take care of self first.

Following tradition, the means through which women attempted to eliminate or minimize the imbalances or illnesses, was accomplished through “stroking the [bad] wind,” and warming practices (personal communication, S. Rama, July 25, 1998). The following sections discuss how women treated bad wind, how they implemented the practice of warming, and specifically, how women implemented warming in the post-natal period.

Coining, a prevalent strategy, was used for an impending or serious illness such as the flu, or for headaches and dizziness. There is no specific frequency for coining. It is done whenever necessary to help oneself get better. Typical responses from interviewees included discretionary use of coining in which they gauged their own needs to use this strategy:

When I am sick I do coining...I do it whenever I feel I need it...it may only be one time a month or two times a month...no special time, just when I feel I need to do it...I do it for headache, dizziness.

Koss chall helps me. I feel like I *have to do it* then it makes me feel better after I do this. Before I used to do this quite often, everyday. Now I only do it once or twice a year if I need it. Before I was sick often.

Another reason offered for coining is its effectiveness in alleviating pain. Most women performed coining on the anterior and posterior chest while applying pressure with a coin dipped in an ointment. Even when done with proper technique, which may produce skin abrasion to some degree, women opted for its positive benefits and its predictable effects, “I am used to coining. It releases pain... Sometimes it takes one month for the marks to fade away. But it does help me... I always feel good after coining.” Even if women attributed feeling badly to a specific illness described from a Western perspective, such as the flu, coining remained as the first action of choice.

For headaches particularly, a mentholated balm or ointment over the affected area was thought to draw out bad wind. A participant dabbed her left and right temples with a cream to alleviate her headache, "I will use tiger balm on my temples for a headache and will place a dab at my nostrils. The menthol vapors help. This practice is *kao eak*." If any of the above strategies did not result in improvement, women sought acupuncture as another form of care. This was a less frequent means of care. Coining, however, was perceived as a specific and common self-care intervention in response to physical discomfort. Additionally, women got extra rest, sleep, or modified activity.

Warming was another self-care strategy based on the women's indigenous knowledge of prevention and cure. Internally, warming was accomplished through the intake of fluids, such as boiled warm water or a tea of roots, herbs, and tree barks prepared with or without alcohol. Herbal tea, or traditional Cambodian medicine, was taken without alcohol as one would take fluids, "I take traditional medicine, bark, roots, leaves, branches, they are boiled and I drink this every time I am thirsty." Herb tea was synonymous with what the women labeled as traditional medicine. Herbs soaked in alcohol relieved menstrual discomfort:

I'll tell my mom how bad my periods are. She'll buy herbs, or tree bark and boil it for me to drink...sometimes I don't drink it...for my menstrual cramps I'll drink a little bit of Henessey [liquor] and mix it with the tree bark. It doesn't always have to be Henessey. I'll only do this once, not every time or every month, only when it's [menstrual cramps] so bad I can't stand it.

For herb tea to be an effective traditional medicine, a specific process was followed in its preparation:

I will follow tradition. I will drink the herbals but without alcohol. I will go with the Chinese plain herbals. Someone will sort the herbs, steam them with water, boil them, then I drink it like a tea. You drink herbals every day. It could be six months or up to one year...I don't know what to buy, but I will go to the store, and tell them what I need. They will usually prepare or gather the

herbs you need for your particular condition. You put the herbs through three boils. You boil once till all the water is gone, then you boil again till it's dry, nothing left, add some more water. Then you boil a third time. You drink the herb tea from the third boil. [You drink] one cup, about eight ounces of tea. Western culture is adapting to some of practices, too. I personally would not know what to buy, but I will go on others' advice—my mom's advice and my mother-in-law.

Women often asked relatives or family members who visit Cambodia to bring back or send specific herbs they are unable to procure here.

Warming practices restored the hot-cold imbalance altered in pregnancy.

Warming included the intake of herbal teas previously described and “hot foods.”

These measures were considered to have a healing and restorative effect:

[After the birth of the baby] I will eat “hot” food, like ginger. Ginger is considered a hot food...stir fry ginger with your food, or use whole black pepper...After birth, women are to eat hot dried food. You avoid chili. The whole purpose of eating hot food is to help cleanse the body...Women at this time are also to drink lots of water, not cold water. It must be warmed or boiled, and you add ginger to the water.

The use of alcohol soaked herbs in the post-natal period is considered for its medicinal purposes in warming the body, eliminating humoral toxins, thereby restoring the hot-cold balance. Interviewees affirmed the use of alcohol-soaked herbs:

After labor with my children, I took traditional medicine—herbs, tree bark, and leaves...to get rid of the blood that follows after the baby is born.

[I] use herbal medicine to help blood running [after birth]. [I] boil and drink herbal medicine with white wine, about 1 ounce daily. How long [this is done] depend on the woman—sometimes one month, three or four months. Bodies not used to American medicine.

Another mechanism for warming was *chpong* or steaming. This self-care strategy was done during the week of the baby's birth. It may be continued up to several weeks as the mother sees fit:

I will follow “*chpong*,” which means “pot steam.” We do “steaming” for generations. We call it “steaming”...it is for the skin and for warming the

body. You bring a big cooking pot with water, and inside you put lemon grass, edible orange leaves, lemon leaves, the Asian type of orange and lemon leaves. You put in something else...I can't think of the name, but it is used as an herbal cooking ingredient. You cook the leaves, heat everything to boiling. I can go to the store and get one big bag with everything pre-mixed. The pre-mixed bag of leaves should last for three days in the same pot. You use a blanket to cover over yourself and you are near the pot and all the steam comes toward you.

In summary, following tradition or the use of indigenous strategies, was generally the first recourse for women when they were not feeling well. These strategies were intended to eliminate or minimize causative factors of illness, such as bad wind and humoral toxins, and restore and rejuvenate the body. From the perspective of the women in this study, cultural strategies were health promoting processes that restored a state of balance in the body.

Essentially, what women did first in self-care was consistent with what they knew. Indigenous knowledge, shared with them and passed on to them through generations, was a vital part of their lives in resettlement. When following tradition did not produce desired results, the women subsequently adapted and integrated strategies with what they called "Western medicine."

Integrating options: "Half and half." Integrating options was a process whereby women individualized, selected, and chose some combination of traditional self-care strategies coupled with "Western medicine." "Western medicine," broadly defined by the participants in this study was the use of over-the-counter medications (such as Tylenol, Advil, Peptobismol), physician-prescribed medications (Tagamet, antibiotics), diagnostic studies (such as x-rays, upper gastrointestinal studies), and invasive interventions (surgery). The women were amenable to over-the-counter and

physician-prescribed medication. “Half and half,” an in vivo code, aptly defines these self-care strategies:

I do half and half. I take herbs. I use traditional Cambodian medicines—herbs. This is the Cambodian side. This is what has been passed on to me from the elder generations. On the American side, I use antibiotics which are prescribed from a doctor for me when I am ill. I use both Cambodian traditional medicine and Western medicine.

The women were reluctant to abandon indigenous strategies altogether for economic reasons previously identified. This also explains their reliance upon indigenous strategies in this second tier of actions. Reliance on trusted indigenous remedies was evident in the sequence with which women employed “half and half” strategies. Some preferred to implement traditional strategies first followed by Western medicine. Others preferred to implement Western medicine first followed by traditional strategies. In either situation, coining, *koss chall*, was prominently used as a precedent to physician-prescribed Western medicine and as an adjunct with over-the-counter antacids and analgesics for its potentiating effect:

When I get sick I use coining a little. When I am sick I take stomach medicine. If I am still sick I will go to the doctor. He gives me something for stomach called Tagment [Tagamet]. It is a pill I take.

Coining helps when I take medicine with coining. I notice that when I take medicine only, the symptoms come back. But if I coin and take medicine, I get better. Sometimes just the coining helps if I coin well. I take Tylenol or Advil with coining.

The women validated their preference for using traditional self-care first. A doctor visit or a hospital visit to urgent care or an emergency room was reserved for a more serious situation when women perceived that things were worsening rather than improving:

I do *koss chall*. If I am more ill I go to the hospital. My daughter takes me. I went to see the doctor. I burn on the right side. I had x-ray and I am waiting for the test results.

When women succumbed to a doctor visit, traditional self-care strategies supplemented their care:

The doctor gave me medicine, vitamins. I took things to strengthen me. I took traditional medicines to help wounds heal faster. These were herbs and roots. I buy these at the market.

This participant, as did others, illustrated beliefs in the effectiveness of traditional medicine. Aside from an adjunct to Western medicine, its usefulness for its potentiating effect was also cited.

With the idea of “half and half,” some women preferred Western medicine first supplemented by following tradition:

Generally I'll take medicine first, like Tylenol. Then I'll usually wait and see what happens. I'll wait one day to see if I get better or not. If things do not change, I will do *koss chall*--once a day for about two minutes. I do it until the skin turns red. If your skin turns red right away that means you are really sick. You know you are really sick when you see your skin change color immediately with coining. If you don't do [coining upon] your body completely, the coining won't work. Then I'll usually take medicine, and then go under a blanket and sweat it out...I'll get better within a few hours. I usually feel better.

In either case, with the use of traditional remedies first or Western medicine first, the women integrated options based on their preferences. Ultimately, they came to know and do what works for them. The preference for the primary use of traditional strategies and the retention of these with a “half and half” approach to self care highlights survival of cultural practices and women's resourcefulness in obtaining care with limited financial.

Self-reliance: “Knowing myself.” Self-reliance in resettlement was a personal comfort zone where women had a strong sense of doing what they perceived best for

their own self interest. It was influenced by indigenous, informed, and personal knowledge. Self-reliance was evidenced by independent self-assertion, withholding information, self-monitoring, and engaging in wellness-promoting activity.

Self-assertion is illustrated in the following statement, "If there's something I want to do, I do it. If I don't want to do it, I won't do it, regardless of anyone's advice. I am independent. I may be soft spoken, but I am independent."

In asserting independent decision making, the women questioned the usefulness of traditional practices. The ill effects of some practices influenced their decision to discontinue these. The use of alcohol soaked herbs was one practice which some women choose to abandon:

People will advise me, "Oh, don't eat pineapple. It is bad for the uterus." I don't see the physiological connection. It doesn't make sense. I do not drink the herbs with wine. The alcohol affects the baby with breastfeeding. If I take alcohol, it goes to the baby when I breastfeed. I do the steaming. There's nothing in that practice that is harmful. Steaming is done with lemon grass, mint leaves, and orange leaves. It feels good. I sit with a blanket and cover myself and do steaming. It smells good. I don't drink alcohol. I will take tea from Thailand. I drink lots of fluids, soup when I breastfeed.

Through their own encounters with education and health information, they decided to vary from using traditional practices and pursue other choices. They relied on self-knowing to deal with their own physical limitations. Women also trusted their own judgment and were comfortable in withholding information as they believed necessary. This is further evidence of self-reliance:

If the doctor does not ask, I don't tell. I don't do anything harmful. I also study and read journals to keep up with health information. I have to be careful with medications. I do not use any Chinese medicines or herbs because some have digoxin in them. That can be harmful.

One participant who had just recently learned of her pregnancy test results decided:

I will not tell my American doctor that I'm using herbals or traditional practices. I am not doing anything that is harmful or hurtful to myself or my baby. I believe it is my choice and I am well informed.

As this participant was well informed, she was also aware that traditional medicines and practices may be unacceptable in the context of Western health care.

Self-monitoring was another characteristic of self-reliance. The women knew for themselves conditions that could cause discomfort or potential problems. They understood the implications of careless actions, and attended closely to self-monitoring:

I cannot eat anything sweet with sugar. I had a blood test. The doctor told me my blood sugar was 126—which is not bad—but also not good. It is borderline. I am not diabetic and I don't have other problems but he advises me to stay away from sweets. Fresh fruit is okay—but cookies, cakes, and desserts like these, not okay. This dessert I don't eat. [She points to a cake dessert she refuses].

Self-reliance was also evidenced by the inclusion of wellness-promoting activity, such as daily exercise, in their lives. Reducing risk for certain conditions assumed importance in wellness-promoting activity:

I like to exercise, swim, eat right. I eat lots of vegetables. I try to watch my weight, so I don't gain weight. I don't eat any canned foods or a lot of canned foods. Canned products put you at higher risk for cancer. I like to drink a lot of orange juice and I eat a lot of carrots for good wound healing.

Self-reliance was sometimes accompanied by experiences of frustration. These experiences were exemplified in a participant's words, "...I have more difficulty now than before—difficult to go see doctor, difficult to stay in hospital; difficult [that] I don't speak English. It is hard for me...I don't know how to ask or how to answer." Women left their doctor appointments without having all their concerns fully heard or explored. They encountered problems of poor communication and inadequate

follow-up. This heightened frustrations, needlessly burdened the women with worry, and most importantly, delayed timely care:

The only time I was really concerned was about the time I experienced chest pain. That was months ago while I was at C___ F___. I was not satisfied with the doctor....I never saw my primary female doctor. Even with calling three months in advance for an appointment I was unsatisfied. I was told they couldn't fit me in and I had to wait. I called and complained, left messages on the phone. I had no results about the x-rays for over one month. Finally the secretary called me and they sent me a letter with the results. When I had x-rays, the x-rays showed I had scarring....At 6:00 P.M. on the dot I would start shivering for no reason at all. When I would get home, my husband boiled hot water for me to drink. Ten to fifteen minutes later I would get so hot! Burning hot! I was to the point I didn't want clothing on. Then in another 15-20 minutes the shivering would be gone. I would be normal the next day. Then at 6:00 P.M. the shivering would start again. It lasted for about one month. Now it's gone. I haven't had anything like that since then. It was so bad—the shivering was like clockwork. At work I had to tell S___ I'd have to leave work early. I didn't want to be on the freeway driving home experiencing this. I had blood tests and nothing showed up. I would experience tightness in my left chest with these symptoms. I felt the doctor was not doing enough. I went to my husband's doctor. I was concerned that I would jeopardize my health insurance coverage. I am covered under his plan. I am very satisfied with my husband's doctor. If I don't like one doctor, I can see another. It is a group practice, not far from here. Things are working well for me now. I was diagnosed with lack of iron. I was almost anemic. My mom said my skin looked yellow. I should have been diagnosed long ago. The first doctor I had was not paying attention.

Key issues the interviewee identified in her encounters center on satisfaction, feedback or explanations of results, and thoroughness in treatment. The issue of satisfaction is a focal one as it relates to trust in subsequently seeking care from others. Although women encountered frustrations and delays, they managed to get through negative experiences by staying informed and trusting their own knowledge and decisions to make changes.

Through self-care strategies, the women resolved imbalance in their lives.

These strategies included traditional practices, "half and half" strategies, and reliance

upon one's own knowledge and decisions. Indigenous knowledge as well as knowledge the women encountered in resettlement influenced this process.

Care Seeking from Others: A Process of Seeking Life Balance

When self-care strategies were ineffective, the women sought external help or aid from others. Care seeking from others still revolved around a perceived imbalance for which the women sought relief. Participants asked for advice, transacted their care through others, and obtained access to care. Participants also sought "Western medicine," such as diagnostic and invasive interventions, as a last resort.

Asking for Advice

Participants asked advice of informal and formal sources. Informal advice was sought from adult children, family members, trusted others in the community, and close friends. Adult children who are informed about health promotion behaviors through their education here were a strong influence upon the women in this study and a source of informal advice, "My daughter advised me to go to the hospital to cut uterus [hysterectomy], because of cancer." Parents are more open to the advice of adult children. Interviewees illustrated these interactions with their parents:

I teach my parents. Lots of Cambodian men and women don't know how to take care of themselves...especially the older men and women. They overeat, they don't exercise. I take my mom to the doctor. She has high cholesterol. I took her to the doctor and I told her to exercise, or at least walk around the whole house--walk around outside the whole house a few times a day. Now my parents, both my parents walk from their house to the beach, and the beach is not far from their house. They walk every morning now for one hour. They've done this now for five years. They don't eat red meat. We bought them a treadmill. I think the young generations should help them. My sisters get information from school. I don't have to talk to them. I want to see my parents healthy. I worry about them.

Health advice transmitted from adult children to parents concerned nutrition, exercise, and the idea of illness prevention. Adult children were also practical in helping their parents facilitate changes by pointing out results of lifestyle changes:

Now my parents take my health advice because they see the results. Both used to smoke. We convinced them to quit smoking. Now neither one of them has smoked in ten years. My parents are willing to learn...My mom and dad said, "You have to want it for yourself." They quit for the kids.

Trusted others within the Cambodian community who possess health expertise or information about accessing health services were sought out for informal advice:

I talked to H___ also. I asked him what could be wrong. He said my pain was most likely due to stress. The pain went away on its own, and I have not been bothered with anything like it since then.

Informal advice-seeking also occurred at social gatherings around cultural holidays or religious celebrations. Through this venue, women shared information and compared their health experiences, "They [elderly at the temple] all advise me on what to do and I watch what they do. I learned from everyone here in the temple."

Formal advice, on the other hand was sought from a health care professional at periodic checkups:

As far as my health is here, I have a heart problem. I take medicine everyday. The doctor tells me I have an enlarged heart. The medication I take is 'Carvedilol'. Is that how you say it? It helps me. I go for a checkup every six months. Before my heart was pounding fast. I cannot hear anything. I lost my voice too! I was so worried. My regular doctor said it might be due to my enlarged heart. I was worried. Sometimes I could hear the pounding. I would listen to it at night. I cannot sleep. The doctor says nothing is worse—it [heart] is normal. I saw a throat specialist—nothing—he could not find nothing.

Advice from a health care professional was sought out when women perceived their situation to be especially serious:

I had a bad fever once. The infection went to my lungs. I finally went to the doctor. He told me, "I cannot help you if you wait too long, or you come too late." I took antibiotics. The doctor gave me penicillin and I got better.

The asking of formal advice is venturing beyond the familiar boundaries of following traditional strategies associated with indigenous knowledge. Perhaps a willingness to explore other spiritual perspectives and other ways of knowing, extended to a willingness to try other forms of care in resettlement. Perhaps the idea of taking care of oneself through seeking formal advice aligns with their idea of doing what is “good.” As the statements above indicate, the women comprehended the advice and care they received, and they understood their part in this care, such as going for a check-up and seeking early care.

They also sought professional advice when their experience of discomfort was unexplainable:

I thought I had a virus or something. I really don't like to rely on medicine for anything. So I took some Tylenol and it didn't help. I went to the doctor, he examined me, I had a pregnancy test done, and it was positive. I am seeing an American doctor for prenatal care. I see the doctor every three weeks. I am very satisfied with the care I get. I see the doctor and the nurse. Sometimes I alternate visits between the doctor and the nurse.

Their encounters in seeking out professional advice were not always satisfying ones. A participant who constantly experienced pain in her legs continued to do the only thing she knew that would help alleviate the pain. She warmed her legs with hot water which brought about some relief. She verbalized a sense of exasperation in her experience of chronic pain. “What else can I do?” she asked. Her visits to the doctor were for stomach problems and she indicated she received medication for this. She was not given the opportunity to have her leg problems explored or examined, “Yes, I have told him already [about her leg problems]. He just give me something for upset stomach call[ed] ‘Tagmet’ [Tagamet] and sent me away!”

There were other ways in which the women sought care in addition to informal and formal advice-seeking. Outside of family and health care professionals, women also sought the help of liaisons who are familiar with the culture. Liaisons transacted care on their behalf.

Transacting Care through Others

Having come from an environment of political upheaval, an important determination in resettlement was who to trust to assist in transacting care. The women in this study primarily relied upon three health care liaisons at a social service agency. Two of these workers were Cambodian, fluent in the language, and had health care backgrounds. The third, a nurse and non-Cambodian, had extensive experience in working with refugee communities. These liaisons were often the first people women contacted to obtain initial access to a primary care physician when they needed medical attention. The liaisons arranged doctor and dental appointments and follow-up care. They also coordinated physician referrals and consultations when necessary. A female liaison accompanied participants to their doctor visits to translate. Transportation and child care were also arranged, if necessary. These workers were trusted intermediaries for participants in this study:

I only trust C___ F___ [incorporated social service agency]. I go to Mr. L___ and L___. I am happy with their help. I depend on C___ F___. Someone takes me [to the doctor]. The staff at C___ F___ usually take me or they will make an appointment for me. Usually some friends and relatives come to help.

These workers, who were familiar with the participants, would take an opportunity to check up on them whenever they were at the social service agency for other matters. Asking about their health and checking their blood pressure were examples of this.

Women juggled their work responsibilities to keep scheduled appointments arranged for them. Nevertheless, transacting care through liaisons also had its mishaps:

I am very satisfied with modern health care. I am very satisfied with the care I get from the doctor. But you know, L___ made an appointment for me on the wrong day, so I missed my doctor appointment. Because I missed the appointment, I did not pick up my prescriptions for my TB medicines.

The interviewee's statement of satisfaction with her care is a significant one relevant to interactions of care-seeking between women and health care providers or liaisons. A keen indicator of satisfaction for the women in this study was the establishment and placement of their trust in others who are in a helping relationship with them. The importance of trust in others comes from having lived through past experiences of suffering and deceit under the Khmer Rouge, which has fueled a sense of distrust of others. These women are intolerant of non-trustworthy behavior and have been observed at social gatherings to quickly transmit their perceptions to others.

Seeking out cultural preferences for care. The liaison workers were also familiar with the cultural preferences of this group of women for care. Cultural preferences for care were honored whenever possible. Women received care from those health care providers and organizations familiar with the culture and indigenous practices of Southeast Asians. Care and help from external sources that have an understanding of their worldview provided a degree of reassurance and less hassle in the context of resettlement. This parallels the self-care process of following tradition, whereby women implemented those indigenous strategies with which they were most familiar.

Women sought out doctors of Southeast Asian ethnicity in clinics or hospitals. This information was generally transmitted by word of mouth, or through referral from social service agencies that specifically address the needs of immigrant groups in resettlement, including their needs to utilize traditional or herbal remedies. One participant aptly summarized reasons for seeking out cultural preferences for care:

Some women see Vietnamese-Chinese doctors because there are Cambodian translators available at those clinics or places. Sometimes transportation is a problem and these doctors provide transportation to their clinics or offices...and it is easier for them [women] to get medicine. Communication, medicine and transportation are three main reasons why people see these doctors specifically.

As this participant pointed out, consideration of these issues, which may seem mundane to an outsider, was important to the women in this study.

Seeking out gender preferences for care. Equally important to women in this study, was the gender of the health professional rendering care:

I go to the doctor. Sometimes the doctor understands my needs. It is a male doctor. I am embarrassed to tell him my problems. With my last child I had a male doctor. That is the reason why I decide not to have any more kids. I do not like going to a male doctor. I prefer to see a woman doctor. I see a woman doctor now.

Other participants confirmed the importance of having a female physician:

I go for regular checkups with a female doctor. My Mom made a gyn [gynecology] appointment for me. It was required as part of a complete physical exam for school. It was so traumatizing! It was my first time to have this done. Nobody told me what it would be like! But the doctor was really nice. She told me that she would take a sample to detect cervical cancer. She gave me a complete breast exam.

Some women continued to adhere to cultural taboos. Even with resolution of the gender issue in care, agreement to certain examination procedures, such as pap smears and breast exams, was held in abeyance.

Getting Access

Prior to resettlement here, access to care was a matter of having enough money to pay for service. Health insurance was a new concept for many of the participants. The women in this study sought access to health care in several ways. One way was through employer coverage of health insurance. Some of the working women in this study were covered through a health insurance plan for themselves, or they were covered on a working spouse's plan. Other women were covered by health insurance plans of their working adult children.

A second way in which women sought health care was through a program of one particular social service agency. This program was funded through private, state, and federal grants. Agency staff who administered the program obtained health care access for the women. The program coordinator, a nurse, had major responsibility for client placement with a primary care physician. Through this program of health care access, the women obtained medical and dental care for themselves and their families.

A third way in which women sought access was through Medicare.

Finally, women sought access for themselves and their families through emergency room or urgent care services for situations perceived as serious:

When I am really sick, I go see American doctor—primary care. When serious go urgent care for headache, flu, high temperature. We see pediatrician for baby. We see the American doctor first. We see herb doctor to prevent and help only. Herb take a long time.

Resorting to Western Medicine

Ultimately, participants reached a point where they were left with a decision in spite of external advice sought from others. When they had exhausted self-care strategies in remedying imbalance or illness, they resorted to Western medicine. At

such a point they may consent to technological methods such as x-ray, diagnostic studies, and surgical intervention. Women came to the recognition that something more must be done:

I went to doctor several times. I have had stomach problems since Pol Pot times. Maybe I ate something no good. The doctor did not see anything wrong. My stomach open[ed] [had surgery]...Here, I prefer to use Western medicine more than traditional medicine. Traditional medicine doesn't help me. This is why I take Western medicine, modern medicine. For my bowel movement problems I tried traditional medicine one more time, but it makes more problems for me...You know I had surgery here before. See, stomach scar, stomach was open [ed]. I felt much better after the surgery. I had to sign a paper in order to have the surgery. For three days I was not able to talk. When I was much too sick, everything looked yellow to me before the surgery. All the doctors introduced themselves to me while I was in the hospital. I had a lot of hurt and pain in my stomach, so I had the surgery. After the surgery, pain gone, and later on I could eat! But my bowel movements are still not so good. I had something also to test my lungs. I had to blow forcefully into some tube after the operation. I recovered quickly at home. I spent eight days in the hospital. It took me one month to recover at home.

After exhausting all self-care efforts at trying to resolve their own perceived imbalances, the women concluded that the only recourse was to seek outside help by consenting to Western invasive procedures. They had become wary of invasive procedures resulting, in part, from their experiences of suffering under the Khmer Rouge. Verbalizations of concern arose when procedures seemed lengthy and when they were not provided with an explanation of results:

I did go to U.C.I. clinic [University of California, Irvine] and took some medicine from U.C.I. clinic. I had an x-ray of the colon. When they did x-ray, it took so long from 1 PM to 4 PM, 4-5 hours. Two doctors took x-rays for 4 hours because my intestine is bent, twisted, crooked....I am worried now. I'm afraid that the U.C.I. test took so long. This colon condition bothers me very much. I will go back to the doctor.

When they experienced relief or alleviation of their physical ailments to their level of satisfaction in resettlement, this provided evidence for them that Western medicine is helpful.

Ultimately, the intended benefit of caring for oneself is the restoration of a natural order in their lives that resonates with their beliefs, values, and cultural ways of knowing and doing. When there was little or no improvement from self-care strategies, women sought help from others. They sought advice, utilized liaisons who are familiar with their health concerns and cultural preferences, and sought access to care in various ways. Finally, the women consented to Western medicine--diagnostic and surgical procedures. The use of self-care strategies and help seeking from others represented reclamation of what was usurped from them by the Khmer Rouge--a sense of control and independence with respect to their personal lives and individual choices. Having resolved perceived imbalance in their lives, they were able to carry out their routines, meet responsibilities of work, care for their families, and enjoy recreation.

*Reaching a Turning Point: The Consequences
of Seeking Life Balance*

There was a point in the continuum of these women's lives where they remained fixed to their past or oriented to their future. This "turning point," another in vivo code, captures the thematic consequences of disharmony or harmony, either of which figured predominantly in women's lives. These dichotomous consequences emerged from the data, and consistently reflected the Eastern theoretical worldview of the participants.

Disharmony

Disharmony was a pervasive unhappiness and disconnection from life. Harmony was a pervasive happiness attended by a spiritual calmness, sense of cohesion, and an orientation toward the future. In participants' terms, "not happy"

captures their meaning of disharmony, and “happy” captures their meaning of harmony. While “not happy” and “happy” are simple terms, they had depth of meaning for the women in this study.

The realization of aloneness as a source of unhappiness was reiterated by participants, “A lot of times I am not happy. I feel sad. I don’t have help. No sister, no brother, no parents”; “I am *not* happy, I don’t have my mom. She died when I was eight years old. I lost my dad too. I am not happy here”; “I have to take care alone.” This aloneness was a departure from the togetherness which had been a mainstay of their culture.

Participants who remained rooted to past suffering experienced a more profound unhappiness, which was expressed in an in vivo code, *koucharang*, or “thinking too much”:

Koucharang—people think about their escape, they run, or they witnessed someone who was killed, or they have killed someone during the war. I dream of these things too. I shake, then I wake up. I say to myself, “It’s just a dream.” Old people keep these bad experiences in their minds... If you think too much, *koucharang*, you cannot do anything. God cannot help... That’s why old people have low energy. That’s why they are sick. They think too much about the past. Then they have pains—like back pain.

Consequently, participants were immobilized, physically and emotionally depleted, by constant preoccupation with past torment. The emotional and physical tiredness resulted in a general disinterest in oneself, and detachment from one’s usual routine:

I still get headaches until now. When I think a lot, I think too much, I get headaches. I think of all of them—pass away. I lost my husband, three more children, my father-in-law, my mother-in-law, a sister and a brother. I have no relatives. I think too much—*koucharang*... Here, in one month I was sick three times. I am not always healthy. I feel *tired—very, very tired* [gestures with limp arms]. I can’t do anything. I feel *emotional tired* and *body tired*. [I am] emotional tired from thinking too much. Body tired—same—from thinking too much...I’m in bed at 9:30 P.M. I wake up at 5:00 A.M., wake up at 4:00 A.M.—cannot sleep. At 2:00 A.M. I wake up and stay up until dark again at

night. Sometimes I cannot sleep at all for one night. Sometimes I am thinking a little bit, then it causes me one whole night of no sleep.

This dwelling in the past becomes a focal point to the extent that women may be unable to move on with their lives in resettlement. They are unable to move through the chaos and suffering of their previous experiences. Their preoccupation with the past saps them of energy and consequently, they may be unable to achieve a sense of spiritual fulfillment, to re-establish kinship ties, or to engage in rewarding work.

Disharmony was also characterized by strain and uncertainty which further compounded the stresses upon the women and their families:

There are many factors that make them [women] not happy. They cannot communicate, they are homesick, they have to make adjustments, they live in fear of government assistance, they are not comfortable. They cannot go nowhere, they cannot use public transportation. They live in fear that they won't get that government money. They know they cannot get it forever. They cannot rely on it for the rest of their lives. How can you feel good when you cannot do these things? Support from the government is unstable. It is everything all put together that creates a problem for them. They are worried about finances, their environment—they cannot get around in a new environment. They worry about family problems—that their kids don't listen to them, they join gangs. They worry if they don't get along with their spouse, husband or wife... Stress is a problem when the kids leave home...Some families are isolated from the Cambodian community. They are more sad, they cannot go anywhere, they cannot speak the language, they can go nowhere because they cannot use the public transportation system. They have to depend on the children to read things to them or to take them out...People get angry, frustrated.

These multiple life stressors created complexity in their lives. They fled and survived the chaos of the past, only to dwell in a state of disharmony in the present. The most poignant evidence of disharmony as a thematic consequence came from the words of a social worker, who was also a former teacher in Cambodia, and an escapee:

Everyone has problems. But with the example of my clients, if they are not busy, or they are not working, they see four walls only. They talk about going back to Cambodia, but they will not go back to Cambodia. Their problem is being connected to life—that is a different kind of problem. They begin to

think of some things in the past—they are not living today—they are not living life today. They are still living the war. So this is what they mean when they say “I am not happy.”

Disharmony, a pervasive unhappiness, characterized by aloneness, *koucharang* or “thinking too much,” strain and uncertainty had a downward spiraling impact upon the physical and emotional well-being of women. These women have had periods of unhappiness in their lives. However, those who continued to dwell predominantly in their past unhappiness, had difficulty getting beyond it. They remained disconnected from the present, and were unable to look ahead.

Harmony

Harmony was another thematic consequence. Emergent in this study was the women’s resolve to restore harmony in their lives in resettlement, a contrast to disharmony. Happiness, a sense of cohesion, and an orientation to the future were characteristics of harmony. Happiness was an “inner happiness” and a “spiritual calm.” Happiness and calmness result from *bonn*, (the earning of merit toward the next life through good deeds), “People that do good spiritually and in life, not as many bad things happen to them as people who do not go to the temple.” “Spiritually I am happy” further exemplifies this characterization of harmony. “Good things will come back to me,” expresses happiness as a consequence of the belief that what they do assures a reciprocal goodness for themselves in a future life. “We teach forgiveness” reflects the instillation of spiritual values. The teaching of spiritual values to others was another way of restoring harmony.

A sense of cohesion was also characterized by having made peace with the past, and moving onward. There was the recognition that they can never return to life as they knew it before the war. That perception of wholeness was destroyed during the

war. They can however, piece their lives back together in resettlement in a way that is once again happy and harmonious. The absence of bitterness and disappointment promoted this forward momentum:

What has happened has happened. Sometimes I cannot accept it. But I am not miserable. I am satisfied with my life. I am proud of myself. I am able to do it, I am able to do things that I set my mind to [do].... I forget about the past. If you mix past and present and future, you get problems with mental health. You get headaches. *I think about being happy first* [her emphasis]... The past? Erase out the past. I don't think about that...I follow the future.

With an outlook to the future, the women recognized a "turning point," an opportunity. They identified a need to move on, learn new skills, and venture into new challenges beyond their current situation. Under Pol Pot's dictatorship, the Khmer Rouge had attempted to halt any movement toward development, growth, and the evolution of society. What is evident, in these women's statements, however, is a zealous endeavor to regenerate and continue that forward movement:

Now I learned I can only do so much [at former place of employment]. I'm grateful that at least I'm involved some way in their lives [children's lives]. I can help them as much as I can. When I left, the kids would cry, "You disown us." I had to hold my tears back, I had to learn more stuff. I know I had to go on. Then if I went back I could help at a different level. I could help them 100%. I was not happy there [former place of employment]. That was my turning point. I learned sooner or later, I need to learn more. There has to be money to support the program. I have to learn how to write grants for the future. I'm looking at the bigger picture. My level of impact is different...It's hard, but my personal growth is better here regarding management. I am *happy* here [her emphasis]. Here, it's a different line of work, and I am satisfied with my job.

There is an effort in resettlement, to continue the pursuit of those goals, careers, and means of self-sufficiency that were once left behind in Cambodia. Education was an important focal point of this future orientation. An outlook toward the future was accompanied by hopes, dreams, specific plans and interests:

I want to go to school...study English, computers. Study English first, then computers. Then I will buy a car next month. It will be an old car! [She laughs at this remark she has made]. I want to make friends. It is not easy for me to make friends... I want to buy a car and go to school for ten more years.

Although some of the elderly interviewees did not have the opportunity to continue with their own schooling or career plans here, they were encouraging and supportive of the efforts of their children to strive for those hopes, dreams, and interests, which were cut short in their own lives. An example of this is reflected in a participant's grateful acknowledgement of the encouragement and support others have given her:

I will read more, continue to learn more, spend more time with my family... I am living my childhood dream. I am *there*! My childhood dream was to get a Ph.D. I am actually in it! I am now working on my Ph.D.! I have a lot of people to help me...who helped me get to this stage.

Rebuilding the culture was another characteristic of harmony. The women were involved in passing on cultural values and in influencing their communities. The passing on or transmission of cultural values took on importance in the preservation of relationships and appropriate mannerisms:

I can teach my children to be calm too. I can teach my children to be good and how to do everything good, so they learn and understand, respect others, talk politely, not be angry. I talk to them politely, softly. I don't give them stress...There's too much bad things going on in the world. I talk to them nicely about how to be good. I talk nice to them...I listen to them too. I talk to them about talking to others politely with respect to everyone...My kids only speak English, they don't speak Cambodian. *but*, they *know* Cambodian culture and Cambodian customs because *I taught them*...Yes, they listen, because I see how they behave around the house and around other people, and elders... I teach them to talk nicely to each other, no yelling, no swearing, no bad words. I don't use these words. I know what they are and I have heard others use them before, but I don't use these words in the house or to my children. I do not hear them swear in the house or use bad words.

From the perspective of other participants in this study, there was evidence that the values that have been communicated and modeled to them, were values which they

embrace. The compelling desire to live by values that exemplify “good” perhaps reflect a response in resettlement to the experiences of past atrocities and family separation. The transmission of trust and respect promote harmony in resettlement:

I want...a family [where we can] to talk to one another and trust [one another] where we love each other. I want to have a family of my own like that. My parents always tell us to “do good.” I find that there is a difference here among American families. My Mom says to all of us kids that to do good is to respect her. She encourages all of us every day to go to school, to get a good job, and to have a good family someday. We should try to respect each other—me and my brothers. She always tells us that.

“Sowing the seed,” yet another in vivo code, metaphorically captures a sub-theme of harmony, that of helping families and community. “Sowing the seed” involves providing guidance and counsel to Cambodian youth. A teacher, also a Cambodian escapee, shared her commitment:

I am looking forward to giving back to the community...When I work with the kids, *my life changed a lot!* I learn from them. They are innocent. They *brighten my life!* I buy prizes for the kids in my class. I spoil them. I buy incentive awards for them, I buy additional textbooks for them. These are called readers...I buy them treats. I care for them so much too. I had financial aid, I got a grant to go to school. I got guidance. I hope I can do the same for others. I’m trying to help those [children] whose parents are illiterate. They have no goal for the kids. I’m trying to sow the seed.

Several of the women in this study were involved in work of a helping, teaching, or advocacy nature in resettlement. Some were employed as social workers, teachers, youth and family counselors, or health care liaisons. Study participants provided baby-sitting services for parents who were attending English classes or on the job training. Others also gave back to the community by providing after-school tutoring or after-school programs and Saturday activities for school-aged children. The offering of help and guidance extended beyond one's family and work. A nurse, also a former escapee, lends guidance to neighbors in her immediate community:

If a mother knows me, I can comment to her about taking better care of her child. Sometimes I see the kids running around in cold weather. I tell them, "Oh it's cold. He should have a jacket." Most people approach me. They know I am a nurse... I can only tell them what I know. I assess and advise them what I know... One mother called me to say her son was coughing for three months. I ask her to take his temperature, look at his color, does he have breathing discomfort, does he eat, and so on. I told her to take him to the doctor and maybe the child has an infection and he may need antibiotics. Another woman called me and said, "I'm forgetful. Am I having another stroke? I am afraid of having another stroke." So I talked to her and questioned her about her symptoms. I referred her to the doctor. Another says, "I'm having diarrhea." I ask that person, "What did you eat?" You cannot just go to them and say directly, "You must do this, this and that." You have to know them first. If someone came up to me and told me how to take care of my kid, and they were a stranger, how would I feel? I know most of the women who call me. They are from my church. We are a small group. Other people who call me are Cambodian women who live in my neighborhood.

In a broad sense, in their efforts to rebuild the culture, in their own way and through their own influence and work, the women were helping to strengthen the Cambodian community in resettlement. While many of the clients served by these women were Cambodian, the helping and advocacy relationship extended to non-Cambodians and others who sought their assistance through the agencies that employed them:

We have to start from ground zero here. Many are not educated. They have no idea! They have no idea about smoking dangers. It's hard to teach them. Through the outreach programs I hope to get the message out about the health dangers of tobacco smoking... People don't understand why something happens. For example, they don't know that a goiter condition is due to iodine deficiency. They just see it as a lump and they accept it as a lump. They think they have the lump because they did something wrong and they must suffer with this. My colleagues and I have to teach them what goiter is, what causes it, and how it can be remedied and taken care of... Many do not even know about surgery. Cambodia as a poor country has no medicines, no doctors, few hospitals, few nurses. Now that people are learning about health, they are more receptive to taking medications and surgery. Unlike here in the U.S., here they do research to support health education. In Cambodia, people don't know about these things... You know there are transnationals in Cambodia. These are business people who head up large firms and corporations. They have found a market for tobacco in third world countries like Cambodia. You notice that there are a lot of older Cambodian people here who still smoke... I work

closely with our outreach programs. We have teaching programs we conduct in schools. We don't go to the schools that are funded through Proposition 99. We can't touch them. But there are a lot of schools in the area where we take our programs. We also go to the temples and push for smoke free temples. I attend many parent-teacher meetings to do presentations, and I work in concert with three other Cambodian agencies on community education programs. My staff and I attend health fairs, colleges, and other social service agencies to teach about health promotion and the dangers of smoking. I teach clients and families who come here. They may be involved in other programs we offer here, but I take the opportunity to teach them too.

In their efforts to help other Cambodians in resettlement, the women have identified a struggle in reconciling traditional views of illness, with health promotion education and advanced medical treatment. They contend with the marketing power of large global corporations, which have, to some degree, influenced people's lives, even as they have migrated from Cambodia to the U.S. The commitment and zealously of women, as represented here, to help rebuild their community through education, aligns well with the spiritual ideal of "doing good."

Collectively, spiritual happiness, a sense of cohesion, and future orientation created harmony in women's lives. In itself, harmony, as a consequence of seeking life balance in resettlement, was not a static endpoint, but rather an evolving and developing entity.

A Theoretical Model of Seeking Life Balance

Theoretical statements which can be made about this study are that: (a) seeking life balance is a wholistic perspective of health; (b) seeking life balance is influenced by knowing and processes of self-care; (c) the relationships between seeking life balance (core perspective), knowing (condition), and caring for oneself (processes) result in a "turning point" (consequence) that may ultimately enrich or diminish one's central perspective; (d) this wholistic perspective of health is culturally defined; and

(e) seeking life balance is a dynamic perspective and developmental process occurring in women, enriched or diminished by evolving processes and changes occurring over a continuum of displacement, transition, and resettlement.

The core perspective of seeking life balance, as reflected in themes of spiritual fulfillment, kinship, and meaningful work, is a wholistic view of health by the women in this study. This centered perspective in the women's lives has remained constant throughout their experiences of chaos and transitions as they moved through time and context. It remained so as the women transitioned from their communities of origin to communities of resettlement. The spiritual aspect of their lives was also a constant and significant influence throughout time and context.

Suffering, migrational experiences, and the challenges and disillusionments in resettlement collectively formed the context of the study. Within this context of chaos and uncertainty women fled Cambodia and awaited resettlement for indeterminate periods of time in refugee camps. Once resettled in the U.S., women had different experiences of work, which influenced their family life.

Patterns of knowing formed the conditions in this study. Traditional ways of knowing or indigenous knowing influenced the process of self-care in resettlement. The women also acquired other knowledge and information in resettlement through various educational resources. This informed knowing coupled with indigenous knowing contributed to their evolving conceptions of health.

Women identified imbalance in their lives--what bothered or concerned them. This was signified by the use of an indigenous term, *min srool*, (also spelled by some of the participants as *min srul*). For women in this study, this meant "not well" or "not

feeling good.” *Min srool* had physical and emotional connotations. What women did to resolve such concern constituted the basic social process of this study, caring for oneself. Ultimately, if the women were able to take care of themselves, they were able to fully participate in those aspects of their lives which they found enriching—achieving spiritual fulfillment, kinship, and engaging in meaningful work. An orderly and sequential process of caring for oneself surfaced in this study.

The women resolved imbalance through successive self-care strategies. These consisted of following tradition (indigenous strategies), and “half and half,” whereby the women employed indigenous strategies coupled with Western medicine or approaches.

Indigenous strategies were perceived as health promoting strategies and were the first order of self-care. Reliance upon indigenous strategies, when they literally had no medicines or health care under the Khmer Rouge, proved effective at the time. Having had this experience as survivors, the women have brought these practices forward in resettlement, and continued to use these strategies in self-care. Having experienced the effectiveness of traditional strategies, the women were reluctant to abandon these altogether, and used integrative strategies, “half and half” options. The women were comfortable in relying upon their own knowledge and experiences. Encounters with new knowledge in resettlement were not competing ideas but co-existing ones aligned with one’s cultural perspective. Self-care strategies, when undertaken, further supported an overall wholistic perspective of life balance.

When the women perceived their self-care as ineffective, they sought help from others. They sought advice, and used health care liaisons familiar with the

culture. Liaisons helped transact and obtain access to care. In getting outside help beyond what they could do for themselves, the women consented to the use of more Westernized approaches to illness such as diagnostic and invasive procedures.

In their quest for life balance in resettlement, the women reached a turning point in their lives. The relationships between seeking life balance (core perspective), patterns of knowing (condition), and caring for oneself (process), were essential to maintaining wholism and centeredness in the fluid and uncertain context of resettlement. These relationships must be supported in resettlement or the negative consequence of disharmony occurs. Disharmony is the disconnectedness from life and an inability of women to move forward through chaos toward transition. Essentially, a preoccupation with chaos resulted in isolation and disengagement from living a fuller life. Disharmony or “not happy” represented fragmentation in their lives here.

Harmony or “happy,” on the other hand, reflected a sense of perceived cohesion in their lives here. While chaos has been a part of these women’s lives, it has been left behind. Chaos was acknowledged as part of experiences and transitions, but it was not a dominant aspect in their lives. From their experiences of suffering, their encounters with other paradigms of knowledge, and unique self-care strategies, the women sought wholeness and continuity in their lives in a manner that was relevant and meaningful. A perspective steeped in an indigenous worldview coupled with a striving to restore natural order in their lives, underscored these women’s attempts to maintain a wholistic perspective in resettlement (Table 2).

The categories and respective themes which emerged from the interviews support a theoretical model of seeking life balance as depicted in Figure 2. The

interrelationships between seeking life balance, patterns of knowing, and caring for oneself in this model are important ones in resettlement. The intactness of these interrelationships resulted in harmony. Additionally, these interrelationships are essential in maintaining harmony and well-being in women's lives as their perceptions of health include spirituality, family relationships, and cultural ways of dealing with *min srool* or imbalance. Harmony further enriches and strengthens these interrelationships, as depicted in the theoretical model. When these interrelationships remain intact, chaos is acknowledged as part of women's experiences and transitions, but it is not a dominant aspect in their lives.

Figure 2. A Theoretical Model of Seeking Life Balance

In contrast, disruption of these interrelationships may result in disharmony. A preoccupation with chaos results in a “disconnectedness” from life. This disconnectedness is represented in Figure 2 by pairs of parallel lines that separate chaos from other interrelationships in the model. A further negative consequence of disharmony is an inability of the women to move through emergence and transition. A preoccupation with chaos isolates women from engaging in a larger process of seeking life balance. Consequently, disharmony diminishes one’s life perspective, whereas harmony enriches it.

Of significance in this model is the means by which women cared for themselves. Indigenous strategies women used in caring for themselves were perceived as health promoting strategies. This cultural perspective of health remained constant as evidenced by the order of self-care strategies in resettlement. Continued reliance upon cultural self-care strategies in resettlement reinforced and supported a sense of well-being. Women have embraced other conceptions of health through their encounters with new knowledge in resettlement. Encounters with new knowledge in resettlement are not competing notions but co-existing ones aligned with the women’s cultural perspective. They acknowledged that health from a Western worldview not only has physical dimensions, but mental and emotional dimensions. These other conceptions of knowledge acquired in resettlement are integrated within the theoretical model and captured in their patterns of knowing.

In this study, the theoretical model of Seeking Life Balance acknowledges the totality of Cambodian women’s lives. Their culture, history, beliefs, experiences, and knowledge bear upon their perceptions of health in resettlement. The model has

integrated significant life experiences and processes which affect their well-being.

Also depicted within this model are the women's passages through time, place, experiences and encounters during periods of displacement, transition, and resettlement.

The findings of this study indicate that Cambodian refugee women who have resettled in the U.S. seek and are able to experience whole and fulfilling lives. This full life perspective is supported by their spirituality, by an ability to care for themselves, and by their use of both traditional and new ways of knowing. The perceptions of health of Cambodian women in resettlement are wholistic ones that have been forged by their experiences and life processes.

Chapter Five

Discussion of Findings

The plight of Cambodian women who have resettled in the U.S. has been one of personal devastation, disillusionment, and struggle. Even so, women in this study have striven to live whole and fulfilling lives. Their journey from life under a dictatorship to life in resettlement has been characterized by dualities. In Cambodian culture, Buddhist tenets promote the sanctity of life, yet the persecution inflicted upon them by their own people, other Cambodians, violated this tenet. As the women lived through tragedies of war it was difficult to comprehend how one Khmer, Pol Pot, could wield such influence to destroy his own people. Another duality was that the women fled persecution and lived through long and uncertain periods of displacement, only to encounter more difficult times and disillusionment in refuge.

In periods of transition within their new communities of resettlement, they encountered other knowledge and information very different from their own cultural frame of reference. As they sought ways to take care of themselves in resettlement, they encountered Western forms of treatment very different from the familiar indigenous treatments administered by kru Khmer or passed on to them by word of mouth.

Their lives in resettlement have also been characterized by unhappiness or happiness, disharmony or harmony. Yet they still strive to find meaning in their lives.

Spirituality has been a steady factor that has sustained them throughout their struggles. This study has illuminated these women's lives in which culture, trauma, adjustment, and movement through time, context, and process have been a part of their lives. In this chapter, findings of this grounded theory study and the resultant model will be compared to current models, theories, and literature.

Seeking Life Balance and Other Relevant Theories and Models

There has been a burgeoning of literature examining the concepts of culture and health beliefs as influencing variables on health outcomes. Key pieces of research and theory relevant to this study are the theory of culture care diversity and universality (Leininger, 1978; 1991), emerging theories of transitions (Meleis, Sawyer, Im, Messias, & Schumacher, 2000; Shih, Meleis, Yu, Hu, Lou, & Huang, 1998), and resiliency (Davis, 2000; Kastle, Wilhelm, & Reed, 2002; Miller & Chandler, 2002).

The theoretical model of seeking life balance aligns well with Leininger's theory of Culture Care Diversity and Universality (1978, 1991; George, 2002). This theory emphasizes to the health care provider the importance of understanding cultural lifeways. This understanding is integral to the process of providing culturally sensitive and culturally competent care in pluralistically diverse communities (Leininger, 1994). The cultural and social structural dimensions which form one's worldview are an integral part of Leininger's theory. These dimensions or factors as depicted in Leininger's theoretical model, the Sunrise Enabler for the theory of Culture Care Diversity and Universality (Leininger, 2004), are technological, religious and philosophical, kinship and social, cultural values, political and legal, economic, and

educational factors. These factors influence care expressions, patterns, and practices in health and illness in a context of environment, language, and ethnohistory.

This grounded theory study of Cambodian women has emphasized the socio-historical-cultural-political influences as they pertain to health perceptions and health care. These influences have been integrated within a theoretical model relevant to the lives of Cambodian women in a specific context and setting. The findings in this grounded theory study parallel the social and cultural dimensions found in Leininger's work. Leininger has identified these dimensions specifically as religious and philosophical factors, kinship and social factors; cultural values, beliefs and lifeways; political and legal factors, and economic factors (George, 2002; Leininger, 2004).

The theoretical model of seeking life balance addresses an environmental context as women in this study have moved from their communities of origin to a community of resettlement. Their language and ethnohistory remain an integral part of their lives in resettlement. The Buddhist philosophy and values embraced by the majority of women in this study parallel Leininger's religious and philosophical factors. These factors are captured in one of the overarching subcategories of achieving spiritual fulfillment. Consistent themes throughout the interviews were the spiritual beliefs and values expressed by the women as they sought to "do good" in their lives.

The parallel in this study to Leininger's kinship and social factor is the overarching subcategory of re-establishing kinship. Women made efforts to re-establish patterns of kinship in resettlement. This was evident in their pursuit of family reunification efforts through legal channels, as well as frequent gatherings with family

members who were also nearby. Re-establishment of kinship patterns was also evident in living arrangements of groups of people who lived together. These groups were comprised of family survivors, extended family, and persons without living kin. Aside from re-establishing tangible boundaries of kinship through reunification, there was also an effort to re-establish kinship through the transmission of cultural values. This was evident in teaching forgiveness, and instilling trust and respect in family relationships.

Another representation of Leininger's social factor in this study of Cambodian women was their engagement in meaningful work. The women in this study were involved in purposeful activity in pursuing a livelihood, obtaining an education, or volunteering their help. The women further expressed their commitment to helping other Cambodians and their families through the nature of their work. They contributed to their communities by offering guidance, counsel, and health education to other Cambodians in resettlement.

Cultural values and beliefs in this grounded theory study parallel the cultural values, beliefs, and lifeways factors in Leininger's work. The indigenous beliefs and knowledge of Cambodian women in this study were key aspects of this grounded theory study. The traditional beliefs and knowledge held by women provided a basis for their actions in restoring balance in their lives. Cultural values, beliefs and lifeways in Leininger's work are also represented in the category of patterns of knowing in this study. In resettlement women also encountered other explanations of health and illness, and other forms of care. The women in this study provided examples of how they integrated new information in a manner that was meaningful and consistent with

their own beliefs and values. This grounded theory study has illuminated cultural influences upon health perceptions from an evolving and changing perspective, rather than a static one. Indigenous knowledge shaped the women's cultural perceptions of illness. Indigenous knowledge also influenced the order of self-care strategies of the women, their preferences for care, and care seeking from others in resettlement.

Political and legal factors in Leininger's work are also reflected in this study of Cambodian women. The parallel to these factors in this study is represented in the women's emergence from chaos and their suffering as a result of political events. The focus upon Cambodian women in the dismantling of a society and its aftermath upon their health and lives have been integral facets of this research. This grounded theory study of perceptions of health of Cambodian women has given attention to the political circumstances which affected their health. Political factors influencing health perspectives, decisions, and health behaviors may be overlooked in studies of transcultural nursing. Understanding these political factors sheds light on the self-care strategies of women and the order of their preferences for care.

Economic factors as identified in Leininger's model are represented in the women's emergence from chaos. The women left behind familiar ways of work. The sudden disruption of their careers, studies, and patterns of work brought about by war left women without economic resources as they transitioned from a period of displacement to resettlement. Another parallel to Leininger's economic factors is the women's experiences of work and the impact of work upon family life in resettlement. Once in resettlement, the economic demands of sustaining a living required the restructuring of family roles and relationships. Economic factors also played a role in

the order of care, where self-care strategies were performed first, followed by seeking care from others. Additionally, health insurance was a new concept to several women upon their resettlement here. The fact that several women were without health insurance affected the order of care.

Leininger (1997) noted that nurses often adopt or use the research paradigms of other disciplines while abdicating altogether the nursing perspective. She emphasized the importance of maintaining a focus on nursing care and the contributions of nursing knowledge to transcultural nursing. The knowledge generated from this study may be useful in facilitating nursing care of Cambodian women in resettlement. The theory of Culture Care Diversity and Universality enables nurses to facilitate effective transcultural care decisions and actions that preserve/maintain, accommodate/negotiate, or repattern/restructure culture care (Leininger, 2004).

Another finding in the current literature relevant to this study is an emerging mid-range theory of transitions (Meleis, Sawyer, Im, Messias, & Schumacher, 2000; Shih, Meleis, Yu, Hu, Lou, & Huang, 1998). Meleis et al. (2000) have proposed that persons who experience a change in health and illness are in a process of transition. Conversely, Meleis et al. (2000) have further proposed persons who are in transition may be more vulnerable to other health risks. A formative matrix for a theory of transitions should include types and patterns of transitions, properties of transition experiences, facilitating and inhibiting conditions, process and outcome indicators, and nursing therapeutics (Meleis et al., 2000). One could consider examples of transitions within the theoretical model generated from this grounded theory study. Developmental stages, life phases, and life events across a continuum of wellness and

illness could be considered as types or patterns of transitions. Identification of the properties of transition experiences, such as characteristics, attributes, or dimensions, may help explicate vulnerability for risk. Facilitating and inhibiting conditions in this formative matrix may include those factors which promote or negate effective transitions. Identification of optimum conditions and conditions of risk would be useful in this matrix for theory development. Identification of specific processes that promote or negate effective transitions toward health may be useful. Outcome indicators resulting from nursing therapeutics may determine which interventions minimize risk and decrease vulnerability in periods of transition. Ultimately, identification of transition processes, facilitative nursing interventions, and outcome indicators will determine those that promote health and those that do not.

This grounded theory study may represent an example of what Meleis and others have proposed as a matrix for a theory of transitions. The Cambodian women in this study experienced transitions on many levels. The model of seeking life balance represents multiple experiences and transitional events throughout the women's lives. An example of a transition spurred by political events was the women's experience of labor camps and their prolonged displacement in refugee camps. Transient circumstances such as these posed risks to their health.

In many ways, the women's experiences of having to adjust economically in the U.S. were major transitions that affected their sense of well-being and other aspects of their lives. Their approaches to work, family relationships, and self-care were different than their previous lives in Cambodia. One example of a transition is represented in the type of work women were able to find here regardless of former

work or professional positions they had in Cambodia. Also related to an economic transition in resettlement was the need to learn other skills necessary for work, such as learning English and using or finding transportation. Dealing with the costs of living and the high costs of health care here in the U.S. was another adjustment. The women's approaches to self care were also a transitional experience driven by economic necessity. Having to live without family or having to negotiate political processes to reunite with family was another transition which involved economic resources. Transitional life experiences like these may be stressful and may ultimately disrupt a sense of well-being.

Meleis et al. (2000) and Shih et al. (1998) emphasized the importance of transitions as they pertained to the perceptions and experiences of women. The acknowledgment of transitions as perceived and experienced by women gives voice to their realities and supports the idea of the totality of their lives. These ideas are reflected in the model of seeking life balance as this study focused on the perceptions of health of women within the context of their experiences. Meleis et al. and Shih et al. have also emphasized the examination of cultural beliefs and values and their influence upon women's experiences of transition. This study may provide an example of that emphasis. Integral to this grounded theory study were the women's cultural beliefs and values and their influence upon processes of care.

One difference between this study and the work of Meleis et al. (2000) and Shih et al. (1998) lies in the type of transitions that the women experienced. Their studies examined transitions that were event specific and context specific--the experiences of women undergoing cardiac surgery in an acute care hospital setting. An

event such as this differs from the experiences of Cambodian women in this study. Cambodian women in this study experienced multiple events and major life transitions simultaneously. Women's experiences as they fled from chaos were characterized by sudden occurrences of events and the women's resultant actions that were not necessarily of their own volition. Temporal aspects of their experiences were indeterminate periods of displacement while awaiting resettlement in a host country. Other experiences included unfamiliar encounters upon their arrival in places of resettlement. Perhaps it is the intensity of multiple transitions and sudden experiences, as in the experiences of the Cambodian women in this study, that increase their vulnerability to health risks.

The findings of this study may lend to the development of transition theory and an understanding of it, as Meleis et al. (2000) and Shih et al. (1998) have proposed. The major thematic categories of this grounded theory study have relevance for a mid-range theory of transitions, with implications for nursing therapeutics. Individuals perceive and experience transitions differently. These perceptions and experiences may be bounded by specific circumstances and events. A formative matrix relevant to transitions (types, patterns, properties, conditions, processes, and outcomes) would be important in the development of a mid-range theory of transitions. With such a theory, nursing therapeutics may be tested, implemented, and evaluated for effective and positive outcomes as defined by those who are in transition.

The results of this study of Cambodian women also parallel the ideas of personal resilience found in the literature. In a study of immigrant women, Miller and Chandler (2002) found that the women had less depression and a greater sense of

personal resilience as they acquired language skills in resettlement. The interrelationships between seeking life balance (core perspective), patterns of knowing (conditions), and caring for oneself (process) which resulted in harmony (consequence) support the findings of Miller and Chandler (2002). The Cambodian women in this grounded theory study encountered new information and learned that there were other ways of caring for illness. Their evaluation of new ideas and options further influenced their personal choices for care. As the Cambodian women in this study learned other new skills in resettlement they were able to move forward in their lives and maintain an outlook for the future.

In another study of health perspectives among focus groups of women, Kasle, Wilhelm, and Reed (2002) found that definitions of optimal health included balance and integration among the physical, social, emotional, and spiritual aspects of life. In this study of Cambodian women, seeking life balance provided an integrative and centered perspective among the various aspects of their lives. A parallel to the physical aspects of life in the work of Kasle et al. (2002) is represented in the Cambodian women's use of self-care strategies in this grounded theory study. The women were able to take care of their physical selves through an orderly and sequential process. For Cambodian women, the subcategories of re-establishing kinship and engaging in meaningful work may be likened to the social and emotional aspects of life in the above study. Kasle et al. (2002) further determined that harmony and stability within family and close relationships were necessary for supporting personal resiliency. Additionally, for Cambodian women, the subcategory of achieving spiritual fulfillment may be likened to the spiritual aspects of life in the

work of Kasle and others (2002). The spiritual beliefs and values of Cambodian women in this grounded theory study provided sustenance in facing difficult situations and new challenges.

Another study of personal resilience is found in a phenomenological study of Southeast Asian refugee women. Davis (2000) examined the meaning of refugee experiences among Cambodian, Thai, and Vietnamese women. Themes of survival, despair, and isolation were prominent among their stories. Davis' work identified the phenomena of psychological resilience which has not been previously explored in studies of Southeast Asian refugees. Psychological resilience is the ability of an individual to survive in spite of the experiences of isolation and despair. Giving meaning to the refugee's experience and acknowledging and validating the loss of one's social structure and culture facilitates adaptation to a new environment. One's family and community affiliations emerged as other themes in Davis' work that supported the phenomena of psychological resilience.

Several aspects of this grounded theory study parallel Davis' research. This study of Cambodian women explored their perceptions of health in the context of their experiences. Similarly, Davis explored the meaning of refugee women's experiences. The efforts of Cambodian women at re-establishing kinship patterns in this grounded theory study offer a parallel to the importance of family support identified in Davis' work. The theme of disharmony as a consequence echoes the themes of despair and isolation in Davis' study.

The difference between this study of Cambodian women specifically and Davis' study which included other Southeast Asian women is a methodological one.

The generation of a theoretical model resulted from this study. Davis' study identified sub-themes which were similar to the periods of displacement, transition, and resettlement depicted in the model of seeking of life balance. An outcome of Davis' research however, was the identification of a phenomena rather than generation of theory. Nonetheless, Davis' work supports the experiences and perceptions of Cambodian refugee women in this study.

Other factors that influence individual resilience have been identified in the literature. As people are helped to find meaning for what has happened in their lives, they themselves are better able to find the right resources for their own care (Somasundaram, van de Put, Eisenbruch, & de Jong, 1999). In a study of two communities that were once ravaged by war in Cambodia, researchers identified several factors which supported individual resilience. These were personal perceptions of the effectiveness of treatment, availability of social networks, the presence and use of traditional healers, and different levels of knowledge of healers and Western treatments. Re-establishing communal life and social structure were also important in supporting personal resilience. These findings parallel the findings of this grounded theory study as the women re-established kinship networks in resettlement, and have found support among family and friends. The Cambodian women who have resettled here in the U.S. have found ways to obtain care through cultural liaisons. Although the women did not identify the presence and use of traditional healers in resettlement, they sought the help of Cambodian liaisons, and preferred care from doctors of Southeast Asian ethnicity. These findings of Somasundaram and others (1999) are also pertinent to this study in that women maintain ties, communication and contact with family,

relatives, and friends in Cambodia. These encounters, too, continually influence their ways of knowing, self-care, and care-seeking.

*Seeking Life Balance: Current Evidence for its
Importance and Relationship to Health*

The idea of balance from an Eastern perspective has received attention in health care. Researchers have acknowledged its relevance to health and well-being. Indigenous knowledge remains prevalent in resettlement where illness is ascribed to a loss of internal balance, dishonoring an ancestor, or violating taboos (Jackson, Rhodes, Inui, & Buchwald, 1997). Similarly, Cambodian women in this study attributed illness to *kamm*--negative actions in a prior life and angry spirits. Choy and others (2000) defined health as a balance of energies. Cambodian women in this study defined health in terms of what they felt and experienced in its absence. An in vivo code, *min srul*, captured their cultural expressions of worry and imbalance. *Min srul kluon* and *min srul jet* were in vivo codes used respectively to reference physical imbalance and emotional imbalance. The thematic categories that emerged in this study validated Davis's work (2001). Regaining balance in the body, use of indigenous practices, and the affiliations among women were key themes identified in Davis's study. Davis's findings support the central perspective of seeking life balance and self-care strategies used by women in this study. Cambodian women in this grounded theory study used indigenous practices first as a means of regaining balance. Affiliations in Davis' study are pertinent to this grounded theory study as Cambodian women re-established kin networks in resettlement and sought advice from family.

Specific to an Eastern worldview, Whittaker (2002) emphasized that both the spiritual and physical context must be harmonious. Shih and others (1998) validated

the cultural role of spirituality in patient's lives. The findings in this study of Cambodian women are similar to those of Whittaker and Shih et al. in that spirituality played a key role in their physical lives. Cambodian women took part in and supported their religious community to earn merit—*bonn*, for a future life. Spiritual beliefs of these women also influenced their health actions and provided refuge in times of emotional distress. Shih et al. also identified patients' major concerns about filial piety or obligation to support extended and immediate family while hospitalized. Cambodian women in this study also demonstrated willingness to support immediate and extended family. Evidence for this is in the composition of members who made up their household.

Other researchers who have conducted studies with refugee populations using Post Traumatic Stress Disease (PTSD) and depression as the primary basis for care and treatment are beginning to re-think this approach. Other factors which may have influenced health outcomes, in spite of the traumatization endured by refugees, are under examination. In a re-analysis of data, Mollica and others (2002) make this point precisely. Indigenous religious and cultural practices and meaningful work had a protective effect in the work of Mollica et al. (2002). These researchers posit a relationship between indigenous religious practices and resilience against trauma as an alternative explanation for health outcomes under extreme conditions, such as those experienced by refugees (Mollica, Cui, McInnes, & Massagli, 2002). Earlier studies of Cambodian refugees by Mollica, et al. (1984; 1987; 1992) used Western diagnostic criteria to assess post-traumatic stress symptoms in these survivors. Although assessment tools in Mollica's work were translated into Cambodian, alternative

explanations for the presence of symptoms were not considered in Mollica's previous work. Unlike Mollica's previous work, this grounded theory study did not attempt to impose any pre-existing diagnostic terminology or pre-established nursing concepts upon the women's stories and descriptions. In this study, efforts were made to capture and preserve relevance and meaning in the context of women's lives.

Emerging from Chaos

Literature spanning last 20 years has addressed sociopolitical issues surrounding refugees. Many of these issues continue to prevail. Dealing with challenges and disillusionment in resettlement, getting access to care, and obtaining culturally appropriate care influence the health of people in resettlement (Williams, 2002). As political conflict continues in many parts of the world, it is of concern to the global community to provide immediate aid and refuge. It is also important to look beyond the provision of immediate assistance toward finding more durable solutions in resettlement (Kelley & Durieux, 2004). An assumption, which may contribute to the lack of attention and follow-up in resettlement programs, is that once resettlement has occurred in host communities, the crises in refugee and immigrant lives end. This grounded theory study of perceptions of health has focused particularly on that period of women's lives beyond the initial crises. The themes and sub-themes arising from the interviews in this study illustrated ongoing difficulties in resettlement as women encountered many challenges.

A comprehensive study of trauma measurements and health status of refugees found that the experiences of women are poorly represented. Additionally context-sensitive trauma over time which influences health status is largely ignored

(Hollifield, Warner, Lian, Krakow, Jenkins, Kesler, et al., 2002). This grounded theory study adds to the literature about the experiences of Cambodian women. Women identified long-term health problems they have had since “Pol Pot” times. Although they viewed these problems as important, they did not feel they were getting full care and attention.

Consistent with the above are findings that welfare-to-work programs have been a component of social service agencies which have aided people in resettlement. Kneipp’s study (2000) which included Asian women has shown that there has been no significant benefit in women’s psychosocial health or their socioeconomic status as women moved from welfare to employment. They enter into low-wage unfulfilling jobs which still leaves them cycling through disillusionment again. The Cambodian women who participated in this grounded theory study were acutely aware of the high costs of living as compared to Cambodia, and expressed difficulty in making ends meet. The need to work long hard hours to provide for themselves and their families detracted from family life and affected their own health. Kneipp’s work indicated that poor physical health places one at higher risk for poor psychosocial health. This idea is reflected in this study of Cambodian women in that the consequence of disharmony may result from perceived imbalance. Similarly, McGuire and Georges (2003) contended that women pay a high psychosocial and emotional price in search of a better livelihood for themselves and their families. Such a price is a diminished sense of health and well-being as a result of the social, political and economic chaos in which they find themselves here in the U.S. (McGuire & Georges, 2003).

Patterns of Knowing

There are other critical aspects of culture that influence knowing and learning. This study of Cambodian women has underscored an understanding of cultural perceptions of health and illness. Acknowledgement of women's patterns of knowing and thinking are important in examining how educational interventions may be implemented with Cambodians in resettlement. Needham's (2003) study demonstrated that Cambodian pedagogy is embedded in Cambodian traditions and social hierarchy. Traditional Cambodian pedagogy consists of group recitations and group activity, which contrasts with the emphasis on individual performance in Western society. Westerners may view these forms of learning as rote or passive learning. Traditional Cambodian pedagogy is linked to social context, relationships, and codes of conduct.

In this grounded theory study, related to Needham's linkages between pedagogy and social context is the fact that women encountered information and advice through gatherings at the temple. The local Buddhist temple perhaps represented a familiar institution in resettlement where women not only worshipped and chanted in unison, but also acquired and exchanged information informally. The manner of recruitment for this study, wherein women referred other participants, is reflective of social relationships. Women learned of this study through others who had participated and were willing to be interviewed. From a historical viewpoint, their willingness to come forth and participate was a marked contrast to earlier "Pol Pot" times. In the past women might have been fearful of questioning as this was negatively associated with persecution or harm in "Pol Pot" times. Codes of conduct in Needham's study referred to interpersonal interactions using respectful, polite, and formal titles of address in verbal communication. In this grounded theory study, the

use of respectful and formal titles of address were essential in rapport building during the interviews. The assistance of a translator who was familiar with these cultural forms of address helped facilitate communication during the interviews.

Similarly, Skilton-Sylvester (2002) maintained that Cambodian women's roles, identities, and how they see themselves in the world influence their participation and learning in resettlement. Roles of Cambodian women in relation to spousal dynamics, their role in the family, work, and future goals or possibilities for themselves determine their participation and retention in post-resettlement programs. History and experiences may continue to exert a profound influence on learning as many Cambodians lost relatives and family because they were educated people. Connecting learning to their identities, roles, and their personal goals for learning also has important implications for teaching and health promotion programs.

The findings of Skilton-Sylvester (2002) are reflected in this grounded theory study through the women's encounters with educational sources. One educational source was the social service agency in Southern California where women were recruited for this study. All of the women in this study participated in post-resettlement programs offered through the agency at one time or another. Unanticipated change in women's roles in the context of resettlement influenced their participation in post-resettlement programs to varying degrees. Role changes encountered by the participants in this study centered upon family and work. Traditional role expectations of Cambodian women were to manage the household and care for young children at home. A role change encountered in this study was that women maintained traditional expectations and also worked outside of the home out

of necessity. The loss of a spouse, the adjustment to being alone, and having to find a means of self-support were other examples of role change.

Full-time employment in one's old age rather than retirement was another example of change and adjustment in resettlement. To varying degrees, women continued their participation in post-resettlement programs for learning English and training in job skills. After-school programs for their children provided by the social service agency while women worked was another reason for involvement in post-resettlement programs. Participation in post-resettlement programs may have helped women to envision their own possibilities as reflected in the category of reaching a turning point in their lives. Women may have eventually discontinued participation in post-resettlement programs as they moved on to other jobs or pursued educational prospects.

Caring for Oneself

An important contribution of this grounded theory study to existing literature is the idea that other structures of knowledge, such as cultural indigenous knowledge, serve a purpose. Studies following the Cambodian conflict were predominantly about treatment interventions based on medical diagnoses for illness (Kinzie, et al., 1980; Kinzie, et al., 1984; Kinzie, 1993; Mollica, et al., 1984; Mollica, Wyshak, & Lavelle, 1987; Nicassio, 1985). There was little interest in exploring or understanding alternative explanations for illness. Sargent and Marcucci (1984) and Kemp (1985) differed from the focus on medically diagnosed treatment interventions by delineating common indigenous practices Cambodians maintained in resettlement. The category of caring for oneself in this study is supported by findings of indigenous practices for

self-care, which prevailed in oral histories of survivors living in California. These oral histories were documented in 1996, seventeen years post conflict (Shek & Auble, 1996). Researchers are beginning to understand the role of cultural beliefs and indigenous practices as they pertain to the provision of health care treatment in resettlement. (Jackson, et al., 1997; Jackson, Chitnarong, Rouen, Taylor, & Thompson, 1998; Jackson, Taylor, Chitnarong, Thompson, Sam, & Fischer, 1998). The prevalence of indigenous self-care practices and cultural beliefs in this grounded theory study of perceptions of health, (twenty-five years post conflict), provide additional evidence for the stability of these practices and beliefs over time.

Ma's (1999) findings in a study of Chinese immigrants in the U.S. are congruent with the self-care strategies and care seeking behaviors found in this grounded theory study of seeking life balance. Of 75 total participants in Ma's study, 94.6% chose to use home remedies and self-treatment first, followed by 45.3% who used Western and traditional clinics in the U.S. A smaller percentage of these participants, 32%, travel to China or Taiwan for care, and 21.3% used primarily Chinese clinics here in the U.S. These findings are similar to those in this grounded theory study in that Cambodian women also gave priority to indigenous therapies first, followed by Western and traditional therapies second. Ma's findings are similar to those of this study in that the Cambodian women maintained close ties with kin living abroad in Cambodia, and asked those relatives to obtain and send traditional medicine. Major challenges in resettlement facing participants in Ma's study were the burdens of seeking care without health insurance in an environment of different cultural beliefs,

language barriers, and transportation issues. These are similar to the issues voiced by the women in this grounded theory study.

Seeking other sources of self care may be attributable to inadequacies of the health care system. Compared to other workers exposed to the same occupational health hazards, occupational injuries of Cambodian and Laotian workers were undocumented and underrepresented. Survey data showed that reports of chronic headache, sensations of ill health, flu symptoms, and exposure to dust, fumes, and solvents were untreated (Azaroff, Levenstein, & Wegman 2002). Consequently, workers developed a mistrust of the health care system. Workers continued to work in spite of their injuries, or preferred to seek other cultural strategies of care rather than negotiate the complexities of workers' compensation. In this study of Cambodian women, there were instances mentioned of potentially unhealthful working environments in the type of work women performed. Work that required long periods of standing, heavy lifting, painting airplane parts, and work in poorly ventilated areas were mentioned. Women in this study who specifically referenced their work environments also continued to work in these settings in spite of their physical ailments.

Difficulties in obtaining access to care, fear of reprisal, refusal of care, and absence of culturally relevant services persist as reasons for not seeking care among resettled groups of people in the U.S. (Hildebrandt, 1999; Srinivasan & Guillermo, 2000). Of these reasons, most pertinent to this study of women are those of obtaining access to care and absence of culturally relevant services. The difficulty for these women in accessing care lay in the lack of health insurance in order to obtain services.

Ultimately, they were able to get this through an employer, working family members, or through Medicare by way of assistance from a Southern California social service agency. The lack of culturally relevant services for these women was evidenced by their preferences in seeking out care from providers of Southeast Asian ethnicity and by their use of Cambodian liaisons who acted as their intermediaries in accessing care.

Cultural insensitivity persists as the reason why women in resettlement are reluctant to seek and obtain care. The non-provision of care by female clinicians, non-responsiveness to inquiries made about their care, and inattention to what the women perceived as problems are important concerns. These concerns, tied to cultural mores and women's identity, influence the health care encounter and future intentions to continue with care (Holroyd, Twinn, & Shia 2001). In health care encounters, identification of a cultural conception of risk from the perspective of the person seeking care is foundational and critical to the caregiving process (Labun, 2001; Murray, Manktelow, & Clifford, 2000).

In this grounded theory study, participants conceded to health screening examinations by a male physician prior to coming to the U.S. This culturally unacceptable encounter may have influenced their perceptions about receiving subsequent care from male physicians. However, in resettlement, the Cambodian women also referenced care they received from both male and female doctors. While there were stated preferences for a female doctor especially during pregnancy, women voluntarily changed their doctors to suit individual needs. There was also reference to non-disclosure of one's cultural practices to American doctors. This suggests that

participants might have been generally aware of the insensitivity of Western health care providers to these cultural practices in resettlement.

In this study of Cambodian women, there was reference to delays or lack of response from the healthcare provider to inquiries about appointments and test results. Delays such as these did not stop women from seeking care, but resulted in re-scheduling appointments through cultural liaisons, or changing doctors. The presence of other physical problems or discomfort was brought to the attention of the health care provider. Inattention to these concerns within their health care encounters may have signaled cultural insensitivity to other problems that bothered them.

Reaching a Turning Point

Women who fled their communities of origin with hopes of improving their situation, instead, found themselves alienated in communities of resettlement. Support for the thematic category of disharmony in this study is found in predictors of loneliness in Kim's study of elderly Korean women (1999). Satisfaction with social support, network size, ethnic attachment, and functional status were predictors of loneliness among these women. A similarity to Kim's study is that Cambodian women expressed being alone and without family as sources of unhappiness. A focus on past events and family losses prevented them from moving forward in their lives. These women further described how their unhappiness ultimately affected their physical and emotional status.

McGuire and Georges (2003) identified themes of feeling lonely, trapped and isolated among Oaxacan women working in the U.S. Among the themes identified in this study of Oaxacan women, the one most relevant to this study of Cambodian

women was that of feeling trapped. Language barriers, worry about finances and their economic situation, inability to use public transportation, and reliance upon children who eventually leave home are factors of confinement. These factors in Cambodian women's lives compounded feelings of loneliness and isolation.

This grounded theory study of perceptions of health of Cambodian women provided evidence that augments or supports existing models, and emerging theories and concepts. The theoretical model of seeking life balance which emerged from this study has integrated women's lives and their experiences across time, place, and process. This study lends support to other conceptions of knowledge grounded in cultural beliefs and values that are meaningful and purposeful in self-care, and in maintaining a sense of well-being. This study and the model arising from it has specifically acknowledged and represented the voices of Cambodian women—their plight, their conceptions of health and illness, processes of self-care, and the difficulties they have encountered in resettlement.

Chapter Six

Critique and Implications of the Study

This study was an inquiry into the perceptions of health of Cambodian women who fled political conflict and resettled in the U.S. This study has also attempted to develop a theory concerning the sequelae of significant life trauma upon the lives of Cambodian women in resettlement. A unifying and central perspective that gave meaning to the women's lives over the course of displacement, transition, and resettlement, is that of seeking life balance. Seeking life balance is a wholistic view of their perceptions of health. This overarching perspective also reflects their experiences of migration, cultural barriers of language and health beliefs, and economic challenges associated with the high costs of care and earning a living. Consequently, the themes of disharmony and harmony reflect the impact of these significant experiences upon their lives in resettlement. Disharmony represents a sense of isolation and disengagement from living a fuller life. Fragmentation is a pervasive aspect of life. Harmony, in contrast, represents a sense of cohesion and purpose in one's life. Striving for a sense of wholeness is a pervasive aspect of harmony. This chapter critiques the strengths and limitations of the study as they relate to these major issues. Implications for further research are also addressed.

Critique of the Study

Major issues in this study concerned gaining *entre* to a community of interest, language barriers, and consideration of ethical issues in the design and conduct of the study. Undertaking of this research as an outsider with an *etic* view of Cambodian culture rather than an *emic* one proved to be a challenging but rewarding experience.

Acquiring Entre

Acquiring *entre* and passage into the lives of a group of women within a community of interest was one challenge of this study. While much volunteer time and effort was spent in acquiring *entre* to this community, it was most productive and beneficial. Given the plight of Cambodians, it was vital to establish a working relationship and to earn trust in the community. A considerable period of time was spent learning about the Cambodian community—its issues, problems, and collaborative partnerships formed to address community needs. Much time was also spent becoming familiar with specialty programs developed to meet the diverse needs of its members—youth, working adults, the unemployed, single parent families, and the aged. The time spent in these activities allowed the researcher to explore the reality in which women in resettlement lived. These observations were important in gaining an initial perspective upon the lives of Cambodian women in this community.

Working as a volunteer on several projects and activities helped establish visibility and demonstrated support of community goals. This overview of community provided the researcher with an understanding of the broader context of resettlement in which the participants dwelt. Participants in this study lived and worked within the immediate community at the time of the study. Establishing working relationships and earning trust in the community also facilitated participant recruitment. Had there been

negative feedback about the study and the interview process, initially or at any time, this information might have been communicated informally where women gathered-- in their homes, at work, at the temple, and at the social service agency where several participated in its programs. Negative feedback might have deterred further recruitment.

Language and Communication

The language barrier presented several challenges in this study. The fact that the researcher had no language skills to directly communicate with the women who preferred to speak in Khmer was a drawback of the study. Although many women were able to communicate at some level in English, they were more comfortable and expressive using their first language. An exception to this, were participants who were came to the U.S. as young children and acquired English language skills in the course of their education here.

Potential problems arising from language differences were addressed early in the study, through the initial backtranslation of the consent form, interview guide, and recruitment brochures. A pilot study further aided the refinement of the interview guide for its conceptual equivalence.

Data collection occurred in spite of the limitations presented by the language barrier. Since the researcher did not speak or understand Khmer, the interviews were conducted through a translator. Preservation of the participants' meaning, understanding, and perceptions of health and illness was vital to this study. This preservation was accomplished by capturing in vivo codes without trying to distort or superimpose a Western frame of reference upon their ideas. Throughout the interviewing and coding phases of the study, pre-established concepts from the

literature, and technical medical and nursing jargon were not imposed upon the data. As women shared experiences about various periods in their lives, efforts were made to truthfully represent their perceptions and issues in their own words. This was accomplished through member checks which provided validity about content that was captured in interviews. Post-interview debriefings with the translator also helped ensure that in vivo codes and meanings were appropriately captured. In capturing the essence of their meaning and raising the data to a conceptual level, their own explanations and cultural expressions were the basis of substantive categories and themes. The women's sharing of their experiences, their responses to questions, and their willing participation yielded rich qualitative data.

Reliance upon an intermediary for communication with study participants also had its drawbacks. Working through the translator yielded rich interviews, but it was a slow process. Not having the ability to communicate directly with the women also meant delays in asking follow-up probe questions. Some of the vibrancy and dynamics of direct interaction and communication with the women may have been lost.

Reliance upon the translator to schedule additional interviews to clarify information with participants who preferred to speak Khmer was another limitation of the study. This was logistically difficult as some had moved away from the community leaving no contact information. In other instances, women had other priorities and family responsibilities which left little time for juggling schedules. Some participants had acquired a new job or changed jobs which also demanded their time and attention.

Consideration of Ethical Issues in the Study Design

Another study limitation arose from an ethical consideration. The decision to refrain from tape recording interviews was a major drawback of the study. Tape recordings during interviews were excluded to prevent or minimize negative emotions arising from reminders of past interrogation techniques. However, tape recordings would have eased the interview process by allowing the researcher to focus more intently on the content and substance of the interview, rather than attending to multiple processes at once, which at times was a source of distraction.

Tape recordings of those interviews predominantly conducted in Khmer would have also permitted an additional means of verifiability. Written transcriptions of these interviews with blind backtranslations of these transcriptions might have allowed for further comparative analysis of data across interviews.

Limitations of an Etic Perspective

The researcher undertook this study as one who had an etic viewpoint on Cambodian culture, rather than an emic one. As an outsider, not fully knowing the culture required considerable effort in acquiring knowledge about it. This included learning about its history, politics and governance, economy, demographics, religions, and current events, which continue to exert influence upon Cambodians. This was a limitation as it delayed entry to the community of interest. An etic perspective also hindered the generation of follow-up questions in the course of interviews. Follow-up questions arose in the process of coding, when it was at times too late to go back for further interviewing for reasons already discussed.

Implications for Further Research

Major implications for research arising from this study suggest expansion of the scope of this research and model testing. Testing the theoretical model generated in this study with a broader group of participants who have varied experiences of displacement, transition, and resettlement is another important research implication arising from this study. Another area for research which warrants further study are those factors that support the health status of Cambodian women, including access to care, quality of care, health promotion and maintenance. This study also suggests that further exploration of indigenous perspectives of health care and self-care are needed. Future work may provide a substantive basis for instrument development.

Development of a Theoretical Model

Testing the relationships identified in this model with larger numbers of people, of varied ages, and transitional experiences of resettlement would further refine the existing model. Relationships in the model may be tested with both genders. Correlations among the conceptual categories in the model may differ for men and women who resettled in the U.S. because of family ties here. There may also be differences for those who initially came as refugees and who have subsequently become U.S. citizens. The interrelationships in the model may provide the basis for testing other predictive relationships. Relationships among conceptual categories in the model might also differ for those who straddle several continents to maintain contact with relatives in the U.S., Cambodia, and other countries where family are located. Those who have no living kin or those who have taken residence with non-kin might also have different conceptions of life balance, disharmony, and harmony. Testing relationships in the model to include these dimensions in the lives of

Cambodians may generate other testable hypotheses. Results of these pieces of research may further redefine or modify conceptual categories within the initial model. Further research and testing of the model would be important in ultimately conceptualizing the essence of health and well-being for refugee and immigrant women.

The model generated in this study may also be tested with other refugee and immigrant groups of different ethnicities for transcultural similarities. It would be important to incorporate specific cultural perceptions of health, illness, and well-being in these studies. It would also be important to explore refugees' encounters in resettlement, and their journeys to resettlement in the U.S. How might their encounters influence their health and self-care processes? Are there similarities or differences in patterns of care-seeking in resettlement among these groups?

Triangulated studies could also be conducted to test the model and its relationships for transcultural similarities. Meta-analyses of the results of such studies may further refine the model, modify it, or generate other testable hypotheses. Meta-analyses of study results may also further define the conception and meaning of health beyond a Western perspective. This re-definition of health, in turn, may highlight needed changes in health care and health care systems.

Future Studies of Health Perspectives of Cambodian Women in Resettlement

Qualitative inquiry into perceptions of health with groups of Cambodian women in resettlement in other communities and regions of the U.S. may serve to confirm or disconfirm thematic categories generated in this theoretical model of

seeking life balance. A study of this nature would offer comparison and contrast with respect to regional differences or similarities.

One cannot ignore context in future studies as it forms an integral backdrop for people's lives. As political conflict has been a significant part of the context of these women's lives, other contexts warrant investigation, with respect to women's perceptions of health. What are the perceptions of health of women who maintain dual and active kinship ties in both the U.S. and Cambodia? What are the perceptions of health of women who are repatriates in Cambodia and who are attempting to reclaim their lives in a post-war environment? Repatriates may include women who at one point resettled in the U.S. and have decided to return to Cambodia.

Perhaps a salient issue implied for further research is quality of life of Cambodian women. This study has provided evidence that culture influences one's worldview, and that to some degree, one's life context influences that worldview. Perhaps a broader research question is, what are perceptions of quality of life of Cambodian women who have lived through war, displacement, transition, and resettlement? How is quality of life defined and expressed in cultural terms? What are manifestations of it? For Cambodian women, is it defined and expressed by the presence or absence of certain values, things, attributes, or characteristics? What is quality of life for Cambodian women who live alone, or who are living with extended family, or who are living with non-kin? Are there universal conceptions of quality of life among Cambodian women, or are there local conceptions specific to sub-groups?

Another important research question is a conceptual one. Are the conceptions of quality of life as defined by Cambodian women in resettlement, consistent with

those of other groups who have defined it, such as the World Health Organization? Conceptual definitions represent paradigms, and paradigms drive societal enterprises. The operationalization of conceptual definitions by societal enterprises would have major implications for subsequent program development and maintenance, funding, and legislative support.

Any forward strides to be made in improving the health status of vulnerable populations must take into account the multiple dimensions and complexities of women's lives in resettlement. Women play a pivotal role in preserving and rebuilding cultural traditions. Within their families and social networks, they also play a pivotal role in integrating new ideas about health care with the old. In this regard, they "follow the future."

The recruitment of participants and their availability to participate in research is another crucial issue in the conduct of research. The factors of time, childcare, work schedules, transportation, personal management of other responsibilities, expectations, and life priorities are important contextual issues to be addressed. Time away from work and other responsibilities may have financial consequences for them which may not be evident to the researcher. What makes these activities additionally burdensome for Cambodian women is difficulty with language, and associated costs in terms of money and effort in juggling these factors. Issues such as these had to be considered, weighed, and negotiated in the design of the study and during the study. Furthermore, Cambodian women may not have had proper care for chronic underlying health problems which may have persisted since their escape. How they have perceived their

problems and previous encounters or experiences concerning their health may influence their decision to participate in health-related research.

Exploration of Indigenous Perspectives of Health and Self-Care

Unbiased and nonjudgmental exploration of other paradigms of care may determine why people in resettlement prefer indigenous strategies over others. It is assumed that people in resettlement have no knowledge of self-care, when in fact, they do. A pattern of behavior that points to this is that the women in this study had indigenous knowledge of prevention and cure, and relied upon these as the first course of action. Unique strategies used in prevention and cure and the underlying belief systems that supported these practices were different. What is the effectiveness of these strategies? What are the underlying reasons or conditions under which people pursue these strategies? What are their conceptions of health risk? What are the health protective mechanisms operating within a cultural belief or value system that have therapeutic and explanatory power? The inclusion of other groups of women who have resettled here either as refugees or immigrants may yield similarities or differences. What are their patterns of knowing, and what self-care processes help them maintain well-being, wholism, and an affirming life perspective in a culture and environment very different from their own? This knowledge can be used positively in the conduct of research. It may facilitate entry to a group of people who maintain a different worldview. It may facilitate trust-building and relationship-building among cultural liaisons or community leaders within the culture who could recruit others for research participation.

Political conflict has spurred displacement of populations. Subsequently, displacement, unwanted by those forced to leave, has generated migratory paths to the

U.S. Resettlement of displaced populations in the U.S., brings diversity. Various cultural groups that have resettled in the U.S. have very diverse social-economic-political histories that may influence their health perceptions, their self-care, and care seeking. It is this point precisely which brings us to another important implication for research, disaggregation of health data. The small numbers of minorities represented in research studies may obscure a very real health care need, as only significant findings are reported and discussed. The loss of valuable information through general aggregation of results renders people's lives, experiences, and health care issues invisible. Failure to examine and delineate culture-specific results further marginalizes people. Disaggregation of data may facilitate understanding of unique cultural, social, economic, and political histories of specific groups and the transitions and barriers they have encountered. Such histories influence their health status, conceptions of health, and health care. Disaggregation of data may aid the design of further research. Support for the health and well-being of people cannot be possible if their problems and issues are rendered invisible.

As political conflict has touched the lives of nearly all Cambodians, inquiry into the health perceptions of Cambodian men who have survived "Pol Pot times" also warrant research. Are men's perceptions of health different than women's? How do their experiences of displacement, transition, and resettlement bear upon their perceptions of health? What conditions, processes, and consequences might be unique in their experiences and in their perceptions? What are the conceptions of quality of life of Cambodian men in resettlement? How do they differ from those of women?

Instrument Development

Instrument development and testing based on the conceptual categories of the theoretical model of seeking life balance would be future steps in moving this study forward. A progression of this grounded theory study would be instrument development to measure the perceptions of health of Cambodian women. Testing of could be done with groups of Cambodian women who have resettled in different U.S. communities.

While the model of seeking life balance might be tested with other groups of people who have resettled in the U.S., it would be imperative to attend to the cultural elements of the research process. Backtranslated instruments would represent the respective cultural perceptions of health, illness, and well-being in the target language. It is preferable and ethical to develop and test instruments with the cultural group for whom they are intended rather than rely on translated instruments developed and tested with primarily English-speaking groups. Instrument development in this manner would best measure cultural conceptions of illness, health and well-being. Research participants may be re-stigmatized as they are reminded again of their differentness when asked to respond to survey tools and questionnaires developed outside of their worldview.

There are gaps in knowledge pertaining to perceptions of health as defined by culturally diverse populations that have resettled in the U.S. Such gaps are subsequently reflected in inaccessible, inappropriate, and insensitive care, or the absence of care altogether. Future nursing research may bridge these knowledge gaps and minimize blind spots fostered by beliefs that a Western paradigm of health and care is a universal one. Future nursing research among culturally diverse groups will

advance nursing science and enrich the body of knowledge that drives culturally appropriate and sensitive care. Through ongoing research in this area, nursing continues to fulfill its professional contract with society in advocating for the dignity, worth, and health and well-being of culturally diverse groups.

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Appendices

Appendix A
Demographic Questionnaire

English Version

Interview Guide: Demographic Information

The following questions will be used as entre to inquiry about health perceptions.

Since a conversational approach will be used in gathering this information, the order in which these questions are asked may vary.

“Before we explore your ideas about health, I am interested in learning about you.”

1. Education: Did you have an opportunity to go to school?
2. Residence: When did you come to the United States?
3. Marital: Are you currently married or living with someone?
4. Religion: Does any particular religious belief guide your life?
5. Age: What is your birthdate?
6. Work: Are you presently working?

Cambodian Version

សេចក្តីណែនាំធ្វើសម្ភាស : ព័ត៌មានប្រជាសាស្ត្រ

សំណួរជាលំដាប់ទៅនេះ នឹងយកមកប្រើធ្វើជាលំដាប់ ដើម្បីសាកសួរអំពីការយល់ដឹងផ្សេងៗ ខាងសុខភាព។ ដោយព្រោះកិច្ចសន្ទនា នឹងត្រូវបានយកមកប្រើ ក្នុងការប្រមូលមូលនូវព័ត៌មាននេះ ម៉្លោះហើយសណ្តាប់ធ្នាប់នៃសំណួរ ដែលអ្នកនឹងបានសួរ អាចនឹងមាន ភាពខុសៗពីគ្នា ។ “មុននឹងយើងរកនូវឧត្តមគតិរបស់អ្នក អំពីបញ្ហាសុខភាព នោះខ្ញុំមានចំណង់សិក្សាអំពីអ្នក” ។ សូមសរសេរ ប្រាប់ឲ្យយល់អ្នក នៅលើបន្ទាត់ទំនេរដែលបានទុកឲ្យ ។

1. ការអប់រំសិក្សា : តើអ្នកបានមានឱកាសទៅរៀន ឬទេ? _____
2. ឱវាសធន : តើអ្នកបានមករស់នៅក្នុងសហរដ្ឋ តាំងពីកាលណា? _____
3. ភាពជាប្តីប្រពន្ធ : នៅបច្ចុប្បន្ននេះតើអ្នកបានរៀបការហើយឬ ឬក៏កំពុងរស់នៅជាមួយនឹងអ្នកណាម្នាក់? _____
4. សាសនា : តើអ្នកមានជំនឿសាសនាអ្វីមួយពិតប្រាកដ ដើម្បីដឹកនាំជីវិតរបស់អ្នកឬទេ? _____
5. អាយុ : តើថ្ងៃកំណើតរបស់អ្នក នៅថ្ងៃណា? _____
6. ការងារ : តើអ្នកធ្វើការឬទេ នៅបច្ចុប្បន្ននេះ? _____

Appendix B

Interview Guides

English Version

Interview Guide: Major Lines of Inquiry About Health Perceptions

“Many nurses have never had the opportunity to explore in detail what ‘health’ actually means to someone from another culture. I am interested in learning what this means for you personally.”

1. As a Cambodian woman, what does ‘health’ mean for you?
 - a. Tell me what is ‘health’
 - b. What are your views about health?
 - c. Do you have an example or story from your own life that may give me a clearer idea about your view of health?
2. How did you learn about health?
3. Have your ideas about health changed since you have been here?
 - a. How have your ideas about health changed?
 - b. In your opinion, why do you think this is so?
4. Is there anything else most important to you that you wish to share about your personal views regarding health?

Cambodian Version

សេចក្តីណែនាំធ្វើសម្ភាស : ខ្សែសំណួរដ៏សំខាន់ៗ ស្តីពីការយល់ដឹងផ្សេងៗ ខាងសុខភាព

“មានគំនិតបញ្ចក់ជាច្រើន មិនដែលមានទិកាសដើម្បីរកឱ្យបានយល់ក្បោះក្បាយ ថាអ្វីទៅពាក្យ ‘សុខភាព’ ហើយនិងមានអត្ថន័យពិតប្រាកដយ៉ាងណា ដល់មនុស្សណាម្នាក់ ដែលមានវប្បធម៌មួយផ្សេងពីគេ ។ ខ្ញុំមានចំណង់ដើម្បីសិក្សាទូរអ្វីៗ ដែលមានន័យសម្រាប់រូបអ្នកផ្ទាល់” ។ សូមសរសេរត្រាងចម្លើយរបស់អ្នក នៅលើបន្ទាត់ទំនេរដែលបានទុកឱ្យ ។

1. ក្នុងឋានៈជាស្ត្រីខ្មែរម្នាក់ តើពាក្យ“សុខភាព” មានអត្ថន័យអ្វីសម្រាប់អ្នក? _____
 - a. ចូរប្រាប់យើង ពាក្យ“សុខភាព”ជាអ្វីទៅ? _____
 - b. តើទស្សនៈរបស់អ្នក អំពីសុខភាព មានអ្វីខុស? _____
 - c. តើអ្នកមានជាតុលាភារណាមួយ ឬរឿងអ្វី ស្តីពីជីវិតផ្ទាល់ខ្លួនរបស់អ្នក ដែលអាចនឹងធ្វើឱ្យយើងមានការយល់ដឹងច្បាស់ជាងមុន អំពីទស្សនៈរបស់អ្នក ផ្នែកខាងសុខភាព ឬទេ? _____
2. តើអ្នកបានរៀនអំពីសុខភាព តាមរបៀបណា? _____
3. តើគំនិតរបស់អ្នកអំពីសុខភាព បានផ្លាស់ប្តូរឬទេ ចាប់តាំងពីពេលអ្នកបានមករស់នៅទីនេះ? _____
 - a. តើគំនិតរបស់អ្នកអំពីសុខភាព បានផ្លាស់ប្តូរយ៉ាងណា? _____
 - b. តាមយោបល់របស់អ្នក ហេតុអ្វីបានជាមានការផ្លាស់ប្តូរយ៉ាងដូច្នោះ? _____
4. តើមានការអ្វីខុសដ៏សំខាន់ចំពោះរូបអ្នក ដែលអ្នកប្រាថ្នាចង់ចែកចាយ អំពីទស្សនៈផ្ទាល់ខ្លួនរបស់អ្នក ដែលជាប់ទាក់ទងនឹងសុខភាព ឬទេ? _____

Cambodian Version Translated back to English

Interview Guide**Important Questions Regarding General Understanding about “Health.”**

“Many nurses never had the opportunity to research in detail what ‘health’ really means to another person from a different culture. I would like to learn what this means to you personally.” Please write your answers on the blank lines provided.

1. As a Cambodian woman, what does the word ‘health’ mean for you? _____
 - a. Tell me the meaning of health? _____
 - b. What are your observations about health? _____
 - c. Do you have example or story from your life that give me a better understanding about your observations of health? _____
2. How did you learn about health? _____
3. Since your lived here have your ideas of health changed? _____
 - a. What are the changes in your ideas about health? _____
 - b. In your opinion, why do you think the changes happened? _____
4. Are there anything else important to you, which you would like to share, your personal views and thoughts regarding health? _____

Revised Interview Guide: Major Lines of Inquiry About Health Perceptions

“Many nurses have never had the opportunity to explore in detail what ‘health’ actually means to someone from another culture. I am interested in learning what this means from you personally.”

1. Health:
 - a. Please think of a time when you felt really well.
 - i. What happens when you are well?
 - ii. What kinds of things are you able to do when you feel well? Or when you feel really good?
 - b. Please think of a time when you were not well.
 - i. What happens when you are not well?
 - ii. What kinds of things are you unable to do when you are not well? Or when you don't feel good?
 - c. Who takes care of you or who helps you when you cannot do something for yourself?
 - d. How do you feel now? Today?
 - e. What examples or stories from your own life would provide a clearer idea of your own personal views about health?
2. How did you learn about health?
3. Have your ideas about health changed since you have been here?
 - a. How have your views about health changed?
 - b. In your opinion, why do you think this is so?
4. Is there anything else most important to you that you wish to share about your personal views regarding health?

Appendix C
Recruitment Brochure

English Version

HEALTH PERCEPTIONS OF CAMBODIAN WOMEN IN RESETTLEMENT

A Study Project to Understand Health through the Eyes of Cambodian Women

What this project is about...

- “health”
- what “health” means to Cambodian women

Who can participate...

- Cambodian women of the community will be invited to participate in the project

What this project will involve...

- An interview at home with a nurse, Olivia Catolico, and a translator from Cambodian Family, Mr. Leao.
- Participants will be interviewed at a convenient time at home.
- The interview will last about 1 hour.
- Participants will be contacted personally or by phone to arrange a convenient time for interview.

Why this project is important...

- The health of Cambodian women is important to their personal well-being.
- The health of Cambodian women is also important to the maintenance of their families and the rebuilding of their communities.

Who may benefit from this project...

- Cambodian women of this community may benefit through better advocacy for health care.
- Nurses will have a better understanding of Cambodian women and how they view health.
- Nurses will have knowledge and insight to find better ways to provide care for Cambodian women.
- Other health care professionals will also benefit from learning about health as Cambodian women see it.

For questions please call...

Olivia Catolico, RN 909-783-1762 (collect); 909-825-7084, ext. 2564
 Heat Leao, Health Educator, Cambodian Family, Inc. 714-571-1975
 Sundarom Rama, Counselor, Cambodian Family, Inc. 714-973-7186

Cambodian Version

ការយល់ដឹងសុខភាពនៃស្ត្រីខ្មែរ ក្នុងការតាំងលំនៅថ្មី
គម្រោងសិក្សាមួយ ដើម្បីឲ្យបានយល់នូវសុខភាព តាមរយៈចក្ខុនៃស្ត្រីខ្មែរ

តើគម្រោងនេះស្តីអំពីអ្វីខ្លះ ...

- “សុខភាព” ។
- តើ “សុខភាព” មានន័យយ៉ាងណាចំពោះស្ត្រីខ្មែរ ។

តើអ្នកណាអាចចូលរួមបាន ...

- ស្ត្រីខ្មែរនៅតាមសហគមន៍ នឹងត្រូវបានអញ្ជើញដើម្បីចូលរួមក្នុងគម្រោងនេះ ។

តើគម្រោងនេះនឹងជាប់ទាក់ទងទៅលើអ្វីខ្លះ ...

- មានការសម្ភាសន៍មួយនៅផ្ទះ ជាមួយនឹងគិលានុបដ្ឋាក(ឈ្មោះ) ឈ្មោះអូលីវី កាតូលីក (Olivia Catolico) និងអ្នកបកប្រែម្នាក់ឈ្មោះលោក ឡេ (Leao) មកពីគ្រួសារខ្មែរ ។
- អស់អ្នកចូលរួមទាំងឡាយនឹងត្រូវបានសម្ភាស នៅតាមផ្ទះ តាមពេលវេលាដែលងាយស្រួល ។
- ការសម្ភាសន៍នឹងប្រើរយៈពេលប្រហែលជាមួយម៉ោង ។
- អ្នកចូលរួមនឹងត្រូវបានទាក់ទងដោយជួបមុខផ្ទាល់ ឬតាមទូរស័ព្ទ ដើម្បីនឹងរៀបចំពេលវេលាដែលងាយស្រួល សម្រាប់ការធ្វើសម្ភាស ។

តើហេតុអ្វីបានជាគម្រោងនេះមានសារៈសំខាន់ម្ល៉េះ ...

- សុខភាពនៃស្ត្រីខ្មែរ គឺមានសារៈសំខាន់ ចំពោះកាយយុស្សឱ្យសេចក្តីសុខស្រួលខ្លួន(គ្រួសារ) របស់ខ្លួនផ្ទាល់ ។
- សុខភាពនៃស្ត្រីខ្មែរ ក៏មានសារៈសំខាន់ណាស់ដែរ ចំពោះការថែរក្សាគ្រួសាររបស់ខ្លួន និងការកសាងសហគមន៍របស់ខ្លួនឡើងវិញ ។

តើអ្នកណាអាចនឹងទទួលអត្ថប្រយោជន៍ អំពីគម្រោងនេះ ...

- ស្ត្រីខ្មែរនៃសហគមន៍នេះ អាចនឹងទទួលអត្ថប្រយោជន៍បាន តាមរយៈការគាំទ្រឲ្យមានសុខាភិបាល ដ៏ប្រសើរ ។
- គិលានុបដ្ឋាកនឹងមានការយល់ដឹងអំពីស្ត្រីខ្មែរ បានប្រសើរជាងមុន ហើយតើមានទស្សនៈដល់សុខភាពជាយ៉ាងណា ។
- គិលានុបដ្ឋាកនឹងមានជីវិតវិជ្ជា និងយល់ដឹង ប្រយោជន៍រកមធ្យោបាយផ្សេងៗ ដើម្បីផ្តល់ការថែរក្សាសម្រាប់ស្ត្រីខ្មែរ ។
- អ្នកវិជ្ជាជីវៈសុខាភិបាលផ្សេងៗទៀត ក៏នឹងបានទទួលប្រយោជន៍ ពីការសិក្សាសុខភាពនេះ ដូចស្ត្រីខ្មែរបានយល់ឃើញ ។

ចំពោះសំណួរផ្សេងៗ សូមទាក់ទងនឹង ...

Olivia Catolico RN (ឈ្មោះអាជ្ញាប័ណ្ណ) 909-783-1762 (Collect ម្ខាងទៀតចេញថ្លៃឲ្យ) ; 909-825-7084 លេខបន្ត 2564
Heat Leao អ្នកអប់រំសុខភាព, ក្រុមសាជីវកម្មគ្រួសារខ្មែរ 714-571-1975
Sundarom Rama អ្នកឲ្យឱ្យ, ក្រុមសាជីវកម្មគ្រួសារខ្មែរ 714-973-7186

Cambodian Version Translated back to English

Understanding Health of Cambodian women in the New World.

A study designed to understand health through the Eyes of Cambodian women

What is the intention of this project...?

“Health”

What is the meaning of “health” to Cambodian women?

Who can participate...?

Cambodian women in the community are invited to participate in this project.

What this project will involve...?

A home interview with, Olivia Catolico, a nurse, and Mr. Leao, a translator from Cambodian Family.

Participants will be interviewed in their homes at their convenience.

The interview will last approximately one hour.

The participants will be contacted personally or by phone to set a convenient appoint for interview.

What is the significance of this project...?

The health of Cambodian women is important to their personal well being.

The health of Cambodian women furthermore is important to the perseverance of their families and rebuilding of their communities.

Who will benefit from this project...?

Cambodian women of this community will benefit through advocacy for better health care.

Nurses will have better understanding of how Cambodian Women view health.

Nurses will have knowledge and information in finding better ways to provide care for Cambodian Women.

Other health care professionals will also gain benefit by learning and seeing the same perspective about health as Cambodian women are seeing.

For questions please contact:

Olivia Catolico, RN (909) 783-1762 (collect); (909) 825-7084, ext. 2564

Heat Leao, Health Educator, and Cambodian Family, Inc. (714) 571-1975

Sundarom Rama, Counselor, Cambodian Family, Inc. (714) 973-7186

Appendix D

Public Service Announcement

English Version

Public Service Announcement

Health Perceptions of Cambodian Women in Resettlement:

Health through the Eyes of Cambodian Women

The following community announcement will be used for various media that have Cambodian audiences: including Cambodian radio, TV channel, newspapers, social service and community agencies, churches or temples, health care organizations, colleges.

Cambodian women who have resettled in the U.S. have faced many new challenges. One such challenge is obtaining appropriate health care services. Understanding 'health' through the eyes of Cambodian women and what it means to them is important in providing health care to this segment of the community. This knowledge will help nurses and other health care professionals develop sensitivity and cultural competence in health care interactions and interventions with Cambodian women.

Maintenance of health is central to the well-being of Cambodian women. The health and well-being of women is also pivotal to maintenance of their families, rebuilding of community, and transmission of cultural values. Any health compromise they face has an impact on their self-sufficiency, their families, and may ultimately result in lost contributions to the community.

Your knowledge and insights are most valued contributions to the understanding of health perceptions of Cambodian women. Ultimately, this knowledge will help nurses and others provide better health care Cambodian women.

Please call any of the following persons for more information on how you can help:

Olivia Catolico, Registered Nurse, Volunteer at Cambodian Family, Inc.
909-825-7084, extension 2564

Heat Leao, Health Educator, Cambodian Family, Inc.
714-571-1975

Sundarom Rama, Counselor, Cambodian Family, Inc.
714-973-7186

Thank you.

Cambodian Version

សេចក្តីប្រកាស កិច្ចការសាធារណៈ
ការយល់ដឹងសុខភាពនៃស្ត្រីខ្មែរ ក្នុងការតាំងលំនៅថ្មី
សុខភាពតាមរយៈចក្ខុនៃស្ត្រីខ្មែរ

សេចក្តីប្រកាសនៃសហគមន៍មានលំដាប់ទៅនេះ នឹងត្រូវបានយកមកប្រើ សម្រាប់ការផ្សព្វផ្សាយព័ត៌មានផ្សេងៗ ដែលមានសវនកៈ (អ្នកស្តាប់ខ្មែរ រាប់បញ្ចូលទាំង៖ ប៉ុស្តិ៍វិទ្យុ, ប៉ុស្តិ៍ទូរទស្សន៍, សារព័ត៌មាន, កិច្ចការសង្គម និងភ្នាក់ងារសហគមន៍, ព្រះវិហារបុរាណាម, អង្គការសុខាភិបាលនានា, ហើយនិងមហាវិទ្យាល័យ ។

ស្ត្រីខ្មែរដែលបានមកតាំងលំនៅ នៅក្នុងសហរដ្ឋ បានប្រឈមមុខចំពោះបញ្ហាថ្មីៗជាច្រើន ។ មានការប្រឈមមុខម្យ៉ាង គឺការឱ្យបានទទួលកិច្ចការសុខាភិបាលដ៏ត្រឹមត្រូវ ។ ការយល់ដឹង“សុខភាព” តាមរយៈចក្ខុនៃស្ត្រីខ្មែរ ហើយនិងការមានដឹងយ៉ាងណាដល់គេទាំងឡាយ នោះគឺមានសារៈសំខាន់ណាស់ ក្នុងការផ្តល់សុខាភិបាល ទៅឱ្យអង្គសហគមន៍នេះ ។ ជីវិតវិជ្ជានេះនឹងជួយដល់គិលានុបដ្ឋាក និងអ្នកវិជ្ជាជីវៈសុខាភិបាលផ្សេងៗទៀត ដើម្បីដោះស្រាយនូវបញ្ហាដ៏ពិបាកៗ និងបង្កើតឱ្យមានភាពអញ្ជូនចេញ(ភាពរស់រវើកទៅវិញទៅមក) ស្របតាមវប្បធម៌ ក្នុងការរួមសម្រាប់ខាងផ្នែកសុខាភិបាល និងការធ្វើអន្តរាគមន៍ជាមួយនឹងស្ត្រីខ្មែរ ។

ការរក្សាសុខភាពគឺជាសេចក្តីដ៏សំខាន់បំផុត ចំពោះកាយប្បសុទ្ធនៃស្ត្រីខ្មែរ។ ការដែលស្ត្រីមានសុខភាពនិងមានកាយប្បសុទ្ធ ក៏ជាការសំខាន់យ៉ាងក្រៃលែងផងដែរ ដើម្បីថែរក្សាក្រុមគ្រួសាររបស់ខ្លួន និងក្នុងការកសាងសហគមន៍ឡើងវិញ ព្រមទាំងការផ្លាស់ប្តូរនូវតម្លៃវប្បធម៌។ បញ្ហាសុខភាពណាដែលចេះតែបណ្តែតបណ្តោយ នឹងមានឥទ្ធិពលមួយលើភាពច្នៃអារម្មណ៍(ភាពស្រស់ស្អាតស្រស់ស្អាត) ចំពោះខ្លួនឯងនិងគ្រួសាររបស់ខ្លួន ហើយនៅទីបំផុត អាចនឹងទទួលបានលទ្ធផលក្នុងការខាតបង់ នូវការបរិច្ចាគផ្សេងៗដល់សហគមន៍ ។

ជីវិតវិជ្ជាហើយនិងការយល់ដឹងរបស់អ្នក គឺជាការបរិច្ចាគមានតម្លៃដ៏អស្ចារ្យ ចំពោះសង្គមភាព(ភាពយល់ឃើញច្បាស់)នៃការយល់ដឹងនូវសុខភាពរបស់ស្ត្រីខ្មែរ ។ នៅទីបំផុត ជីវិតវិជ្ជានេះនឹងជួយដល់គិលានុបដ្ឋាក និងអ្នកផ្សេងទៀត ដើម្បីផ្តល់សុខាភិបាលឱ្យបានប្រសើរ សម្រាប់ស្ត្រីខ្មែរ ។

សូមទាក់ទងនឹងមនុស្សមាននៅខាងក្រោម ប្រយោជន៍ឱ្យបានព័ត៌មានថែមទៀត និងអំពីលក្ខណៈដែលអ្នកអាចជួយ ឬចូលរួមបាន។

Olivia Catolico ពេទ្យមានអាជ្ញាប័ណ្ណ ជាកម្មវិស័យសាធារណៈក្រុមសាជីវកម្មគ្រួសារខ្មែរ ។
(Registered Nurse, Volunteer at Cambodian Family, Inc.)
909-825-7084 Extension 2564 (លេខបន្ត)

Heat Leao អ្នកអប់រំសុខភាព ក្រុមសាជីវកម្មគ្រួសារខ្មែរ (Health Educator, Cambodian Family, Inc.) ។
714-571-1975

Sundarom Rama អ្នកឱ្យដឹង ក្រុមសាជីវកម្មគ្រួសារខ្មែរ (Health Educator, Cambodian Family, Inc.) ។
714-973-7186

សូមអរគុណ

Cambodian Version Translated back to English

Public Announcement

**Understanding Health of Cambodian Women in Resettlement
Health through the Eyes of Cambodian Women**

The following community announcement will be used for Cambodian audiences: they include radio broadcast, TV channel, newspapers, social service and community agencies, churches or temples, colleges and universities, and health organizations.

Cambodian Women resettled in the United States have faced numerous new challenges. One of the challenges is finding an appropriate health care. By understanding "health" through the Eyes of Cambodian Women and the knowledge of what it means to them is important in providing health care needs to this part of community. This knowledge will assist nurses and other health care professionals and facilities in health responses to Cambodian Women.

Maintaining health is most important to the well being of Cambodian Women. The health and well being of Cambodian Women is also pivotal to preserve their families, rebuild their communities, and the conversion of cultural values. Any and all health difficulties have a great impact on their self-sufficiency, their families and eventually may cause the loss of contribution to the community.

Your knowledge and insights set a very high value to the contributions to the understanding health of Cambodian Women. In conclusion, the knowledge will help nurses and others provide better health care for Cambodian Women.

Please contact the following individuals for more information on how you can help.

Olivia Catolico, Registered Nurse, Volunteer at Cambodian Family, Inc.
At (909) 825-7084, extension 2584

Heat Leao, Health Educator, Cambodian Family, Inc.
(714) 571-1975

Sunroom Rama, Counselor, Cambodian Family, Inc.
(714) 973-7186

Thank you,

Appendix E

Appointment Reminder

English Version

Appointment Reminder

Health Perceptions of Cambodian Women in Resettlement:

**A Study Project to
Understand Health Through the Eyes of Cambodian Women**

Date: _____

Dear Mrs./Ms. (name) _____,

Please remember our appointment on (day), _____ (date), _____ (time) _____. As we agreed, we will meet for about (1) one to one and one-half hours (1½) hours at (address _____).

If you have any questions or concerns, please call any of the following people:

Olivia Catolico, Registered Nurse (909-825-7084, ext. 2564)

Heat Leao, Health Educator (714-571-1975)

Sundarom Rama, Counselor (714-973-7186)

I look forward to our discussion and your own ideas or views about the health of Cambodian women in this study project.

Sincerely,

Olivia Catolico
Volunteer, Cambodian Family

Cambodian Version

សេចក្តីវិញ្ញាបនបត្រ
 ការយល់ដឹងសុខភាពនៃស្ត្រីខ្មែរ ក្នុងការតាំងលំនៅថ្មី
 គម្រោងសិក្សាមួយ ដើម្បីឱ្យបានយល់នូវសុខភាព តាមរយៈចក្ខុនៃស្ត្រីខ្មែរ

ថ្ងៃទី: _____

គោរពមកដល់អ្នកស្រីអ្នកនាង (ឈ្មោះ) _____
 សូមនឹកចាំអំពីការណាត់ជួបរបស់យើង នៅ(ថ្ងៃ) _____ (ថ្ងៃទី) _____ (វេលាម៉ោង) _____ ដូចយើង
 បានព្រមព្រៀងនឹងគ្នាមកហើយថា យើងនឹងជួបគ្នាប្រហែលជាពីមួយ(១)ម៉ោង ទៅមួយម៉ោងកន្លះ(1½) នៅឯ
 (អាសយដ្ឋាន _____)

បើសិនជាអ្នកមានសំណួរផ្សេងៗ ឬមានកង្វល់អ្វី នោះសូមទាក់ទងនឹងមនុស្សនៅខាងក្រោមនេះ៖

Olivia Catolico ពេទ្យមានអាជ្ញាប័ណ្ណ (909-825-7084 Ext. 2564)

Heat Leao អ្នកអប់រំសុខភាព (714-571-1975)

Sundarom Rama អ្នកឱ្យដំណឹង (714-973-7186)

ខ្ញុំមានសេចក្តីសង្ឃឹមថាចំពោះការពិភាក្សារបស់យើង ហើយនិងចង់ដឹងនូវឧត្តមគតិឬមន្តស្តីរបស់អ្នកផ្ទាល់ អំពីសុខភាពនៃស្ត្រីខ្មែរ
 នៅក្នុងគម្រោងសិក្សានេះ ។

ដោយនូវការរីករាយ

Olivia Catolico

កម្មិកសមាជិក គ្រួសារខ្មែរ (Volunteer, Cambodian Family)

Cambodian Version Translated back to English

Confirmation of Appointment
Understanding Health of Cambodian in Resettlement

**A Study Project to understand Health through the Eyes
of Cambodian Women**

Date: _____

Dear Mrs./Ms. (name) _____,

Please remember our appointment on (day), _____ (date), _____ (time) _____. As we
agreed, we will meet for about (1) one to one and one-half hours (1½) hours at
(address _____).

If you have any questions or concerns, please call any of the following people:

Olivia Catolico, Registered Nurse (909-825-7084, ext. 2564)

Heat Leao, Health Educator (714-571-1975)

Sundarom Rama, Counselor (714-973-7186)

I look forward to our discussion and your own ideas or views about the health of
Cambodian women in this study project.

Sincerely,

Olivia Catolico
Volunteer, Cambodian Family

Appendix F

Backtranslation Schematic

Backtranslation and Blind Backtranslation Schematic

Appendix G
Consent Form

English Version

Consent Form**Health Perceptions of Cambodian Women in Resettlement**

This is a study about Cambodian (Khmer) women. The purpose of this study is to help others understand my personal views about health. This study will also explore my views about health since I have migrated and resettled here in the United States.

I will be interviewed at home for 1 to 1½ hours by Ms. Olivia Catolico, Registered Nurse and volunteer at Cambodian Family and Mr. Heat Leao, Translator and Health Educator at Cambodian Family. I may be interviewed a second time to explain things in more detail. A second interview may last from 30 minutes up to 1 hour. I may have a copy of the main questions in Khmer during the interview.

My participation in this study will help nurses understand how Cambodian women view health. With this understanding, nurses can provide better care suited to the health needs and culture of Cambodian women. It is important that my responses are honest and represent my own ideas.

Since this project is about my views on health, it is important that my ideas are represented accurately. To accomplish this, I am aware that Olivia Catolico will take written notes during the interview to record my ideas. If I withdraw from the study, any written notes taken during my interview will be given to me to dispose as I wish.

Any information I provide for this study is confidential. I will not be identified by name or through any information I provide in this interview. The translator who is present during the interview will keep information confidential. The translator will

also sign a consent form of confidence. Any information about this study that is published or shared with others will not identify me in any way.

My participation does not affect any program services or benefits I receive. My participation does not affect my job or my association with Cambodian Family, Inc.

I will experience no physical discomfort or risk as a study participant and there is no cost to me. I may consult with other family members or significant others before giving my permission if I believe this is necessary.

I choose to participate freely and may stop at any time without pressure or bad consequences. I may also choose not to respond to some questions.

I am aware that licensed health care professionals in are required by law to report incidents of child or elder abuse. Studies such as this one from the School of Nursing at the University of San Diego require that participants be informed of this obligation.

I will be informed of the study results. There are no other written or verbal promises, only what is stated above.

I have had an opportunity to ask questions about this study. I am satisfied with the answers and I understand the above information. If I have any questions at any time during the study, I may call Olivia Catolico at 909-825-7084, extension 2564, or 909-783-1762 (collect). If I prefer to ask my questions about this study in Khmer, I may call Mr. Heat Leao at 714- 571-1975. He will contact Olivia Catolico and ask my questions of her.

I agree to participate in interviews.

Participant Signature: _____

Date: _____

Translator Signature: _____

Date: _____

Researcher Signature: _____

Date: _____

Olivia Catolico, RN
Doctoral Candidate
School of Nursing
University of San Diego

OR:

Participant Mark: _____

Date: _____

Participant Name: _____

Date: _____

Translator/Witness Signature: _____

Date: _____

Researcher Signature: _____

Date: _____

Olivia Catolico, RN
Doctoral Candidate
School of Nursing
University of San Diego

OR:

Participant unable to sign because: _____

Authorized Signature: _____

Date: _____

Relationship to Participant: _____

Researcher Signature: _____

Date: _____

Olivia Catolico, RN
Doctoral Candidate
School of Nursing
University of San Diego

Cambodian Version

ក្រដាសបំពេញកិច្ចការសម្រាប់
ការយល់ដឹងសុខភាពនៃស្ត្រីខ្មែរ ក្នុងការតាំងលំនៅថ្មី

ខ្ញុំត្រូវបានគេប្រាប់ឱ្យដឹងថាខាងស្រី Olivia Catolico ជាបេក្ខជនម្នាក់ នៅសាកលវិទ្យាល័យសានទីអេហ្វូ កំពុងតែធ្វើការសិក្សាស្រាវជ្រាវមួយ ស្តីអំពីស្ត្រីខ្មែរ ។ គោលបំណងនៃការសិក្សានេះ គឺដើម្បីជួយអ្នកដទៃទៀតឱ្យបានយល់នូវទស្សនៈផ្ទាល់របស់ខ្ញុំអំពីសុខភាព ។ ការសិក្សានេះក៏នឹងស្ទង់នូវទស្សនៈរបស់ខ្ញុំ អំពីសុខភាព ចាប់ពីការដឹងពីខ្លួនផ្ទាល់លំនៅ និងបានមកតាំងលំនៅនៅក្នុងសហរដ្ឋអាមេរិក ។

ខ្ញុំនឹងបានសម្ភាសដោយខាងស្រី Olivia Catolico ជាពេទ្យមានអាជ្ញាប័ណ្ណ និងជាកម្មករសមាជិក(អ្នកស្ម័គ្រចិត្ត)ម្នាក់ នៃក្រុមសាធិវត្សស្រាវជ្រាវខ្មែរ ហើយនិងលោក Heat Leao ជាអ្នកបកប្រែ ព្រមទាំងអ្នកអប់រំសុខភាព នៃក្រុមសាធិវត្សស្រាវជ្រាវខ្មែរ នៅឯផ្ទះខ្ញុំចំនួន១ម៉ោងទៅ១ម៉ោងកន្លះ ។ ខ្ញុំយល់ថា ខ្ញុំអាចជ្រើសរើសនឹងមួយ ក្រៅពីផ្ទះរបស់ខ្ញុំ ដើម្បីធ្វើសម្ភាសនេះ ។ ខ្ញុំក៏យល់ដែរថា ភាពព្រមព្រៀងគ្នាទាំងសងខាង ស្តីពីពេលវេលាដែលងាយស្រួល នឹងបានរៀបចំឡើងសម្រាប់ការសម្ភាសនេះ ទោះបីជានៅនឹងផ្ទះរបស់ខ្ញុំ ឬក៏នៅទីក្រៅពីផ្ទះរបស់ខ្ញុំក្តី ។ ខ្ញុំអាចនឹងបានសម្ភាសជាលើកទីពីរ ដើម្បីពន្យល់សេចក្តីឱ្យបានក្បោះក្បាយថែមទៀត ។ ការសម្ភាសន៍លើកទីពីរ អាចនឹងមានរយៈពេលពី៣០នាទី រហូតដល់ទៅ១ម៉ោង ។ ខ្ញុំអាចនឹងមានសន្និដ្ឋានក្រដាស នៃប្រធានសំណួរមួយ ជាភាសាខ្មែរ នាក់ម្នាក់ពេលធ្វើសម្ភាស ។

ការចូលរួមរបស់ខ្ញុំក្នុងការសិក្សានេះ នឹងជួយដល់ពួកគេឱ្យបានយល់នូវលក្ខណៈ ដែលស្ត្រីខ្មែរមានទស្សនៈយ៉ាងណា អំពីសុខភាព ។ តាមរយៈការយល់ដឹងនូវរឿងនេះ នោះពួកគេឱ្យអាចផ្តល់ការថែរក្សាយ៉ាងប្រពៃ សមស្របសេចក្តីត្រូវការសុខភាពហើយនិងវប្បធម៌នៃស្ត្រីខ្មែរ ។ វាជាការសំខាន់ណាស់ ដែលសេចក្តីឆ្លើយតបរបស់ខ្ញុំ បានដំណាងនៃគំនិតរបស់ខ្ញុំផ្ទាល់ ។

ដោយព្រោះគោលការណ៍នេះ ស្ត្រីអំពីទស្សនៈរបស់ខ្ញុំ មានទៅលើសុខភាព នោះវាមានសារៈសំខាន់ណាស់ដែលថា គំនិតរបស់ខ្ញុំត្រូវបានដំណាងយ៉ាងត្រឹមត្រូវ ។ ដើម្បីឱ្យបានសម្រេចការនេះ ខ្ញុំជ្រាបថា ខាងស្រី Olivia Catolico នឹងកត់ហេតុការណ៍ នៅនាក់ម្នាក់ពេលសម្ភាសន៍ ដើម្បីកត់នូវគំនិតរបស់ខ្ញុំ ។ បើសិនជាខ្ញុំដកខ្លួនចេញពីការសិក្សានេះ នោះកំណត់ហេតុផ្សេងៗដែលបានកត់នាក់ម្នាក់ពេលសម្ភាសន៍របស់ខ្ញុំ នឹងបានឱ្យមកខ្ចីវិញ ដើម្បីបំភ្លឺចោលតាមការខ្ញុំប្រាថ្នា ។

ព័ត៌មានអ្វីមួយដែលខ្ញុំផ្តល់សម្រាប់ការសិក្សានេះ គឺជាការសម្ងាត់ ។ ខ្ញុំនឹងមិនត្រូវបានបញ្ចេញដោយចំណេះ ឬតាមរយៈព័ត៌មានណាមួយ ដែលខ្ញុំផ្តល់នៅក្នុងសេចក្តីសម្ភាសន៍នេះឡើយ ។ រីឯអ្នកបកប្រែ ដែលមានមុខនៅក្នុងកំឡុងពេលសម្ភាសន៍ នឹងរក្សាសម្ងាត់ដល់ព័ត៌មានជានិច្ច ។ អ្នកបកប្រែក៏នឹងចុះហត្ថលេខា លើកិច្ចព្រមព្រៀងលាក់ការណ៍មួយច្បាប់ផងដែរ ។ ព័ត៌មានអ្វីៗស្តីពីការសិក្សានេះ ដែលបានបោះពុម្ព ឬបានចែកចាយជាមួយអ្នកដទៃ នឹងមិនបានបញ្ចេញឈ្មោះខ្ញុំ នៅក្នុងបក្សាណាមួយឡើយ ។

ការចូលរួមរបស់ខ្ញុំ មិនប៉ះពាល់ដល់កិច្ចការកម្មវិធី ឬអត្ថប្រយោជន៍(កម្រៃ)អ្វីមួយ ដែលខ្ញុំទទួលបានឡើយ ។ ការចូលរួមរបស់ខ្ញុំ មិនប៉ះពាល់ដល់ការងាររបស់ខ្ញុំ ឬសមាគមរបស់ខ្ញុំ ជាមួយនឹងក្រុមស្រាវជ្រាវខ្មែរឡើយ ។

ក្នុងឋានៈជាអ្នកចូលរួមសិក្សាម្នាក់ ខ្ញុំនឹងមិនជួបប្រទះនូវភាពភ័យខ្លាចស្រួលរួបរួម ឬការគ្រោះថ្នាក់អ្វីឡើយ ហើយក៏មិនអស់ថ្លៃចំពោះខ្ញុំផង ។ បើសិនជាមានបញ្ហាសុខភាពអ្វីមួយ បានផុសឡើងនៅនាក់ម្នាក់ពេលសម្ភាសន៍ នោះខ្ញុំនឹងបានបញ្ជូនឱ្យទៅប្រភពមួយដ៏យ៉ាងត្រឹមត្រូវ ។ ខ្ញុំអាចពិគ្រោះជាមួយនឹងសមាជិកស្រាវជ្រាវផ្សេងទៀត ឬក៏ជាមួយនឹងអ្នកសំខាន់ៗផ្សេងទៀត មុននឹងមានការឱ្យសេចក្តីអនុញ្ញាតរបស់ខ្ញុំ បើសិនខ្ញុំជឿថាការនេះជាសេចក្តីចាំបាច់ ។

ខ្ញុំសម្រេចចិត្តចូលរួមដោយសេរី ហើយអាចនឹងឈប់នៅពេលណាក៏បាន ដោយគ្មានការបង្ខិតបង្ខំ ឬក៏មានលទ្ធផលអាក្រក់អ្វី
សោះឡើយ ។ ខ្ញុំក៏អាចនឹងសម្រេចចិត្ត មិនឆ្លើយនូវសំណួរខ្លះ ឬសំណួរអ្វីមួយ បានផងដែរ ។

ខ្ញុំជ្រាបថា អ្នកវិជ្ជាជីវៈថែរក្សាសុខភាពមានអាជ្ញាប័ណ្ណ ត្រូវបានតម្រូវដោយច្បាប់ ដើម្បីរាយការណ៍សេចក្តីបានមន្ទិលសង្ស័យ
នូវភាពគ្រោះថ្នាក់នៃកុមារម្នាក់ ឬការរំលោភជនជរា ឬក៏ស្ថានភាពផ្សេងៗ ដែលមនុស្សម្នាក់ស្ថិតនៅក្នុងភាពគ្រោះថ្នាក់មួយ ដោយ
គេចមិនផុត មានចំពោះខ្លួនផ្ទាល់ ឬក៏ដល់អ្នកដទៃទៀត ។ ពាក្យ“រំលោភ” មានន័យថា មនុស្សម្នាក់ត្រូវបានគេធ្វើទុក្ខទោស(ប្រ
ព្រឹត្តល្មើសលើ) ។ បើសិនជាខ្ញុំបានសង្ស័យថា មានស្ថានភាពមួយជាប់ទាក់ទងនឹងការរំលោភឬការធ្វើទុក្ខទោស នោះខ្ញុំនឹងត្រូវ
បានបញ្ជូនទៅប្រភពដ៏ត្រឹមត្រូវមួយ ។ ការសិក្សាបែបនេះ ចេញពីគំនិតបង្កើនសាលា នៅសាកលវិទ្យាល័យសានឌីអេហ្គូ
កម្រៅឱ្យអ្នកចូលរួមបានជំរាប នូវកាតព្វកិច្ចនេះ ។

ខ្ញុំនឹងបានជំរាបនូវលទ្ធផលនៃការសិក្សានេះ ។ គ្មានសេចក្តីសន្យា ជាលាយលក្ខណ៍អក្សរដោយផ្ទាល់មាត់អ្វី ក្រៅពីនេះឡើយ គឺ
មានតែអ្វីៗដែលបានថ្លែងនៅខាងលើតែប៉ុណ្ណោះ ។

ខ្ញុំបានមានឱកាសមួយដើម្បីសួរសំណួរ អំពីការសិក្សានេះ ។ ខ្ញុំបានឆ្លើយតបនឹងចម្លើយនានា ហើយខ្ញុំក៏បានយល់ដល់ព័ត៌មាន
នៅខាងអន្លើផង ។ បើសិនជាខ្ញុំមានសំណួរអ្វី នៅត្រាណាមួយ នាក់ឡុងដោនការសិក្សានេះ ខ្ញុំអាចទាក់ទងនឹង Olivia Catolico
តាមទូរស័ព្ទលេខ 909-825-7084 លេខបន្ត 2564 ឬ 909-783-1762 (ម្ខាងទៀតចេញថ្ងៃឡូ) ឬក៏ 1-800-873-9865 (លេខពត
តិតថ្ងៃ) ។ បើសិនជាខ្ញុំចង់សួរសំណួរអំពីការសិក្សានេះ ជាភាសាខ្មែរ នោះខ្ញុំអាចទាក់ទងនឹងលោក ឡេ-ហៀត(Heat Leao) តាម
លេខ 714-571-1975 ។ លោកឡេ-ហៀត នឹងទាក់ទងទៅ Olivia Catolico ហើយសួរទៅនាង នូវសំណួរដែលខ្ញុំមាន ។

ខ្ញុំយល់ព្រមដើម្បីចូលរួមក្នុងការសិក្សានេះ ដូចបានពណ៌នាស្រាប់ ។

ហត្ថលេខាអ្នកចូលរួម : _____ ថ្ងៃខែ : _____
ហត្ថលេខាអ្នកបកប្រែ : _____ ថ្ងៃខែ : _____
ហត្ថលេខាអ្នកស្រាវជ្រាវ : _____ ថ្ងៃខែ : _____

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University of San Diego (សាកលវិទ្យាល័យសានឌីអេហ្គូ)

ឬ :
គំនូសអ្នកចូលរួម : _____ ថ្ងៃខែ : _____
ឈ្មោះអ្នកចូលរួម : _____ ថ្ងៃខែ : _____
ហត្ថលេខាអ្នកបកប្រែ អ្នកសាក្សី : _____ ថ្ងៃខែ : _____
ហត្ថលេខាអ្នកស្រាវជ្រាវ : _____ ថ្ងៃខែ : _____

Olivia Catolico, RN (ពេទ្យមានអាជ្ញាប័ណ្ណ)
Doctoral Candidate (បច្ចុប្បន្ន)
School of Nursing (គីលានុបដ្ឋានសាលា)
University of San Diego (សាកលវិទ្យាល័យសានឌីអេហ្គូ)

អ្នកចូលរួមមិនអាចចុះហត្ថលេខាបាន ដោយព្រោះ : _____

សិទ្ធិមន្តហត្ថលេខា : _____ ថ្ងៃខែ : _____

ចំនាក់ចំនងនឹងអ្នកចូលរួម : _____

ហត្ថលេខាអ្នកស្រាយជ្រាវ : _____ ថ្ងៃខែ : _____

Olivia Católico, RN (លេខមានអាជ្ញាប័ណ្ណ)

Doctoral Candidate (បេក្ខជន)

School of Nursing (គិលានុបដ្ឋានសាលា)

University of San Diego (សាកលវិទ្យាល័យសានឌីអេហ្គូ)

Cambodian Version Translated back to English

Consent Form

Understanding Health of Cambodian Women in the New World

I was informed that Ms. Olivia Catolico, Registered Nurse of University of San Diego is in the process of doing research regarding Cambodian Women. The purpose of this study is to help others understand my prospect about health. This study will also research my views since the time I was relocated and resettled in the United States of America.

I will be interviewed with Ms. Olivia Catolico, Registered Nurse and Volunteer at Cambodian Family together with Mr. Seang Lim, Translator and Health Educator at Cambodian Family. The interview will take place at my home or any place chosen by me outside of my home that is agreeable to all parties involved. I understand that I may be interviewed a second time to explain this in more detail. A second interview will last any time between 30 minutes up to 1 hour. I will have a copy of the leading questions in Khmer during the interview.

My association in this study will help nurses understand how Cambodian Women view health. With this knowledge and understanding, nurse can provide better health care suitable upon the need and culture of Cambodian Women. It is important that my answers are sincere and represent my own ideas.

Since this proposal is about my views on health, it is essential that my ideas be represented correctly. To achieve this, I am aware that Ms. Olivia Catolico will be taking notes during the process of the interview to record my ideas and responses. If I

withdraw from the study, any and all written document taken during the interview will be given to me to dispose as I wish.

Any information I provide for this study will be confidential. I will not be identified by name or through any information I provide in this interview. The translator, present during the interview will keep information confidential. The translator will also sign a confidentiality agreement. Any information distributed or shared with others will not identify me in any way.

My participation does not affect or change any program services or benefits I receive. My participation does not affect my job or my association with Cambodian Family, Inc.

My involvement in this study will not encounter any bodily discomfort or danger as study participant; in addition, there is no cost to me. If there is any health problems or concerns appear during the process of the interviews, I will be referred to an appropriate resource. I may discuss with other family members or significant others before giving consent if I feel this necessary.

I decided to participate freely and can stop at any time without pressure or bad consequences. I can also choose to disregard or omit any questions.

I am aware that it is required by law that health care professional to report any and all suspected incidents of child or elder abuse or situations in which a person clearly poses as dangerous to self or others. "Abuse" means that a person has been harmed. If a situation of abusive or harmful has been suspected, I will be referred to an appropriate resource. Studies such, as this from the School of Nursing at the University of San Diego is necessary that participants be advised of this obligation.

I will be informed of the outcome of the study. There are no additional written or verbal promises, other than what has stated above.

I have the opportunity to ask questions regarding this study. I am satisfied with the answers and understand the information provided above. If I have any questions at any time during the process of the study, I am welcome to call Ms. Olivia Catolico at (909) 825-7084, extension 2564, or at (909) 783-1762 (collect) or 1-(800) 873-9865 (toll free). I prefer to ask questions concerning this study in Khmer, I may call Mr. Seang Lim at (714) 1975. He will contact Ms. Olivia Catolico inquiring about my concerns.

I agree to participate in study as described.

Participant Signature: _____ Date: _____

Translator Signature: _____ Date: _____

Researcher Signature: _____ Date: _____

Olivia Catolico, RN
 Doctoral Candidate
 School of Nursing
 University of San Diego

OR:

Participant Mark: _____ Date: _____

Participant Name: _____ Date: _____

Translator/Witness Signature: _____ Date: _____

Researcher Signature: _____ Date: _____

Olivia Catolico, RN
 Doctoral Candidate
 School of Nursing
 University of San Diego

Appendix H
IRB Approval

University of San Diego

Committee on the Protection of Human Subjects

Name

4/20/99

Date

Dear Researcher/Faculty Advisor:

Enclosed is a copy of your proposal approved by the Committee for Protection of Human Subjects. This research project is approved for a period of one year. At the conclusion of the research, the researcher must complete a brief summary report. (Please see CPHS policy in the Faculty/ Administrators Handbook.) A copy of the summary report form is enclosed.

If you continue your research beyond the one-year approval period, you must submit this report along with Forms A and, for expedited reviews, Form B. Please note that you must submit this request one to two months before the anniversary date of the original approval so that we can renew our approval before it expires.

We will send you a letter during the tenth month of your research project approval period requesting your summary report or continuation approval request.

Also enclosed is a Change of Address form you may use to keep us informed of changes in the address of either the researcher or the faculty advisor.

We appreciate your cooperation in these matters. Thank you.

Sincerely,

Gary Schneider, Chair
Committee for Protection of Human Subjects

5998 Alcalá Park, San Diego, California 92110-2492 619/260-4553

Appendix I

Analysis Matrix

Analysis Matrix

Setting & Context	Demographic Variables	Time Perception	Informant Perspectives	Relationships	Social Structure	Strategies	Consequence

Open Coding

	Categories											
	Subcategory			Subcategory			Subcategory			Subcategory		
Interview												
Interview 1												
Interview 2												
Interview 3												
Interview 4												
Interview 5...												

Axial Coding*

	Category											
	Subcategory			Subcategory			Subcategory			Subcategory...		
Labels	Label 1	Label 2	Label 3...									
Interview 1												
Interview 2												
Interview 3												
Interview 4												
Interview 5...												

*dimensional levels--conditions, context, action/interaction, consequences

Selective Coding/Domain Analysis

Included Terms	Semantic Relationship*	Cover Term
1.		
2.		
3.	—————→	—————
4.		
5....		

*strict inclusion, spatial, cause-effect, rationale, location for action, function, means-end, sequence, attribution.

Appendix J

Copyright Clearance

Order Confirmation

Republication Licensing Service

Copyright Clearance Center

Account Name: OLIVIA CATOLICO **Account Number:** 2000182759**Order Number:** 1223782 **Order Date:** 9/17/2004**Date to be Published:** 02/15/2005 **Est. Invoice Date:** 11/16/2004**Document Reference:** 9-17-04**Title:** SEEKING LIFE BALANCE: THE PERCEPTIONS OF HEALTH OF CAMBODIAN
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